Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Setting the Direction

Primary & Community Services Strategic Delivery Programme

ISBN 978 0 7504 xxxx x

CMK-22-xx-xxx(xxxx)
E6800910

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Acknowledgements

I would like to take this opportunity to formally put on record my thanks to all members of the Steering Group that have supported the development of this strategic framework so far. I would also like to thank all of the people and organisations who have engaged in this work to date - your welcome enthusiasm, ideas and feedback have made our task all the more productive!

I believe that together we have achieved a lot in a very short period of time but equally recognise that this is only the start of the journey. Whilst we have clearly set the direction, there is still a long way to go before we have a health service in Wales that truly delivers the right care to the right person at the right time in the right place by the right staff.

The challenge now is for all of us to embrace the opportunity that the current NHS reforms offer to deliver the paradigm shift towards community-based care, where safe and appropriate to do so. I know that I can rely on the Steering Group members to continue to champion this goal and support the new Local Health Boards (LHBs) and their partners in the pursuit of excellence!

Dr C D V Jones CBE

Foreword

It gives me great pleasure to provide the Foreword to *'Setting the Direction: Primary & Community Services Strategic Delivery Programme'* written by Dr Chris Jones and colleagues.

The vast majority of health and care needs are met in local communities by primary care and community services. We all want our care to be local, convenient, and of consistently high quality. We want to be looked after by practitioners whose goals are to help us live healthy lives and to support us when we need it.

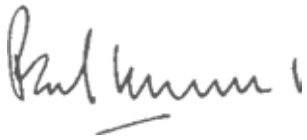
At the heart of the new NHS are LHB's which are responsible for the health of their populations. For the first time, a single organisation will plan and deliver all the health services in an area. We now have a real opportunity to build on the strengths of primary and community services, and to realise our ambition to create a truly integrated health service in Wales.

Strong partnerships across the public and not for profit sectors are essential if we are to build the network of care required to meet the needs of our most vulnerable citizens. A central tenet of the vision set out by Dr Jones is the imperative to tailor services to meet individual needs, always with the aim of supporting people to remain independent.

The work undertaken during preparation of this report has identified a wealth of ideas and best practice across Wales. The concept of integrated services designed to meet individual needs is our vision for the future.

Dr Jones and his colleagues have produced a compelling report, and have set a clear direction for NHS Wales and its partners. The challenge now is to build on the momentum generated over the last few months, and to work together to deliver integrated care for the citizens of Wales.

To quote the title of the presentation to the Welsh NHS Confederation Conference on 12 November 2009 at which Dr Jones launched the report, **"Lets get on with it!"**



Paul Williams OBE OStJ DL
Director General, Health & Social Services
Chief Executive, NHS Wales

Introduction

The key purpose of this document is to set out a framework aimed at assisting LHBs in the development and delivery of improved primary care and community based services for their local populations; particularly for those individuals who are frail, vulnerable and who have complex care needs.

We must aim to deliver community-based services across Wales that are reliable and accessible irrespective of where people live. Services must be specifically designed to enable individuals to improve their lives; to enable them to maintain their independence as long as possible, and to support them as they become frail and vulnerable to remain safely in their home. At the same time, carers need to have confidence in the services that are required.

The NHS, together with all other public service providers, will need to improve efficiency and redesign services to meet the demographic demands of the future in a financially challenging environment. It is clear to everyone that the status quo is not an option. This vision for primary and community services has at its heart improved outcomes for the citizen, more effective and efficient ways of working within the NHS and with partners including the voluntary sector, carers, and most importantly the patient.

Building on services already evidenced in Wales, key elements of the vision identify the need for:

- Citizens to develop confidence in their ability to manage their own health through improved information, knowledge and self care.
- Close alignment of health and social care in a system that delivers preventative, pre-emptive, reactive and rehabilitative care focused around the needs of the individual;
- The principles of public health to be firmly embedded in service planning and design.
- The development of services that are characterised by excellence in communication, information, integration and organisation, and available 24 hours a day.
- Systems and processes that guide people through services, where individual elements of care are joined-up and easily navigated;
- Sharing high quality information appropriately to inform decision-making;
- Effectively managed interface between ***in-hours*** and ***out-of-hours*** services so that governance and accountability for care is clearly defined and understood. This must include 24 hour access to scheduling services;
- Strong clinical leadership at locality level supporting local engagement and understanding;
- Flexible working across professions and organisations to ensure that skills are utilised to maximum effect and that services meet the need of the citizen.

It is not unreasonable to suggest that the success of the current NHS reforms will be measured against our ability to deliver on this agenda. There is a clear expectation that public services as a whole need to work together and more cohesively if we are to be effective. As key leaders and influencers within our communities and organisations, a unique opportunity now exists to demonstrate that we can rise to this challenge.

