# A HEALTHY CARING POWYS


## DELIVERING THE VISION

## DISCHARING OUR DUTIES IN RELATION TO THE JOINT AREA PLAN

**DOCUMENT STATUS: DRAFT version 0.3**

**6th March 2018.**

**Please note some of the graphics in this document will be further developed following approval of the content.**

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## FOREWORD

This document builds on the first integrated Health and Care Strategy for Powys which was developed from thousands of conversations between the residents of Powys and key partners. It is the first of its kind in Wales.

A new Regional Partnership Board was formed in 2016, as part of the Social Services and Well Being Act. This legislation requires the production of a Joint Area Plan to outline how services could be delivered in an integrated way in the future, in response to the Population Assessment. It also outlines the delivery intentions for the Health and Care Strategy.

Delivery of the Health and Care Strategy will be critical to improving the social, health, economic, environmental and cultural well-being of Wales as part of Powys's longer term Wellbeing Plan.

The vision 'Healthy Caring Powys' promotes a more holistic way of supporting people by working together more effectively, through multiple levels of integration. For example NHS and social care, physical and mental health and via secondary and primary care.

A new model of care has emerged enabling people to 'Start Well', 'Live Well' and 'Age Well' through focusing on wellbeing, early help and support, the big four health challenges and joined up care. Family, communities, home and the environment are essential to wellbeing. This is why the new model will focus on care within the home and community, enabling communities to feel connected by utilising local talents and resources more, and providing health and care in a fit for purpose environment. Digital First, Workforce Futures, Transforming in Partnership and Innovative Environments will be key enablers to achieving the vision.

These are undoubtedly challenging times, particularly with prolonged austerity and the demographic changes in Powys. There is a compelling need to work differently if services are to be transformed for the future.

Everyone's efforts to influence and shape the Strategy are acknowledged and appreciated and it will be exciting to progress the vision into action to secure a Healthy, Caring Powys.

**Cllr Rosemarie Harris,**
**Leader, Powys County Council**

**Prof Vivienne Harpwood**
**Chair, Powys Teaching Health Board**

# CONTENTS

# 1. Purpose

This document has been developed in line with the Joint Planning framework agreed by Powys County Council and Powys Teaching Health Board, under the Health and Care Strategy Development Programme. It is a technical document which also acts as the Joint Area Plan and will be used as a core basis for the 10 year strategy. It has two purposes:

- To set out in more detail the core drivers of the Health and Care Strategy, the opportunities for development and the rational for the vision 'A Healthy Caring Powys'.
- To outline 5 year priorities of key partners that form the Regional Partnership Board.

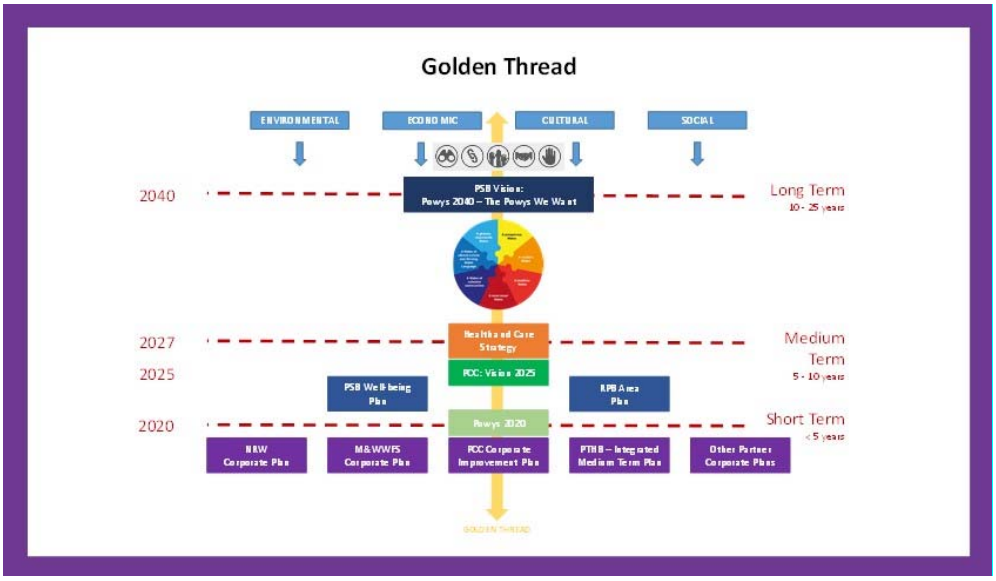
The priorities respond to the Population Assessment undertaken in 2016-17, which identified care and support requirements in Powys.

http://pstatic.powys.gov.uk/fileadmin/Docs/Adults/Integration/Powys_Population_Assessment_Summary_-_Final_V1.pdf

A wide range of data and available research and intelligence has been explored, together with examination of the views and feedback of Powys residents and partners, all of which have shaped this document.

This work draws a golden thread across all key planning arrangements, including the Council's Corporate Improvement Plan (aligned to the Vision 2025) and Powys Teaching Health Board's Integrated Medium Term Plan (IMTP).

This is visualised in the diagram below.




The Council and the Health Board have been working together to develop integrated services over the past few years. Glan Irfon is the first Integrated Health and Care Centre, working in partnership with BUPA, this facility provides a range of integrated health and care services. We also have other section 33 arrangements in place for example Reablement, Community Equipment and IT.

There are substantial opportunities for further integration and integrated working between the Health Board and Powys County Council, as well as with the third and business sectors. The feedback from the people of Powys supports this approach as a means of simplifying and improving the service users experience across the whole pathway of health and care.


The Health and Care Strategy provides the future vision and direction of travel for integrating health and social care services, and demonstrates the high level of commitment from the Health Board, Powys County Council and its partners to provide one seamless health and care system for Powys residents.

Integration opportunities also span across the borders of Powys for example; the Mid Wales Health Care Collaborative has been established to address the local needs of the Mid Wales region; this involves making sure health and care services across Powys, Ceredigion and Gwynedd are effectively joined up to meet population needs.

The challenges of integration are well understood and include:

- Establishing new forms of governance and operational structures.
- Aligning performance and planning frameworks of health and social care.
- Developing capacity in primary and community care for more innovative whole system approaches.
- Overcoming differences in organisational and professional cultures including terms and conditions.
- Managing and addressing the financial pressures of both systems.
- Ensuring local and national political support.

There is a collective ambition to work together to overcome these challenges to gain the benefits of a prudent health and care system - do only what is needed, care for those with the greatest health and care needs first, reduce inappropriate variation, public and professionals are equal partners through co-production.

Partners who provide services on behalf of the Council or the Health Board play a critical role in health and care provision. The intention is to fully involve people as equal partners. Therefore social enterprise, co-operative organisations, co-operative arrangements, user led and Third Sector options are being considered as part of the plan to promote and deliver care and support and preventative services. A Social Value Forum has been established and will provide, amongst other forums, opportunities to engage on implementation of the Health and Care Strategy and Delivery Plan.

Working differently is not always easy so the development of a culture and approach that supports integrated team working across organisational boundaries and across the full spectrum of need (see page below) will be essential.

The Regional Partnership Board (RPB) provides an integrated approach to working together with cross sector leadership and a strong shared commitment to providing seamless, integrated health and social care services, to support people to across the life course.

## OUR APPROACH

The long term vision for health and care in Powys is set out in the Health and Care Strategy for Powys which was published in March 2017. It was developed by the Health Board and Powys County Council working in partnership with stakeholders, partners and the public. It was informed by the Powys Public Service Board Well-being Assessment, the Regional Partnership Board Population Needs Assessment and extensive engagement and research as to what Powys residents and partners have said about health and care in Powys.

The long term vision identified the importance of enabling people to 'Start Well', 'Live Well' and 'Age Well' through focusing on wellbeing, early help and support, the big four health challenges and joined up care.


It identified four key enablers critical to delivery of the vision.

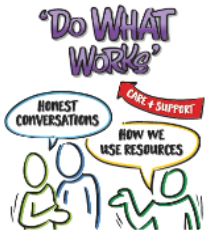

The key challenges and opportunities for each of the above areas are on pages 29-53.

# 2. Principles and Strategy 'At A Glance'

Six principles were identified through our extensive engagement, this will guide how we create a healthy, thriving future for the people and communities of Powys. Achieving the vision means finding the right balance between these principles.


**Do What Matters**

We will focus on 'what matters' to people. We will work together to plan personalised care and support focusing on the outcomes that matter to the individual.




**Do What Works**

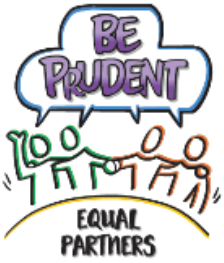
We will provide care and support that is focused on 'what works' based on evidence, evaluation and feedback. We will have honest conversations about how we use resources.


**Focus on Greatest**

We will focus resources on those with greatest need for help and support, in a way that looks ahead to future generations.


**Offer Fair Access**

We will ensure that people have fair access to specialist care and to new treatments and technologies, helping to deliver a more equal Powys and recognising rural challenges.




**Be Prudent**

We will use public resources wisely so that health and care services only do those things that only they can and should do. Supporting people to be equal partners and take more responsibility for their health and care.


**Work with People and Communities**

We will work with individuals and communities to use all their strengths in a way that maximises and includes the health and care of everyone, focusing on every stage of life – Start Well, Live Well and Age Well.

Bwrdd Partneriaeth Ranbarthol Powys
Iechyd a Gofal Cymdeithasol
One Powys Yn Un
Powys Regional Partnership Board
Health and Social Care

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

Powys | GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys Powys Teaching Health Board

WE ARE DEVELOPING A VISION OF THE FUTURE OF HEALTH AND CARE IN POWYS...


WE AIM TO DELIVER THIS VISION THROUGH-OUT THE LIVES OF THE PEOPLE OF POWYS...

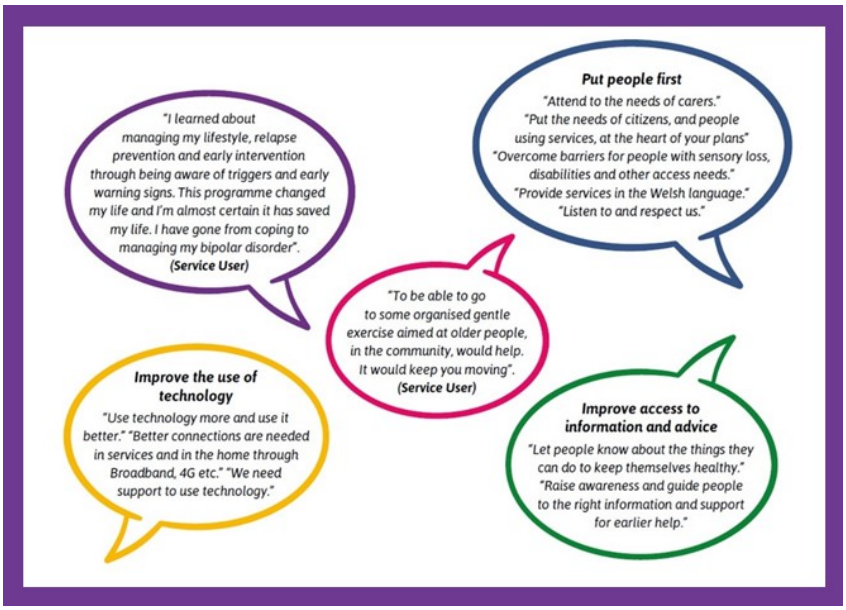

WE WILL SUPPORT PEOPLE TO IMPROVE THEIR HEALTH AND WELLBEING THROUGH...


OUR PRIORITIES AND ACTION WILL BE DRIVEN BY CLEAR PRINCIPLES...


THE FUTURE OF HEALTH AND CARE WILL IMPROVE THROUGH...


WORKFORCE FUTURES | INNOVATIVE ENVIRONMENTS | DIGITAL FIRST | TRANSFORMING IN PARTNERSHIP

# 3. Health and Care Strategy Engagement




During the Health and Care Strategy Development Programme, we have engaged with over 1,000 people to develop the future vision for health and care in Powys to 2027 and beyond. This document is built on what the people of Powys have said about their health and care — in service user surveys, complaints, compliments, engagement events, service user forums and conferences. Here are some example service user quotes:

A number of events were held during 2016 and 2017 to support the development of the 'Health and Care Strategy for Powys' and 'The Delivering the Vision'. The sessions were very interactive, capturing the outputs via visual minutes.


A joint consultation was undertaken on the Health and Care Strategy for Powys and the Wellbeing Plan during April 2016 and further engagement events have taken place early in 2018 to seek feedback on the content within this document.

# 4. Strategic Context

The Health and Care Strategy has been developed under the legislative and planning guidance in Wales and utilises practice in relation to national and international health and care systems.

## 4.1 ALL WALES CONTEXT

### 4.1.1 THE SOCIAL SERVICES AND WELLBEING ACT

This act imposes duties on local authorities, health boards and Welsh Ministers requiring them to promote the well-being of those who need care and support, or carers who need support.

The Social Services and Well-being (Wales) Act changes the social services sector:

- People have control over what support they need, making decisions about their care and support as an equal partner.
- New proportionate assessment focuses on the individual.
- Carers have an equal right to assessment for support to those who they care for.
- Easy access to information and advice is available to all.
- Powers to safeguard people are stronger.
- A preventative approach to meeting care and support needs is practised.

The principles of the act are:

- The Act supports people who have care and support needs to achieve well-being.
- People are at the heart of the new system by giving them an equal say in the support they receive.
- Partnership and co-operation drives service delivery.
- Services will promote the prevention of escalating need and the right help is available at the right time.

The Local Authority and the Health Board are working collaboratively to ensure better integration of health and social care, the Health and Care Strategy demonstrates the joint commitment and level of ambition.

The Social Services and Wellbeing Act under the Partnership Arrangements Regulations (Part 9) require the establishment of pooled funds in relation to:

- The exercise of care home accommodation functions.
- The exercise of family support functions.
- Functions that will be exercised jointly as a result of an assessment carried out under section 14 of the Act or any plan prepared under section 14A.

