Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/3279/13

David Rees AC
Cadeirydd
Y Pwyllgor Iechyd a Gofal Cymdeithasol

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31 Hydref 2013

Annwyl David

Sesiwn Graffu – Gofal heb ei drefnu: parodrwydd ar gyfer gaeaf 2013-14

Yng nghyfarfod y Pwyllgor Iechyd a Gofal Cymdeithasol ar 9 Hydref cytunais i roi gwybodaeth ichi am y canlynol:

i. Esboniad o'r trefniadau i roi brechiadau rhag y ffliw i blant yn y practis cyffredinol neu yn yr ysgol, a'r oed y bydd plant yn cael y brechiadau hyn;
ii. Darparu dolen i'r adroddiad blynyddol ar berfformiad practisau meddygon teulu o'i gymharu â'r Fframwaith Canlyniadau Ansawdd perthnasol;
iii. Darparu manylion pellach am y polisi o gynnig triniaeth ddewisol y tu allan i GIG Cymru os nad yw'r gwasanaeth yn gallu ei ddarparu oherwydd pwysau'r gaeaf;
iv. Ystyried cwblhau gwaith i asesu effaith gohirio gofal dewisol ar ofal heb ei drefnu yng Nghymru;
v. Darparu dolenni/copïau o gynlluniau'r Byrddau Iechyd ar gyfer gofal heb ei drefnu.

Yn ogystal â hynny, cytunodd y Dirprwy Weinidog Gwasanaethau Cymdeithasol i roi manylion am y prosiectau gofal integredig sydd ar y gweill yng Nghymru.

Cais gan y Pwyllgor am wybodaeth bellach

Mae'r Pwyllgor hefyd wedi dweud ei fod yn awyddus i gael gwybodaeth bellach am y canlynol:

i. Sut y byddwn yn ystyried cynyddu'r capasiti ar draws y system iechyd a gofal cymdeithasol yn ystod cyfnodau eithriadol o brysur yn y gaeaf, nid mewn ysbytai yn unig;
ii. Y rhesymeg a gaiff ei mabwysiadu er mwyn dosbarthu'r £150 miliwn yn ychwanegol a ddyrannwyd i'r portffolio iechyd a gwasanaethau cymdeithasol ar gyfer blwyddyn ariannol 2013-14, fel y cyhoeddwyd ar 8 Hydref 2013.

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Sesiwn Graffu – Gofal heb ei drefnu: parodrwydd ar gyfer gaeaf 2013-14

i) Esboniad o'r trefniadau i roi brechiadau rhag y ffliw i blant yn y practis cyffredinol neu yn yr ysgol, a'r oed y bydd plant yn cael y brechiadau hyn

- Bydd meddygon teulu yn brechu plant 2 a 3 oed
- Caiff disgyblion blwyddyn 7 (11-12 oed) eu brechu yn yr ysgol.

Gofynnir i feddygon teulu hefyd:

- Frechu unrhyw blentyn ym mlwyddyn 7 nad yw'n cael ei frechu yn yr ysgol, am ba bynnag reswm;
- Cynnig brechlyn i'w chwistrellu i unrhyw blentyn y cynghorir iddo beidio â chymryd y chwistrell Fluenz drwy'r trwyn.

ii) Darparu dolen i'r adroddiad blynyddol ar berfformiad practisau meddygon teulu o'i gymharu â'r Fframwaith Canlyniadau Ansawdd perthnasol

Cyhoeddwyd yr ystadegau diweddaraf yn ymwneud â'r Contract Gwasanaethau Meddygol Cyffredinol: Ystadegau'r Fframwaith Canlyniadau Ansawdd ar gyfer Cymru, 2012-13, ym mis Medi 2013. Mae'r rhain yn cynnwys data ar gyfer y flwyddyn hyd at ddiwedd mis Mawrth 2013. Gellir dod o hyd i'r ystadegau ar y Fframwaith Canlyniadau Ansawdd drwy ddilyn y ddolen hon:

http://wales.gov.uk/topics/statistics/headlines/health2013/general-medical-services-contract-quality-outcomes-framework-2012-13/?skip=1&lang=cy

iii) Darparu manylion pellach am y polisi o gynnig triniaeth ddewisol y tu allan i GIG Cymru os nad yw'r gwasanaeth yn gallu ei ddarparu oherwydd pwysau'r gaeaf

Mae modd caniatáu i'r Byrddau Iechyd ddefnyddio capasiti yn rhywle arall o hyd, a hynny naill ai drwy Fwrdd Iechyd Lleol arall yng Nghymru yn y lle cyntaf, ac yna o fewn y GIG yn Lloegr. Dim ond os na fydd y posibiliadau hyn yn dwyn ffrwyth y gall Byrddau Iechyd Lleol geisio capasiti ychwanegol yn y sector annibynnol yng Nghymru a Lloegr, os nad ydynt yn gallu ymdopi â'r galw yn lleol.

Rhaid i'r Byrddau Iechyd roi gwybod i Lywodraeth Cymru eu bod yn bwriadu defnyddio capasiti amgen, a rhaid iddynt ddarparu tystiolaeth eu bod wedi sicrhau gwerth am arian os ydynt yn penderfynu rhoi'r gwaith allan ar gontract.

