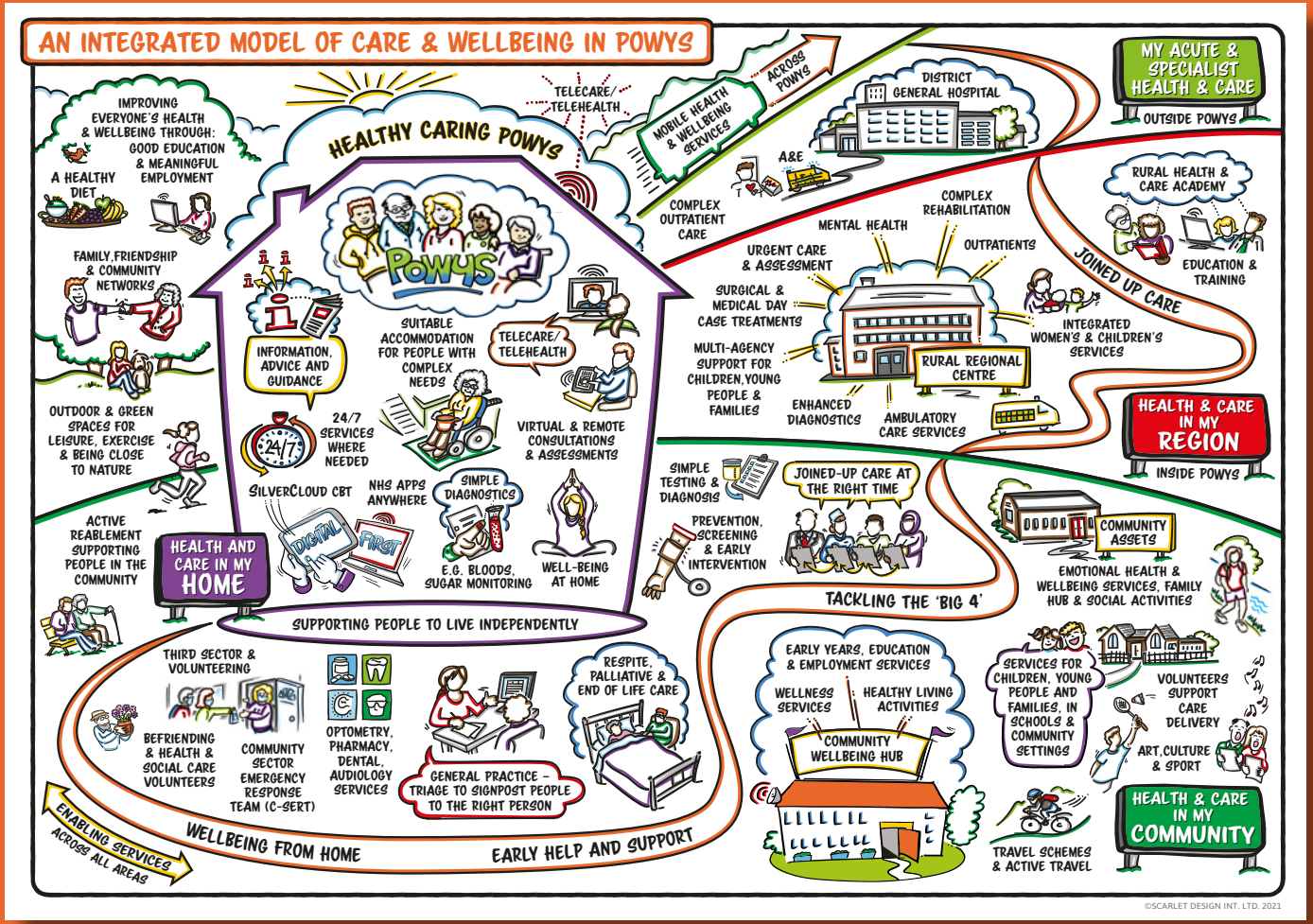
Appendix B: Integrated Model of Care & Wellbeing

AN INTEGRATED MODEL OF CARE & WELLBEING IN POWYS

MAY 2021



Ffeil Gogledd Powys

North Powys Wellbeing

Powys

Bwrdd Partneriaeth Ranbarthol Powys
Iechyd a Gofal Cymdeithasol

One Powys Yn Un

Powys Regional Partnership Board
Health and Social Care

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

A STRATEGY FOR THE FUTURE

This new integrated model of care and wellbeing is a once in a lifetime opportunity to transform health and care services for the population in the rural heart of Wales, as well as harnessing and accelerating the opportunities for digital advances that Covid-19 has presented. The model is also part of a Wales-wide response to the increasing demands and new challenges facing the NHS and social care. These include an ageing population, lifestyle changes, public expectations and emerging medical technologies.

In June 2018, the Welsh Government published 'A Healthier Wales: Our Plan for Health and Social Care'. The ambition of A Healthier Wales is for the health and social care systems to work together, to help people live well in their communities, meet their health and care needs effectively and provide more services closer to or at home, so that people only need to use a hospital for treatment that cannot be provided safely anywhere else.

The new integrated model of care and wellbeing sits under the overarching Powys Health and Care Strategy.

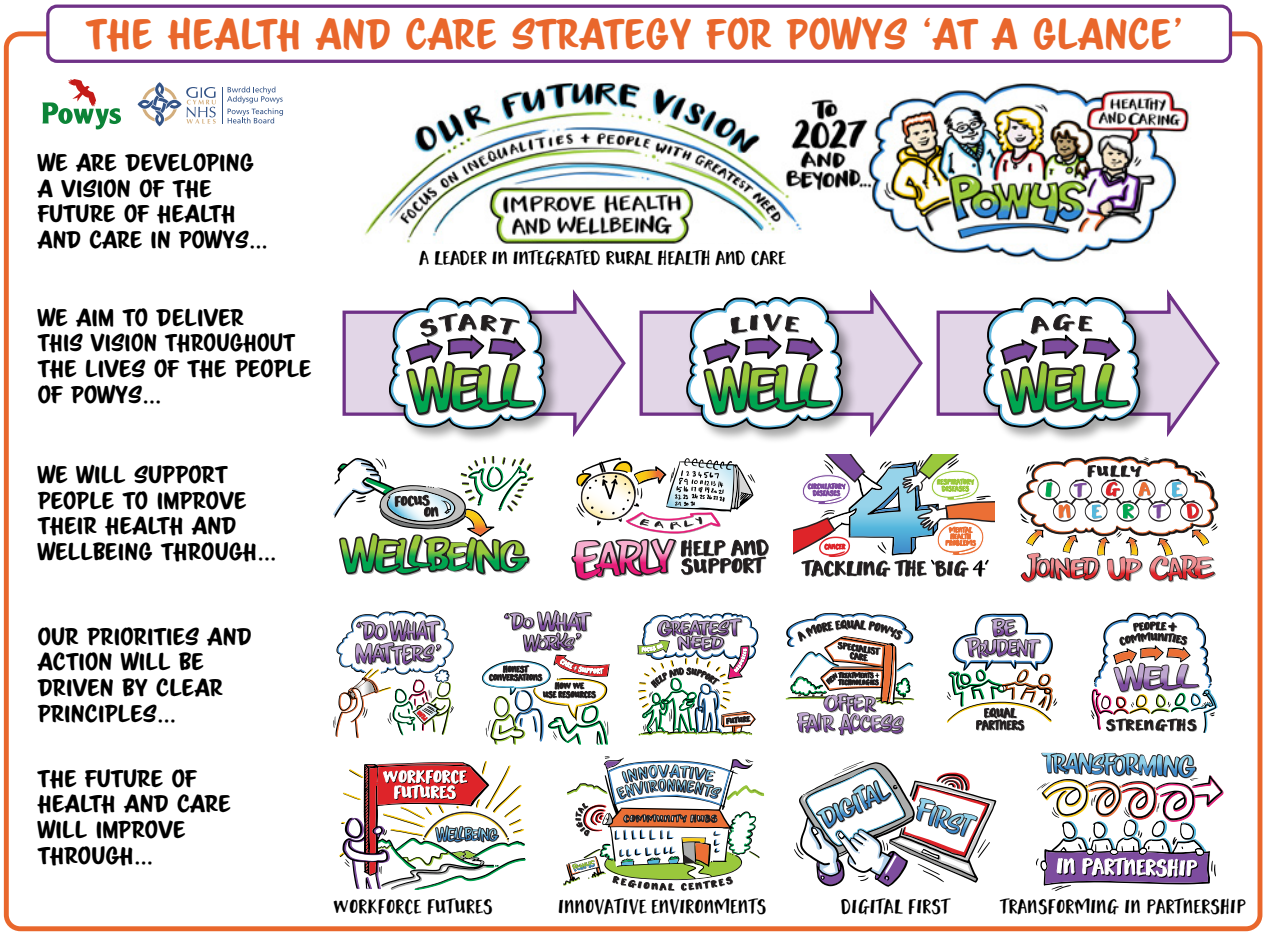
We asked local communities in north Powys and people who provide services, both in and out of the county, to tell us what works well now and what could be improved in the future. To help focus our conversations we looked at how we deliver services in three distinct ways:

- At home and in the community
- At a district or regional level
- At a county or out of county level.