We are actively pursuing the requirement in relation to residential and nursing care home accommodation by the due date of April 2018. There are a number of other pooled budgets which have been agreed under Section 33 in Powys. These include:-

- Glan Irfon - a 12 bed health & social care unit which is a partnership between BUPA care staff, community nurses, reablement, physiotherapy, occupational therapists and social care staff, providing a flexible approach to meet the health and social care needs of the community.

- Community Equipment Service.
- Reablement.
- Ystradgynlais Integrated Care Team.

### 4.1.2 FUTURE GENERATIONS ACT

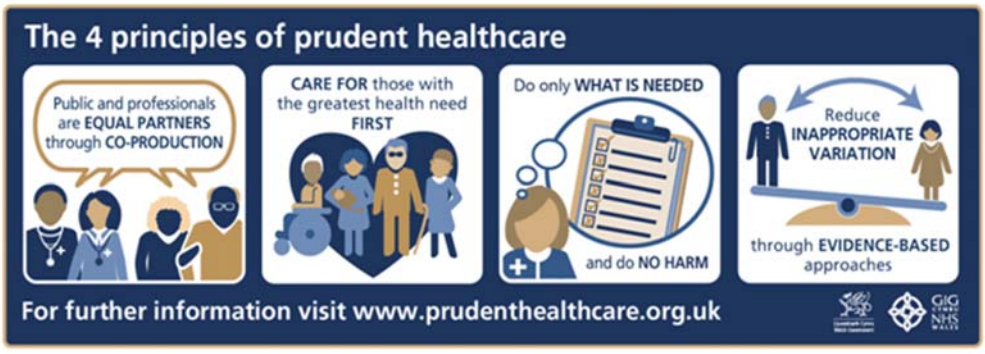
The delivery of the Powys Health and Care Strategy is a key contribution to improving the economic, environment, cultural well-being and health of Wales as part of the long term Powys Wellbeing Plan.

This Act was a key guide in developing the future Health and Care Strategy. The seven well-being goals and 5 key ways of working guided our thinking about the longer term vision for Health and Care in Powys.

Throughout the development of the health and care strategy, the Health Board and Powys County Council has sought to apply the sustainable development principle to its vision through planning for the long term, focussing on prevention and well-being, working in collaboration and involving and engaging stakeholders.

### 4.1.3 PRUDENT HEALTHCARE

The principles of prudent health and care continue to inform and influence the Health and Care Strategy.




Co-terminosity between PTHB, Powys County Council and PAVO (Powys Association of Voluntary Organisations) alongside the work in progress in relation to integrated delivery between PTHB and Powys County Council provides significant opportunity to progress prudent health and care across these partner organisations.

### 4.1.4 PARLIAMENTARY REVIEW OF HEALTH AND SOCIAL CARE IN WALES

The Health and Care Strategy has been reviewed against the recent Parliamentary Review and is supportive of the “one system” vision against the four mutually supportive goals – ‘the Quadruple Aim’:

- Improve population health and well-being through a focus on prevention;
- Improve the experience and quality of care for individuals and families;
- Enrich the wellbeing, capacity and engagement of the health and social care workforce;
- Increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste.

The next phase of work will focus on how to deliver a new model of care in an innovative way to meet future population needs and make best use of resources. This will be achieved through working with communities, staff and partners.

### 4.1.5 TAKING WALES FORWARD - PROSPERITY FOR ALL

The national strategy for 'Taking Wales Forward': Prosperity for All (2017) identified commitments and five cross cutting themes that will have the greatest potential contribution to long-term prosperity and wellbeing, these are early years, housing, mental health, social care, skills and employability.

### 4.1.6 NHS PLANNING GUIDANCE AND FINANCE ACT

The Health and Care Strategy supports the aspirations of the recently launched NHS Wales Planning Framework (2018-21) to develop rolling 3 year plans with a longer term view and the NHS Finance Act 2014. It is aligned to the Council's 2025 vision – a strategic statement setting out a number of medium term priorities for the Council and cross references to the Councils annual Corporate Improvement Plan discharging its general duty under the Local Government (Wales) Measure 2009 to set out the Councils improvement objectives for the next 12 months or longer.

## 4.2 INTERNATIONAL HEALTH AND CARE SYSTEMS

National and international health and care systems that provide for rural and remote communities have formed part of the research basis. In Scandinavia integrated health and care systems provide far more out of hospital care and support independent living in people's own communities. In Holland specialist care for people with Dementia is provided in a housing and not a care setting, integrated into communities of people of all ages. In Australian and Canadian rural communities which are similar to Powys in many ways but much larger and more remote - technology is utilised to link people to specialist opinions and care many hundred of miles away from their homes. In New Zealand – a clear vision was behind 'one system, one budget', giving staff skills to support them to innovate through a new model of integrated health and care – the 'Canterbury Model'.

## 4.3 POWYS CONTEXT

### 4.3.1 RURALITY

The population base and rurality of Powys means that it is not viable to provide secondary care services via a District General Hospital within Powys. People currently flow into five main neighbouring health economies – and further afield for specialised health services. There are opportunities to provide alternatives to secondary care services in Powys and some of this work has already progressed in areas. The ability to commission alternative pathways will be critical in the success of upscaling this work across Powys.

Improving access to services is a strong issue being fed back by our local population. The Wellbeing assessment identified that for Transport - Powys is ranked in the bottom 10% of local authority areas in Wales in terms of access to services, particularly in terms of access to services by foot or public transport.

In Powys there is a strong Third Sector and Voluntary provision which helps to overcome some of the rurality issues. Further utilising the strength of Third Sector provision and other partner organisations will enhance the success in bringing care closer to home.

### 4.3.2 SUSTAINABLE HEALTH AND CARE SERVICES

More locally, within Powys sustainability of health and care services is a key driver for developing the Health and Care Strategy. Largely the sustainability challenges are driven by workforce, rurality and reconfiguration of secondary services from across the border of Powys. Sustainability issues also exist across the borders of Powys.

In North Powys, The Shrewsbury and Telford Hospital NHS Trust (SaTH) is a significant service provider for Powys residents. Every year approximately 203,606 contacts take place in Shropshire for Powys residents. Under the NHS Future Fit Programme a number of service options have been developed, the current preferred option is for emergency and critical care to remain at the Royal Shrewsbury Hospital with the majority of planned surgery taking place in the Princess Royal Hospital in Telford. Public consultation is due to take place during 2018/19 http://nhsfuturefit.org/. This may result in people having to travel significantly longer for day case or planned surgery. The Health and Care Strategy has started to consider the options in response to the proposed changes through the potential establishment of a Rural Regional Centre in Newtown, more details are provided on page 60 and 61.

Hywel Dda Health Board are running a Transforming Clinical Services Programme which is looking at options for how services could be provided in the future; this may impact on services provided to Powys residents in the Machynlleth area. The emerging model could present further opportunities to provide care closer to home within the Wellbeing Community Hub in Machynlleth and potentially strengthen links with the Regional Rural Centre in Newtown. http://www.wales.nhs.uk/sitesplus/862/page/92263.

In Mid and South Powys, a formal partnership has been put in place between Wye Valley Trust and South Warwickshire NHS Foundation Trust to drive service improvement and economies of scale. An Accountable Care Organisation is being formed to achieve integrated services across primary, community, acute and social care to implement the Sustainability Transformation Planning process covering the Herefordshire and Worcestershire area. The potential impact is not yet known, but could result in some services moving further away. Continuing to strengthen local service provision via a Regional Rural Centre in Llandrindod Wellls will potentially reduce some of the impact by providing more services locally.

In South Powys, the reconfiguration of services, changes to pathways and service delivery will potentially impact on numerous pathways of care for Powys residents, predominantly from the south and south east of the County. Initial conversations have taken place with Cwm Taf and Aneurin Bevan UHBs and agreement reached to take a population based approach for the population of the 'Heads of the Valleys' catchment area with regard to future service planning and the impact of the New Grange Hospital. Continuing to strengthen local service provision via a Regional Rural Centre in Brecon will potentially reduce some of the impact by providing more services locally.

### 4.3.3 FINANCIAL CONTEXT

The Health Foundation report – The Path to Sustainability, October 2016 – calculated that NHS spending pressures in Wales would rise on average by 3.2% and 4.1% for adult social care per year to 2025/26 with funding held flat in real terms.

In 2016 the Health Board undertook some internal demand and capacity modelling, this identified that if we do nothing to change the way we work, future growth in demand for health services, would mean an additional cost pressure within the health board of nearly

£24.5M over the next 10 years (assuming tariff inflation for secondary care services would be 1% per annum).

The Health Board's Integrated Medium Term Plan outlines a variety of approaches to maintain its plan to contain costs within resource. The savings target of 1.3% is subject to work that is currently underway and at this stage is not yet fully defined, but is based on the assumption that the health board will focus on securing better efficiency as well as service redesign.

The level of investment to support the rising pressures and improvement within the Council's Social Services is a significant challenge to the local authority's financial planning. It is recognised that it is no longer affordable to maintain the Council in its current form. A significant transformational approach is required to meet this challenge and deliver a balanced budget over the medium term. This is illustrated by the fact that the recent Medium Term Financial Strategy identifies that the council must make a saving of £15.988m between April 2018 and March 2022. It is proposed that this will be achieved by a range of measure including:-

- The redesign of our Social Care services and management structures including the commissioning of services.
- Where there is value to be added we will work regionally to improve purchase power and make better use of specialist skills where critical mass does not exist in Powys.
- Continue to build on the success of our early intervention and prevention approach with well-defined and integrated care pathways, including a joint approach with Powys teaching Health Board and other partners such as the Third Sector.

The implementation of the Health and Care Strategy and Joint Area Plan will require us to work differently and to invest in some areas to deliver a new model of care, this will be reliant on the ability to fund new initiatives, commission effectively and to disinvest in other service areas, where safe and appropriate to do so.

### 4.3.4 DEMOGRAPHY

The Population and Wellbeing Assessments demonstrate the significant challenges facing provision of health and care in Powys. With a greater proportion of people aged over 50, an elderly population increasing at rates above those expected elsewhere in Wales and a predicted decrease in the number of births over the next ten years, a corresponding impact on demand can be anticipated. This impact of demography modelled over the next five to ten years, is over and above the potential impact of epidemiological factors such as obesity, smoking or alcohol use.

The reducing child population means we need to ensure we are able to continue to sustain and develop universal and targeted services – investing in early years is key to supporting the longer term wellbeing of future generations.

In Powys 26% of people are aged over 65 or over (compared to 18% in the UK); this is projected to increase by 38% in 2036. A paper published by Kings Fund, Demography Future Trends UK highlighted:

- ''The annual costs of health and social care are significantly greater for older people.
- The number of elective and non-elective hospital admissions for older people has increased more rapidly than the growth in absolute numbers.

- Current projections suggest that a high proportion of older people in the future will be living on their own and are therefore likely to require formal care.
- The number of older people with care needs is expected to rise by more than 60 per cent in the next 20 years''.

Exploring new approaches such as assistive technologies, mobile working and integration of services can help to bridge the gap between future need and resources.

Both the ageing population and improvements in treatments and interventions also means people are living with multiple diseases and more complex care needs. This means, there is a need to look more holistically at a person's needs. Looking further ahead to prevent people from becoming ill through early help and support can have the greatest impact on ill health and premature mortality, as well as focusing on the things that prevent us from disease such as smoking, alcohol and being overweight.

The next few pages provide a summary of the key findings from the wellbeing and population assessment, of which the Health and Care Strategy and Joint Area Plan are based upon and respond to, in relation to the identified care and support requirements.

### 4.3.5 WELSH LANGUAGE

The regulation standards will require the Health Board and the Council to plan their work to improve their offer including more services through the medium of Welsh. Building on the Welsh Government's strategic framework for Welsh language services in health, social services and social care which has helped to improve Welsh language services in the sector.

According to the 2011 Census, 18.6% of the population of Powys speak Welsh - a total of 23,990 Welsh speakers. 34% of Welsh speakers were between 5 and 17 years old.

Ystradgynlais has the highest number of Welsh speakers – 3369 according to the 2011 census. But second in terms of the number of Welsh speakers is Newtown, with 1600 Welsh speakers, and Machynlleth third with 1119.

Wards with the highest percentages of Welsh speakers are in the Dyfi, Banw and Tanat valleys in Montgomeryshire and in the Ystradgynlais area in Brecknockshire. 64.2% of the residents of Cadfarch, near Machynlleth speak Welsh, 56.5% in Llanerfyl, 50% in Pen-y-bont-fawr and 42.8% in Ystradgynlais.

Many Welsh speakers can only communicate their care needs effectively through the medium of Welsh, and for many Welsh speakers, using Welsh is a requirement not an optional extra.

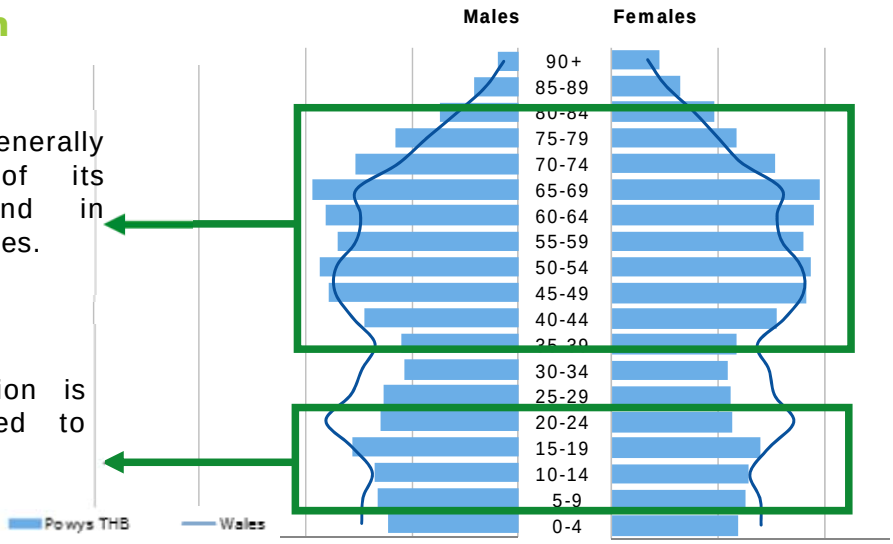
It is a priority to maximise the active offer to speak welsh, ensuring people can secure their rights and entitlements by using their own language to communicate and participate in their care as equal.