LHBs will need to work with their partners to ensure that the workforce is engaged in the change process; patients and the public believe that the NHS is responding to their needs; and that the policy requirements of the Welsh Assembly Government (WAG) are delivered.

However, this is not just an agenda for the NHS in Wales. Success will be dependent upon the contribution of Local Authorities (LAs), Voluntary Sector Partners and Independent Sectors all working together to deliver safe, sustainable and affordable services for the citizen. The role of Local Service Boards (LSBs) in providing community leadership to this process cannot be underestimated.

It is also important that Public Health Wales and the Directors of Public Health within the LHBs are fully engaged in the redesign of services. This will ensure that we build an evidence base focussed around population need which informs effective change management.

In this document we set out the vision for the future and also outline a number of key issues that will need to be considered in designing structures and services for the future **(Appendix 1)**. This is deliberately not prescriptive, as we need to enable local solutions to be developed according to local need. I very much hope that you find this document informative and helpful as you move forward.

This document is the first step in a process that will initiate the changes necessary to realise the strategic intention to deliver the rebalancing of care between acute hospital and community settings, placing the preventative primary and community agenda at the centre of service redesign in Wales

A desk-top exercise has been undertaken in six of the LHB's, with representation from all stakeholder groups, to test the model against existing services and identifying the feasibility of moving towards the new system of working. These exercises have involved more than 600 participants and have served to confirm that the vision as described is consistent with current policy direction. The overwhelming impression gleaned from the exercises was one of enthusiasm and a generally positive endorsement for the proposed model and its components, whilst recognising the specific needs within localities and communities that will merit further attention and consideration through implementation.

The Policy direction has been set; the various enabling strategies have been agreed; the organisational boundaries between in-hospital and out-of-hospital health services have been removed; the challenge now is for us to deliver on the change agenda!

Creating the Vision

Context

Creating world-class health services in Wales requires the transformation of primary and community services. This means whole-system change across the health and social care policy framework, creating organisational structures and service delivery models, which establish the best possible conditions for patients, carers and NHS staff in a high quality system.

The policy building blocks are already in place. *'A Question of Balance', 'The Wanless Review', 'Designed for Life', 'One Wales'* and the *recent NHS reforms* all point towards strengthening primary and community services and reducing the pressures on acute hospitals. The *'Chronic Conditions Management Framework'* seeks to shift the focus towards active management of high risk groups; the Annual Operating Framework identifies specific targets to improve referral management, delayed transfers of care, and other key efficiency measures; the capital planning processes are beginning to create an infrastructure which aligns primary and secondary care needs and supports the delivery of holistic models of care; and the commissioning of training is beginning to reflect demands for new roles in the community.

The creation of the seven LHBs in October 2009 has brought primary, community and secondary care services together within a unified organisational structure. This must enable integrated planning, holistic service provision and effective transfer of resources to facilitate new ways of working and service delivery. The need for effective and visible clinical leadership to focus professional ownership also needs to be seen as a key issue by the new LHBs. The roles and responsibilities of the LHB Vice-Chair, Directors of Public Health and Directors of Primary, Community and Mental Health Services will be key components in ensuring a clear focus on the needs of the population for "out-of-hospital" services.

Although there are examples of good practice in the delivery of primary and community services within Wales, there is limited evidence of whole-system changes that are delivering significant shifts in the overall models of care, and associated resource and staffing flows. Without this, the agenda will continue to be dominated by the acute hospital. It is also apparent that no single vision for the way in which sustainable services could be delivered in the future - across rural, urban and city environments - has been developed. In the absence of a clear strategic framework, change continues to be small scale and piecemeal and existing service tensions remain.

It is therefore imperative that the Primary and Community Services Strategic Delivery Programme is built upon a clear vision that makes the connections between government policies, national strategies and evidence based service improvement plans. This is a key reference point underpinning service transformation and as such must be simple, reflect world-wide best practice and relate to the challenges and opportunities facing NHS Wales in the next 5 - 10 years.

By bringing together all of these components we seek to reassure and build confidence across Wales that the health and social care services will meet current and future needs of the population.

Issues and Problems with the Current System

A major weakness in the present system is that the interface between local services provided by GPs and acute hospital services, comprises a patchwork of service provision, the access and quality of which is highly dependent on where people live. This means that GPs often struggle to find the appropriate service configuration for patients whose complex needs extend beyond the role of primary care. In these

circumstances they may decide to manage the patients within their own homes or send them to hospital, with considerable variation in decisions made and often inappropriate and sub-optimal outcomes achieved. Hospital services are likely to be too focused on more complex problems, and may be too stretched to adequately deal with such patients. Service fragmentation and lack of co-ordination between out-of-hospital agencies means that the management of patients and care provided is not always as the result of a coherent and effective care pathway, with a focus on the whole patient journey. The rationale for a co-ordinated, coherent, available and accessible array of continuing care and intermediate care services is clearly evident. Such services would include rapid response, enablement, rehabilitation, admission avoidance and accelerated discharge services for all who need such an approach. However, the reality is that they are not in place and are not likely to be in the near future. A review of the present situation suggests that there are a number of interlocking problems:

- There is no coherent planning, management and governance model across the health and social care system. Each component part is overly focused on managing its own concerns with insufficient joint solutions to common challenges. This is reinforced by:
  - Health and social care agencies trying to tackle too many unrelated targets, which cause tensions within and between organisations;
  - Budgeting arrangements that focus organisations on their own internal needs rather than dealing with the problems of the populations they serve;
  - The creation of care pathways tend to be fragmented and medically orientated based around single diseases. This results in little focus on the whole patient journey, and does not recognise social care needs are primarily determined by function, not by disease;
  - The current system of out-of-hours services and its relationship within 'mainstream' primary care services is at best disjointed and generally lacks cohesion and co-ordination; NHS Direct appears to have had little impact in deflecting demand from primary care services and in some cases has intensified pressures on GP services;
  - Nursing professionals working within the community are at risk of professional isolation;
  - Organising community support for patients at home has become so complicated that it is often easier to admit to hospital to ensure that comprehensive assessments are undertaken.
- Capacity across the system is not well developed, for instance:
  - The degree of variation in the provision of community services is so great that people are admitted to and kept in hospital when this could otherwise be avoided;

- Changes in practice have reduced the exposure of GPs (both experienced and new) to acute care in the community resulting in a widening skills gap eg. managing Community Hospital beds, minor injuries;
- GPs who would prefer community-based solutions are unable to identify and access appropriate care provision and are 'forced' to send people on to hospital;
- The absence of shared leadership by front line professionals in all agencies;
- The independent and voluntary sectors often have to act as intermediaries and 'back stop' for services across the care spectrum, especially end of life management, but, in some cases, they lack adequate professional and financial resources;
- Paramedics are not sufficiently empowered to make clinical decisions on assessment, that a patient can safely remain at home;
- Lack of 24-hour access to supporting services (e.g. District Nursing) together with poor information and communication means there is inconsistency between decision making in core-hours and the out-of-hours period.

- In consequence separate parts of the system operate independently:
  - Interventions in the community are often focused on crisis management rather than preventative support;
  - The opportunities presented by the GMS contract to create capacity in the right place for patients have yet to be fully utilised;
  - Doctors in Acute Assessment Units/A&E Departments are often very reluctant to discharge patients because they are concerned by the lack of transparency or existence of community services;
  - In-hospital care of complex patients can become over complicated and is overly "OLOGY" or specialist focused;
  - A&E departments are often used as places of safety when care cannot be sustained in the community, as opposed to its appropriate use in the assessment and treatment of complex acute illness or injury;
  - Organisations and professionals are often reluctant to share information and poor communication between organisations is clearly evident;
  - Unhelpful boundaries that exist between organisations and professional groups. There have been limited attempts to instigate common joint workforce planning across health and social care;
  - There is an absence of agreed population bases on which to effectively organise services or effectively engage with service users and citizens;
  - The financial and budgetary systems do not easily facilitate joint-working across sectors.