We discovered people are enthusiastic about transforming health and care services in north Powys, in part by delivering more services in-county, closer to where people live.

In developing the model of care and wellbeing we took care to keep a balance between ambition and reality. This will help us deliver meaningful change, within the boundaries of what we can realistically achieve. As we develop more detailed action plans, we will test our ability to deliver the new model, continue to share information, ask for feedback and explain the reasons behind our decisions.

THE HEALTH AND CARE STRATEGY FOR POWYS 'AT A GLANCE'



WHAT WE KNOW

Powys is a large, rural county. It covers a quarter of the land mass of Wales and is the most sparsely populated county in England and Wales. More than half of the county's residents live in villages and small hamlets.

This geography makes it hard to provide the same level of services for everyone. Many people tell us that, although they do not want to leave their community, access to services and social isolation is a problem, in particular for those who are older and live in more remote locations.

Inequity of Service:

- Evidence shows that people in the most deprived areas in Powys live more years in poor health compared to people in the least deprived areas. Health inequalities increase when services do not reach those who are at most risk. However, health inequalities can be reduced when services work together with a focus on early intervention, adverse childhood experiences, wellbeing and independence.
- Evidence shows that the difference in cognitive outcomes between children from the least and most deprived areas continues to grow over 10 years. Across Wales there is also a clear link between levels of deprivation and rates of overweight or obesity. 28.4% of children who live in the most deprived areas are overweight or obese compared to 20.9% in the least deprived.
- Just over 1 in 5 children in Powys are estimated to be living in poverty, after housing costs have been considered. Children who grow up in poverty are more likely to have poor health which can have an effect on the rest of their lives. This is a particular concern in the areas of north Powys that score high on several factors associated with the Welsh Index of Multiple Deprivation (WIMD).
- Unhealthy lifestyles increase demand on health and social care services and reduce people's ability to live a fulfilling life. Although rates of physical activity in Powys are above the Wales average, nearly 6 in 10 adults are overweight or obese and this figure is predicted to rise. Just under 1 in 5 adults in the county smoke and 4 in 10 drink more than the recommended amount.
- Developments in technology are changing how we provide some health and social care services and support. For example, more people can access services in or closer to home.
- Population changes mean there will be more older people and fewer younger people living in Powys in the future. And while people are living longer, these years are not always healthy. New treatments are also being developed which could help more people live for longer, but they are costly. To meet future demand we must change the way we deliver services so they are both affordable and sustainable.
- Services around the county's borders are changing. The Shrewsbury and Telford Hospital NHS Trust, the main acute hospital provider for many north Powys communities, is changing its services and moving more to Telford. Every year around 65,000 people travel out of county for day-case and outpatient procedures. With the right workforce, facilities and diagnostics, we could provide many of these services locally.
- We depend on volunteers to deliver care and are fortunate enough to enjoy strong support for this. However, to maintain levels of care we must improve how we support our volunteers and continue to recruit new ones. Covid-19 has presented and opportunity for care to be delivered differently, utilising volunteers to establish community response teams and maximising technological opportunities to provide care through digital means.

BY 2027 PEOPLE IN POWYS WANT TO BE ABLE TO SAY...

"I am responsible for my own health and wellbeing."

"I enjoy a range of opportunities which mean I am able to lead a fulfilled life."

"I have easy access to information and advice that helps me make healthy lifestyle choices for myself and my family."

"I am confident my children have opportunities that help give them the best start in life."

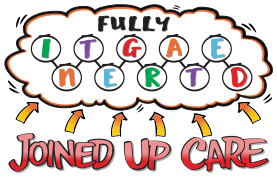
"I have easy access to information, advice and support that helps me live well with my chronic condition."

"I have easy access to information and support about my condition."

"My condition was diagnosed early."

"After my diagnosis I received treatment quickly."

"I continue to receive high-quality treatment and support as near to my home as possible."



"When I need to, I can access services as near to my home as possible."

"I am treated with dignity and respect."

"I receive care and support which is focussed on what matters most to me."

"I receive continuity of care which is safe and meets my needs."

"I enjoy health and wellbeing through support from my local community and access to the natural environment."

"I receive support which helps me balance my responsibilities as a carer and enjoy a fulfilled life."

THOSE WHO PROVIDE HEALTH AND CARE SERVICES IN POWYS WILL:

- LISTEN TO THE PEOPLE OF POWYS ABOUT THEIR HOPES, FEARS AND OPINIONS ON HEALTH AND CARE SERVICES.
- PROVIDE CARE WHICH MEETS THE NEEDS OF THE INDIVIDUAL AND HELPS THEM MANAGE THEIR OWN CARE BUDGET.
- INFLUENCE HOUSING, EDUCATION, LEISURE AND IN-WORK POVERTY TO REDUCE HEALTH INEQUALITIES.
- HELP COMMUNITIES DEVELOP HUBS AND ACTIVITIES THAT ENCOURAGE CULTURAL WELLBEING, PHYSICAL ACTIVITY AND SOCIAL INTERACTION.
- MAKE THE MOST OF THE OPPORTUNITIES THAT DEVELOPMENTS IN TECHNOLOGY BRING TO IMPROVE COMMUNICATION, DELIVER NEW SERVICES AND PROVIDE SERVICES AT MORE CONVENIENT TIMES.
- ENCOURAGE PEOPLE TO DEVELOP A WELLNESS PLAN, BE AWARE OF THE IMPACT OF THEIR LIFESTYLE AND ACT WHEN THE TIME IS RIGHT.
- IMPROVE ACCESS TO SERVICES, PROVIDE BETTER SCREENING, EARLY DIAGNOSIS AND SUPPORT.
- WORK TO THE SUSTAINABLE DEVELOPMENT PRINCIPLE UNDER THE FUTURE GENERATIONS ACT'S FIVE WAYS OF WORKING TO DEVELOP SUSTAINABLE SERVICES AND PROMOTE THE WELSH LANGUAGE.
- DELIVER SERVICES AS CLOSE TO PEOPLE'S OWN HOMES AS POSSIBLE TO SAVE PEOPLE TIME AND MONEY AND REDUCE CARBON EMISSIONS. PEOPLE WILL ONLY NEED TO TRAVEL OUT OF COUNTY TO RECEIVE SPECIALIST CARE AND COMPLEX SERVICES WHICH WE CANNOT SAFELY PROVIDE THROUGH DIGITAL TECHNOLOGY OR CLOSER TO HOME.

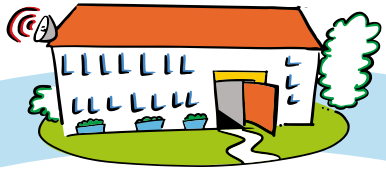
IF YOU LIVE IN POWYS, WE ASK YOU TO:

Support activities that help people feel part of their community and able to take part in making decisions about what matters to them.

Be an equal partner in the decisions that are made about your care and support.

Work with health and social care providers in a flexible way to help them make the most of limited resources for the benefit of everyone.

Take action to maintain good health and wellbeing, including through leading a healthy lifestyle, considering public health and other advice, learning about your condition, self-referral, attending screening and using digital apps where you feel comfortable to do so.



Act as a champion to help develop integrated community hubs that bring people and communities together.

Look after your own health and wellbeing and be an expert in managing your own care.

Use digital technology, such as telecare, telehealth and communication aids, to support your independence and help you receive care at the right time.

WHAT THE INTEGRATED MODEL WILL LOOK LIKE: 2027 AND BEYOND

Evidence tells us that:

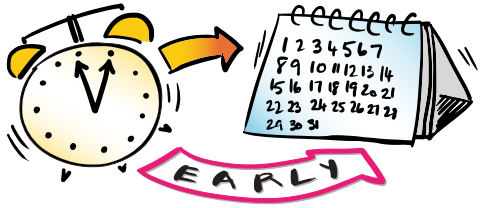
- People enjoy better health and wellbeing when they are active partners in their own care.
- Education is a key way to encourage positive lifestyle behaviours in people of all ages.
- Encouraging children and young people to live healthy lifestyles now helps them to live more healthy lives in the future.
- A positive working environment and well-paid work that people can take pride in helps create social and economic wellbeing.
- A positive living environment, including good-quality housing, affordable heating and easily accessible local amenities, helps people enjoy good health and wellbeing.
- Services are most effective when they are universally accessible but reflect differing need.
- Targeted health promotion and disease prevention in deprived communities and through schools helps reduce the impact of the 'Big 4' diseases: mental health, cancer, respiratory and circulatory disease.