## 4.3.5 WELLBEING & POPULATION ASSESSMENT

### A Changing Population

The population in Powys is generally older both in terms of its demographic make-up and in comparison to the rest of Wales.

The working adult population is smaller in Powys compared to Wales.




**8 %** Projected overall decline in the Powys population by 2039.

The population of children and young people in Powys is predicted to decrease within the next ten years, mainly due to an on-going trend for young people to leave the county in favour of more urban areas, as well as the reduced birth rate across Powys. However, the number of those aged over 65 and 75 will rise faster in Powys compared with Wales. The 65+ age group in Powys is projected to increase by 37% by 2033 and the 85+ population is estimated to increase by 121% over the same time period in Powys.

**15 %** Powys population aged 15 and under.

**59 %** Powys population of working age.

**26 %** Powys population aged 65 or over.

**5,500** people migrated out of Powys in 2015

**5,900** people migrated into Powys in 2015

The number of young people and those of working age is predicted to decrease while the number of older adults in Powys is predicted to increase.

## 4.3.6 ECONOMIC WELL-BEING AND POVERTY

**Access**
**Poverty**

Powys is the most deprived Local Authority in Wales for access to services. 42 Lower Super Output Areas (LSOA) are among the least affluent 10% of areas in Wales.

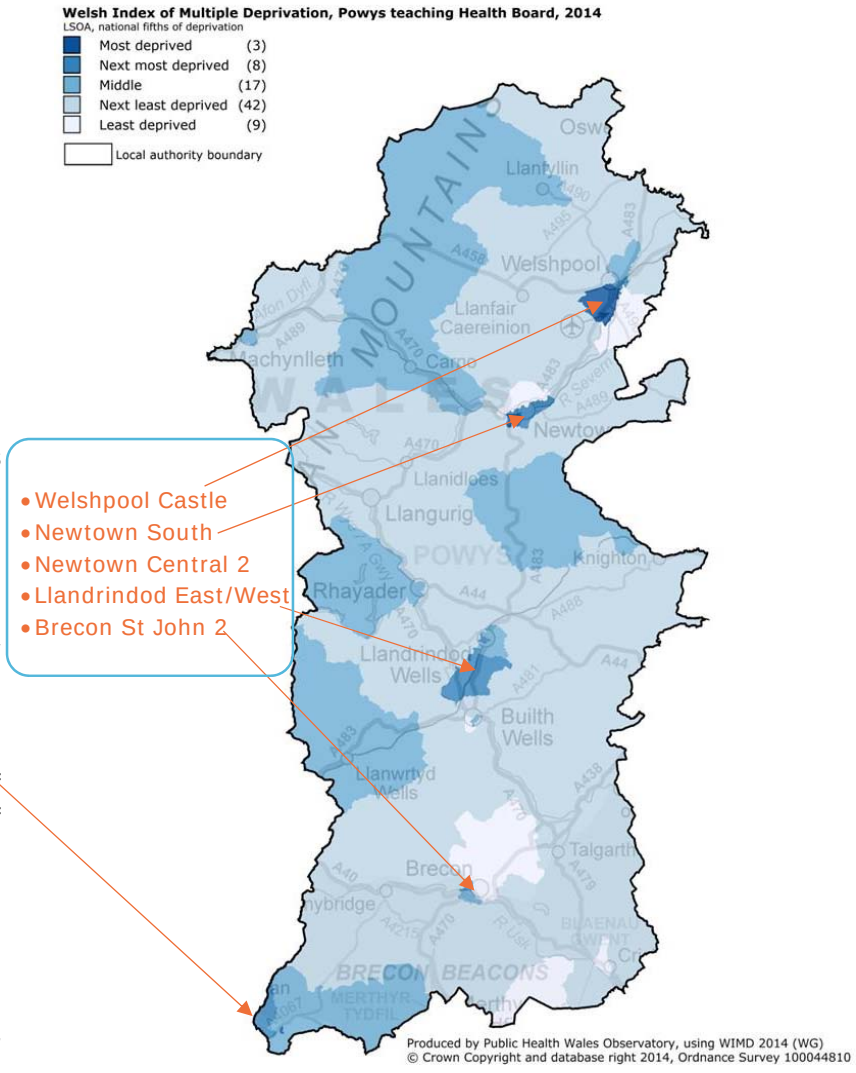
Economic well-being is above the Welsh average but there is hidden poverty in Powys associated with rural communities.

On average, Powys residents earn consistently less than people in many other Welsh Local Authorities, ranking third lowest in Wales.

Five LSOAs in Powys are among the most deprived 30% in Wales while Ystradgynlais 1 is the most deprived area and is among the 10% most deprived LSOAs in Wales.

Powys has a disproportionately high number of small businesses, alongside a high proportion of self-employed workers. This needs to be seen in the context of 11.3% of men and 8.9% of women of working age in Powys having no formal qualifications.

Between 2004 and 2013, there was a reduction in the proportion of Year 11 leavers not in education, employment or training.




**£487** Average weekly income in Powys (£539 Wales).

**13%** Children living in poverty in Powys (21.9% Wales).

**24%** Households in Powys in fuel poverty (23% Wales).

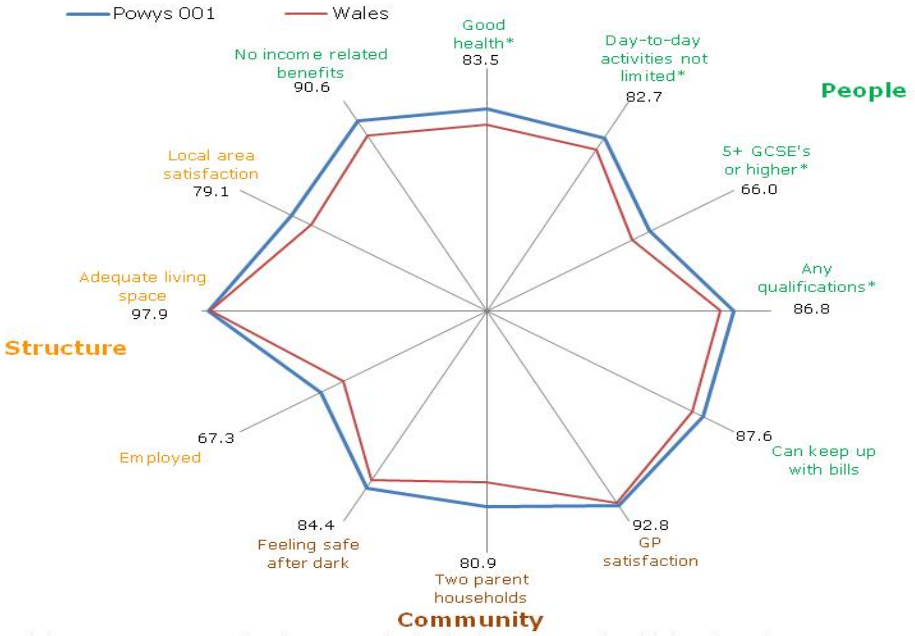
## 4.3.7 Community Well-being and Health Assets

**83%** Of Powys residents report that they feel they belong to their local area (Welsh average 76%).

Powys has a high prevalence of the assets required for resilient, self-reliant communities. This is almost universally the case, with good levels of provision relative to Wales, whether looking at people, community or structural assets. The only area where more attention may be required in some parts of Powys is in relation to education and training. Improving educational attainment in more deprived parts of Powys would provide for comprehensive coverage across all communities of the key assets for strong communities.

**Health Asset indicators, percentages, Powys 001 and Wales**

Produced by Public Health Wales Observatory, using NSW (WG), Census 2011 (ONS) and DWP




*These percentages are directly age-standardised using aggregated weightings from the 2013 European Standard Population.

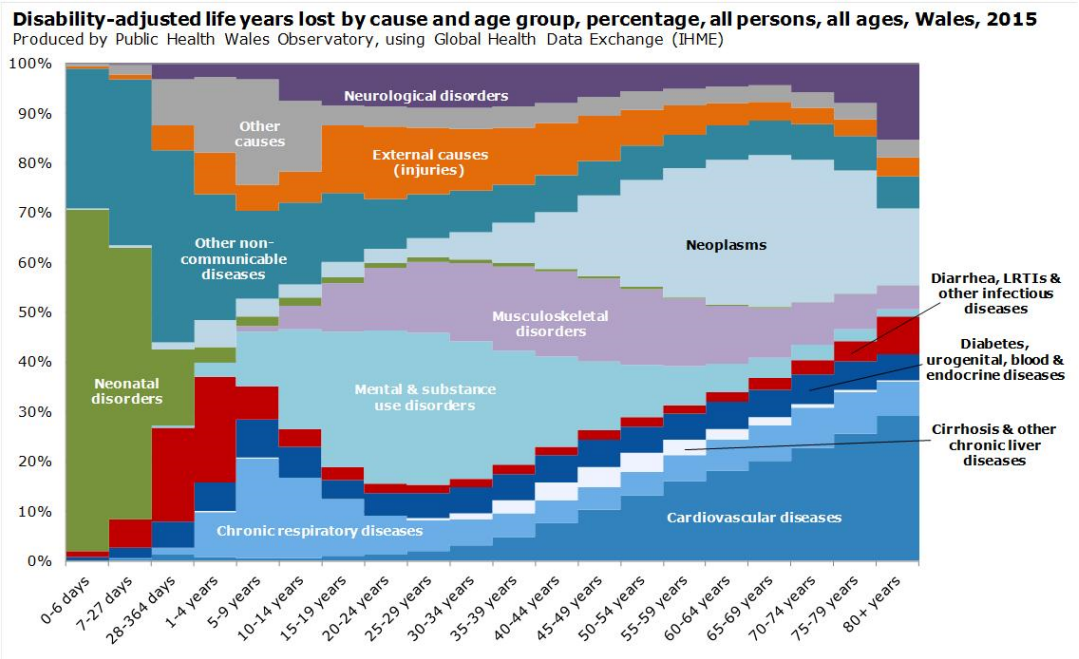
- Public sector services in Powys include 98 schools, 17 branch libraries and 2 mobile libraries, 16 leisure centres, 10 hospitals, 18 fire stations and 14 police stations.

- Powys is the second most expensive place to buy a house in Wales (8.7 times the median annual gross pay for a full time job in Powys, 6.4 in Wales).
- House prices vary considerably across the County with Crickhowell and Langattock being the most expensive and Ystradgynlais and Ystradfellte being the least expensive.

- A total of 859 people are supported by domiciliary care in Powys, a lack of infrastructure and assistive technology has reduced the viability of independent living.

## 4.3.8 Burden of Disease

The *Health and its determinants in Wales*[2] report provides an overview of the health and well-being of the population of Wales. It outlines the main areas of health need and presents the complex picture of health in Wales. Although information is shown on an all Wales basis, the picture it presents of disease and disability throughout the life course is equally likely to apply to Powys. Given the importance of maintaining health and well-being, it is useful to see the relative contribution made by different causes to ill health and disability across the life course. This is shown below using disability-adjusted life years as a measure of ill health.




Source: Public Health Wales

This illustrates the contribution made to ill health by different causes at different stages of the life course. Cancer (neoplasms) and cardiovascular diseases feature from birth but are shown to impact on the majority of people in later life. Chronic respiratory diseases feature from birth and have the biggest impact in early years through to adulthood. Mental health disorders feature prominently from the early years onwards, but the biggest impact is seen during adulthood. The Health and Care Strategy for Powys recognises the need to address these four causes, bringing them together under the heading “The Big 4”.

Musculoskeletal disorders are also shown to be a significant cause of disability and ill health, especially in relation to working age adults. The incidence of musculoskeletal disorders will addressed through actions that fall within the “Focus on Well-being” (i.e. keeping adults healthy and active), and through “Early Help and Support” (i.e. ensuring prompt access to diagnosis and treatment for those people with chronic conditions).

## 4.3.9 Population Assessment Specific Key Findings

The following section provides an overview of the key findings from the Wellbeing and Population Assessment based on the core themes within the Regional Partnership Board Area Planning guidance.

### 4.3.9.1 CHILDREN AND YOUNG PEOPLE

[1]"Family relationships'' were identified as the most important aspect of wellbeing to children.

- 91% of respondents lived in a home where they were happy.
- 90% said that they felt safe.

Of those children receiving care:

- 74% of the respondents said that their views about their care and support had been listened to.
- 78% felt that that they'd had the right information or advice when they needed it.

The most common age group of vulnerable children is 10-15 years old, this makes it hard to find suitable foster parents as their needs are greater. More children are being placed on the child protection register, with neglect being the most common reason. The number of cases referred to the Youth Justice Service has fallen since 2010, along with the number of children in need. This is in the context of a statutory requirement for Powys County Council to improve children's services, following a negative review by Care Inspectorate Wales during 2017.

### 4.3.9.1 OLDER PEOPLE

[2]'Many older people in Powys say they want to stay in their own home and stay connected to their community.

- 81% of respondents felt that their home was suited to their needs. The most common cause for complaints regarding their homes related to the poor quality or lack of adaptations in the home.
- 26% of people felt they had to move into a residential care home because of a decline in their health and inability of family or carers to provide support to them.

[3]'People have said there are a lack of places to go for older people during the daytime and have stressed the importance of the existing day time services and the respite it provides to carers.

- 91% felt that they were able to communicate in their preferred language.
- 80% of respondents said they were happy with the support they receive from family, friends and neighbours.
- 75% said that they felt safe. Of those who did not, a large majority were concerned about the possibility of falling and not being able to call for help.

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[1] citizen questionnaire

[2] citizen questionnaire

[3] citizen questionnaire

- 66% of adults felt they were part of the community, while 27% disagreed or felt this only some of the time - isolation was felt the key reason for this.