Ar hyn o bryd, mae Byrddau Iechyd Prifysgol Abertawe Bro Morgannwg a Chaerdydd a'r Fro wedi hysbysu Llywodraeth Cymru eu bod yn ceisio sicrhau capasiti ychwanegol i drin cleifion cardiaidd. Mae hyn yn cael ei wneud ar y cyd â Phwyllgor Gwasanaethau Iechyd Arbenigol Cymru. Mae Bwrdd Iechyd Prifysgol Caerdydd a'r Fro yn trefnu i hyd at 112 o gleifion gael eu trin gan ddarparwyr eraill. Mae Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg hefyd wedi cytuno â Phwyllgor Gwasanaethau Iechyd Arbenigol Cymru ar gynlluniau i drin cleifion nad ydynt yn llwyddo i'w trin o fewn 36 wythnos erbyn diwedd mis Mawrth. Bydd hyn yn golygu defnyddio darparwyr allanol ar gyfer rhywfaint o'r gwaith.

iv) Ystyried cwblhau gwaith i asesu effaith gohirio gofal dewisol ar ofal heb ei drefnu yng Nghymru

Mae trafodaethau ar y gweill ag un Bwrdd Iechyd i gasglu'r wybodaeth hon er mwyn cael darlun i'n galluogi i ddeall y mater yn well. Rhoddir diweddariad pellach unwaith inni dderbyn yr wybodaeth hon. Nid yw Llywodraeth Cymru yn casglu'r wybodaeth hon yn ganolog ar hyn o bryd, fodd bynnag.

v) Darparu dolenni/copïau o gynlluniau'r Byrddau Iechyd ar gyfer gofal heb ei drefnu

Mae fy swyddogion wedi cysylltu â'r Byrddau Iechyd i'w hatgoffa fy mod yn disgwyl iddynt gyhoeddi eu cynlluniau ar gyfer gofal heb ei drefnu. Byddaf yn ysgrifennu at y Pwyllgor i roi diweddariad ar y mater maes o law.

Yn ogystal â hynny, cytunodd y Dirprwy Weinidog Gwasanaethau Cymdeithasol i roi manylion am y prosiectau gofal integredig sydd ar y gweill yng Nghymru.

Mae manylion y prosiectau gofal integredig sydd ar y gweill yng Nghymru i'w gweld yn Atodiad 1.

Cais gan y Pwyllgor am wybodaeth bellach

i) Sut y byddwn yn ystyried cynyddu'r capasiti ar draws y system iechyd a gofal cymdeithasol yn ystod cyfnodau eithriadol o brysur yn y gaeaf, nid mewn ysbytai yn unig

Paratowyd cynlluniau ar gyfer y gaeaf ar y sail fod capasiti yn golygu mwy na gwelyau mewn ysbytai. Er bod y cynlluniau wedi rhoi llawer o sylw i sicrhau bod ysbytai yn gallu ymdopi'n briodol â'r galw, mae'r holl Fyrddau Iechyd wedi bod yn edrych ar gapasiti yn y gymuned, gan weithio'n agos â phartneriaid i gynyddu'r cyfleoedd hyn i'r eithaf.

Er enghraifft, mae Bwrdd Iechyd Prifysgol Caerdydd a'r Fro wedi bod yn diwygio ac yn gwella ei drefniadau amserlennu ac ariannu'r Timau Adnodd Cymunedol ym mis Rhagfyr a mis Ionawr, mewn ymgais i gynyddu capasiti'r Sector Gofal Cartref a chan weithio gyda'r trydydd sector i edrych ar gyfleoedd.

Mae Bwrdd Iechyd Prifysgol Betsi Cadwaladr yn datblygu gwasanaethau gofal canolraddol cadarn ar gyfer y gaeaf, gan ddefnyddio gwelyau ailalluogi mewn cartrefi gofal a fflatiau tymor byr â darpariaeth ailalluogi mewn Tai Gofal Ychwanegol.

Mae'r ddogfen ar Ddatblygu Gwasanaethau Cymunedol sydd ynghlwm yn Atodiad 1 hefyd yn tynnu sylw at amrywiaeth o fodelau a ddatblygwyd mewn ymgais i gael gwell cydbwysedd rhwng galw a chapasiti drwy gydol y flwyddyn. Bydd adroddiad y Grŵp Rhyngwyneb Ysbytai a'r Gymuned hefyd yn cynnwys argymhellion i asesu a sicrhau bod digon o gapasiti ar draws y system iechyd a gofal cymdeithasol.

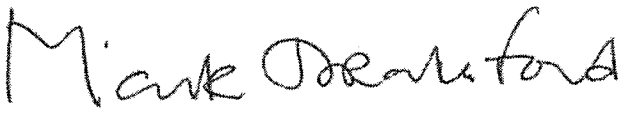
ii) Y rhesymeg a gaiff ei mabwysiadu er mwyn dosbarthu'r £150 miliwn yn ychwanegol a ddyrannwyd i'r portffolio iechyd a gwasanaethau cymdeithasol ar gyfer blwyddyn ariannol 2013-14, fel y cyhoeddwyd ar 8 Hydref 2013

Amlinellais fy rhesymeg ar gyfer dosbarthu'r £150 miliwn yn ychwanegol yn y datganiad ysgrifenedig a gyhoeddais ar 17 Hydref 2013.

http://www.assemblywales.org/cy/bus-home/bus-business-fourth-assembly-written-ministerial-statements.htm?act=dis&id=251137&ds=10/2013

Hyderaf fod yr uchod yn glir ac yn fuddiol.

Yn gywir



Mark Drakeford AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

ATODIAD 1 – SAESNEG YN UNIG

Community Service Development – LHBs in Wales

Background

Following on from the presentation to the Nuffield Institute on the local developments within community services in Wales, a summary document was prepared outlining the various community service models that Health Boards across Wales were either developing or implementing (drafted March 2013). In order to gain a broader understanding of these models, the following report outlines how these initiatives are to be measured and monitored going forward, along with a summary of the progress that is being made in terms of their development and implementation.

In order to get a sense of the models that are being developed, information has been captured on:

- The overall aim of the initiative and the services that are to be provided.
- Whether these services are being delivered in specific localities or LHB wide and in conjunction with partners outside of secondary care health services.
- Whether the Health Board has received Invest to Save funds to develop/implement its model.
- The mechanisms that have been put in place to measure improvements.

Overview of Models – Key Points

The following is a snapshot summary of the Community Service Delivery models being implemented across Wales:

- All of the Health Boards in Wales are either developing or implementing at least one mode that will assist in the development of community health care services. In some instances the number of projects that are being delivered amount to Five (Powys Teaching Health Board).
- All of the models include partnership working with Secondary Care services, including Primary Care partners, Local Government, Social Services and/or third sector organisations.
- Seven of the eleven projects are being delivered LHB wide.