We expect the new integrated model will:

- Promote independence and self-care where possible.
- Use digital and traditional paper-based channels to publish and share information about community wellbeing activities to help people engage with local groups and develop the friendships and social networks that are essential to maintain resilient communities.
- Use voluntary sector and social networks and increase green and social prescribing so that people can take part in more community-based activities to improve their health and wellbeing.

- Provide one-stop, universal and targeted early and primary prevention services at integrated community hubs that bring together education, welfare, housing, leisure, health, social care and the third sector.
- Support an active travel infrastructure (where appropriate) to encourage people to choose active travel and reduce their carbon footprint.
- Help people achieve a healthy weight through, for example, access to dietetics, behavioural change approaches and physical activity specialists.
- Influence housing, education, leisure and in-work poverty to improve health outcomes and reduce health inequalities.
- Provide opportunities for employment, training and career progression that help people stay living and working in Powys, enjoy job satisfaction, increased wellbeing and contribute to the growth of the local economy.
- Help people manage their behaviour and clinical risk in new ways such as delivering programmes from community venues and through digital technology.
- Make sure we have a skilled and supported workforce who are equipped to provide children, young people and their families with high-quality services, in line with new legislation and best practice.

WHAT THE INTEGRATED MODEL WILL LOOK LIKE: 2027 AND BEYOND



EARLY HELP AND SUPPORT

Evidence tells us that:

- Inequalities experienced in childhood affect people's outcomes in later life. For example, children who experience disadvantage are more likely to adopt harmful behaviours which can lead to mental illness, cancer, heart disease and diabetes. When agencies work together they are more likely to identify at-risk children early and provide families with the right support at the right time.
- People with long-term conditions account for around 50% of all GP appointments and 70% of inpatient bed days. When they take part in health promotion and disease prevention activities, these people can benefit from a long-term reduction in their disease burden. Where people with long-term conditions need ongoing support, multi-agency intervention can help them stay at home for longer and only go into hospital when there is a clear need.
- Early screening and diagnostic testing and quickly establishing care pathways can reduce the long-term burden of disease. When people have help to adopt a healthy lifestyle and access mental health support they can change their behaviour and further reduce the long-term burden of their disease.

We expect the new model of care and wellbeing will:

HELP CHILDREN START WELL

- Recognise the importance of the first 1000 days of a child's life and provide activities that help children develop resilience as they move into adulthood.
- Ensure provision of good quality childcare and improve early years parenting and transition to school programmes so that every child starts school ready to learn.
- Make sure every child has the support they need to reach their full potential at school.
- Provide early intervention, multi-agency services for families who are most in need so that more children who are at risk stay at home.

HELP COMMUNITIES BECOME SELF-SUSTAINING & MORE RESILIENT

- Help people draw on their own strengths and the support available to them in their community to reduce the need for statutory interventions.
- Make better use of public buildings so we have more facilities from which communities and providers can bring children, young people and adults together to share skills and experience through a wide range of intergenerational activities.

SUPPORT PEOPLE WITH LONG-TERM CONDITIONS TO LIVE WELL

- Monitor people's lifestyles so we can target resources to meet need and reduce the impact of clinical and social risk factors.
- Identify people who are at risk of developing a disease and provide prompt local diagnosis, one-stop services (including counselling and psychology) and support at home.
- Provide more, and increase access to expert patient programmes and advance care planning so people can support themselves and manage any urgent interventions to reduce hospital admissions.
- Give people the support, care and equipment they need to live as independently as possible.
- Help clinicians and professionals with specialist interests work together to improve local services through a more integrated approach across agencies.

WHAT THE INTEGRATED MODEL WILL LOOK LIKE: 2027 AND BEYOND

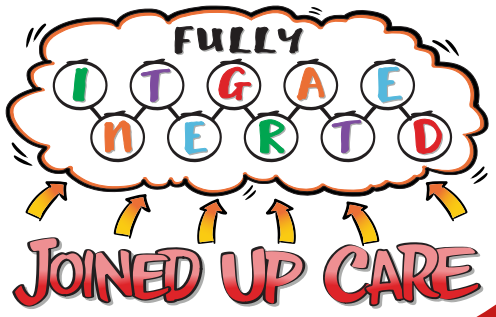
Evidence tells us that:

- The unknown effects of Covid-19 will directly impact how we manage survival rates and treatment for the Big 4. We know that Covid-19 has presented difficulties in accessing services, and increased waiting times for diagnostics and treatment
- Good mental health improves people's overall life chances including their education, home life, employment, safety, physical health, independence and life expectancy. Integrated, multi-disciplinary and multi-agency services that are easy to access help people enjoy good mental health and wellbeing and so live well.
- Although new treatments have resulted in better survival rates, cancer incidence rates and the demands on services continue to rise.
- Early identification of people who are at risk of developing diabetes, respiratory or circulatory diseases and musculoskeletal disorders will help to prevent incidence and reduce people's long-term disease burden.

We expect the new integrated model of care and wellbeing will:

- Encourage people to reduce behaviours that contribute to the Big 4 (smoking, poor diet, physical activity, stress).
- Better identify and manage key clinical risk factors: high blood pressure, high cholesterol, high blood sugar.
- Reduce incidences of the Big 4 through better education and healthier work and lived environments.
- Make screening easy for people to access and ensure they are well informed about why they have been invited to attend screening and the importance of doing so.
- Use agreed pathways to address the Big 4 and improve outcomes based on national planning guidance and evidence.
- Remove the stigma around mental illness so that people who live with it are understood and valued in their community.
- Integrate mental and physical health services.
- Support the development of dementia friendly communities to enable people with dementia to stay living at home, in the community of their choice.
- Learn from existing work, for example that in Brecon, to create more intergenerational activities for school children and older people, in particular those who live in a residential care home or attend a day centre.

WHAT THE INTEGRATED MODEL WILL LOOK LIKE: 2027 AND BEYOND



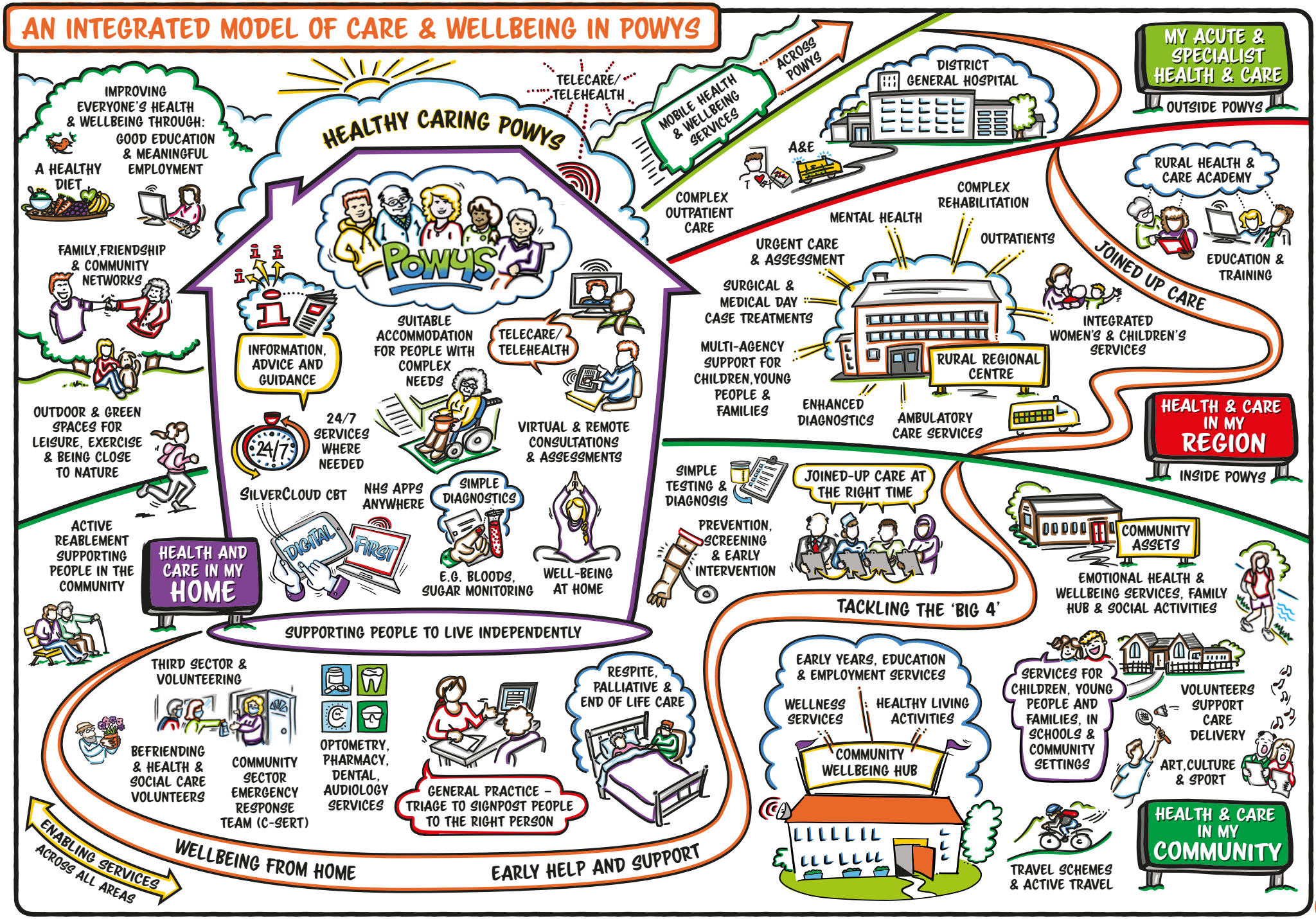
Evidence tells us that:

- The longer a patient stays in hospital the higher their chances of being admitted to nursing or residential care are. People stay living independently for longer when they spend less time in hospital and receive appropriate care and support at home.
- Multi-agency assessment and holistic, personalised care can reduce duplication and eliminate gaps in service provision, address equity issues and ensure the needs of an individual are shared, understood and met in a timely way.
- It is not yet known the impact of Covid-19 on both demographics and demand. Changing demographics mean demand for complex health and social care packages will go up in the future.

We expect the new model of care and wellbeing will:

- Increase and improve multi-agency working across education, housing, welfare, emergency and healthcare services to provide a seamless health and social care service.
- Involve people in making decisions about their care so that the services we provide are focussed on what matters most to them.
- Provide 24/7 multi-agency urgent care in the community for people who do not need to attend an emergency department or be admitted to hospital.
- Provide ambulatory care as locally as possible so that people receive a prompt diagnosis and improved access to treatments.
- Provide more local accommodation so that fewer children and adults are placed out of county.
- Coordinate care to prevent unnecessary hospital admissions and help people return home as soon as possible after a necessary admission.
- Encourage people to complete advance care planning and choose where they would like to receive end of life care.
- Support people with complex needs to live independently for as long as possible and, when it is no longer possible, to have prompt access to residential care.
- Provide reablement services that help people quickly regain as much independence as possible.
- Provide timely personalised care through anticipatory care planning and individual budgets.
- Work with children, young people and their families to co-produce plans and make the changes children need as quickly as possible.
- Provide a flexible and affordable mix of high-quality placements for children who are looked after that meet their individual needs and keep them as close to their home communities as possible, where safe to do so.
- Encourage good parenting, specialist support and well-planned journeys into adulthood so that children in our care achieve the best possible outcomes.
- Make sure every person who needs one has easy access to a key worker.
- Make sure people have clear information, before and throughout any statutory involvement, in a format they can access and understand and that contains key contact details, their current situation and the next steps that are planned.

AN INTEGRATED MODEL OF CARE & WELLBEING IN POWYS



SERVICES AND SUPPORT FOR PEOPLE AT HOME

FOCUS ON WELLBEING

- Information about wellbeing services.
- Video consultations with their GP or hospital consultant.
- Good-quality, affordable accommodation to help people live healthily and independently.
- Technology such as sensors, monitors, alarms, mobile apps and digital assistants, to help people self-care and live independently.
- Some diagnostics and test results, carried out and shared electronically.
- Stronger communities and more local groups to support people's wellbeing at home.

EARLY HELP & SUPPORT

- The right support at the right time, including 24/7 services where needed, so people can stay living at home and avoid unnecessary admissions to hospital or residential care.
- Targeted services for disadvantaged families delivered by multi-agency, multi-disciplinary teams.
- Digital applications that help people manage their long-term conditions; improved access to community resources for people who do not want to use technology.
- Mobile health and wellbeing services including simple diagnostics such as bloods and glucose levels.
- Easy access to equipment, aids and adaptations that help people of all ages stay living at home.

TACKLING THE 'BIG FOUR'

Cancer

- More support and advice from third sector services.
- A link worker to ensure people receive coordinated services that meet their needs.

Mental Health

- Online cognitive behavioural therapy.
- Crisis management and interventions seven days a week through a dementia home treatment team.
- Services and treatment, as soon as people need them.

Circulatory Disease

- Technology so people can monitor their own condition.
- More support to rehabilitate people who are recovering from a stroke.

Respiratory Disease

- Technology so people can monitor their own condition.
- More support for people with complex conditions.

JOINED UP CARE

- Support to transfer from acute care to home so people can regain their independence as quickly as possible.
- More hospital at home services (e.g. intravenous antibiotics, heart failure follow-up, palliative care, pulmonary rehabilitation) so people can avoid hospital admissions and stay living at home, or return home more quickly following a hospital admission.
- Suitable accommodation for children, young people and adults who have complex needs.
- Prompt access to short-term accommodation and, for people who are able to return home, help so they can do so as soon as possible.
- Timely access to respite care.
- Palliative and end of life care.
- Residential care for children, young people and adults with mental health and learning difficulties, as close to their community as possible.

SERVICES AND SUPPORT FOR PEOPLE IN THE COMMUNITY

FOCUS ON WELLBEING

- Community wellbeing hubs that provide wellness services such as intergenerational activities, independent living, green and social prescribing, healthy living activities and services that focus on the early years, education and employment.
- Community champions and key link workers who will help people access information, advice and support.
- A consistent point of contact who will coordinate services for vulnerable families and those facing difficulties.
- First aid awareness and training to help communities support themselves.

EARLY HELP & SUPPORT

- Multi-agency, multi-disciplinary services for children and young people, delivered at school and in other community settings.
- More optometry, pharmacy, dental and audiology services in community settings.
- Timely access to respite care.
- Simple diagnostics and testing at home or in a community setting.
- Professionals who will help people connect with others in the community and the range of services available to them.
- Access to GP services through clinical triage which will assess people's needs and signpost them to the right person within the multi-agency, multi-disciplinary team.

TACKLING THE 'BIG FOUR'

Cancer

- Screening, support and services, including palliative care suites, close to where people live.

Mental Health

- Support for people with less complex needs through primary care teams and third sector organisations.
- Support for people with more complex needs from community teams.
- Services from a multi-agency, multi-disciplinary mental health team.
- Dementia-friendly communities.

Circulatory Disease

- Multi-agency teams who will provide prevention and early intervention services.

Respiratory Disease

- Multi-agency teams who will provide prevention and early intervention services.

JOINED UP CARE

- Step up and step down reablement and rehabilitation services to help people avoid unnecessary hospital admissions and, where they do need to be admitted, help them return home as soon as possible.
- Minor injuries and illness services linked to an urgent care centre via GP practices.
- Pre and post-operative care for people with less complex needs, close to where they live and with links to consultants in acute hospitals.
- GP-based virtual wards that include social care and third sector agencies to help identify vulnerable patients and frequent users of health and social care services, stratify their risk and prevent their needs from escalating.
- Easy access to a one-stop, multi - agency, multi-disciplinary clinic.

SERVICES AND SUPPORT FOR PEOPLE IN THE REGION

HEALTH & CARE IN MY REGION
INSIDE POWYS

FOCUS ON WELLBEING

- A multi-agency campus approach.
- Reduced travel and improved access to services through access to a Rural Regional Centre for the north Powys population.
- Advice and support for people who need advanced levels of care to help them live a healthy lifestyle.
- Technology that will give people access to community wellbeing hubs across north Powys.

EARLY HELP & SUPPORT

- Multi-agency support for children, young people and families via dedicated hubs.
- Information, advice and help from integrated, multi-disciplinary teams, accessed via a one-stop call centre.
- A wide range of diagnostic services so that people receive an early diagnosis and treatment as locally as possible.
- Ambulatory care services, outpatient consultations and some surgical and medical day case treatments, including chemotherapy and transfusions.

TACKLING THE 'BIG FOUR'

Cancer

- Outpatient appointments, early cancer diagnosis and non-complex chemotherapy.