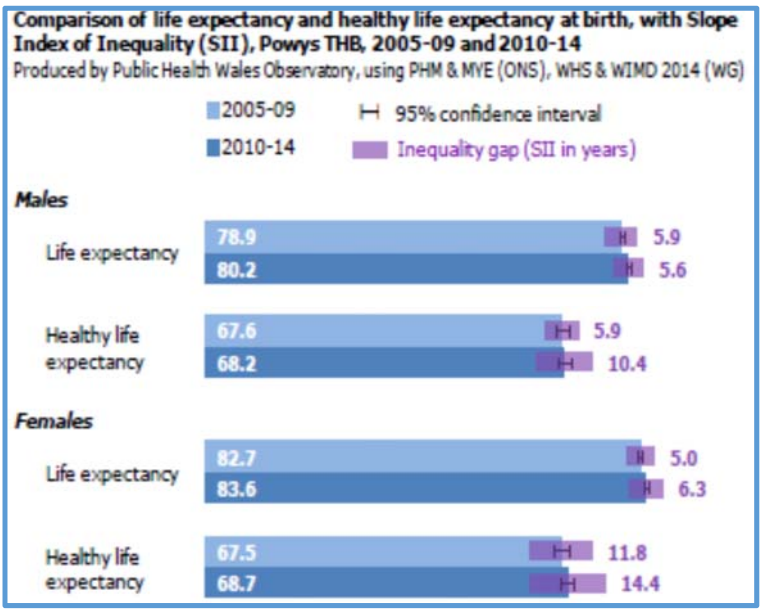
[4]'Of those adults and older people receiving care and support:

- 72% said they had been actively involved in the decisions about how their care and support was provided.
- 83% said that they were happy with the care and support they had.

### 4.3.9.3 HEALTH AND PHYSICAL DISABILITIES

When you compare Powys with the rest of Wales, we experience significantly higher life expectancy for men and women. This continues to improve, yet inequalities have widened between the most and least affluent along the social gradient (The social gradient in health refers to the fact that inequalities in population health outcomes are associated with the socioeconomic status of individuals (Rebalancing healthcare, working in partnership to reduce social inequity, Welsh Government, 2015-16).

The digram below shows the comparison of life expectancy (LE) and healthy life expectancy (HLE) at birth, with Slope Index of Inequality (SII), Powys THB, 2005-09 and 2010-14




Children living in the least affluent parts of Powys can expect to live six years less than a child living in more affluent areas (Public Health Wales NHS Trust, 2016). Also, a child brought up in the least affluent areas can expect to live 10 years less in good health if they are male, and 14 years less if they are female.

When compared with the rest of Wales, Powys adults tend to have healthier lifestyle behaviours. However, nearly 6 in 10 adults are overweight or obese and this is predicted to continue to rise (Public Health Wales NHS Trust, 2016).

Several serious conditions are associated with being overweight or obese. They include type 2 diabetes, hypertension, coronary heart disease and stroke, osteoarthritis and cancer.

Just under one in five adults currently smoke (Public Health Wales NHS Trust, 2016). Smoking is the single greatest cause of preventable mortality. Smoking causes a range of cancers, it leads to cardiovascular disease and a range of respiratory conditions, e.g. COPD and emphysema.

[4] citizen questionnaire

Four in 10 adults drink in excess of guideline amounts (Public Health Wales NHS Trust, 2016). Regular drinking to excess can cause cancer, stroke, heart disease, liver disease, brain damage, and damage to the nervous system. The impact of unhealthy lifestyles on individuals and wider health and social care services means that prevention is an important topic for the population assessment.

Just over one in three adults report eating five or more portions of fruit and vegetables in the previous day. In Powys, nearly four in ten adults reported being physically active on five or more days in a given week. In contrast, a quarter of the population reported that they did no physical activity.

Residents of Powys generally report higher levels of engagement with healthy behaviours than in Wales as a whole. Powys residents self-report higher levels of regular fruit and vegetable consumption, they report exercising more and drinking to excess on a less frequent basis than in the rest of Wales. Of those residents who responded to the citizen survey, only 52% of adults said they could do things that were important to them - health and mobility issues were raised as being the main limiting factor.

#### 4.3.9.4 LEARNING DISABILITY AND AUTISM

A high proportion of the population in Powys have a learning disability compared with the rest of Wales. Autistic spectrum disorders are the most common presentation of disability within children in Powys. There are 753 people known to have autism: 302 children and 421 adults.

The number of people in Powys with a learning disability is increasing, particularly in the older age categories and this has significant implications for the type and volume of support likely to be needed in the future. The percentage of people with learning disabilities is predicted to increase by 1.7% between 2015 and 2020. However the percentage of people with a severe learning disability is predicted to slightly decrease over the same period (-0.4%).

There are 370 people with Learning Disabilities who are supported to live in the community. A range of long-term and short-term accommodation services are commissioned in Powys, including residential care placements and supported living tenancies. However, there are also people that are placed out of county. These placements include small domestic settings, residential homes, residential specialist colleges, specialist behavioural facilities and larger residential communities catering for a diversity of service users with differing disabilities, care needs and behaviours which challenge services. To enable these people to return home would require an appropriate infrastructure within health and social care to sustain local placements.

The citizen survey reported that children with learning disabilities said they would like more control over their lives and to be able to access the community activities which other children do.

Key priorities identified through the population assessment include: information, staying healthy, choice, control and relationships, flexible support, accommodation/housing, opportunities for work leisure and learning, staying safe, moving on and transition, good support and consultation and co-production.

### 4.3.9.5 MENTAL HEALTH

The average lost years to life for males with mental health problems is 11 years and for women is 6 years. 1 in 4 people in the UK will experience a mental health problem each year. In Powys 10.4% of adult population report being on the mental register (Wales 12.4%).

8% of the Powys population report being treated for depression or anxiety and it is one of the top three leading causes of disability. One in four patients presenting to their GP live with depression with the average GP seeing at least one patient with depression during each surgery session.

In Powys in 2013-14, there were 1,024 dementia patients according to PTHB records. At 44% Powys, along with Ceredigion, has the highest projected rise in the number of people with dementia in Wales. Dementia prevalence increases with age, roughly doubling every five years for people aged over 65 years. Dementia affects 20% of people over 80 years of age in the UK and one in 14 people over 65. In Powys it is thought that only 39.6% of the projected number of people with Dementia have a diagnosis.

For children and young people, anxiety/stress was by far the most reported presenting issue for young people in Powys, followed by self-esteem related issues (self-worth and depression) and relationships with others (family and friends).

Overall, the number of assessments undertaken by Powys CAMHS (Child and Adolescent Mental Health Service) has increased between April 2014 and March 2016 and overall during this period, people are waiting less time for an assessment.

In 2015/16, a total of 68 cases referred to “Team around the Family” highlighted emotional health and wellbeing as an area for improvement. Following the intervention, 29 cases showed an improvement in emotional health and wellbeing. During the same period, 64 cases highlighted identity, self-image and self-esteem as an area for improvement and following the ‘Team Around Family’ intervention, 35 had shown an improvement in this area.

Improving mental health is a critical issue for people of all ages and its impact is cross cutting, affecting life chances; learning, home life, employment, safety, physical health, independence and life expectancy.

### 4.3.9.5 SENSORY IMPAIRMENT

The term ‘people with sensory loss’ is used to refer to the following:

- People who are Deaf; deafened or hard of hearing.
- People who are Blind or partially sighted.
- People who are Deafblind: those whose combined sight and hearing impairment cause difficulties with communication, access to information and mobility.

Key findings are:

- Total population aged 18 and over predicted to have a moderate or severe hearing impairment is 17,243 (2013) rising to 20,118 in 2020.
- Total population aged 18 and over predicted to have a profound hearing impairment = 395 (2013) rising to 470 in 2020.
- People aged 18-64 predicted to have a severe visual impairment = 49.

- People aged 65-74 predicted to have a moderate or severe visual impairment = 1,009(2013) rising to 1,123 in 2020.
- People aged 75 and over predicted to have a moderate or severe visual impairment = 1,846 (2013) rising to 2,295 in 2020.
- People aged 75 and over predicted to have registerable eye conditions = 945 (2013) rising to 1,175 in 2020.

#### 4.3.9.6 CARERS

There are 16,154 carers known in Powys, of which 576 of these are young carers. The increasing numbers of carers (up by 14% since 2001) is of particular significance as unpaid carers, usually family members, contribute significantly to maintaining the well-being of individuals with complex needs due to long term physical or mental ill-health, disability or old age in the community. The health and well-being of carers is affected by their caring responsibilities, as many may experience ill health, poverty and problems accessing employment. In Powys, 65% of unpaid carers are over 50 and 39% are retired. Their health is typically below average, and some carers are now providing more than 50 hours of care each week. Of those carers who took part in the citizen survey; 33% said they could do things which were important to them with 24% saying this applied only part of the time and 29% felt supported to continue in their caring role.

The number of young carers is increasing, with most providing up to 19 hours of care. Some young carers, due to their responsibilities, are missing out on school time. This can have an effect on their education and future prospects. Due to the increasing elderly population, more young people are finding themselves with caring responsibilities.

Dementia prevalence increases with age, roughly doubling every five years for people aged over 65 years. Dementia affects 20% of people over 80 years of age in the UK and one in 14 people over 65.

It is estimated there are 4,256 people in Powys aged over 65 with dementia. At 44% Powys, along with Ceredigion, has the highest projected rise in the number of people with dementia in Wales. Generally it is thought that only 39.6% of the projected number of people with Dementia have a diagnosis.

#### 4.3.9.7 VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE AND SEXUAL VIOLENCE

In 2016 Powys has seen a 10% rise in the number of domestic violence incidents being reported, compared with 2015. Domestic violence appears to be more prevalent in the north of Powys, where BME (Black, Minority and Ethnic) and LGBT (Lesbian, Gay, Bisexual, Transgender) groups are also more likely to be affected. Many crimes are still not reported, and the number of incidents is expected to rise over the coming years. This rise continues an existing trend with an overall increase of 75% since 2010.

The 2016-2019 Joint Commissioning Strategy for Domestic Abuse in Powys identified the following priorities for action:-

- *Prevention: Violence* against women, domestic abuse and sexual violence is prevented and wherever possible there is early identification and intervention to limit harm to victims and survivors.
- *Protection:* Suitable and effective processes are in place to protect all individuals experiencing violence against women, domestic abuse and sexual violence.

- *Support:* Individuals experiencing any form of violence against women, domestic abuse and sexual violence can access appropriate, high quality support wherever in Wales.

#### 4.3.9.8 OLDER PEOPLE ACCOMODATION

More people over 65 are now living on their own in Powys, there are 19,000 lone person households out of a total of 59,100 households (2015). Many people are finding it increasingly difficult to perform basic domestic tasks. A total of 859 clients are supported by domiciliary care in Powys, a lack of infrastructure and assistive technology has reduced the viability of independent living. Despite this, there has been an increase in the number of adult clients supported in the county. As our elderly population increases, there will be more demand for suitable accommodation options. By 2035, more people are expected to be living alone and the number of people with dementia is also expected to increase. We will need to accommodate citizens within their local communities, whether that is in their own home, in sheltered or extra care accommodation, or a nursing home.

# 5. Strategic Challenges and Opportunities

## 5.1 START WELL, LIVE WELL AND AGE WELL

The Health and Care Strategy seeks to enable children and young people to 'Start Well', for people to 'Live Well' and for older people to 'Age Well'.


Focusing on enabling children to 'Start Well' is fundamental to improving the longer term wellbeing of our resident population.

There is a growing body of scientific evidence that shows the foundations of a person's lifelong health—including their predisposition to obesity and certain chronic diseases—are largely set during this 1,000 day window. There is also growing evidence that our experiences during childhood can affect our health throughout the life course. Adverse childhood experiences are increasingly being linked to effects throughout the life course, contributing to a number of physical and mental health problems in adulthood and ultimately greater disability and (premature) mortality.


As the needs of our population have changed, more people are living with cancer, mental health, respiratory disease, circulatory disease and musculoskeletal disorders. There is a need to ensure people can 'Live Well' through being healthy and active and by accessing early help and support. Living well during adulthood can create huge benefits in older age.


As the older population in Powys is projected to increase faster than the rest of Wales, it is important that we enable older people to feel supported to live independently in a home of their choice and to remain healthy and active members of the community.

Across the life course, we will focus on the four key areas, promoting wellbeing, offering early help and support to people, tackling the big four diseases that limit life and providing joined up care. The next few pages describe the importance of the life course approach and the strategic challenges and opportunities in Powys.


# Wellbeing

## 5.2 WELLBEING STRATEGIC CHALLENGES AND OPPORTUNITIES

### 5.2.1 COMMUNITIES

A core part of individual and community wellbeing is the feeling of being connected to others and having a meaningful purpose. The rurality of Powys can lend itself to people becoming socially isolated. Evidence shows there is a clear link between loneliness and poor mental and physical health and that specific interventions such as exercise, group activities and volunteering can reduce social isolation & promote mental wellbeing. Feeling connected can improve satisfaction with life including greater resilience emotionally and physically.

The Social Service and Wellbeing Act and The Parliamentary Review of Health and Social Care in Wales, identifies the need to put people in control by strengthening individual and community involvement through voice and control in health and care, and ensuring all ages and communities have equal opportunities for involvement. This needs to be supported through a model of care that enables equal relationship between people and professionals and for people to make informed decisions based on the choices available to them.

In Powys there are strong and resilient communities. There are opportunities to build on these strengths to improve future wellbeing through intergenerational services, which are community and/or statutory led. This includes building on the strength of Third Sector capacity and volunteers, and evaluating areas of good practice such as community connectors and home support services to fully realise the potential benefits across the whole of Powys.

In Powys, people in the most deprived communities live more years in poor health compared to people in the least deprived areas. There is a 10 year difference for men and a 14 year difference for women in healthy life expectancy in Powys. Overall life expectancy differs by around 6 years for both men and women.

By growing up in a deprived area, children are more likely to have poorer health which will impact on the rest of their lives. Evidence shows that over a period of 10 years, cognitive outcomes for children in high and low socio-economic status diverge over time. Across Wales, there is a clear correlation between levels of deprivation and rates of overweight or obesity, ranging from 28.4 of children living in the most deprived areas being overweight or obese to 20.9% in the least deprived.

### 5.2.2 HEALTH AND WELLBEING

Health and care interventions that do not reach those at greatest risk are likely to increase the inequity in health outcomes. Reducing inequalities can be achieved through effectively working across health, local authorities, schools and other agencies by upstream interventions throughout the life course, but with particular emphasis on wellbeing, the first

1000 days, adverse childhood experiences and independence. There is a need to work much more closely with our communities to intergenerational services that support everyone including those who need it most.