- The key outcome benefits for the majority of the models are: reduced length of stay/early discharge; reduced admissions into secondary care services and; improved outcomes for the patient (e.g. reablement).
- The majority of Health Boards are utilising efficiency and productivity health measures to demonstrates the success of there community models (e.g. the number of admissions, average length of stay etc.) along with social care measures such as delayed transfer of care performance. In addition, some Health Boards (ABMU, Cardiff & Vale, Cwm Taf and Hywel Dda) have also incorporated mechanisms that will enable patient experience to be quantified.

A fuller description of the models for each Health Board are provided on the following pages, whilst the actual plans, progress reports etc provided by each health board are available on request.

Invest to Save Funds

Across Wales, four Health Boards are receiving Invest to Save funds from Welsh Government to develop their Community Service models. Those receiving Invest to Save funds are:

Health Board	Community Service Model
Aneurin Bevan	Gwent Frailty Programme
Cardiff & Vale University	Wyn Campaign
Cwm Taf	@ Home Services
Hywel Dda	Community Virtual Ward (part of Out of Hospital Care Model)

All of the aforementioned Health Boards are currently in discussions with Welsh Government's Knowledge and Analytical Services and Swansea University's Centre for Innovative Ageing in order to develop a robust evaluation framework for the Invest to Save projects. It is hoped that the framework will assist in the identification of the benefits realised from Community Service projects (cost savings, the impact on service user wellbeing and model testing), whilst recognising the difficulties of measuring benefits in the short term and for older people's services where there is a greater need for hospital care and increased co-morbidity.

An interim report on the development of individual evaluation plans for the Invert to Save projects is to be made available during July 2013, but it is anticipated that this preparatory work will continue until June 2014.

Additional Community Service Projects

In addition to providing information on the projects that were already known to Welsh Government (as outlined in the March 2013 Summary), Health Boards were asked to provide details of any other community service projects that were being developed and implemented. Appendix A - Additional Community Service Projects provides a brief summary of the projects being implemented by ABMU, Cardiff and Vale and Cwm Taf.

Health Board	Additional Community Service Projects
ABMU	Acute GP Unit at Singleton Hospital (Swansea)
	Acute Clinical Team (Neath Port Talbot)
	Integrated Health and Social Care Teams (Bridgend)
Cardiff & Vale	Elderly Care Assessment Service
Cwm Taf	Reablement Services for People with Cognitive Impairment
	Discharge Liaison Pilot
	Home Medication Administration Service

Going Forward

It is recommended that Community Service Models should be included on the agenda for future Quality and Delivery meetings, linked to unscheduled care activity.

<table>
<tr><th colspan="4">Community Resource Teams</th></tr>
<tr><td>Aim</td><td colspan="3">To support people to live at home, preventing hospital admissions and to facilitate timely discharge from hospital.</td></tr>
<tr><td>Service Description</td><td colspan="3">The following are some of the services in place within Swansea, NPT, and Bridgend areas:
Nurse-led rapid response assessment (within 4 hours) – 8.00am to 8.00pm, 7 days a week.
Consultant-led ‘hot clinics’ to provide in-depth assessment, with further access to further investigation & rehabilitation.
Single point access to all adult social care and intermediate care services.
Nurse led falls assessment within 24 hours of referral.
Home IV antibiotic therapy, includes prescribing antibiotics, monitor patients & review bloods.
Emergency placements for clients who are not able to be supported within their home.
Stroke rehabilitation.
Continuing health care services – nursing, domiciliary & respite care.
Specialist practitioners including palliative, tissue viability, dementia, medicine management, continence, young person’s sexual health education.
Reablement services including residential reablement.
Integrated approaches to contracting, contract monitoring and quality assurance of long term care being developed through the Western Bay Programme.
Integrated community network teams of district nurses, social workers and occupational therapists co-located in community hubs in plans in Bridgend.
Expanded services in place in Neath Port Talbot following changes in community hospital service model and more out of hospital care pathways in place between primary and secondary care.</td></tr>
<tr><td>Scope of Service</td><td colspan="3">Local delivery - Swansea, Neath Port Talbot and Bridgend.</td></tr>
<tr><td rowspan="2">Delivery Partners
(In addition to Secondary Care)</td><td>Swansea</td><td>Neath Port Talbot</td><td>Bridgend</td></tr>
<tr><td>GP
Local Authority
Third Sector</td><td>GP
Out of Hours
Local Authority</td><td>Local Authority
Third Sector
GPs</td></tr>
<tr><td>Invest to Save Funding</td><td colspan="3">No.</td></tr>
<tr><td>Timeline for Improvements</td><td colspan="3">Each locality service has started from a different timeline and there is a different emphasis across the localities. Through the Western Bay Health and Social Care Reform Programme and the Health Board’s Changing for the Better Programme, a new joint Community Services Project Board has been established which will drive the development of improved community services (including CRT services) across the whole area. Modelling work to look at options for scaling up current health and social care is being finalised; an initial business case has been developed and detailed business cases will be presented in December. A standard specification for the CRT is being developed. A standard set of performance metrics are also being developed to ensure consistency in measuring outcomes.</td></tr>
<tr><td>Key Principles being Monitored</td><td colspan="3">Rapid medical assessment/diagnostics
Rapid response – admission avoidance
Domiciliary rehab
Domiciliary intake reablement
Residential IC beds</td></tr>
</table>

Mechanism used to Monitor Improvements	Performance Dashboard within ABMU Health Board The following indicators are being used/and or developed within ABMU and will be further developed and refined by agreement on a common set of performance metrics across health and social care being developed (as referenced above)		
	• Community Resource Team Services – indicators that reflect the range and type of services provided and effectiveness ie. numbers of patients managed with IV antibiotics at home, numbers receiving reablement packages, number of avoided admissions. Response times.	• Interface with hospital services: emergency admissions for patients aged 65+, bed days consumed, length of stay indicators.	• Effectiveness - % of patients admitted to residential care, nursing home care and number of placements into these settings made directly from hospital.