Mental Health

- 24/7 care for a maximum of three days at a crisis house for people who have urgent needs but who do not need to be admitted to an inpatient facility.
- Integrated disability, mental health and alcohol and substance misuse teams.

Circulatory Disease

- One-stop clinics to diagnose conditions and provide services including psychology support and rehabilitation.

Respiratory Disease

- One-stop clinics to diagnose conditions and provide services including psychology support.

JOINED UP CARE

- Intensive rehabilitation service for people who have suffered a major trauma or stroke.
- Improved services for women and children.
- An urgent care assessment within 0-4 hours and 24/7 out of hours support, where people meet agreed criteria and a multi-disciplinary team is present.

ANDREW'S STORY SEE PAGE 16

CATHERINE'S STORY SEE PAGE 19

SERVICES AND SUPPORT FOR PEOPLE OUT OF COUNTY

MY ACUTE & SPECIALIST HEALTH & CARE OUTSIDE POWYS

FOCUS ON WELLBEING

National wellbeing campaigns:

- Immunisations
- Smoking
- Weight-related illness
- Alcohol
- Substance misuse
- Pollution
- Awareness of the 'Big 4'
- Physical activity

EARLY HELP & SUPPORT

- Children's medical and surgical day case procedures.
- Complex outpatient appointments which require specialist diagnostic tests and support from multi-disciplinary teams which cannot be staffed in Powys.
- Complex birthing, antenatal and postnatal care.
- Specialist diagnostics such as CT scan and PET scans.

TACKLING THE 'BIG FOUR'

Cancer

- Complex cancer treatments including chemotherapy and radiotherapy, diagnostics and surgery.

Mental Health

- Specialist inpatient services in and out of county.

Circulatory Disease

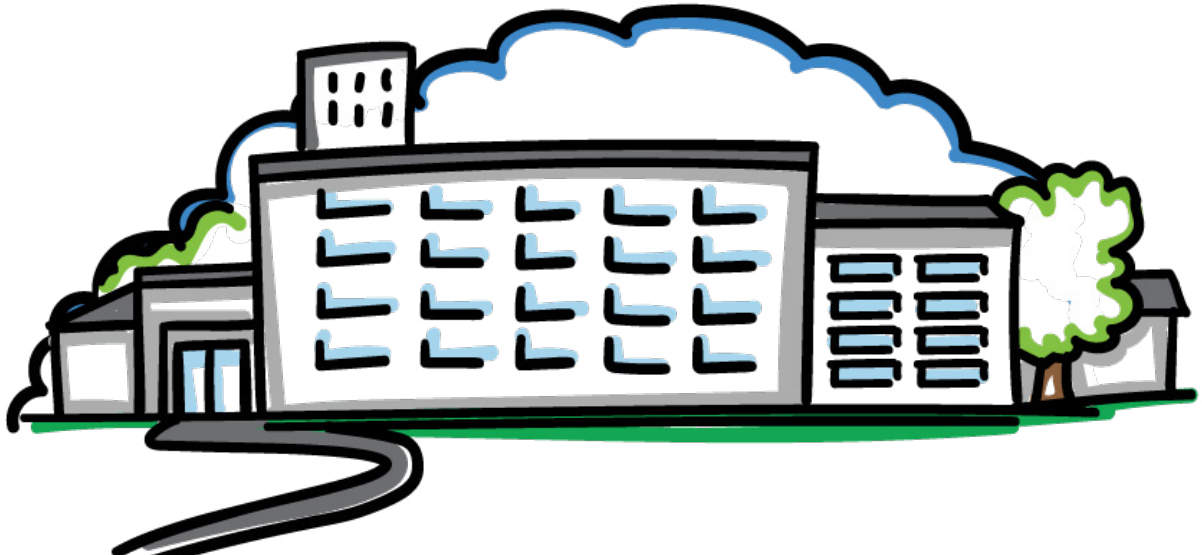
- Complex investigations and diagnostics.
- Inpatient services for stroke and heart disease.

Respiratory Disease

- Complex investigations and diagnostics.
- Inpatient services.

JOINED UP CARE

- Acute and specialist inpatient medical and surgical care.
- Specialist tertiary care.
- Accident and emergency services including complex acute ambulatory care and assessment.
- Major trauma services.



FRANK'S STORY SEE PAGE 21

ANDREW'S STORY IN 2021...

Andrew is 13 and lives in Newtown with his mum and dad. He has an older brother who has recently left home to go to university. Both his parents work. The family has two cars.

Andrew has suffered with enlarged adenoids since he was ten. They cause him discomfort and interfere with his breathing which affects his daily life. In particular they can stop him taking part in physical activity, which is something he really enjoys. They also mean he suffers from frequent middle ear infections which have caused him to have some time off school. Although this hasn't affected his academic performance, it does affect his parents who have occasionally had to take unpaid leave from work at short notice.

Andrew's GP referred him to an ENT consultant at the Royal Shrewsbury Hospital. Before his appointment, the consultant asked Andrew to complete a sleep study which meant his mum had to drive to Shrewsbury to collect the study equipment and drive back to return it the following day.

After the appointment Andrew was told he would need to have an adenoidectomy. He had a pre-operative assessment in Telford which found he was fit for the surgery. However, it has been postponed several times and now more than six months have passed which means his pre-operative assessment has expired and he'll have to travel back to Telford for another one.

These delays have upset Andrew as he has not been able to take part in the outdoor activities he enjoys. The visits to and from Telford have also been difficult for his mum and dad who have had to take time off work, sometimes unpaid, which has occasionally left their household finances a little short.

Andrew is still waiting to have his surgery.

ANDREW'S STORY IN 2027

Improvements to his care and wellbeing include:

Andrew walks to school where he studies an extended curriculum that teaches him how to look after his health and wellbeing. He enjoys a healthy lifestyle playing sport and taking part in outdoor activities in the green spaces near to his home. Andrew's older brother is studying adult nursing at the Rural Health and Care Academy in Newtown.

Andrew's parents both have meaningful employment in the local area and the family enjoys a stable income. Andrew's mum cycles to work on dedicated cycle paths and his dad walks.

They both also benefit from flexible working arrangements. This means that when Andrew has to take time off school because of his ear infections one of them can easily be at home to care for him.

Andrew's GP referred him to a specialist ENT consultant at the Royal Shrewsbury Hospital. However, Andrew's first appointment with her was held at the Rural Regional Centre in Newtown. And all his appointments since then have been held from Andrew's home using video conferencing technology which his parents have on their laptop computer.

The sleep study equipment was available from the Rural Regional Centre in Newtown. Andrew also went there for his pre-operative assessment. The nurse who carried out the assessment recorded the results on his electronic patient record. Everyone involved in Andrew's care has access to this record.

Andrew's surgery is due to take place in six weeks' time at the Royal Shrewsbury Hospital.

CAROL'S STORY IN 2021...

Carol is 51 and lives in Caersws with her three children: Tom who's 17 and goes to sixth-form college in Shrewsbury, Charlie who's 12 and goes to school in Llanidloes, and Thea who's 4 and goes to pre-school in Caersws. Thea has mild learning difficulties which Carol believes were caused by a convulsion she had when she was two. Although Carol called 999 there were no ambulances available and it was some time before Thea was admitted to hospital.

Carol feels guilty she couldn't get Thea to the hospital herself and is angry at the system. She sometimes loses her temper on the rare occasions she sees Thea's primary care team.

Carol works as a domiciliary care worker on a zero hours contract with a local care company. She took the job so she could work flexibly and balance her need to earn money while caring for her family. However, she's often asked to work when it isn't convenient but feels she has to say yes so she keeps her job and her tax credit payments don't change.

Charlie is a talented footballer and has been asked to play for the Llanidloes under 13s team. However, training is the evening and although another parent has offered to share lifts Carol still struggles to get him there regularly.

Tom recently received a formal warning from both his college and the police after he was caught in possession of marijuana on the college grounds. It isn't easy for Tom to get support with his drug misuse as the nearest centre is in Welshpool and he would have to go on the bus which is expensive and unreliable.

Carol is also worried about the effect spending time in a large town is having on Tom and would happier if he could attend college closer to home. Getting to Shrewsbury is expensive and Carol can only claim back some of Tom's daily train fare.

CAROL'S STORY IN 2027

Improvements to her care and wellbeing include:

The local multi-agency team for children and young people understand the importance of the first 1,000 days of a child's life. Everyone involved in Thea's care is actively helping her to develop and build resilience. Carol feels confident that although Thea has special needs she's ready to start mainstream school.