Supporting healthy lifestyles is a key contributor to the future wellbeing of Powys residents. Unhealthy lifestyles place greater demand on health and social care services and reduce people's opportunity to live fulfilling lives.

Smoking continues to remain the single greatest preventable cause of premature death and ill health in Powys and is one of the main contributors to health inequalities. Just under 1 in 5 adults currently smoke and 4 in 10 adults drink in excess of guideline amounts.

In Powys, more people are generally active than in the rest of Wales, and people in Powys are generally healthier than in the rest of Wales. However nearly 6 in 10 adults are overweight or obese, this equates to 58% of adults being overweight or obese (Wales 59%). Excess body weight is a major contributor to preventable morbidity and premature mortality. Being overweight or obese increases the risk of developing a wide range of serious health problems including type 2 diabetes, cardiovascular disease, cancer and musculoskeletal conditions such as osteoarthritis.

Whilst a greater proportion of the Powys population engages in healthy behaviours compared with Wales, there remains significant challenge in further improving health behaviours and health outcomes.

### 5.2.3 CARERS

The health of carers is Powys is reported as being typically below average. Some carers are now providing more than 50 hours of care each week. 65% of unpaid carers are over 50 and 39% are retired. Powys is below the Welsh average in the proportion of carers assessed and who were then provided with support (Wales 58.2% and Powys 34.8% - 2013/14 baseline).

Being a young carer can significantly impact on their wellbeing, education and future opportunities. Young carers have a significantly lower attainment level at GCSE and are much more likely to be Not in Education, Employment or Training (NEET).

Respite is hugely important to carers and at times is limited in parts of Powys.

The Social Services and Well-being Act is designed to ensure that carers can access a wider range of appropriate services in a more flexible way. Key areas identified for development include:

- Information, Advice and Assistance (IAA) - access to comprehensive information relating to all types of support and respite services. IAA services will play an important role in signposting carers and others to preventative care and support services in their community without the need for formalised assessments.
- Integrated Assessment - a duty to undertake a proportionate carer's assessment where it appears that a carer has need for support to ensure that more energy is focused on delivering support.
- Community Based Preventative Services – The new arrangements for support will mean the majority of carers will receive support through the provision of IAA services and or be supported through community based preventative services.

- After Assessment – A national 'eligibility framework' will be developed and the detail of how this will operate will be set out in Regulations.
- Support Plans – If a carer is assessed and confirmed as having an 'eligible need' for support the local authority will put in place a support plan for the carer, and will carry out further assessments and revise the plan if there has been a change in the carer's circumstance.
- Direct Payments – Carers who are assessed by their local authority as having an eligible need for support will be entitled, as now, to receive direct payments (subject to financial assessment) so that they can arrange their own support.

## 5.3 WELLBEING INTENDED OUTCOMES

**Through successfully focussing on wellbeing, people in Powys will say;**

- I am responsible for my own health and wellbeing.
- I am able to lead a fulfilled life.
- I am able and supported to make healthy lifestyle choices about my mental and physical health, and wellbeing, for myself and my family.
- I have life opportunities whoever I am and wherever I live in Powys.
- The environment/community I live in supports me to be connected and to maintain my health and wellbeing.
- As a carer I am able to live a fulfilled life and feel supported.


# Early Help and Support

## 5.4 EARLY HELP AND SUPPORT STRATEGIC CHALLENGES / OPPORTUNITIES

The impact of unhealthy lifestyles on individuals and wider health and social care services means that early help and support is a key strategic focus. Providing early help and support in an integrated way is vital across the life course to improve wellbeing, prevent people from disease, enable people to lead fulfilled lives and manage ill health effectively.

### 5.4.1 ACHIEVING THE BEST START IN LIFE

Significant evidence supports the need to focus on the first 1,000 days of a child's life. The right nutrition during this 1,000 day window has a profound impact on a child's ability to grow, learn and thrive. Nutrition during pregnancy and in the first years of a child's life provides the essential building blocks for brain development, healthy growth and a strong immune system. In fact, a growing body of scientific evidence shows that the foundations of a person's lifelong health—including their predisposition to obesity and certain chronic diseases—are largely set during this 1,000 day window.

There is also growing evidence that our experiences during childhood can affect our health throughout the life course. Children who experience stressful and poor quality childhoods are more likely to adopt health harming behaviours during adolescence which can lead to mental health illnesses and diseases such as cancer, heart disease and diabetes later in life. These negative experiences are referred to as ACE's – Adverse Childhood Experiences, they can alter how children's brain develops, as well as change the development of their immunological and hormonal systems. Preventing ACE's can have a huge impact on children's well being and reduce additional costs to the health system. Tackling ACE's will rely on having the intelligence on how many people are exposed to ACE's; this information can often prove difficult to obtain. Midwifes, and health visitors will be crucial in supporting this, identifying potential issues at point of conception and identifying those children at risk and identifying appropriate intervention support.

In Powys the number of looked after children is low compared to Wales, however there are more complex needs arising and more children being placed on the child protection register, with neglect being the most common reason. There is a need to develop a local plan to ensure prevention of adverse childhood events and appropriate focus on the first 1,000 days. There are also opportunities to look at how health and social care work with schools to talk to children about their wellbeing. Broadening staff understanding around the early beginnings and what services are available is essential to ensuring children are getting the right level of support as early as possible.

## 4.5.2 INTEGRATION OF PRIMARY AND COMMUNITY CARE SERVICES

Primary and community care services are fundamental to wellbeing and ensuring early help and support to residents in Powys.

In Powys there are seventeen General Practices with practice list ranges from 2,957 to 15,512 patients. There are a number of factors currently affecting the sustainability of general practice services including GP recruitment, removal of the minimum practice income guarantee, rurality associated with cost pressures of working across multiple sites. New workforce models are being piloted to include community pharmacists, urgent care practitioners, advanced nurse practitioners and physician associates. Some General Practices are already utilising technology to provide virtual consultations as support to other GP practices.

Some practices are working from within buildings which require substantial maintenance and repair investment. There are two practices (Welshpool and Newtown) whereby the premises are no longer fit for purpose. Opportunities to integrate general practice within new health and care developments should be explored, this is currently being progressed in the Machynlleth area.

There are similar risks in sustainability of primary care dental services across Powys, key challenges include gaps in provision, single practicing dentists, recruitment and training. The Health Board have provided some support to primary care dental services via the Community Dental service, there are further opportunities to improve access through developing mobile dental services and by bringing services closer to home for people. The latter is subject to capacity being available within existing buildings or new developments such as the Regional Rural Centre in Newtown.

Optometry services within Powys work well, there are further opportunities to expand services on the high street, reducing demand on secondary care services. There are also opportunities to improve access to support for people who are visually impaired.

## 5.4.3 SUPPORTING PEOPLE WITH CHRONIC CONDITIONS

People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days. There is an ever-increasing demand on primary and community care services from people with long-term conditions.

Screening is an important component of the pathway, to identify people who have chronic conditions or who are at risk of developing them, this can help prevent disease or lessen the severity of illness.

Barriers to making better lifestyle choices for people with long term conditions include poor health literacy and lack of psychological support to modify their behaviour. This has been combined with a current medical model which has usually meant people playing a fairly passive role in their condition management.

Around 70-80 per cent of people with long-term conditions can be supported to manage their own condition (Department of Health 2005). Self management has potential to improve health outcomes in some cases, with people reporting increases in physical functioning (Challis et al 2010). It can improve experience, people reported benefits in terms of greater confidence and reduced anxiety (Challis et al 2010). Self management, combined with

tailored information and signposting, education and psychology support will improve outcomes and potentially reduce hospital admissions. Community pharmacy could be integrated within Wellbeing Community Hubs and Regional Rural Centres to support prevention and management of short and long term conditions and to promote self care.

There are opportunities to develop chronic condition services so that more services can be provided locally, through an integrated approach that supports people with multiple conditions via a single management plan and chronic condition co-ordinator. Ensure holistic needs on the individual and their family are met.

## 5.5 EARLY HELP AND SUPPORT INTENDED OUTCOMES

**Through successfully focussing on early help and support, people in Powys will say;**

- I can easily access information, advice and assistance to inform myself and remain active and independent.
- As a child and young person I have the opportunity to experience the best start in life.
- I have easy access, advice and support to help me live well with my chronic condition.


# The Big Four

**Mental Health, Cancer, Respiratory, Circulatory**

## 5.6 THE BIG FOUR STRATEGIC CHALLENGES AND OPPORTUNITIES

The Public Health Report for Wales, 'Making a Difference Investing in Sustainable Health and

Well-being for the People of Wales' highlighted that making a fundamental shift to re-focus the health and care system on prevention, early help and support will improve wellbeing and in the longer term reduce the burden of disease.

The Health and its determinants in Wales report, illustrates the contribution made to ill health by different causes at different stages of the life course. Cancer (neoplasms), cardiovascular diseases, respiratory diseases, and mental health disorders all feature prominently from the early years onwards. Neoplasms (cancers, 19%) and cardiovascular disease (18%) are the leading causes of disability-adjusted life years (DALYs) by cause, in Wales, 2016 and the main causes of years of life lost (YLL) in 2016. Musculoskeletal disorders and mental and substance use disorders were identified as the main causes of years lived with disability (YLD).

The Health and Care Strategy for Powys recognises the need to address these four causes, bringing them together under the heading "The Big 4".

In tackling 'The Big Four' the current system can be slow to diagnose people; this leads to deterioration whilst people are waiting and can therefore increase costs, mental health implications and lower self-esteem.

### 5.6.1 MENTAL HEALTH

Improving mental health is a critical issue for people of all ages and its impact is cross cutting, affecting life chances; learning, home life, employment, safety, physical health, independence and life expectancy.

The Kings Fund 'bringing together physical and mental health' published a compelling the case for seeking to support physical and mental health in a more integrated way, in addition to integration of health and social care. It identified there are high rates of mental health conditions among people with long-term physical health problems, and that there is reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health.

The average lost years to life for males with mental health problems. Women with mental health problems on average lose 6 years this is the biggest health inequality.

In Powys 10.4% of adult population report being on the mental register (Wales 12.4%). It is estimated there are 4,256 people over 65 with Dementia and 8% of the Powys population report being treated for depression or anxiety.

For children and young people, anxiety/stress was by far the most reported presenting issue for young people in Powys. The number of referrals to the Children Mental Health service increased over the last two years.

Mental health services previously had complex arrangements in Powys with services being delivered to Powys residents by three neighbouring health boards and the ability to deliver change was increasingly challenging. The management of services were recently brought back into the health board and new rural community models of care are being developed to improve services and address some of the key workforce challenges.

Recent recruitment challenges in the north of the county, led to the development of an alternative inpatient model, these services are now provided via a Dementia Home Treatment Team and feedback from service users has been positive. There are further opportunities to embed consider this approach across South Powys.

Reducing stigma associated with mental health services remains a challenge. There is a need to improve awareness of the range of mental health issues by linking access to information and support on mental health to all other services that are universally available. This would also help to provide earlier interventions.

### 5.6.2 CANCER

Cancer incidence rates are increasing and there is a need to ensure future demand can be met. There continues to be variation in cancer outcomes across Wales, and there is a need through commissioning to ensure equity of access and quality.

Nearly all cancer services are provided outside of Powys either in England or Wales. The current service provision includes primary prevention, screening, advice and guidance, end of life support including hospice. People requiring diagnosis and treatment are referred to the nearest external District General Hospital or specialist cancer centres. It can be difficult to co-ordinate care due to the use of multiple providers and the cross border complexity this brings. Case management and co-ordination is therefore crucial to ensuring that people with cancer receive the right information, early help and support and high quality, effective services. There are opportunities to improve communication and work more collaboratively to redesign the whole system and to provide care closer to home for services such as chemotherapy, as well as other parts of the cancer pathway. These opportunities would also build on the strengths of the existing community nursing team.

The risks of cancer are proven to reduce as the health status of the people is improved. Focus on primary prevention to reduce smoking, alcohol consumption and obesity will positively impact on the future risk of people developing cancer.

People are receiving earlier diagnosis through effective screening programmes. In Powys screening is undertaken through the National Screening Programmes as well as through Third Sector screening activities. It has been identified that onward referral from screening to mobile screening units in Powys needs to be reviewed in order to ensure that the referral pathway is appropriate for people whether that is in England or Wales. This needs to take into consideration travel and potential onward referral. Work to improve screening rates

through a coordinated approach, identifying local need, and working collaboratively with the national screening programmes and our Third Sector partners is required.

The age-adjusted cancer incidence rate in PTHB has increased from 567 cases per 100,000 population in 1995, to 632 cases per 100,000 population in 2014. The one year survival rate for all cancers has improved by 12 percentage points in PTHB between 1995-99 to 2009-13. Nearly three quarters of persons diagnosed with cancer in 2009-13 were alive one-year after diagnosis.

More people are living with and beyond cancer, this means improving quality of life and experience is paramount. For many this becomes a 'long-term condition' and many more people are living with the physical and psychosocial consequences of their cancer or its treatment. The recently implemented Powys Community Cancer Nurse pilot has demonstrated that when people are offered holistic needs assessment appointments, and are able to access the appropriate services and information, a real difference can be made. Powys is keen to learn from examples of good practice such as the successful Implementing Cancer Journey Programme from Glasgow, and is working with Macmillan to explore the opportunities for implementing a proactive community response to the needs of people with cancer in a rural setting.

The majority of people with cancer responding to the Macmillan Cancer Survey (90%) rated their overall care as 7/10 or more, however only 15% said they were offered a written care plan, Powys respondents scoring the lowest out of all health boards and less than half (45%) felt they completely discussed the impact of cancer on their day-to-day activities.

The Annual Report 2015/16 of the Director of Public Health for PTHB highlighted the following key messages for cancer:

- The four most common incident cancers in Powys are prostate, female breast, colorectal and lung cancer.
- The incidence of lung cancer is significantly lower (better) in Powys than in Wales for the period under consideration. For all other cancers considered, the incidence rate in Powys is not significantly different from the national rate.
- One and five year survival rates from individual cancers amongst the Powys population are, in general, not significantly different to the national rates.
- Findings have highlighted the need for ongoing surveillance of ovarian and oesophageal cancer, although the analyses are based on relatively low numbers.