Aneurin Bevan Health Board

Gwent Frailty Programme		
Aim	To keep people independent in their homes, through admission avoidance and earlier discharge. By focusing on prevention and ensuring clients have their health and social care needs solved quickly.	
Service Description	• Single point access. • Access 8.00am to 8.00pm, 7 days a week, 365 days a year. • 0-4 hour response time for health & social care urgent components. • Emergency care at home • Reablement	• Up to 6 weeks rehabilitation and review • Falls assessment, falls clinic • Two weeks rapid medical intervention including CGA • Hot clinics • Onward referral where required
Scope of Service	LHB wide delivery. 5 Community Resource Teams across Gwent.	
Delivery Partners In addition to Secondary Care	• Local Authority • Voluntary Sector	
Invest to Save Funding	Yes.	
Timeline for Improvements	• Payback of Invest to Save bid not noted on information provided. • In the process of developing the Invest to Save evaluation framework with Welsh Government and Swansea University. Consideration is to be given to applying the 'theory of change' to plans.	
Key Principles being Monitored	• To reduce the usage of bed days related to the patients who could be seen by CRT. • Growth in activity in CRT patient/client care.	• Reduction in Residential and Domiciliary care packages (Social Care)

<table>
<tr><td rowspan="2">Mechanism used to Monitor Improvements</td><td>Reduction of Bed Day Usage</td><td>Growth in CRT Activity</td><td>Social Care Packages</td></tr>
<tr><td>• Overall bed days utilised
- Admission avoidance <2 days
- Acute Ages 75+ >14 days
- Acute Ages <75 >10 days
- Community Ages 75+ >28 days
- Community Ages <75 >21 days
• Length of stay
- Acute hospitals for frailty cohort</td><td>• Total activity
- Reablement
- Falls
- Rapid response - medical
- Rapid response - other</td><td>• Social Care DToC.
• Older people supported in the community.
• Older people whom authority supports in care homes.
• Total no. of domiciliary care hours per week for service users where the package is 10-20 hrs per week, less than 10 hrs per week & more than 20 hrs per week.
• Total no. of general & mental health residential placements on the last day of the quarter for older people.
• Total no. of general & mental health nursing placements on the last day of the quarter for older people.</td></tr>
<tr><td colspan="3">• A combination of finance & performance reports are sent to the Gwent Frailty Joint Committee & meetings are held with Welsh Government on a quarterly basis.
• Local Evaluation - exploring opportunities for an ‘organisational raid’ to be undertaken by Academia Wales.</td></tr>
<tr><td>Progress to Date</td><td colspan="3">• An adverse variance for the number of bed days for the frailty patient cohort has been reported for 2012-13 against the targeted profile and has deteriorated in comparison with 2011/12 and 2010/11.
• A reported growth in CRT activity, but it has not achieved the levels of activity expected from the investment of extra resources.
• Social Care indicators illustrate a broadly stable position for 2012/13. Further work is to be undertaken on the social care indicators to understand trends and future target levels for the Frailty Programme.
• High level modelling undertaken to determine how the Programme has contributed to the management of growth for the cohort.
• Support in Anticipatory Care Planning where appropriate alongside GP referrals.
• Instruction of FOPAL (Frail Older Persons Assessment & Liaison) team in line with frailty at the front door – MDT presence to assess patients in admission areas of RGH and NHSS and facilitate discharge with CGA in place and management plans.
• Introduction of drivers and care bundles and use of frailty index for appropriate referrals.
• Mental Health Nurse Practitioners in post in 3 localities within CRT.
• Facilitating Early Stroke Discharge from secondary care
• The profile of the people living at home and in community hospitals is increasingly complex and the community based staff are extending their core skills to support managing this complexity.
• 7 day working of the medical model covering 4 of 5 areas from March 2013.</td></tr>
</table>

Betsi Cadwaladr University Health Board

Enhanced Care at Home (Denbighshire and Anglesey)	
Aim	To provide an increased level of care to patients in their own homes, who otherwise would have to be admitted to a community hospital or an acute hospital. For patients who are already in hospital, Enhanced Care can also support some of them to be discharged home sooner than they might have been.
Service Description	• The patient's GP practice acts as the 'gatekeeper' of the service. The GP decides whether or not a patient's health and social care needs can be safely met at home. • The GP provides the medical care to the patient and is supported by a multi-agency, multi-disciplinary 'team' including an Advanced Nurse Practitioner, District Nurses, Health Care Support Workers; Therapy staff; and Social Worker support. The voluntary sector also provides support where required, together with community equipment. GPs and the wider 'team' have access to specialist advice and support from Care of the Elderly Consultant and Consultant in Palliative Care Medicine. • A care plan is agreed by the GP and Enhanced Care 'team' for each patient who receives Enhanced Care, including the ability to provide a 24/7 service if required, with the needs of any carers also considered. • The length of time that a patient receives Enhanced Care varies but is usually up to 14 days. However, when someone requires Enhanced Care for a longer period of time (such as in the provision of terminal care), this can be provided although usually this is no longer than 28 days. • Before patients are 'discharged' from Enhanced Care, a full review of their ongoing health and care needs is done and the necessary arrangements are put in place to provide ongoing care. This is very similar to the type of assessment and ongoing arrangements that are done when a patient is discharged from hospital. • Enhanced care is provided for any adult over the age of 18 whose GP agrees can be safely cared for at home. However the majority of patient who would benefit from Enhanced Care are over the age of 65. • It is estimated to deliver at least 3,366 episodes of care across North Wales per year once fully implemented. • Plans to be developed to deliver the service in Meirionnydd, Central/South Denbighshire, North West Flintshire and South Wrexham in 2013, and the service will be rolled out to all localities in a phased.
Scope of Service	LHB wide delivery in a phased approach.
Delivery Partners In addition to Secondary Care	• Local Authorities across North Wales • GPs • Voluntary Sector
Invest to Save Funding	Yes – for 4 localities out of 14 in North Wales.
Timeline for Improvements	• Provision of service in 8 localities by Autumn 2013 • Develop evaluation framework and reporting for the I2S localities and clear mechanisms for impact on unscheduled care by December 2013 • Additional capacity in the community will support unscheduled care provision from Autumn 2013 onwards • I2S localities to provide over 1,000 episodes of care (equivalent to 40 beds) over a full year (by Autumn 2014)
Key Principles being	• More people are appropriately and safely cared for in their own home