Carol's employer values its team and provides excellent opportunities for career progression. As a result Carol has recently been promoted into a management role. This has increased her sense of wellbeing and given her family extra stability and financial security.

Carol attends lots of community groups in Caersws so has robust social connections and feels her whole family is well supported.

Tom was recently caught in possession of marijuana on his sixth-form college grounds and was given a formal warning from both his college and the police. However, Carol is grateful that Tom attends sixth form close to home and feels sure that her robust connections in the community will help her look out for him and keep an eye on what he's up to.

Tom told his GP that he got involved in drugs because he was feeling depressed. As a result his GP referred him to a nature-based intervention as an alternative to medication so Tom could benefit from being outside in the green spaces close to his home.

DAVID'S STORY IN 2021...

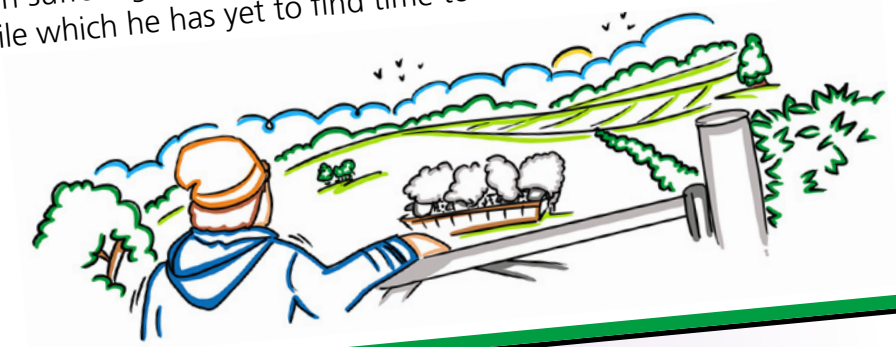
David is a 26-year-old farmer. He lives alone in a remote location in Llanwddyn, one of the most sparsely populated areas in Powys. His family live on another farm about twenty miles away. They bought David's farm five years ago for the extra grazing land and so that he would have a home and business of his own.

Since moving to Llanwddyn, David has been feeling isolated and cut off from his family and friends. Because the farm is in a valley he has no mobile reception in the house and his broadband connection is via satellite which is expensive and unreliable.

Before moving to the farm, David used to enjoy going to the gym and swimming pool at his local leisure centre. Now his nearest leisure centre is a 40-minute drive away in Welshpool. He also used to enjoy going to the Young Farmers' Club. However, because of the demands of the farm he is finding it difficult to go back.

Often David's only social interaction is with his family, and this usually ends up as just a chat about work and money. He is concerned about cash flow and, while he wants to make his father proud and prove that he can manage a farm, market prices have been low and David is beginning to feel a sense of failure. He's struggling with the maintenance costs on several of the vehicles he needs to run the farm and because his farmhouse is rated as band F, his council tax is high.

David tends to work late in the evening because he doesn't like going back to an empty house where he has very little to do. He has also been suffering from aches and pains in his neck and shoulders for a while which he has yet to find time to visit his GP about.



DAVID'S STORY IN 2027

Improvements to his care and wellbeing include:

Although David lives alone in a rural area, he feels well connected to his family and friends via his reliable mobile phone signal and high-speed unlimited broadband.

Since moving to Llanwddyn, despite the demands of farming on his personal time, David has been able to enjoy an active social life and strong support networks. He attends a variety of local groups which he found out about after a quick search on his iPad.

Before moving to the farm, David enjoyed going to the gym and swimming pool at his local leisure centre. Although his opportunities to use these facilities are now more limited, David appreciates the acres of open countryside that surround him and uses the landscape to stay fit and healthy, both physically and mentally.

David's close friends understand the demands of farming life and often lend a hand when they have spare time. For example, David recently suffered from aches and pains in his neck and shoulders but was able to visit his GP before his health deteriorated because one of his neighbours offered to carry out his morning duties on the farm.

CATHERINE'S STORY IN 2021...

Catherine is 35 and lives with her husband on their farm near Garthmyl, a few miles from Newtown. Some time ago Catherine discovered a lump in her left breast. She visited her GP who referred her to oncology at the Royal Shrewsbury Hospital where she was diagnosed with Stage 3 breast cancer, with 12 of her lymph glands also affected.

Catherine's oncologist referred her to the Princess Royal Hospital in Telford for a lumpectomy. After the procedure she had to stay overnight in hospital. When she'd recovered she then had to go to the Royal Shrewsbury Hospital every three weeks for a course of chemotherapy. This made her feel very poorly. She also felt exhausted from all the travel to and from appointments. On several occasions her temperature spiked after her treatment which meant she had to travel back to Shrewsbury to be admitted to hospital.

After her chemotherapy, Catherine had to undergo 23 sessions of radiotherapy. Although each session only lasted 15 minutes, Catherine had to travel 40 miles each way to receive the treatment. This added to her exhaustion and, she feels, affected her recovery.

Although Catherine has now finished her treatment she still has to travel to Shrewsbury for regular check-ups. She finds this difficult, particularly as some of the appointments have only involved a conversation which Catherine feels could have happened just as well over the phone.

Catherine's husband found it very hard to balance the demands of running the farm with supporting her at all her different appointments. He couldn't always manage to be away from the farm, even for just a few hours. This meant Catherine sometimes had to travel alone or ask her friends and family to help out – something she found hard to do when she was feeling unwell from all her treatment.

CATHERINE'S STORY IN 2027

Improvements to her care and wellbeing include:

Before she had her lumpectomy Catherine had to have a pre-operative assessment. This was carried out at the Rural Regional Centre in Newtown. The nurse who completed the assessment recorded the results on Catherine's electronic patient record which can be accessed by everyone involved in her care.

When Catherine had recovered from her surgery, she attended the Rural Regional Centre in Newtown every three weeks for a course of chemotherapy. Because she could receive the treatment locally, Catherine found it easier to tolerate as she was not exhausted from travelling long distances and had more time in the comfort of her own home, close to her network of care.

Catherine has now finished her treatment but still has regular appointments with her oncologist. Where possible these are held using a video link so Catherine does not have to make any unnecessary journeys.

Catherine and her husband are part of a thriving rural community. This means they have a strong network of support locally and found it easy to get help to run the farm so Catherine's husband could support her at all her appointments.

MARIE'S STORY IN 2021...

Marie is 65 and lives in Machynlleth. She is an unpaid carer for her 87-year-old mum who has COPD. Marie's mum lives in a second-floor flat in a sheltered housing complex near to the town centre. As well as caring for her mum, Marie also has a part-time job at the local supermarket. She walks to work and does not have a car.

Marie's mum has become increasingly frail and short of breath recently and can no longer manage the stairs up and down to her flat, especially as she has to carry oxygen to help her breathe. This means she depends on Marie to do all her shopping and housework as well as some of her personal care. Her illness is also affecting her mental health and her mood is changing for the worse.

Recently, as she was leaving her mum's flat, Marie fell down the stairs and fractured her hip. As a result she spent a week in Bronglais Hospital. Since being discharged from hospital Marie has had to attend a weekly appointment at the fracture clinic.

She sometimes struggles to get to this as hospital transport isn't always available. There is a bus she could take but it runs at irregular times, is expensive and Marie finds it very uncomfortable to get on and off the bus with her sore hip.

While Marie is unwell an elderly neighbour is doing some shopping for her mum. However, there is no one to help with her care needs or housework and Marie is getting increasingly concerned about her. This is on top of Marie's other worries about the amount of time she is having to take off work. She is struggling to manage her money and is worried she could lose her job.

MARIE'S STORY IN 2027

Improvements to her care and wellbeing include:

Marie was relieved when her mum was able to move into an extra care scheme where she can receive the care and support she needs to keep her safe and well.

Marie visits her mum regularly and they both enjoy spending time in the grounds around the care home. The trees and green spaces have a positive effect on both her mum's respiratory difficulties and her mood.

Marie recently fell and fractured her hip. She had to spend a short time in Bronglais Hospital but was discharged as soon as it was safe for her to return home. She has to go to the fracture clinic every week and is given a lift there by the local community transport scheme.

While Marie was in hospital and recovering at home she found it difficult to visit her mum, but they've kept in touch through video calls. This has given Marie peace of mind that her mum is safe and well. Marie's neighbours and friends have also helped her with shopping and cleaning while she recovers.

Marie was unable to work for a while after fracturing her hip but didn't worry as she received sickness pay so could keep on top of all her household bills. Her employers have been very understanding and keep touch, asking if there is anything they can do to help.

FRANK'S STORY IN 2021...