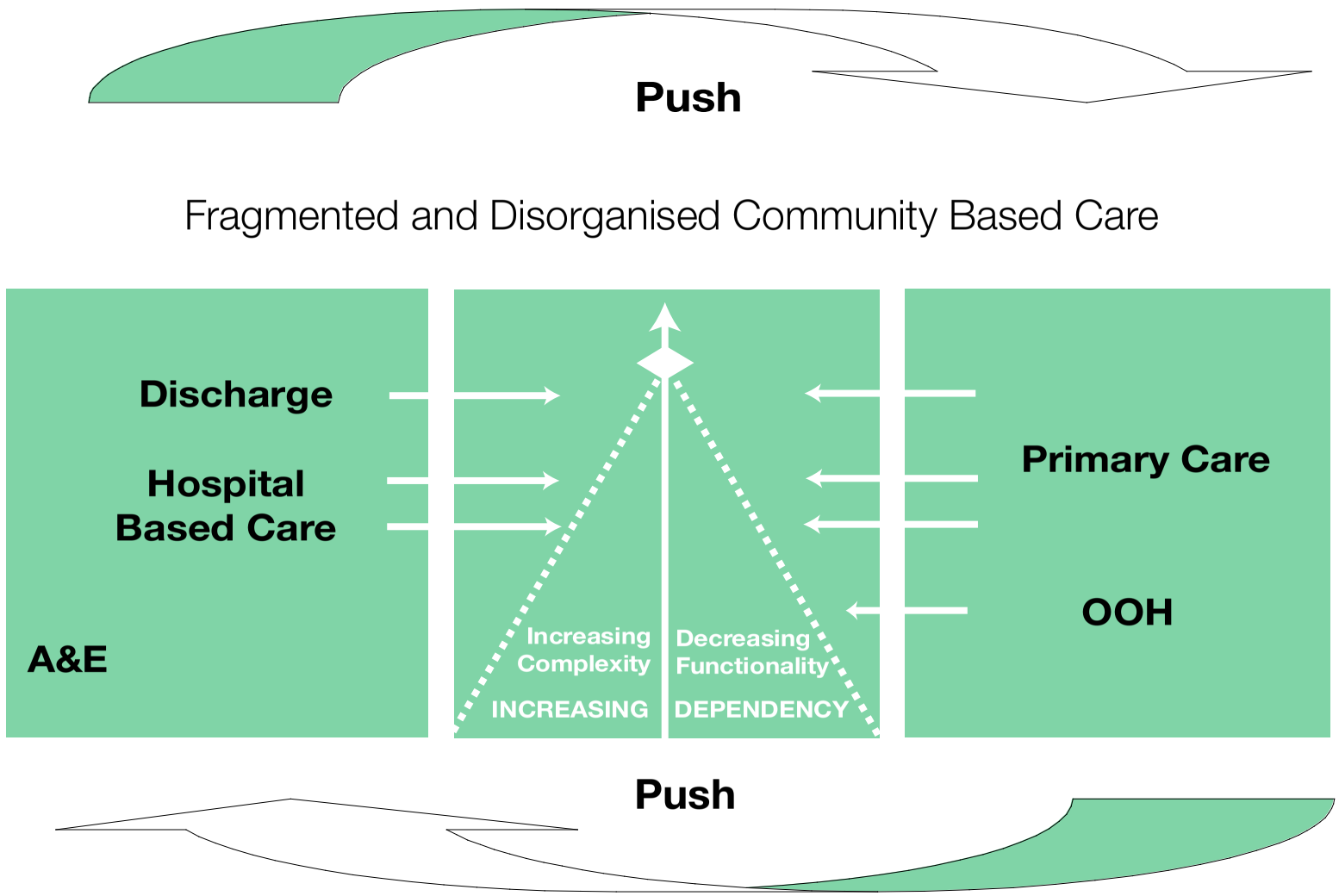
- The system is out of balance and this causes real problems, examples include:
  - A service-target and evidence-base that has a predominantly hospital-care focus;
  - A health system that has, historically, gravitated services and patients towards hospitals, thus restricting the sustainability and effectiveness of community based services;
  - The number of emergency admissions to hospitals across Wales which remains excessive, with potentially damaging consequences in relation to the management of elective procedures;
  - Bed pressures created by delayed transfers of care and increased admissions result in some patients being discharged too quickly, often resulting in repeat admissions and incomplete episodes of care;
  - Hospital discharge is a source of conflict, rather than an opportunity for partnership, with hospitals desperate to free beds for those on waiting lists. Social services departments unable to offer appropriate care packages because of staff shortages. The apparent lack of appropriate community facilities and nursing home beds;
  - Too many people are in the wrong place in the care system, and in locations where their health is unlikely to improve and, in some cases potentially deteriorate.

In summary, the current system is characterised by:

- Fragmented and disorganised out-of-hospital care, making navigation difficult for the citizen and professional alike;
- Inaccessible records resulting in limited exchange of information between different parts of the system;
- There is no robust and consistent governance framework, making it difficult to establish clear lines of accountability;
- Service availability and quality highly dependent on location of residence.

Figure 1 shows the current system of care which is based on patients 'sticking' at various points in the system and being 'pushed' in and out of hospital. It means that people are often not treated in the right place for their particular needs; their care is not as good as it should be and professional skills are not used to their optimal effect. Because community-based services are perceived as not being good, people feel the need to place great store on defending the buildings where they have received services in the past, even if these are no longer the most appropriate and effective location. Any revised vision for primary and community services will need to address the above issues and facilitate the move towards a whole-system approach to health and social care within Wales.

Figure 1: Current System of Care "Push System full of Black Holes"



The gaps in provision and barriers to integration are created by:

Care which is fragmented

Records which are not integrated

Governance which is fractured

Capacity which is variable

Expertise which is variable and diminishing

The Proposed System for Primary and Community Care Services

Key Assumptions

There are a number of key assumptions underpinning this vision:

- There are no significant new monies to invest in the delivery of new primary and community services;
- Leadership and management will need to demonstrate the capacity to deliver whole-system transformation;
- Clinical leadership and NHS team ethos will need to be reinvigorated;
- The LHBs will need to work to a common framework for engagement and design but local delivery models will be tailored to local need;
- Out of hospital services will need to be easily recognised and become respected for accessibility, reliability and quality.

Success will be dependent upon strong engagement of communities and professionals from all agencies in the development and provision of these services. However, if Wales truly aspires to a world-class, citizen-focused system that provides the right treatment and care to the right patient at the right time in the right place by the right person in the right way, the deficiencies of the current system - identified earlier - need to be addressed.