Monitored	• Number of episodes of care provided supporting reduced hospital admissions and early discharge • Patient & Carer satisfaction
Mechanism used to Monitor Improvements	Joint Outcome Measures: 1. Number of 'step-up' admissions to enhanced care 2. Number of patients where discharge has been facilitated by Enhanced Care 3. Estimated bed days saved for those patients on Enhanced Care – by condition and hospital site – measured against the total 4. Levels of care package/hours per week measured at pre-admission, at start of enhanced care, end of enhanced care and post enhanced care 5. Cost of care packages for step up for Social Services and for Clients 6. Prevention of placement in care homes 7. Number and reasons for delayed discharges from Enhanced Care (which could be due to wait for a care package) 8. Admissions to hospital beds 9. Length of stay in hospital beds 10. Repeat admissions to Enhanced Care 11. Destination of patients when they are discharged from Enhanced Care 12. Emergency admissions by GP practice 13. Outcome Star model – patient questionnaires for qualitative information linked to certain goals such as mobility, general care, dealing with emergencies etc. This would be carried out in their own words which are agreed at the beginning of Enhanced Care and evaluated at the end and then possibly again in about 3 months.
	Evaluation Framework: A framework is being developed to evaluate the delivery of the new service to include, patient outcomes and satisfaction, increase in number of patients cared for in their own home and reduction in demand for inpatient services, and cost effectiveness.
Progress to Date	• The ECH service has been in place in North Denbighshire for over 3 years and more recently Anglesey ('step up' patients only at present) • In August 2013 the service commenced in a further three localities, namely North West Flintshire, Meirionnydd and South Wrexham

Cardiff and Vale University Health Board

Wyn Campaign	
Aim	To support people to regain and retain independence by delivering safe and efficient support, delivering a good experience and creating sustainable services.
Service Description	• Communication Hub providing a single point of contact for the citizen with a range of local services, interest groups or healthy ageing programmes. Also, acts a single point of contact for referral for assessment by the most appropriate agency. • Comprehensive geriatric assessment via Elderly Care Assessment Services or at home. • Intervention by a range of therapists including physiotherapist, occupational, speech & language and dieticians. • Falls assessment. • Case management for people with long term conditions. • Intravenous drug administration. • Nursing support. • If admitted to hospital, assessment by a multi-disciplinary team in EU & patient tracking and rehabilitation/reablement at home. • Co-ordinated long term care planning for those with complex needs.
Scope of Service	LHB wide delivery (Cardiff and Vale of Glamorgan Local Authority areas)
Delivery Partners In addition to Secondary Care	• GP • Local Government • Social Care • Thirds sector partners (voluntary services)
Invest to Save Funding	Yes
Timeline for Improvements	Based on the payback of Invest to Save funds: • Capacity released in 2013/14 will support improved flow and performance in waiting times etc. • In 2014/15 the Community Resource Team will be sustained through benefits realisation (savings made from removing the need for surge capacity & by bed closures). • Estimated bed reduction of 79 by 2015/16.
Key Principles being Monitored	Phase 1: • Improve response time for facilitated discharge from hospital to home. • Improve falls management and prevention in the community. • Improve chronic condition management for those at most risk of admission to hospital. • Provide in-reach to care home to prevent avoidable admission. • Prioritised ‘step up’ response to people identified by ECAS & Frail Older People’s Advice & Liaison Service (front door turnaround)

<table>
<tr><th colspan="3">Wyn Campaign</th></tr>
<tr><td rowspan="4">Mechanism used to Monitor Improvements</td><td colspan="2">Performance Indicators</td></tr>
<tr><td>• Emergency admissions to hospital for people aged 65+.
• Emergency bed usage for people aged 65+.
• Shift in balance from care home to home care provision.
• Re-admissions avoided by FOPAL.
• Falls data submitted to NLIAH: reducing harm from falls.
• Admission to care home direct from acute hospital.
• Discharge to usual place of residence.
• Number of people dying at home.</td><td>• Unplanned hospital attendance.
• Readmission within 14 days of discharge.
• DToC due to waits for packages of care or modifications to the home environment.
• Admission avoided by ECAS.
• Patient/Carers Experience Questionnaire (treated as an individual with dignity & respect; been worked with & not ‘done to’; provided with timely information and; received joined up services).</td></tr>
<tr><td colspan="2">Reporting Mechanism</td></tr>
<tr><td>• Wyn Steering Group & Engine Room (monthly).
• Integrating Health and Social Care Board (bi-monthly).</td><td>• Welsh Government Invest to Save team (quarterly).
• Each partner organisation reports into its own governing body.</td></tr>
<tr><td rowspan="4">Progress to Date</td><td colspan="2">Initiatives</td></tr>
<tr><td colspan="2">• Pathway redesign: Condition specific e.g. #NoF, amputee, stroke and falls, plus an aspirational ‘whole systems’ pathway.
• The establishment of an Integrated Discharge Service to support complex discharge from hospital.
• The testing and establishment of the first phase of the Frail Older People’s Advice & Liaison Service.
• Further development of the Elderly Care Assessment Service.
• The development and testing of a care co-ordination model.
• Work with GPs on the end of life pathway and piloting of the advance care planning protocol.
• Work on joint health and social care commissioning.
• Further development of Community Resource Teams to provide consistency across localities & a focus on targeted intervention.
• Inter-agency workforce/team development.
• Improvements in medicines management across the care pathway.
• The development and implementation of IT solutions to support integrated working.</td></tr>
<tr><td colspan="2">Efficiencies (comparison with the previous year)</td></tr>
<tr><td colspan="2">• Emergency admission to hospital for people aged 65+ is increasing.
• A&E attendance for peoples aged 65+ is increasing.
• The number of people aged 65+ being supported in the home has increased, whilst the number supported in a care home has reduced.
• Discharge to usual place of residence has increased.
• Discharge to care homes form acute service has fallen.
• During financial years 2010/11 and 2011/12 readmission rates have consistently averaged 11.9% (Cardiff residents aged 65+ discharged from General Medicine of OPAIC).
• Between 3% and 9% of DToC reasons are attributed to homecare and modifications to the home environment.</td></tr>
</table>