### 5.6.3 RESPIRATORY

One in twelve people are said to have a respiratory illness and Wales has the highest prevalence of asthma in Europe. In Powys Chronic obstructive pulmonary disease (COPD) affects 2,216 adults or 2% of the population. This figure is projected to rise to 3,264 by 2019.

Improving the respiratory health of the population of Powys is a challenge and if it is done well it can improve the lives of people and their families. People who have a respiratory condition need access to care and support whenever it is needed.

Tobacco control, preventing the update of smoking, reducing smoking prevalence are all preventative measures which need to be taken to reduce incident rates.

There is significant opportunity for more telehealth/digital health care and to support self monitoring. Self monitoring takes place via key health indicators monitored on a daily basis

by a smart phone. The smart phone apps and other technologies are able to support in diagnosis and prescribe medication.

There are also opportunities for technology to support the National Exercise Referral Scheme enabling people to self refer and by making them more accessible services in communities through use of video link and skype.

### 5.6.4 CIRCULATORY DISEASE INC. DIABETES, HEART DISEASE AND STROKE

Approximately 3,174 adult patients are living with the consequences of stroke. 2% of adults have had a stroke in Powys. This figure is projected to rise to 3,340 over the next three years.
There needs to be greater emphasis on identifying and engaging with people who are at greater risk of developing a stroke, tackling the determinants which contribute directly to an increased risk of stroke. Working proactively with this cohort will help to reduce the risk of a stroke. There are opportunities to further strengthen emotional and psychological support for people who have had a stroke, and to develop the provision of stroke rehabilitation in people's own home through suitably trained staff to be based across Powys.

The total number of patients diagnosed with diabetes in Powys increased to 8,469 in 2015/16; generally there has been an upward trend in the past five years. Of these; 647 have type one diabetes. Evidence shows the onset of diabetes can be delayed or prevented through improved management of obesity, smoking and high blood pressure. Effective management of the condition can increase life expectancy and reduce risk of complications. Self management is the essential element of diabetes care and is an important area of focus, it relies on good access to psychology services.

80% of diabetic service costs are associated with complications developed from diabetes e.g. renal, heart failure and amputation. Some of which can then have an impact on social care needs and on the economy potentially due to loss of employment. There is a significant impact to be had through preventing people from developing diabetes and from effective management of those who have diabetes.

Proactive identification of people who are at risk of developing type 2 diabetes is essential to ensuring earlier diagnosis and reducing onset through targeted lifestyle intervention and psychology to support changing behaviours. There are opportunities to develop more localised services in Powys, this includes the expansion community provision through one stop services via an integrated health and care team which ensures timely access to advice and guidance from consultants to prevent unnecessary referrals to secondary care.

Increased delivery of effective education and lifestyle services will encourage greater responsibility of people and communities to improve their lifestyle.

There are approximately 4,432 patients living with coronary heart disease in Powys or 4% of the population. This figure is projected to remain largely unchanged over the next three years. The team see approximately 400 of these people, there are opportunities for greater focus on risk management and for working with all people with heart disease to ensure appropriate prevention and early intervention.

In Powys there are high levels of people with Atrial Fibrillation, therefore a need for general health promotion in relation to blood pressure and pulse checking to improve understanding of how individuals can support themselves with this condition.

There are opportunities to expand local services in Powys through developing one stop services to undertake echos and angiograms. This would require broadening the team's skill base and commissioning secondary care advice and guidance but would reduce travel times significantly for people.

## 5.7 THE BIG FOUR INTENDED OUTCOMES

**Through successfully focussing on 'The Big Four', people in Powys will say;**

- I have easy access to support, information and early diagnosis.
- I have early intervention and appropriate treatment.
- My treatment and support is high quality, evidence based and timely as locally as possible.


# Joined Up Care

## 5.8 JOINED UP CARE STRATEGIC CHALLENGES AND OPPORTUNITIES

The health and care system is complex, often there are multiple organisations involved in caring for an individual and this can results in handovers, delays and repetition when sharing information. With growing expectations and increasing complexity of need, its important services become more flexible to respond and help people to navigate easily to ensure early help and support.

### 5.8.1 URGENT CARE

The majority of unscheduled care services are provided outside of Powys with the exception urgent care and minor injuries. Currently there are sustainability issues with the provision of out of hours services, short term mechanisms have been put in place but a longer term solution aligned with the new NHS 111 service is required. In Powys, there is significant variation in the minor injuries services across Powys, which are provided from within GP practices and /or community hospitals. There are opportunities to develop a new model of care to strengthen minor injury and illness provision and ensure residents are clear on what services they can access where across Powys.

Avoiding unnecessary admissions to hospital is a key area of work for the Health Board and Powys County Council. The Virtual Ward has been in operation for a number of years. There is a need to ensure this service is admitting people who are truly those who will benefit the most, i.e. those most at risk of unplanned hospital admission, and ensure effectiveness in terms of their experience and cost.

There is also an increasing need to develop alternative pathways to prevent admissions to hospital, this is due to the neighbouring secondary care providers, who are reconfiguration services which might impact on access to emergency care for Powys residents.

Evidence shows holistic case assessment and a personalised case management plans reduce duplication and provide the case manager with a detailed understanding of the needs of the individual and their carer. Care co-ordination centres can improve discharge planning processes, providing opportunities to release inpatient capacity, but more importantly can reduce unnecessary hospital stays. Prolonged bed rest results in a reduced functional capacity of multiple body systems (especially the musculoskeletal system). We know that if people who are admitted stay in their pyjamas or gowns for longer than they need to, they have a higher risk of infection, lose mobility, fitness and strength, and are at risk of increased dependency. Further work is required to reduce length of stay/delayed transfers of care and prevent people from being admitted to hospital, through increasing alternative provision for those people who dial 999.

### 5.8.2 PLANNED CARE

A number of planned care services are provided from within Powys mainly from within the community hospital outpatient and day case departments. There are opportunities to further improve planned care services by:

- People to access electronically advice, book appointments and get test results.
- Commissioning advice and guidance services from secondary care organisations to reduce referrals into secondary care.
- Developing one stop services locally to reduce the need for multiple appointments (sometimes out of county), improve experience and outcomes.

In 2016 clinically led internal demand and capacity modelling work identified significant opportunities to repatriate outpatient and day case activity into Powys, to reduce unnecessary travel out of county. There is a growing evidence base to support a shift of services from secondary care to primary and community through clinical led pathway redesign. This would further utilise the two state of the art theatres based in mid and south Powys, creating potential opportunities to develop surgical services within the Newtown area.

### 5.8.3 NEW MODEL OF CARE – LLANDRINDOD WELLS AND MACHYNLLETH

There are opportunities to develop unscheduled care and planned care services through Regional Rural Centres. Capital funds have been secured for Llandrindod Wells Hospital, this hospital is strategically placed in Powys to support the repatriation of services from Wye Valley Hospital. The scheme will reconfigure departments to maximise capacity, improve experience and productivity, and will provide fit for purpose accommodation that improves infection control and meets health and safety. It provides further capacity to repatriate activity from secondary care and to opportunities to develop and expand existing services within the hospital. For the longer term, there is a need to look more broadly at the population and future health and care model within this area to strengthen Llandrindod Wells as a Regional Rural Centre.

Capital funds are also being secured for Bro Ddyfi Hospital in Machynlleth. The business case seeks to address issues with backlog maintenance costs for the front block which are estimated at £4,268,516 (inclusive of fees and VAT) and to address fundamental issues including compliance, infrastructure, water ingress and first floor accommodation which has become unsafe. The geographical location of Bro Ddyfi Hospital in Machynlleth is strategically placed to develop a 'Wellbeing Community Hub' to serve the north west Powys population. It has strong links with Bronglais Hospital in Aberystwyth and is further developing links with Tywyn Community Hospital. There is a need to further align the capital investment project work with the health and care model developed during 2018/19 and to progress this work with the community under the umbrella of the Mid Wales Healthcare Collaborative.

## 5.9 JOINED UP CARE INTENDED OUTCOMES

**Through successfully focussing on 'Joined Up Care, people in Powys will say;**

- I have timely access to equitable services as locally as possible.
- I am treated as an individual with dignity and respect.
- My care and support are focused around what matters most to me.
- I receive continuity of care which is safe and meets my needs.
- I am safe and supported to live a fulfilled life.
- I receive end of life care that respects what is important to me.


# Workforce Futures

## 5.10 WORKFORCE STRATEGIC CHALLENGES AND OPPORTUNITIES

A key strength is that the workforce in Powys is committed and professional. Findings from the recent staff survey are positive. The way in which we plan, recruit, support, develop and deploy staff, will be vital in addressing the risks associated with the delivery of the Health and Care Strategy.

### 5.10.1 GENERLA WORKFORCE CHALLENGES:

- The working age population is predicted to significantly reduce in the next 20 years.
- Significant number of younger people are leaving the county to pursue further education and careers out of county.
- The workforce is unstable in terms of single professional roles.
- Ageing workforce, a large percentage of the workforce is over 50.
- There are areas in Powys where it is hard to attract/recruit for all employers.
- Not making the best use of prevention and community based services due to lack of knowledge, information /understanding.
- Capable post retirement population resource could be utilised.
- Lack of workforce plan and strategy across the whole health and care system.
- Utilising the skills of carers to join the workforce.

There are also wider considerations that must be explored in terms of ensuring shared organisational cultures that span organisations. This involves supporting innovative approaches that will be needed for the workforce to succeed.

### 5.10.2 RECRUITMENT AND RETENTION

Recruitment and retention remains particularly challenging across all care and clinical groups – with General Practice being a critical issue. Within adults social care there are areas where recruitment and retention is more difficult, including mental health social workers who are Approved Mental Health Professionally qualified. In domiciliary care, it is becoming more difficult for providers to recruit staff, this is an area where increased use of direct payments and the dynamic purchasing system are intended to secure more creative approaches.

The current situation results in higher than desired use of temporary workforce solutions and/or challenges in sustaining services.

Both the Health Board and Powys County Council are developing their recruitment and retention capability. This needs to be undertaken in the context of a wider joint workforce plan which considers private, independent and Third Sector and recognises Volunteers and Carers as part of the wider team.

New workforce roles have been developed and piloted. Further opportunities need to be explored around more generic roles to support people with long term conditions, and providing greater flexibility within integrated health and care teams to be able to respond to an individual's holistic needs in a timely way.

Evidence suggests that engaged staff have better job satisfaction and those at the frontline are the best placed to identify the barriers to improvement and to develop innovative services.

Effective staff and partner engagement is crucial to implement the Health and Care Strategy and Area Plan. There have been recent improvements, but there are still opportunities to develop a more integrated approach.

## 5.11 WORKFORCE INTENDED OUTCOMES

**Through successfully focussing on 'Workforce Futures', people in Powys will say;**

- Those who I need to support me are able to make decisions and respond because they are well informed and qualified. If they can't help me directly they know who can.
- As a carer, I and those who I care for are part of 'the team'.
- I can access education, training and development opportunities in Powys that allow me to secure and develop my skills and opportunities.
- I am enabled to provide services digitally where appropriate.
- I am engaged and satisfied with my work.


# Innovative Environment

## 5.12 INNOVATIVE ENVIRONMENT STRATEGIC CHALLENGES AND OPPORTUNITIES

### 5.12.1 OUTDATED BUILDINGS

The geographical distribution of the health board's estate and its functionality has evolved around traditional patterns of care and much of the estate is now outdated. At forty five per cent, the Health Board has the highest proportion of healthcare estate in Wales that pre-dates 1948. The draft results of the recent six facet survey indicate that backlog maintenance of the estate is likely to be in the order of £60-£70M. Only 62% of the estate is in condition category B or above, the worst in Wales.

The Primary Care estate is more modern, although the newest facility is now 12 years old. The majority of practices are under direct GP ownership which can cause challenges in recruiting new GPs.

Powys County Council owns over 700 land and building assets (excluding council houses) These can be broadly split into the following categories:

- Operational e.g. Schools, Care Homes, Offices, Depots
- Commercial Estate e.g. Business units, Livestock Markets
- Farms Estate - PCC own about 150 farms.
- Community Assets e.g. War memorials, Outdoor recreation
- Surplus Estate - These are properties which have been declared surplus by a service and are in the process of being sold. There are in the region of 30- 40 of these at any one time.

In terms of care and support services the following table illustrates the type and number however not all are owned or run by the council.

| Type | Number |
|---|---|
| Sheltered Housing | 2006 units |
| Extra Care | 58 units |
| Intermediate Care | 1 x 12 bed unit |
| Residential Care | 684 |
| Day Centres | 6 (council run) |

The majority of the Council's estate is based on out dated models of delivery and requires significant investment to transform the way we provide care.

The ambition is to develop public sector assets to provide integrated facilities where they are required. Providing modern facilities will support new ways of working, but there is also a need to ensure utilisation of existing assets and to meet future standards of the built environment. The Health and Care Strategy and Area Plan is the vehicle for discussing the future opportunities with Powys residents, who will shape the nature of service delivery and the estates requirements to enable this.

### 5.12.2 OPPORTUNITIES TO CONCERNTRATE SERVICES WITIN INTEGRATED REGIONAL RURAL CENTRES

The current configuration of health and care services in Powys is fragile in areas, often it is difficult to staff services in multiple locations with low levels of activity and this results in services being provided less frequently, with reduced productivity and high costs. The key reasons are due the geographical size of Powys and the population base, this makes it difficult to provide services in multiple locations and for staff to gain the right level of experience and skills working in a rural setting.

Developing Regional Rural Centres will concentrate services, improve productivity and staffing. Brecon and Llandrindod Wells are well established centres with theatres, day case and outpatients, and further expanding their provision will be important as they are strategically placed to repatriate activity from neighbouring secondary care organisations. Newtown is a key area for development. There are multiple health and care buildings, some of which are not fit for purpose, such as the children's centre (Ynys y Plant) and the mental health facility (Bro Hafren). The condition of these services inhibit service user experience and prevent service modernisation. There is a significant opportunity to develop a new integrated health and care facility in Newtown to bring together existing services under one roof and fully realise the benefits from the delivery of a new health and care model for this population.