Creating a Pull System

The proposed system of care will deliver an easily recognisable, highly organised model of integrated community services that will act as a bridge between primary care and the acute hospital. Services will be focused on the holistic needs of the citizen and delivered by the NHS, LA's and other partner agencies working together.

The approach will change from reactive crisis management to a proactive, co-ordinated and preventative agenda, with a particular focus on high risk patient groups and those with increasing frailty. Such services will enable an increasing number of people to be managed effectively in their communities and localities, avoiding unnecessary and often debilitating hospital admissions.

This system would replace the current "push" hospital-discharge model with one that **actively pulls patients** towards high quality organised services closer to home.

Organisational Arrangements

It is evident that care sector organisations deliver services to differing population bases, so "macro-level" co-ordination between organisations is crucial. While the new LHBs cover much larger population bases, the local authority level partnerships (including LSBs, Health Social Care & Wellbeing (HSCWB), Children and Young People, local children safeguarding boards, Community Safety Partnerships, Protection of Vulnerable Adults) provide effective leadership vehicles for care and wellbeing services and are the bridge between LHBs and LAs. Although "community localities" will form the core structural building block of the new community services, the LA level partnerships will continue to provide strategic leadership and agree, for example, financial models and budgetary arrangements. It will also be essential, that issues relating to inter-organisational workforce planning are given appropriate priority in order to provide the trained and skilled workforce necessary to deliver the new community based health and social care services model.

Locality Working

LHB management structures will need to reflect the proposed system which is predicated on the co-ordination of services on the basis of "localities". Although having indicative populations of circa 30,000 - 50,000, the crucial concepts relating to localities are that:

- Their boundaries are agreed between health and social care sectors, and be meaningful in terms of geography, natural communities and functions such as patient flows;
- Their focus is primarily on the patient and service user (and relevant agent/ advocate) rather than on professionals and organisations;
- They are of a population size which enables effective and efficient delivery of community services;
- They are led by multi-sector locality leadership teams which will include a GP, LHB clinical lead and social services members, who will drive locality service planning and be responsible for service delivery;
- They are able to utilise the full community based resource, responding to local needs and, where appropriate, create truly integrated multi-professional teams across health and social care;
- They utilise joint leadership to lower the boundaries between and within organisations and professional groups;
- They have clearly specified budgets and resource availability and move towards joint accountability for performance and resource utilisation;
- They actively strive towards developing improved communication mechanisms between organisations;
- They engage with others (e.g WAG) to establish an evidence-base for what works and what does not work in integrating health and social care and managing changes appropriately.

The statutory requirements for Health Social Care and Wellbeing (HSCWB) Strategies at LA level will continue to be central to the service improvement agenda. The "Locality Model" will enable the development of local HSCWB Delivery Plans that better reflect the particular needs of individual communities that can be aggregated at LA level and LHB level to inform the overall development and performance-management agenda.

Building Community Capacity and Capability

The interface between the GP surgery and the district general hospital will be the area for greatest transformation, with community services moving from a poorly organised, under-resourced function, to become the pivotal force in the organisation of health and social care. Bringing together those already working in the community into a coherent system under multi-agency locality leadership will positively impact on the delivery of scheduled and unscheduled care, as well as improving the patient and service user experience. Primary care will continue to provide the crucial core key services currently delivered at practice level. They will also play an active role in the identification of patients in high-risk groups which would benefit from the enhanced services available from the Community Resource Teams. This proactive approach will lead to the maintenance of independence and wellbeing and the avoidance of unnecessary hospital admissions.

The Community Resource Team (CRT) will include all those health and social care professionals currently working in localities (outside primary care practices), and will be boosted, over time, by additional members, depending on local needs and service

re-design. They may include GPs and other primary care professionals including pharmacists, nurses, therapists and social workers with advanced skills in assessment and management of complex needs with community-based consultants. These teams will create a strong, multidisciplinary approach focused on the maintenance of more complex cases in the community. Co-ordinated care management systems for both physical and mental health will be developed to include:

- Specific admission avoidance schemes;
- Supportive discharge schemes;
- Chronic condition case management;
- Enhanced preparation for scheduled care;
- Enhanced medicines management;
- Advanced access to diagnostics;
- Active rehabilitation.

As the system matures, consideration will be given to the alignment of other professionals (e.g. paramedics) to the Community Resource Teams to enhance the holistic care model. These services will actively support assessment and discharge planning at the "front-door" of the acute hospital and will also support the clinical supervision of cases within community hospitals, nursing homes and other health and social care settings.

Whilst responsive to local circumstances and need, the Community Resource Teams will operate to common governance standards of delivery and performance across the wider LHB. There will also have a key role in the education, training, recruitment and retention of highly skilled practitioners within primary care and community services and, where necessary, provide supportive interventions and networks for practices and teams where they struggle to meet standards, through schemes such as, for example, the Primary Care Support Unit (PCSU).