Cwm Taf Health Board

@ Home Services			
Aim	To move care out of the hospital and into local community to improve the health and well being of individuals.		
Service Description	• Reconfiguration of existing services to enhance the @Home Service which includes the Community Integrated Assessment Service, Community Ward, IV Service, Reablement and Intermediate Care Services, Reablement for Cognitive Impairment, Home Medication Administration Scheme, Discharge Liaison Nurse pilot and Specialist Practitioners e.g. Tissue Viability, Lymphoedema, Continence, Parkinson etc. • The Community Integrated Assessment Service (CIAS) enables GPs to refer people over 65 to a rapid access assessment clinic (up to 72 hours) if extra medical care or therapy support is needed. • A ' Community Ward' providing care that would normally be available on a hospital ward in the community or in a patient's home. • Delivering IV Therapy in either a patient's home, local nursing or residential homes, includes the provision of intravenous medicine and co-ordinating the input of district nursing services. • Continue the provision of reablement services that promote optimum levels of independence for patients through the delivery of short term multidisciplinary intervention. • Single Point of Access established to refer patients to adult social care and integrated care services.		
Scope of Service	LHB wide delivery.		
Delivery Partners In addition to Secondary Care	• Primary Care Services – GPs and Medical Health Services • Local Authority • Third sector		
Invest to Save Funding	Yes.		
Timeline for Improvements	Payback of invest to save bid not noted on information provided. Cash releasing efficiency savings planned from 2014/15. Cash releasing efficiency savings are planned for 2014/15 and 2015/16. In the process of developing the Invest to Save evaluation framework with Welsh Government and Swansea University.		
Key Principles being Monitored	• Prevent admission. • Support early discharge. • To improve quality of life for client & carer.		
Mechanism used to Monitor Improvements	Prevent Admission	Early Discharge	Quality of Life
	• Admissions avoided for over 65 population - COE, General Medicine, Fractures, GP. • Admissions within 30 days contact with the services (ex reablement). • Admissions from nursing & residential homes	• Length of stay for those patients accessing reablement services. • DToC	• Patient outcomes as measured by therapy outcome measures. • No. accessing reablement/intermediate care services. • Patient experience.
	Monitored via a Project Board which reports to the Setting the Direction Assurance Collaboration. Monthly performance reports are produced and a Quarterly Invest to Save Checkpoint report submitted to Welsh Government.		
Progress to Date	• Lower than planned no. of referrals to Community Integrated Assessment Service, however referrals to CIAS are increasing		

	following changes to the Service Model, however current pressure on acute service in terms of emergency admissions are impacting on the organisation's ability to reconfigure acute services and therefore reducing the impact of the @Home services. • Community Ward contacts continue to increase enabling earlier hospital discharge for patients requiring continued intervention. • Implementation of Falls Pathway • Referrals to reablement services exceeding targets which is enabling a greater number of discharges from the DGH and Community Hospitals • Delayed Transfers of Care are decreasing and patient flow increasing enabling greater capacity within DGHs. • Working closely with WAST to implement three referral pathways, Falls; Epilepsy and Diabetes to reduce the number of avoidable admission to the DGH • Number of patients treated as part of the IV component of the @Home Service continues to increase. We are also working with the Independent Sector targeting patients requiring IV intervention and provision of sub-cut fluids in five large Nursing/Care Homes • Patient information developed • Currently undertaking an evaluation of the @Home Project with support from Swansea University.

Hywel Dda Health Board

Out of Hospital Care Model		
Aim	Development and alignment of community network services and functions that work together to deliver 'out of hospital care'.	
Service Description	Delivering care closer to home, by co-ordinating care that is designed around the needs of the individual and provided by a local interdisciplinary network of people with a range of skills coupled with moving patients/service users from a model of dependency to self-care/enablement. • Improve the consistency of service delivery and patient outcomes. • Identification of demand and risk stratification. • Surveillance and care co-ordination, including telephone case management, guided self management and secondary prevention (includes musculoskeletal interface clinics, self referral, lifestyle services, tele-health for COPD, diabetes and heart failure etc). • Communication, including information sharing and development of a communication hub (e.g. booking appointments, single point access for health and social care community services). • Case management and navigation, including virtual ward development and integrated community response.	
Scope of Service	LHB wide with community services are aligned to 7 geographical localities.	
Delivery Partners In addition to Secondary Care	• Primary Care • Local Government • Social Services • 3rd Sector Services	
Invest to Save Funding	Yes. Invest to Save funding has been received for the **Community Virtual Ward** element of the model.	
Timeline for Improvements	Out of Hospital Care Model	Community Virtual Ward element
	• Capacity released in 2013/14 will support improved flow and performance in waiting times etc. • In 2014/15 the Community Resource Team will be sustained through benefits realisation (savings made from removing the need for surge capacity & by bed closures).	• Rebalance number of acute & community beds in system with phased workforce shift to community service & overall reduction in WTE (phased). • Development of clinical pathways and new ways of working (from Jan 2013 and to be further developed through the Population Health Programme of Work. • Cash releasing efficiency savings planned from 2013/14.