Frank, 80, and his wife Sarah, 78, have been married for 55 years. They live in a large house in Welshpool which they own outright. However the house is in need of some modernisation and as a result is becoming cold and damp. As well as struggling to maintain their home, Frank and Sarah also find it hard to keep on top of their everyday cleaning and to look after their garden.

Frank worked as a spray painter for a local factory but had to take early retirement because he developed occupational asthma, brought on by his exposure to the spray paint. His breathing is gradually getting worse and he is finding it increasingly difficult to walk to the local shops.

Frank has also recently been diagnosed with lung cancer after he began to cough up blood. His doctors are confident they can treat his cancer so he has been offered therapeutic treatment rather than palliative care. However, this means he will have to be admitted to the Royal Shrewsbury Hospital which is 40 miles away.

Sarah has dementia and Frank cares for her so he is worried about what will happen to her if he goes into hospital or his health deteriorates quickly. Her symptoms include confusion and night-time wandering. She recently tripped and fell while wandering and was admitted to hospital with a fractured femur.

The couple's only son died 15 years ago so they have no family nearby who can help them out. Although they are well-liked by their neighbours, because they rarely leave the house, Frank and Sarah also do not have a network of support in their local community they can call on.

FRANK'S STORY IN 2027

Improvements to his care and wellbeing include:

The local authority has clear evidence that well-maintained houses contribute to people's overall health and wellbeing. As a result, in partnership with local third sector providers, they have funded and carried out work to modernise Frank and Sarah's home.

The council also provide additional support to help Frank and Sarah with day-to-day cleaning and tidying. And a local voluntary group helps look after their garden. This means the couple can continue to live independently in their own home and community.

As a result Frank and Sarah are meeting more people and are also happy to invite visitors into their home. This has strengthened their sense of community belonging and helped them build up a strong local network of friendship and support.

Frank has been able to receive most of his cancer therapy in the Rural Regional Centre and has not had to travel out of county. He also receives support from the county's Breathe Well Programme which is helping him manage the symptoms of his occupational asthma.

Frank has a shared care agreement in place with his primary care team. This means they are able to monitor his health using digital consultations and applications and have been able to adjust his treatment befor any change in his symptoms becomes problematic.

KEY ENABLERS

Key enablers provide the foundation on which the future of health and care in Powys will improve. They are a fundamental part of the Health and Care Strategy for Powys and run through all the strategies, frameworks and delivery plans that sit underneath it.

The key enablers listed here describe the services, support, resources, relationships and infrastructure we must have in place to deliver the new model of care.

INNOVATIVE ENVIRONMENTS

- The built environment helps agencies work together to provide care closer to home.
- Generic and flexible spaces with electronic booking systems support remote and agile working.
- Assets are shared across partners under the multi-agency wellbeing campus.
- All new buildings are digitally-enabled and designed to support wellbeing in a socially distanced way.

WORKFORCE FUTURES

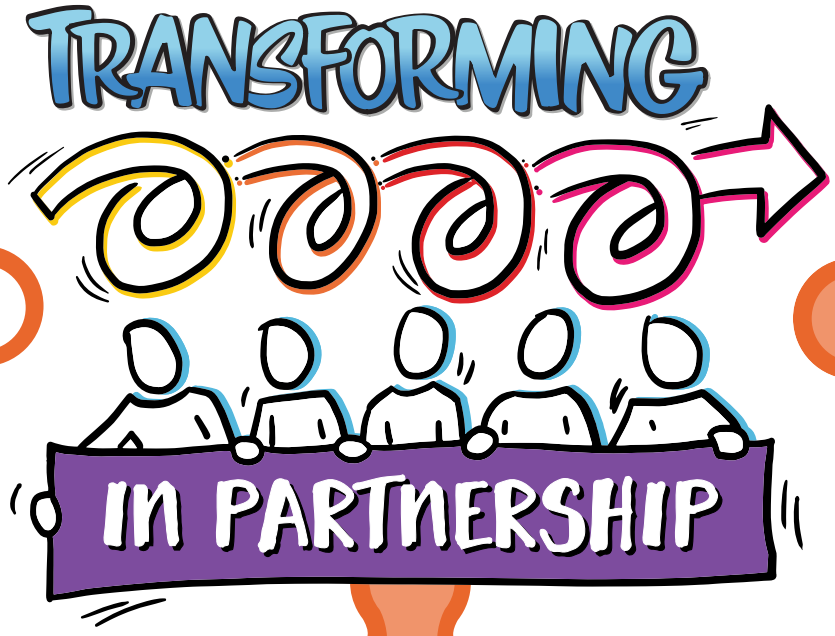
- A multi-agency workforce where people work together across organisations to meet the demands of a rural county and provide seamless health and care services.
- Powys is recognised as a leading provider of effective, rural health and care and is seen as a first-choice employer.
- A flexible workforce makes the most of resources, including digital technology, through having the right person with the right skills in the right place at the right time.
- Volunteers and unpaid carers are supported and recognised as key members of our workforce.
- A Rural Health and Care Academy where we can grow health and care leadership and skills in response to local need.
- Clinical and professional leadership teams have more capacity and capability.

DIGITAL FIRST

- A stronger infrastructure provides a platform so we can deliver services through digital media, tools and technology.
- Cross-border information sharing protocols and IT solutions improve communication and enable agile joint working.
- A single health and social care record is accessible across agencies including the police, housing, education, social care and health.
- Digitally enabled environments support increased use of digital applications such as health checks, monitors, the e-market place, software for remote consultations and diagnostics, risk stratification tools and artificial intelligence.

TRANSFORMING IN PARTNERSHIP

- Integrated, evidenced-based pathways and assessments are used across multi-agencies and multi-disciplinary teams.
- Strategic partnerships support the delivery of the new model of care and triple integration.
- Individuals, families and communities are involved in planning and providing services.
- Voluntary, third sector and social enterprises provide more health and social care services.
- Agencies use integrated commissioning, funding and delivery mechanisms to provide services.
- Clinical commissioning and networking support integration between primary, community and secondary care services.
- Agencies work with private sector businesses to support wellbeing.



THE CHANGES WE EXPECT TO SEE

WHERE WE ARE NOW	WHERE WE WOULD LIKE TO BE BY 2027
Most people receive diagnostics, outpatient and day case treatments outside of Powys.	Most people receive diagnostics, outpatient and day case treatments in Powys.
Most children receive paediatric diagnostics, outpatient and day case treatments outside of Powys.	There is a small increase in the number of children who receive paediatric diagnostics, outpatient and day case treatments in-county. However, due to the specialist skills required for more complex diagnostics and treatments, most children will continue to receive this care outside of Powys.
Most people receive specialist care outside of Powys.	More people receive specialist care in Powys, including via digital applications when it is safe and effective to do so.
People receive rehabilitation services in a mix of acute and community settings.	More people receive rehabilitation services in community settings and their own home.
People travel to Cardiff or Stoke for complex rehabilitation services.	Some people receive complex rehabilitation services in Powys.
People receive most of their cancer diagnostics and treatments outside of Powys.	People who need less complex cancer diagnostics and treatments can receive these at the Rural Regional Centre or, where possible, in their home.
People can access different care and support services at home, depending on where they live.	All people can access the same care and support services at home and, when needed, can access 24/7 multi-agency care.
A small number of people can access urgent care at home or in a minor injuries unit.	More people can access urgent care at home, in the community or at the Rural Regional Centre.
Some people have access to technology that helps them self-care and live independently.	Most people who need it have access to technology that helps them self-care and live independently.
A large number of adults and children receive care through statutory services.	Multi-agency early help and support teams identify people in need early so fewer adults and children go into the care system.
Demand for health and care services is rising.	An investment into prevention and early intervention means more people enjoy good health and wellbeing and prevents demand for health and care services rising in the longer term.

EXPLANATIONS OF SOME OF THE TERMS AND WORDING IN THE STRATEGY

- **ACUTE CARE:** short-term treatment for an illness or injury, usually provided by a hospital.
- **ADVANCE CARE PLAN:** a person's plan for their future care that they make in partnership with their care providers and, if they wish, with help from their family and friends.
- **CARE PATHWAY:** a map of the care people receive that includes prevention, diagnosis, assessment, treatment, palliative and end of life care. It is designed to help health and care organisations improve the services they provide.
- **CLINICIAN:** a health professional such as a doctor, nurse or pharmacist who regularly deals with patients.
- **COGNITIVE BEHAVIOURAL THERAPY:** a talking therapy that can help people change how they think and behave, develop coping strategies and improve their mental health.
- **COMMUNITY WELLBEING HUB:** a place where people can access a wide range of information, advice and support, receive services and take part in activities.
- **CO-PRODUCTION:** a way of involving as many people as possible in the creation of public policies and services. In co-production everyone is treated as an equal partner.
- **EARLY INTERVENTION:** where a person receives services at the earliest possible stage to prevent problems forming or getting worse in the future.
- **END OF LIFE CARE:** support and care for people who are nearing the end of their life so they can live as comfortably as possible in the time they have left. People can receive end of life care at home, in a hospital, hospice or other care setting.
- **(LOCAL) HEALTH BOARDS:** the seven NHS bodies in Wales that plan, design, develop and secure health and care services for the people who live in their area.
- **HEALTH INEQUALITIES:** avoidable differences in health between people. Health inequalities can be as a result of differences in access to care, the quality of the care available, behavioural factors such as smoking and alcohol misuse,

Continues on next page >

EXPLANATIONS OF SOME OF THE TERMS AND WORDING IN THE STRATEGY

Continued

and other things that affect health such as education, employment and housing.