### 5.12.3 OPPORTUNITIES TO ENHANCE COMMUNITY FOCUS

Wellbeing Community Hubs create environments which enhance community focus and improve wellbeing. There are multiple drivers for creating these hubs across Powys:

- The current community asset base is not fit for purpose and will require significant investment.
- Joint capital investment can generate efficiencies and enable existing assets to be disposed of.
- Access to services can be improved by single points of contact for one stop appointments / opportunities and to aid transport links.
- Co-location of staff teams can enhance working relationships and improve the service user experience.
- There is a rich community resource base on which to draw to ensure a comprehensive range of integrated services that help people to stay connected.
- There is fragility within the services currently being provided from within Knighton Hospital, partly due to the rurality of the area. This presents a need to review the current service model and look at innovative ways to delivering health and care.

### 5.12.4 SUPPORTED ACCOMODATION

Ensuring provision of supported accommodation in Powys is important in securing future provision for children, people with learning disabilities and older people. The following key challenges have been identified:

- There is falling demand for standard residential care services and current supply exceeds projected demand overall, in addition the bed provision is not necessarily located where needed
- The results from a condition survey by the Council's Corporate Property demonstrate that the Council owned homes require significant investment (circa £4.2m) in order to bring them up to industry standard.
- Evidence shows us that the more independent people are, and the better connected with their local communities and services, the better their health and wellbeing.
- Research suggests that inaccessible or inappropriate housing can significantly reduce the ability of people who have ill-health or a disability to lead, good quality lives and in many cases is a direct contributor to unnecessary entry into long-term care.
- The current supply of accommodation available across the county is limited and there is a clear message from Powys citizens that they generally want to stay at home and therefore require alternative provision to residential care.

### 5.12.5 CHALLENGES IN TRANSFORMING SERVICES ACROSS POWYS

Creating an innovating environment is not just about buildings, it's about creating an environment whereby it is easy to spread learning and good practice. In Powys, there are pockets of good practice and innovative working such as the Community Connector Service, Befriending and Home Support and Dementia Matters, however mainstreaming and sustaining this work is proving hard due to the rurality of Powys and austerity. Some key challenges are:

- There are excellent examples of innovation and improvement but it is difficult to scale up or to main stream the approach particularly in relation to early help and support.
- Although improvements have been made in relation to projecting future need / demand this needs to be a more integrated approach.
- A collective approach to measuring impact, outcomes and social value is essential to targeting and aligning our resources.
- Research and development needs to play a critical role in the ongoing innovation and commissioning process.

New ways of evaluating pilots and upscaling to deliver change at pace across Powys is required to ensure we make a positive difference to health and care.

## 5.13 INNOVATIVE ENVIRONMENT INTENDED OUTCOMES

**Through successfully focussing on 'Innovative Environment', people in Powys will say;**

- I am part of a thriving community that has a range of opportunities for health and social care, social events, access to advice and guidance services to support my well-being.
- I have access to Regional Rural Centres providing one stop health and care services – diagnostic, advice and guidance, day treatments, etc. which reduces unnecessary out of county travel.
- I am encouraged and supported to utilise the great outdoor environment to support my well-being and care.
- I am able to have my home adapted to help me to live independently and make me feel safe.
- I have care in a fit for purpose environment that enhances my experience.


# Digital First

## 5.14 WORKFORCE STRATEGIC CHALLENGES AND OPPORTUNITIES

### 5.14.1 INFORMATION ADVICE AND GUIDANCE

Information Advice and Guidance is a core requirement of the Social Services and Wellbeing Act. Evidence shows that if people receive the right information, advice and assistance at the right time, and in the right place it prevents things from escalating and becoming a crisis, thus reducing the need for formal assessments.

There are a wealth of community services who are placed to support people accessing information, advice and assistance but would benefit from better co-ordination at local level to understand their role in the health and care pathway.

The sharing of information between partners when doing home visits is vitally important in improving the safety and well-being of Powys residents, and a collective approach in sharing information; skills and resources, is the sufficient yet most effective approach in moving forward in a holistic way.

The approach to sharing information and alerting partners to those at risk within the home should continue to be developed, enabling each organisation to help the other in this regard to the benefit of Powys residents.

### 5.14.2 IMPROVING ACCESS THROUGH DIGITAL OPPORTUNITIES

Digital opportunities are significant and can improve access to services, enable people to remain independent and empower people to be more in control through greater access to targeted information. Good quality data and technology can aid the process of self-serve and reduce the call on a person to person response. New technologies can also offer huge opportunities from earlier diagnosis, as well as enabling rapid response to avoid hospitalisation. They can help health and care professionals to work together as a “team around the person” and reduce the need for people travel for appointments. Technology apps also have a big role to play in helping motivate people to manage their own health and wellbeing, self-care and manage their own medications.

Digital implementation is reliant on having a good infrastructure. In Powys, 63% of rural communities have a poor mobile phone signal or none at all. The central and northern parts of the County are particularly affected. Solving access problems is also not simply about infrastructure. In 2014/15 the Wales National Survey reported that 63% of 65-74 year olds and only 29% of people aged 75 and over were using the internet. It should also be noted digital exclusion amongst disabled people (38%) is double the figure for all adults (19%) Whilst providing support is critical, usability and affordability are also significant barriers.

On-going investment to retain a fit, robust and safe infrastructure is fundamental for any digital capability and to maintain current business continuity. The challenge is to ensure we maintain our infrastructure in a cost effective manner whilst being adaptable to the organisations and industry change that affect us. Continued investment in this area is fundamental.

The Health and Care Strategy recognises the importance of digital inclusion, the impact and benefits it brings to the residents of Powys. The PSB Wellbeing Plan takes into account the key priorities required to improve digital inclusion and infrastructure and this dependency will monitored to ensure appropriate linkage with the Joint Area Plan.

### 5.14.3 OPPORTUNITIES FROM ASSISTIVE TECHNOLOGY

Benefits from assistive technology are significant, it can reduce home care, prevent people from going in to residential or nursing care, reduce the need for day care, reduce the need for supported living and help people manage with conditions such as Alzheimer's and Dementia. An assessment of the impact of use of telecare in Blackburn with Darwen between 2008 and 2010 evaluated the outcomes for 114 users, evidencing significant reductions in escalations of care. Evaluation of the assistive living technology programme between 2008 and 2012 showed a net reduction in costs of £2.2 million directly attributable to the use of Assisted Living Technology.

Telehealth and telemedicine can promote self-care and support for people and carers. It can enable clinicians, managers and support staff to work more effectively and efficiently whether in community hospitals, primary care facilities or out in the community. It will also reduce travel time and miles for people and staff and allow for more agile working.

Electronic health and care records enable joined up care and reduce the need for people to repeat information being shared with multiple professionals. Further work is required to maximise the potential of Welsh Community Care Information System (WCCIS) to include:-

- Use of WCCIS as a predictive tool in relation to population assessments.
- Supports integration of care planning processes with financial processes to provide clarity on spend and unit costs.
- Better alignment of care and support information for children and young people.
- Building methodology to understand the impact and value of external / commissioned services by enabling them to record activity in relation to their contribution to care and support plans in order to enhance the whole picture on WCCIS.

## 5.15 DIGITAL FIRST INTENDED OUTCOMES

**Through successfully focussing on 'Digital First, people in Powys will say;**

- I am able to find and do what I need online, such as make or change appointments, pay my bills, self assess or reach a doctor or consultant without having to travel.
- I am helped to use technology and gain access to resources to allow me to be digitally independent.


# Transforming In Partnership

## 5.16 TRANSFORMING IN PARTNERSHIP STRATEGIC CHALLENGES AND OPPORTUNITIES

### 5.16.1 INCREASING SOCIAL VAULE

People should be involved in designing and operating services at all levels, from individual to population. There is a need to empower people to produce innovative solutions for delaying, preventing and meeting the need for care and support through local networks and communities.

The section 16 duty also means putting robust arrangements in place to secure involvement of people in the design and operation of services. This means focusing on outcomes and supporting more arrangements designed with and led by people who need care and support and carers who need support. Encouraging local people and businesses to be more actively involved in communities can support people to achieve their well-being.

Powys Regional Partnership has established a Social Value Forum who will work with the RPB to address the following:-

- Advise the RPB about what it needs to do to support and build and stabilise the market
- Provide scrutiny and challenge to the work of the RPB
- Align work to the future model of care particularly around community focused outcome based prevention and early intervention services.
- Support the commissioning process:-
- Needs assessment work – mapping and gapping
- Engaging service users / consultation
- Share ideas for service re-design
- Promote the work of the RPB and act as ambassadors for the Health and Care Strategy.
- Identify, share and learn from good practice
- Identify ways in which to quantify and generate greater social value

### 5.16.2 IMPROVING SAFEGUARDING

Safeguarding in Powys is everyone's business and requires shared understanding and ownership of both the issues and solutions across all organisations, professionals and the public.

Improving over time other opportunities for partnership arrangements (including third sector) for early intervention and support to ensure any safeguarding risks can be reduced or mitigated at the earliest opportunity to impact positively on outcomes for vulnerable people.

All residents should live their lives free from violence, abuse, neglect and exploitation and their rights are protected. All safeguarding work is sensitive to and firmly rooted in respect for differences in race, ethnicity, culture, ability, faith and sexual orientation. Engaging with and being responsive to the needs of all stakeholders, including children at risk, adults at risk, carers, service providers and the wider community, is essential in implementing the Health and Care Strategy and Area Plan.

### 5.16.3 MORE JOINT COMMISSIONING

Part 2, section 16 of the Act introduces a duty on local authorities to promote the development, in their area, of not for private profit organisations to provide care and support and support for carers, and preventative services. These models include social enterprises, co-operative organisations, co-operative arrangements, user led services and the Third Sector.

The Third Sector can and do provide good value flexible services at community level in response to local need, particularly in relation to early help and support.

Developing pooled budgets and joint commissioning and grant arrangements for Third Sector provision will enable jointly our ability to improve wellbeing and provide early help and support.

The Social Services and Wellbeing Act - Partnership Arrangements Regulations (Part 9) require the establishment of pooled funds in relation to:

- The exercise of care home accommodation functions;
- The exercise of family support functions;

Pooled budgets can aid the delivery of seamless services.

### 5.16.4 IMPROVING ACCESS AND TRANSPORT

Access to services is a key issue within the wellbeing assessment. The Health and Care strategy aims to overcome this issue through bringing care closer to home through greater utilisation of digital first and by creating innovative environments which support Regional Rural Centres and Wellbeing Community Hubs.

Non-emergency transport is another key factor in improving access to services. In Scotland, research was conducted to identify and, where possible, measure the economic and social benefits generated by community transport (CT). The research identified the following in relation to Health.

- Community Transport services are seen to be of significant importance in tackling isolation and promoting social inclusion. Community Transport provides a means for isolated individuals to interact – e.g. 68% of all respondents indicated that the CT service they used was very important 'just to get out'.
- Community Transport services are seen as important in promoting wellbeing, quality of life and mental health. 75% of applicable respondents to our survey agreed that without the service they would find it difficult to access activities. Almost half of all respondents 'strongly agree' that their physical health is better because they use the Community Transport service.
- The research also strongly supported the view that Community Transport is a key facilitator in leading to the earlier detection and treatment of emerging health issues.

60% of applicable respondents agreed that they now see the doctor quicker and/or more often because of the Community Transport service they use. Similarly, 39% of applicable respondents agreed that the Community Transport service makes it much easier for them to get their medication. Without the Community Transport service, individuals sometimes put off going to the doctor, not wanting to be a burden on their families.

### 5.16.5 SUPPORTING THE WELSH LANGUAGE

The regulation standards will require the Health Board and the Council to plan their work to improve their offer including more services through the medium of Welsh. Building on the Welsh Government's strategic framework for Welsh language services in health, social services and social care which has helped to improve Welsh language services in the sector.

According to the 2011 Census, 18.6% of the population of Powys speak Welsh - a total of 23,990 Welsh speakers. 34% of Welsh speakers were between 5 and 17 years old.

Ystradgynlais has the highest number of Welsh speakers – 3369 according to the 2011 census. But second in terms of the number of Welsh speakers is Newtown, with 1600 Welsh speakers, and Machynlleth third with 1119.

Wards with the highest percentages of Welsh speakers are in the Dyfi, Banw and Tanat valleys in Montgomeryshire and in the Ystradgynlais area in Brecknockshire. 64.2% of the residents of Cadfarch, near Machynlleth speak Welsh, 56.5% in Llanerfyl, 50% in Pen-y-bont-fawr and 42.8% in Ystradgynlais.

Many Welsh speakers can only communicate their care needs effectively through the medium of Welsh, and for many Welsh speakers, using Welsh is a requirement not an optional extra.

## 5.17 TRANSFORMING IN PARTNERSHIP INTENDED OUTCOMES

**Through successfully focussing on 'Transforming in Partnerships, people in Powys will say;**

- As a Powys resident I 'tell my story' once and I am confident that those looking after me are working together in my best interest considering welsh language and cultural diversity.
- The services I receive are coordinated and seamless.
- I am able to access buildings and resources which are shared for multiple purposes, by multiple organisations.
- My community is able to do more to support health and wellbeing.

# 6. Vision into Action

## 6.1 START WELL, LIVE WELL, AGE WELL SUCCESS

Health and care services need to work for all people of Powys throughout their life and therefore a key aspect to the strategy is its ambition to enable children and young people to 'Start Well', for people to 'Live Well' and older people to 'Age Well'. Success will be measured against these life cycle stages and key outcome measures. The below graphics show what successful delivery of the Health and Care Strategy outcomes looks like for people in Powys throughout their lives.