Out of Hospital Care Model		
Key Principles being Monitored	• Reduction in hospital admission. • Improved productivity. • Improved health outcomes. • Better patient experience. • Community based provision strengthened.	• Reduce the risk of health deterioration & improve the wellness of individuals at risk of hospital admission, readmission, health crisis (frail & chronic conditions). • Reduce unscheduled care demand (OoH & A&E attendance). • Reduce unplanned acute hospital admissions & readmissions. • Earlier hospital discharge for patients requiring continued intervention. • Reduce the number of acute hospital beds. • Rationalisation of CHC expenditure. • Improve quality by optimising the acute pathway for older people with complex needs. • Move towards local financial accountability.
	Out of Hospital Care Model	Virtual Ward Development
Mechanism used to Monitor Improvements	• Reduction in the number of emergency hospital admissions & re-admissions. • Improvement in DToC delivery. • Number of individuals receiving telehealth. • Number of MDT clinic sessions for frail adults accessible within 48 hours of referral (Carmarthenshire) • No & % of people (includes carers) reporting that their quality of life & level of confidence/independence was restored/improved after episode of care from community services. • No & % of people who received enabling intervention to optimise independence by CRT. • No of people who require a reduced / no longer require health & social care package after an enabling intervention by CRT. • No of falls, epilepsy and hypoglycaemia events that are referred to the Community Resource Teams by WAST (avoiding A&E attendance)	• Average LoS for Emergency Care (Combined Medicine) • DToC (non mental health). • Emergency admission & readmission rates for chronic conditions & ALoS. • Reductions in emergency packages of care. • Reduction in emergency admissions via A&E – WAST. • No of people who require a reduced health or social care package after a CRT intervention. • People reporting that their quality of life & level of confidence/independence was restored/improved.
	The Community & Chronic Conditions Management Board steering the Out of Hospital Care work programme and monitoring the progress reported by county delivery groups and task & finish sub groups has now been disestablished with a view to embedding the function within the revised governance structure of the HB in respect of performance and delivery monitoring. Quarterly Invest to Save checkpoint reports are submitted to WG on the Community Virtual Ward element.	

Out of Hospital Care Model		
Progress to Date	• Locality leadership teams developed (with 7 GP leads). • CRT established in each locality. • Communications hub in Carmarthenshire now 24/7. • Implementation of services for chronic conditions from level 1 to level 4 of the CMM triangle across Health Board. • Prevention services provided through patient education, information & targeted advice aimed at chronic disease. • Specialist from hospital services, community & primary care working together in community based clinics or via telemedicine links (Joint frailty clinic commenced in Oct 12). • Implementation of falls pathway. • Joint care beds available in each county providing a convalescence model in the community. • Specialist nurses & therapists aligned to CRT.	• Planning work for implementation has been completed. • Skills mapping & role redesign work undertaken across professional groups. • New roles have been recruited within therapy professions, nursing & support workers. • Workforce shift from acute based services to community teams providing 'in reach' to hospital for therapy professions & some specialist nursing roles. • Scoping work complete on appropriate tools/methods of case finding. • Development of a menu of complimentary preventative services and of systems to target resources towards a more anticipatory approach across the primary & community services.

Powys Teaching Health Board

Model	Reablement Service	Care Transfer Co-ordinators	Community Resource Team
Aim	Provide short term support to individuals to retain or regain their independence by promoting well being, independence, dignity & social inclusion.	Facilitate the seamless transfer of patients from nominated District General Hospitals to own home, community hospital, residential home or nursing home.	Provision of locality level specialist advice & support for patients along the scheduled & unscheduled care pathways.
Service Description	Based on an intake model. Supports health by promoting improved self care & treatment in a community setting so that people remain at home where appropriate.	Co-ordination of the transfer of patients at the earliest opportunity.	• CRTs are independent prescribers & work at the advanced level supported by medical consultant teams. • CRTs include MDT community services such as falls, COPD, parkinsons, cardiac services, neuro clinics and MND MDT.
Scope of Service	LHB wide.	LHB wide	LHB Wide
Delivery Partners In addition to Secondary Care	• Local Government • Social Care	• GP	• Primary care teams. • Local Government / Social Services
Invest to Save Funding	No.		
Mechanism used to Monitor Improvements	• Section 33 Agreement between Powys CC & Powys LHB established which includes operational monitoring Group. • A monitoring framework is in place.	• Reduction in ALoS in community hospitals. • Reduction in the number of patients awaiting & the length of time patients awaiting for transfer from District General to own home, community hospital, residential care or nursing home. • Reduction in DToC.	• Powys HB and County Council have formally approved the Joint Maturity Matrix as a framework for co-ordinating the implementation of an integrated model of care within the 3 localities of Powys. • The matrix reflects WG guidance – Setting the Direction & Better Support at Lower Cost. • Progress against the matrix is reported to the Integrated Care Pathway for Older People Programme Board. • A suite of outcomes/performance indicators is being developed.
Progress to Date	The service is operational but will make a transition during 2013/14 to an 'intake model' & work is underway to design this service.	• Completed the recruitment of Care Transfer Co-ordinators to each locality & associated district general hospital. • Objectives are set against the monitoring criteria above.	• Using the framework, Health and Social Care teams at locality level have developed and are progressing actions plans to deliver key themes of WG guidance including Community Resource Teams.

Model	Builth Model	Virtual Ward
Aim	Improving the quality of life & life chances for the local population by offering the most appropriate care options close to the individual's main residence.	To reduce unscheduled care attendances at the MAU by 20% (particularly for older people) by developing local community based services & interdisciplinary working across health & social care.
Service Description	• Development of a single access patient flow system through a communication hub. • The use of residential care beds for individuals with stable medical conditions that require clinical nursing interventions & services. • Provision of personal care during an individual's short stay by Residential Care Team. • Work towards clinical & organisational integration within adult social services with single care management plan for those admitted into residential care beds. • Develop case management & pro-active case management finding through risk stratification/screening approaches to encourage self management. • Patients on case loads will have one identifiable named key worker for their health/socials care needs.	• Case management of the most at risk & frail patients. • Daily virtual ward rounds with the GP, district nurse & practice based social worker. • Weekly multidisciplinary team meetings (including age care consultants). • Interdisciplinary operational policy. • Virtual ward patient status at a glance boards. • SBAR handover tools. • Practice level frailty registers. • Quarterly morbidity & mortality meetings. • Monthly operational management meetings.
Scope of Service	Local Delivery – Builth Wells	Local Delivery – South Powys
Delivery Partners In addition to Secondary Care	• GPs • Social Care Services	• GP & district nurse • Social workers
Invest to Save Funding	No.	
Mechanism used to Monitor Improvements	• Developing an outcome/performance framework which will link to a locality & countywide performance framework for the PCC/PLHB Integrated Care Pathways for Older People Programme. • Outcome framework to be overseen by a local Joint Service Management Group.	The Virtual Ward is measured through: • The Powys Enhanced Service agreement with the GPs. Measures the frailty register & those with a MDT discussion & plan of care. • MDS data from secondary care. Provides impact of the proactive case management (above) by a reduction in MAU attendances. • Unscheduled care performance report submitted to Unscheduled Care Board.
Progress to Date	• A service model has been developed. • Additional community nursing staff have been identified & released for specialist training in their new role. • Construction on a new Integrated Health & Social Care Centre is complete & delivery is to commence during July 13. A tender has been issued to secure a new service provider for personal care in the new 12 Shared Care Unit.	• Virtual ward has been implemented across South Powys (Haygarth, Crikhowell, Brecon & Ystradgynlais) during 2013. • Multidisciplinary interagency operational policy in place. • 2nd Phase: The management of people with long term conditions across the full Community Resource Team by streamlining care across practice nurses & specialist nurses with a focus on self management with leadership informed by psychological

		approaches. • Facility opened on 2 September 2013 and beds will open in December 2013.