The relationship between GP practices, community staff and locality structures is critical to success. Ownership must lie as close to the patient and service user interface as possible. In implementing structures, LHBs will need to work with all parties in building teams that ensure continuity, trust and effective joint decision making according to the needs of the community. This must include detailed consideration of clinical responsibility at all levels.

Common service models and information-sharing will underpin traditional primary care services both within core hours and the out of hour's period. The localities will ensure delivery of an integrated primary care system 24/7. The GP record, with all appropriate safeguards in terms of information protection, will form the core data set to inform clinical decision making by primary care; out-of-hours services, community services, A&E/Acute Assessment Units and discharge planning functions of acute hospitals.

Building capacity and capability within the community will require the development of joint Health and Social Care Teams such that truly integrated services can be delivered to the citizen. This will also require investment in shared, secure and robust information systems across health and social care to underpin joined up 24/7 community-based services. LSB's will be key enablers to this integrated approach which is critical to success.

Communications and Information

Services need to be organised and focused around the patient/service user with high quality information and effective communication being central to the delivery of bespoke care. Informing Healthcare has a key role to ensure that enhanced access is made available to the GP record, without compromising security and confidentiality, thereby enabling relevant information to be readily available to support

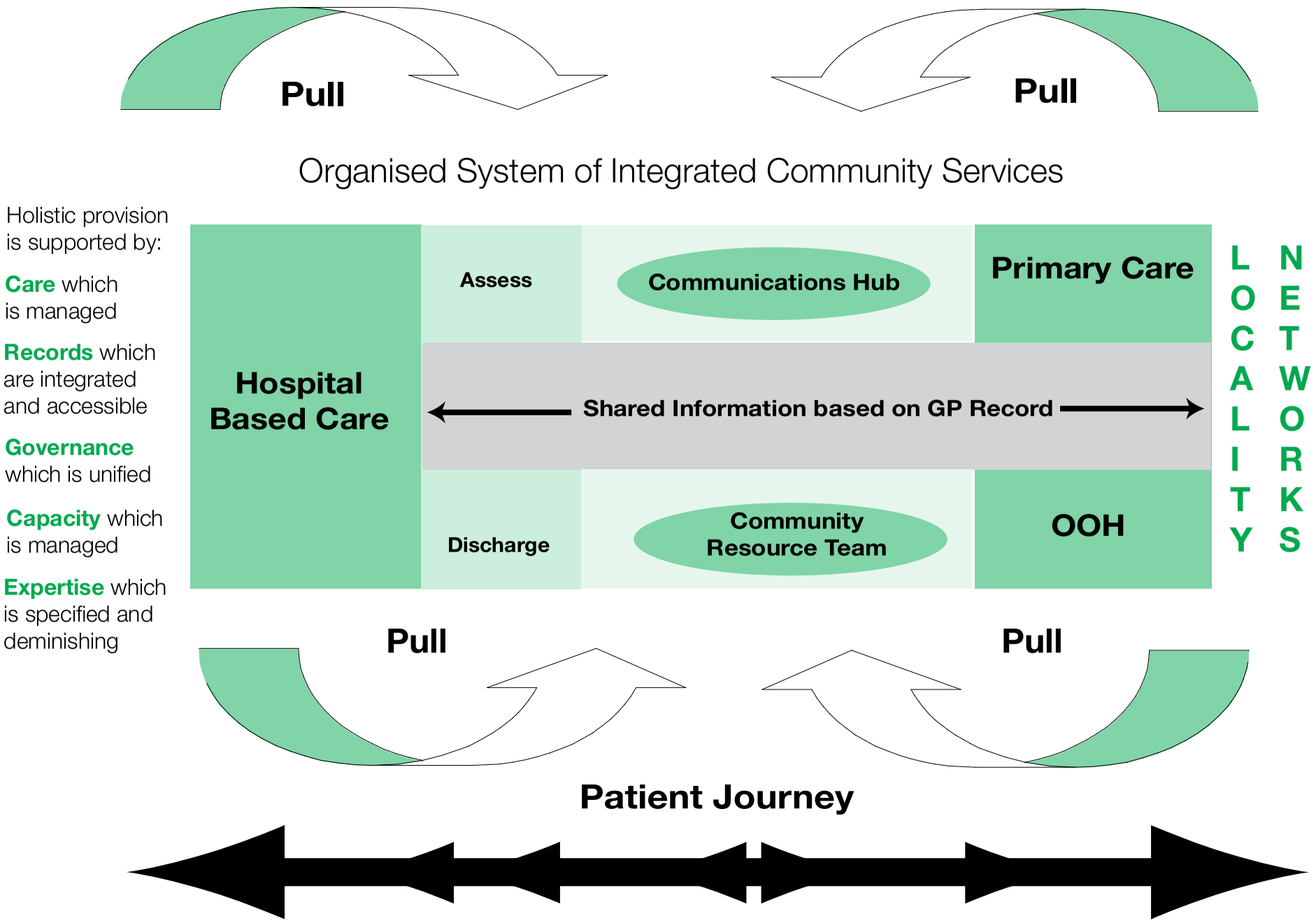
effective clinical decision making by all relevant professionals.