- **INTEGRATED CARE:** where service providers work together in a coordinated way to improve the care they give to people.
- **JOINED-UP WORKING:** where different organisations work together to identify and solve problems, avoid duplication and make the most of the resources they have available.
- **LONG-TERM CONDITION:** a condition that cannot be cured but can be controlled with medication and other therapies.
- **MINOR INJURY UNIT:** a clinic service for less serious injuries such as cuts, sprains, minor head injuries and minor burns and scalds.
- **MODEL OF CARE AND WELLBEING:** a plan to improve health and care services and deliver them in new ways.
- **MULTI-AGENCY:** where health and care organisations work together to share information, make joint decisions and coordinate the services they provide.

- **MULTI-DISCIPLINARY TEAM:** a team of health and care workers from different disciplines who each provide specific services to a person and who work together to provide these services under a care plan.
- **PERSONAL BUDGET:** funding a person receives from social services that they control and use to pay for their care and support.
- **PRIMARY CARE:** services that provide the first point of contact in the healthcare system such as a GP, dentist, pharmacist and optician.
- **REABLEMENT:** services that help people learn or relearn the skills necessary for daily living.
- **RURAL REGIONAL CENTRE:** a centre where people can access services such as those currently provided in community hospitals, GP surgeries, pharmacies and day care centres.
- **SECONDARY CARE:** healthcare provided by a medical specialist after a referral from another provider, usually a GP.
- **SELF-CARE:** when a person takes responsibility for their own health and wellbeing.
- **TECHNOLOGY ENABLED CARE (TEC):** technology such as telehealth, telecare and telemedicine that helps people maintain their independence, live safely and enjoy an improved quality of life. Also known as assistive technology.
- **TERTIARY CARE:** highly specialized medical care.
- **THIRD SECTOR:** non-public, not-for-profit organisations that work to further social, environmental or cultural objectives. Can include voluntary organisations and charities.
- **URGENT CARE CENTRE:** where people can receive treatment for conditions that need urgent attention but are not life threatening.
- **VIRTUAL WARDS:** a community-based service that provides multi-disciplinary care at home to prevent people identified as high risk from being admitted to hospital.

HOW WE DEVELOPED THIS INTEGRATED MODEL OF CARE AND WELLBEING

We developed this integrated model of care for Powys using a co-production approach because we wanted to involve as many people as possible, in an equal way.

We launched the programme in Llanidloes and Newtown on June 14th 2019. Immediately following the launch we held two periods of engagement:

1. June to September
2. December

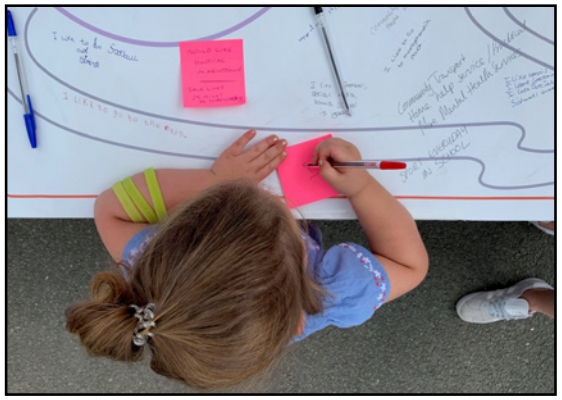
To ensure we heard from as many people as possible we:

- Attended 31 events
- Held 12 sessions that were open to the general public
- Held sessions with organisations and groups that have specific knowledge and experience of health and wellbeing services

To help us record everyone's views in a way that we could translate into this model of care and wellbeing, we created a set of materials based on four main areas of care and support:

- Health and care in the home
- Health and care in my community
- Health and care in my region - inside Powys
- My acute and specialist health and care - outside Powys

The plan on page 11 of this document is a summary of everyone's views and how we intend to improve health and wellbeing for the people of Powys.



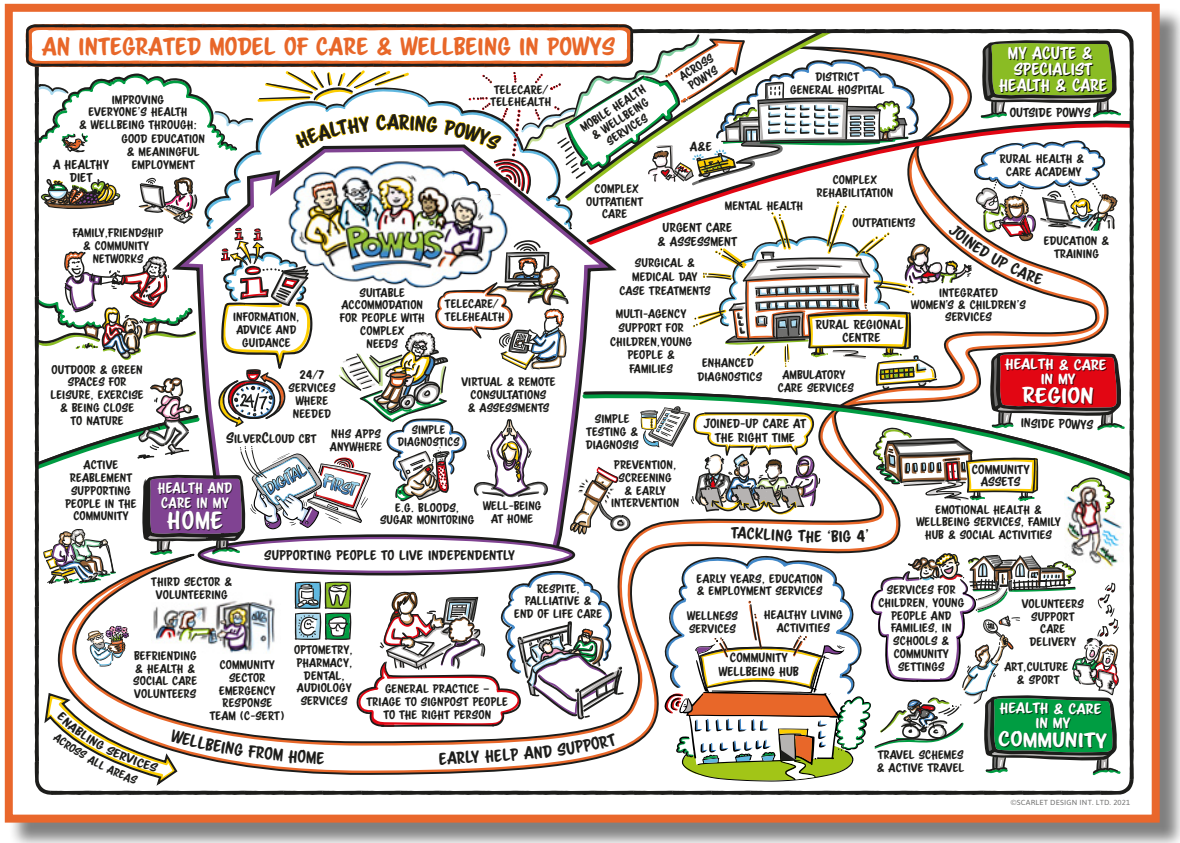
This report has been produced by the North Powys Wellbeing Programme team at Powys Teaching Health Board and Powys County Council.

GET IN TOUCH:

For more information, to ask a question or share your views please:

Email: powyswellbeing.north@wales.nhs.uk

Write to us: North Powys Wellbeing Team, Ladywell House, First Floor, 1.7, Newtown, Powys.



Gofal Gogledd Powys

North Powys Wellbeing

Powys

Bwrdd Partneriaeth Ranbarthol Powys
Iechyd a Gofal Cymdeithasol

One Powys Yn Un

Powys Regional Partnership Board
Health and Social Care

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board