Appendix A – Additional Community Service Projects

Abertawe Bro Morgannwg University Health Board

Acute GP Unit at Singleton Hospital	
Aim	To reduce the number of hospital admissions by promoting community services as an alternative to hospital care.
Core Deliverables	• A GP triage of all GP referrals to the acute medical intake at Singleton Hospital. • Arrange patients into appropriate clinical pathways at the point of telephone triage or following face to face patient consultation.
Delivered By	Staffed by GPs who work closely with physicians, consultants, therapists and nurse assessors.
Benefits	• Patient experience – patients are given an informed choice about the most appropriate care pathway; decisions are made with them rather than for them and; avoid the social and psychological impact of a hospital stay. • Prompt access to senior clinical decision makers who can divert patients to alternative pathways • Avoid medical admissions. • Bed reduction.

Acute Clinical Team	
Aim	To increase the level of care to patients in their own home and avoid hospital admissions.
Core Deliverables	• Rapid nurse led response within 4 hours (7 days a week). • IV Antibiotics Service – patients managed at home by receiving intravenous antibiotic therapy. • DVT Pathway – 4 hour response time for patients with suspected DVT. ACT visits & assesses the patient & delivers warfarin (if appropriate). Clinical team take daily blood tests & anticoagulant therapy until the patient reaches therapeutic levels. • Endoscopy/Vitamin K – Anticoagulant patients being managed at home before and after endoscopy procedure.
Delivered By	A nurse led acute clinical team. Referrals to the DVT pathway are made by GPs.
Benefits	• Patient experience – care delivered within their own home. • Avoid hospital admissions.

Integrated Health and Social Care Teams	
Aim	For older people and those with complex needs, provide an integrated approach to health and social care thereby reducing duplication and enabling patients to access care through a single point of access.
Core Deliverables	• Integrated management structure with professional leadership. • Single point of access to community health and social care services in place. • All referrals to the CRT and Adult Social Care received through a single route.
Delivered By	Three integrated health and social care network teams being created in Bridgend.
Benefits	• Professionals can share information on vulnerable patients & target support. • Reduced duplication of referral and assessment. • Timely interventions provided to patients/service users at risk. • Improved co-ordination of care plans and discharge support. • Reduction in admissions for vulnerable patients. • Early discharge.

Cardiff and Vale University Hospital

In addition to the Wyn Campaign, Cardiff and Vale University Health Board provided details of its Acute Response Team and Vale Elderly Care Assessment Service. Both of these projects were established prior to the Wyn Campaign and have been developed further via the Wyn Campaign. Details of both of these projects are provided below:

Vale Elderly Care Assessment Service (ECAS)	
Aim	• To provide Consultant Geriatrician led multi-disciplinary comprehensive assessment, timely review of older patients who are at risk or deteriorating in the community or failing in residential homes.
Core Deliverables	• To provide GPs with a rapid-access Geriatrician-led inter-disciplinary service, this allows timely review of older patients who are at risk or deteriorating in the community or failing in residential homes. • To provide a full (and written) multi-disciplinary assessment to enable Social Services and Primary Care Teams to support older people in their own homes. • To provide a community/hospital based rehabilitation plan where appropriate.
Delivered By	• A multidisciplinary team, including Consultant Geriatricians, nurses, therapists, social services. • Maintaining close links with the Vale Community Resource Service (VCRS) and Day Hospital to maximise appropriate rehabilitation and support for older people in the community.
Benefits	• Avoid unnecessary admissions to acute hospitals. • One stop multi-disciplinary assessment. • Optimum independence for patients. • Patient satisfaction.

Acute Response Team (previously noted in March 2013 update)	
Aim	To provide nursing therapies and care to patients in their own home by visiting those who are registered with a GP in the Cardiff and Vale area.
Core Deliverables	• Provision of a rehabilitation programme to ensure patients reach their optimum independence. • Assess patients in their place of residence or prior to discharge from hospital to provide intravenous medicine at home. • Provision of deep vein thromboses services (including monitoring, administration of medicine, education and support). • Provision of care and equipment to enable end of life care to be delivered at home.
Delivered By	A multidisciplinary team, including nurses, support nurses, physiotherapists and occupational therapists. Specialist advice and support are also sought from microbiology and pharmacy departments, district nurses, Marie Currie Support Project and specialist palliative care services.
Benefits	• Expedite transfer home. • Reduce hospital admissions. • Optimum independence for patients. • Patient satisfaction.

Cwm Taf Health Board

Reablement Services for People with Cognitive Impairment	
Description	Specialist OT staff provide a programme of reablement which is tailored to the needs of the individual and their families/carers.
Progress	Service established during 2012.

Discharge Liaison Pilot	
Description	Discharge Liaison Nurse (DLN) with the single point of access to reablement and intermediate care services.
Progress	• Pilot has proved to be successful. • A commitment moving forward to sustain this post and rotate the DLN team into the service. • In the process of redesigning the DLN service and has been aligned to the Community Resource Team. • Next step is to review the function of the role and link to complex care co-ordination.

Home Medication Administration Service	
Description	Enable patients to maintain their independence in their own home, by providing medication administration support.
Progress	Service has been in place since 2007. The number of individuals that the service supports has increased by 69% since April 2012.