In addition, work is underway to develop integrated Communications Hubs to improve communications for patients and staff. These Hubs will develop to provide a range of services, including:

- Supporting referral processes and better scheduling the work of the Community Resource Teams;
- Providing comprehensive service registers;
- Signposting people to the right services, facilitating the navigation of the public, patients, carers and healthcare professionals through the health and social care system;
- Supporting the sharing of appropriate information across health and social care services;

In the longer term a more sophisticated system of scheduling across the care continuum should be included within the model to stream-line activities. **Figure 2** describes an integrated model of care which is predicated on a system whereby patients are actively managed or "pulled" through primary, community and secondary care according to the ability to meet their needs. This is the basis of the vision for the new NHS in Wales.

Figure 2: Future Systrem of Care “Sseamless Pull System” with Integrated Access to Information



Role of LHBs and WAG

It is imperative that primary care continues to develop and reflect local needs. The infrastructure including IT, buildings, communications and access to investigations will need considerable support and development, while the need to ensure recruitment, retention and training, of the primary care workforce needs focus and effort on a continuing basis. In this regard LHB's have a key role to play in ensuring that the drivers and capacity to meet these requirements are in place. The complex interfaces between independent contractors and salaried workforce should not be allowed to become a barrier to achieving service re-design, if required. LHBs will need to ensure that good relationships, effective governance through strong, visible management and clinical leadership are in place and strengthened as the development agenda progresses.

Similarly, issues around contractor services across primary care should not be the sole focus of activity, and the potential for service re-design and delivery must not be missed. It is worth emphasising the significance of the role of nurses and allied health professionals in terms of their contribution to the modernisation agenda if the proposed system of care is to materialise and be successful.

The Welsh Assembly Government has to take a lead in facilitating and enabling the necessary changes, with primary and community services having an increasingly strong focus within the relevant structures within WAG and NHS Wales to engender a whole system approach to policy development.

One of the key enabling factors will need to be the development of an overarching National Programme that will bring together the relevant policies and strategies to facilitate the development and oversight of Local Delivery Plans in each of the LHB areas. Where organisations manage networks across more than one LHB area, consideration will need to be given to the integration of delivery plans to ensure continuity of access and provision.

Within the NHS, the accountability will firmly lie with the LHBs for delivering this agenda; however success will be highly dependent upon joint working with LAs and Voluntary Sector partners. It is therefore critical that LSBs are fully engaged in this process.

Key Issues for Consideration in the Design and Delivery of New Models of Care

Appendix 1

In driving forward this agenda there are a number of key issues that need to be considered by LHBs and their partners as they begin to redesign and realign services within communities.

The model describes a number of key themes which can be summarised as follows:

- Information Framework
- Communications
- Locality working arrangements
- Enhancing skills in the community

The Steering Group has been very clear that it is for local communities to design their own systems in response to local circumstances and as such there is no prescriptive mechanism by which these issues should be considered and addressed. However, the following questions are intended to help LHBs and their partners to consider the issues in developing local solutions as part of the transformation agenda.

The questions are by no means exhaustive and are designed simply as a prompt for discussion between LHBs, LAs, Voluntary Sector partners and other stakeholders.

Information Framework

Purpose:

Accurate, up-to-date information is central to effective decision making in the management of an individual's care. Core information needs to be available to clinicians 24 hours a day to enable services to be safely co-ordinated around the needs of the individual.

This framework aims to identify how existing systems can be used more effectively to enable information to be shared where it will benefit the individual and at the same time preserving the underpinning information governance requirements.

Issues for consideration:

- What precise functions are required? Are there any differences in-hours and out-of-hours?
- What systems are already in place to enable staff to:
  - Carry out their day to day tasks (e.g. order a test)
  - View previous records and correspondence
  - Analyse what they have been doing and assess progress
  - Communicate with the individual citizen and other professionals
  - Access knowledge services
- Where are "community staff" records held? Do community-based Nursing staff input information into a specific module within the GP system that can be accessed on a read-only basis by others? If not, could this be achieved for all community-based staff?
- How do staff access the information they need when they are working in the community or the patients own home?
- How are prescribing records shared across primary and secondary care and across the speciality interfaces?
- What are the information governance concerns regarding shared information (as opposed to joint records)?

Communications

Purpose:

The model is predicated on future systems of communication that are designed to provide a single point of access for the co-ordination, scheduling and tracking of individualised care across the interface between the hospital and community setting. This has been described as the Communications Hub.

Through Case Managers, integrated access to information to support decision making will enable care to be co-ordinated on an individualised risk-management basis to ensure that individuals can be managed in the most appropriate place according to need.

Issues for Consideration

- Which services within the following categories should be included within the communications hub?
  - Preventative services
  - Pre-emptive services
  - Reactive services
  - Rehabilitative services
- What communications and information infrastructure currently exists between health and social care within the LHB area? How can this be developed to provide the basis for the Communications hub?
- How are Out Of Hours (OOH) services in health and social care provided? What scope exists for integrated call handling in the OOH period extending, over time, to in-hours provision?
- Have you undertaken an exercise to map current communications mechanisms across primary, secondary and social care? What potential exists for early-wins in terms of integration?
- What would a single point of access for booking of appointments and transport look like within the LHB community? How could this be achieved?
- Have you undertaken a cost-benefit analysis of integration within the NHS across the LHB area? Have you considered including Social Services within this assessment?
- What mechanisms for case co-ordination currently exist within health in the LHB area? Are these underpinned by clearly defined pathways & protocols? Are these restricted to health? Is there any opportunity to extend across social care as well?
- If there are no existing case-co-ordination arrangements in place, what opportunity exists through workforce redesign to create this capacity and capability? Should this be restricted to health or is there greater opportunity for joint arrangements with social care?

Locality Working

Purpose:

The model describes a system of empowered localities in the form of Locality Networks which will be developed around natural communities as a key platform for local service planning and delivery. They will be built around Primary Care, Community and Social Care teams, working together across agreed populations to plan and deliver integrated core out-of-hospital services.

Issues for Consideration

- How will LHB structures foster and develop strong local ownership and leadership in the development and delivery of out-of-hospital services?
- How will clinical leadership and engagement from Primary and Secondary Care be assured?
- What specific services will be managed and delivered at Locality level in years 1, 2 and 3?
- What services will be aligned to Localities in years 1, 2 and 3?
- How far and to what extent will budgetary responsibility be devolved?
- How will Public Health Teams be engaged at Locality level to support the change agenda?
- What functions will need to be delivered at LHB level, LA level and Locality level to support delivery of the new model of care?
- How will the balance be achieved between the need for locality focus and consistency across the LHB area?
- How will the focus be retained at LA level for statutory partnerships (including engagement with LSBs)?
- What accountability arrangements will need to be in place to manage cross-boundary issues?
- If there are no existing case-co-ordination arrangements in place, what opportunity exists through workforce redesign to create this capacity and capability? Should this be restricted to health or is there greater opportunity for joint arrangements with social care?

Enhancing Skills in the Community

Purpose:

One of the key mechanisms for developing advanced skills within the community setting is the establishment of a Community Resource Team which is intended to support Primary Care and Hospital Clinicians to maintain individuals at home and in the community. “Specialist generalist skills” will be highly developed within these teams to complement existing expertise in the enhancement of outcomes for patients with complex needs.

The Community Team will work closely with Primary Care to develop a strong multi-disciplinary approach to co-ordinated complex care in the community.

Issues for Consideration

- How many telephone numbers will citizens need to know to use the services within your area and across Wales? Do you want a single number access point for all unscheduled care?
- How will existing advanced skills in the community be assessed?
- How can existing GPs and other community professionals be part of this Community Resource Team?
- What contractual arrangements need to be in place to encourage local GPs to increase their skills portfolios to be part of this arrangement?
- What additional skills need to be developed? How can this be factored into workforce plans and educational contracts?
- What will the governance arrangements be? Who will be “in-charge” of the patient’s care when?
- How will the Community Resource Team relate to community hospitals? Will they have admission rights and once patients are admitted, who will be responsible for their care?
- How does the Community Resource Team link with the Communications Hub?
- How are high-risk individuals identified for support from the Community Resource Team?
- How will Primary Care, community teams and acute-hospital based teams interact with the Community Resource Team to delivery truly multi-disciplinary care?

Steering Group Members

Appendix 2

Dr Chris Jones (Chair)	Chairman, Cwm Taf LHB
Joanne Absalom	Director Primary, Community & Mental Health Aneurin Bevan LHB
Professor Mansel Aylward	Cardiff University
Professor Chris Butler	Cardiff University
Professor Donna Mead	University of Glamorgan
Dr Lyndon Miles	Vice-Chair, Betsi Cadwaladr LHB
Dr Martin Murphy	Informing Healthcare
Professor Ceri Phillips	Swansea University
Robert Pickford	WAG, Social Services Division
Graham Williams	WAG, Social Services Division
Chris Riley	WAG, Health Strategy Unit
Dr Kay Saunders	GP (Representing BMA/GPC Wales)
Sue Thomas	Nurse (Representing RCN)/Primary Care Advisor
Alison Williams	Director Primary, Community & Mental Health, Cwm Taf LHB
Ellis Williams	Director Social Services, RCT CBC