### START WELL

"I am happy, healthy and ready to learn"

"My parents lead a healthy lifestyle, they are confident and well supported to help me meet my needs"

"People around me are helping me to make the right decisions and equip me to make healthy choices"

### LIVE WELL

"My environment enables me to live healthily, easily, knowing how to access information and advice as I need it"

"I receive the right care and treatment as locally as possible"

"I have positive relationships with others and remain connected to my community"

### AGE WELL

"I have housing and support options that enable me to remain independent in my community"

"I have strong intergenerational relationships"

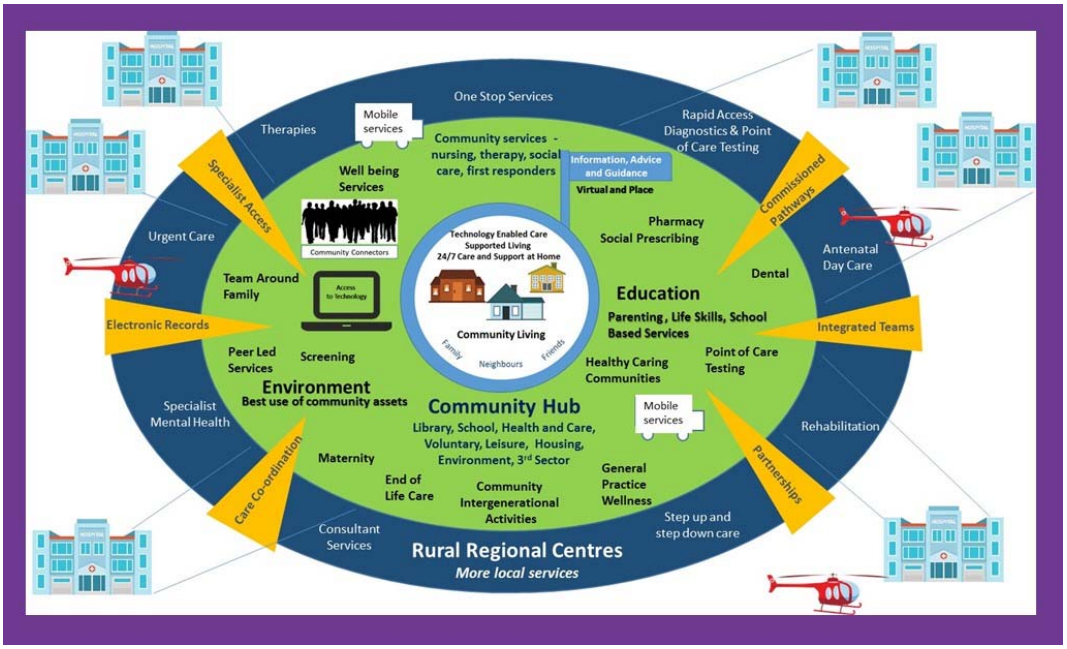
"I still have choices about my life"

## 6.2 NEW MODEL OF CARE

To create a 'Healthy Caring Powys', the new model of care will:

- Enable people to be in control.
- Re-focus the system more around wellbeing and early help and support.
- Create one seamless system which meets future population needs.
- Ensure value and high performance in what we do.
- Provide health and care at home or within the community, whenever it's safe to do so.
- Maximise the use of digital technology to improve access to and delivery of care.
- Improve the environment.

The diagram below illustrates what the 'blueprint' for what the future model for health and care in Powys could look like. Further work will be undertaken in each locality within Powys where local partners and the community will develop local models based on the blueprint. Personas are included in appendix B, these describe the model through the 'Start Well', 'Live Well' and 'Age Well' approach.




People's expectations are growing for greater personalisation and choice, and for more local services which are available at a convenient time, potentially outside of traditional working hours. Powys residents will be able to choose wisely, information, advice and guidance will be more accessible, utilising technology to help people make healthy lifestyle choices about their physical and mental wellbeing, as well as enabling people to navigate the health and care system.

Home was fed back was an important factor during the engagement events, in relation to improving wellbeing. The future model has home in the centre of the system, supported by an informal network of family, friends and neighbours. The community will also play a key role in providing an environment which enables people to be able to take more responsibility for their own wellbeing, to access early help and support and joined up services via a Wellbeing Community Hubs.

Developing our community environments to encourage people to be socially and physically active will be an important part of our new system. Age UK (2010) states that research shows the figure of those over 65 often or always lonely is between 6 and 13%. 10% of the over 65 population stated they were lonely and or isolated equating to approximately 2800 people. The Age UK research stated that isolation and loneliness is comparable to the impact of smoking fifteen cigarettes each day and has a greater effect on mortality than current public health priorities such as obesity, drinking alcohol or being sedentary.

Health and care staff, volunteers, partners and citizens will work together to improve wellbeing and deliver outcomes which meet future population needs. This will involve strengthening individual and community involvement in the way health and care is provided and working with communities (where needed) to help them to utilise their local strengths and resourcefulness to improve wellbeing for the community – this may include for example connecting people to community services such as reading or walking groups, upskilling volunteers, creating social spaces to bring people together, developing services which utilise outdoor space and developing peer led support services.

Health and care literacy underlines the importance of managing health, self-monitoring and communication with health professionals. Low health and care literacy is linked to less use of preventive care, reduced safety of care and poor adherence to medication and treatment, more hospitalisation, worse health outcomes and greater risk of death. There needs to be clearer information available to the public on care, the outcomes and the choices available not just the treatment and setting –this will enable people to take appropriate responsibility for their own wellbeing, and make informed choices about their care.

Over the years, medical advances have turned many life-threatening conditions such as some cancers and heart disease into long-term conditions, as more people survive acute episodes of illness and live many years with their conditions. This helps to explain why the additional years of life people are living may not always be healthy years. Evidence suggests that the disease burden will continue to escalate unless there is a change in focus for health and care systems to shift to early help and support. We therefore need to re-focus our system to preventing people from becoming ill through promoting healthy lifestyles, actively identifying people at high risk of illness and by providing early help and support to those people with diseases to enable them to live well with their condition. There are also opportunities to look more alternatively; there is a growing evidence base to support looking at alternatives to medication – such as social prescribing, cognitive behavioural therapy, Third Sector support and exercise on prescription.

The future model will be re-oriented to focus on prevention based outcomes, focusing on reducing the likelihood of adverse childhood experiences and preventing the burden of disease. People will be able to identify early, if they are at risk of developing a disease and will be supported to reduce this risk and future impact. For those people who have a disease they will be supported to self care and to live well with their condition.

Focus on wellbeing, early help and support and joined up care will reduce the burden of disease. Pathways of care will be designed to focus on meeting future need and reducing inequalities. People will be able to make informed choices about their condition and be given greater independence and control. Our future system will be re-orientated to reduce dependency and promote people to utilise their strengths. It will encourage people to anticipate their future needs and to plan with their families in advance to meet their needs their end of life care.

High quality and effective community services will enable people to get screening and diagnostic tests when needed, access help with medications and be supported by psychological therapeutic interventions.

Technology enabled care is our first choice at home and will be supported through the development of more effective integrated community based services.

Care and support will be seamless without artificial barriers between physical and mental health, primary and secondary care, or health and social care. The new model care is organised around the individual and their family's holistic needs and is focused on what matters most to people about their wellbeing. Continuity of care is achieved through integrated health and care teams working with local communities with easy access to electronic records and professional advice and guidance.

Fast and responsive local services with the right skills and technology will provide urgent response and prevent people having to go to hospital, nursing or residential care.

Easy access to care in the community for people with complex needs and palliative care will be provided with appropriate intervention and support.

The rural geography of Powys and the complex commissioning arrangements are key factors in bringing care closer to home wherever possible. We are seeking to shift the balance of outpatient, day care, diagnostic and elective inpatient services to community or primary and community settings to improve access and quality of care within Powys, and to promote independence and reduce demand and dependence on high cost intervention services.

Moving healthcare closer to home is important in addressing the pressures of future demand and ensuring people get care and support in an environment which best meets their needs, this may also avoid further costs in the longer run of expensive hospital environments.

The new model and will focus on:

- Home
- Neighbourhood approach / Wellbeing Community Hubs
- Regional Rural Centres

### 6.2.1 CARE CLOSER TO HOME

There is a strong national and international consensus that we should strengthen care closer to home. Both digital technology and workforce are key enablers to increasing the services provided within the home. Technology will enable access to specialist advice and opinion and can help people to live safely and independently. Flexible community based services can support people in their own to live well and access early help and support.

#### 6.2.1.1 CORE TO THE MODEL OF CARE

- People are able to live independently for as long as they wish to do so through support from their family and friends, carers and technology enabled care.
- In times of crisis, there is urgent provision of care at home to prevent people from going into hospital or care settings.
- Collaborative working with the housing team to support people in affordable and insulated accommodation to deal with issues which inhibit their wellbeing.

#### 6.2.1.2 POTENTIAL BENEFITS

- Evidence shows that investing in joint initiatives between health, housing and social care can support people to maintain their independence and reduce the number of admissions to hospital. Improving living conditions and wellbeing in the home will prevent future expensive health issues developing in the longer term.
- People have choice about whether they want to die at home.
- New treatments and technology are reducing the need for people to travel for appointments.
- Enables a focus on what matters to the individual and assessment of broader individual's need.

### 6.2.2 WELLBEING COMMUNITY HUBS

Based on a partnership with residents, this is a neighbourhood approach which focuses on community need, not just individual need. There is a growing emphasis on asset[5]-based approaches to promoting health and wellbeing in marginalised communities that utilise the capacity, skills, knowledge, connections and potential within the community, rather than focusing on the needs and problems. Wellbeing Community Hubs can provide a means for alternative approaches to service delivery underpinned by the principles of community involvement and partnership. They can facilitate this by providing a place where different local partners in a neighbourhood can come together and address the issues that matter most to them. Wellbeing Community hubs can provide services for the community, but also by the community.

Wellbeing Community Hubs can also be run and managed by a dedicated community organisation or can be owned or managed by a public agency such as health, local authority or a housing authority but still this retains substantial input and influence from the community. Wellbeing Community Hubs most commonly operate out of buildings, from which multi-purpose, community-led services are delivered. They often host other partners and access to public services, of which co-location can be an efficient and effective use of resources.

#### 6.2.2.1 CORE TO THE MODEL OF CARE

- To understand the needs of our local communities and develop intergenerational Wellbeing Community Hubs which are linked to Regional Rural Centres and provide a means for alternative approaches to service delivery.
- To create an opportunity to bring communities together to enable people to address wellbeing issues which matter most of them.
- To offer one stop services which focus on wellbeing and reduces the complexity of the existing offer.

[5] The asset based approach, is a term coined by *Professor Bob Hudson.* and is based on valuing the capacity, skills, knowledge, connections and potential in a community. It doesn't only see the problems that need fixing and the gaps that need filling.

#### 6.2.2.2 POTENTIAL BENEFITS

- Wellbeing Community Hubs can provide a more holistic approach to helping people with their problems. They often have an 'open door' policy and are able to help people access a range of services under one roof – making services more accessible and desirable.
- Community Hubs are in themselves a good use of local resources, and the model can help to underpin enterprising and resilient communities.
- People are incentivised to focus on their well being and that of others.
- Encourage children and young people to utilise outdoor community spaces linked to Wellbeing Community Hubs.
- Connecting people with the outdoor environment can improve mental and physical wellbeing. Green health prescribing can reduce reliance, costs and potential side effects of prescribed drugs.

### 6.2.3 REGIONAL RURAL CENTRES

There is an ambition to develop public sector assets with partners that provide integrated health and care services for Powys communities.

Regional Rural Centres will be integral to the communities of Powys and could provide some of the services currently provided separately in facilities such as community hospitals, GP surgeries, pharmacies, elderly day centres and residential care facilities, as well as some secondary care services from within our neighbouring District General Hospitals.

Such centres should reflect the unique nature of the rural context of Powys and therefore include strong relationships with providers of services that cannot be delivered currently in Powys. These centres would provide additional services to Wellbeing Community Hubs and will provide the opportunity of delivering more services in Powys that are currently provided out of Powys for example, this could include some day case surgical services and/or advanced physiotherapy and rehabilitation services. The scale and scope of the centres will need to reflect the nature of the population they serve e.g. population size, health need, demography, deprivation and also the services (and service changes) in partner commissioned services that currently serve those populations.

Three areas have been identified as strategically important in developing Regional Rural Centres, these are Newtown, Llandrindod Wells and Brecon. According to the Welsh Index of Multiple Deprivation (WIMD) these areas have been identified as being among the worst 30% of areas in Wales. The link between deprivation and poor health is well recognised. People in the most deprived areas have higher levels of mental illness, hearing and sight problems, and long term conditions.

Powys is also identified as one of the most deprived area in Wales for access to services, the population is spread thinly across a large area. Developing three Regional Rural Centres, (supported by Wellbeing Community Hubs) geographically spread across Powys will improve access to services and prevent people travelling out of county for some services, improving their experience.

The development of Regional Rural Centres will also support community development. We will work with our local communities to develop and strengthen community assets that support people to feel safe, with opportunities to benefit from and take part in

environmentally based schemes, live healthily for longer and contribute to their communities for the benefit of all.

#### 6.2.3.1 CORE TO THE MODEL OF CARE

- Integrate health and care services to meet holistic needs of individuals.
- Move services (where safe and effective) from secondary care out of county hospitals into our Regional Rural Centres.
- Utilise digital technology to provide virtual clinics accessing secondary care professionals.
- Linkage to and provision of adequate supported living accommodation and nursing homes.
- Community development and stakeholder involvement to deliver wider community benefits.
- To offer one stop services and deliver as much of the care pathway as locally as possible within Powys.

#### 6.2.3.2 POTENTIAL BENEFITS

- Integration of health and care services.
- Improve access and reduce unnecessary travel time for people.
- Strengthen Powys as a place to work.
- Create new service development and partnership opportunities.
- Improve service user experience.

#### 6.2.3.3 REGIONAL RURAL CENTRE - NEWTOWN

Newtown sits within the North Central Powys region which has a population of 29,758, it is the largest town in Powys. It acts as one of the main employment centres, as well as being a major industrial area. Based on the uptake of free school meals, this community area is one of the most deprived in the county. Further adding to this evidence, North Central Powys has the highest number of children placed on the child protection register. According to the Welsh Index of Multiple Deprivation (WIMD), some small parts of this area are severely deprived, with poor scores relating to both health and the economy. Further evidence is found in the high number of homeless presentations, as well as the large increase in the number of reported crimes.

The strategic importance of Newtown has been recognised in relation to strengthening joint working between Bronglais District General Hospital and Shrewsbury Hospital through the Mid Wales Health Care Collaborative work, and in relation to the emerging Betsi Cadwaladr UHB clinical strategy work and the Future Fit Programme in Shropshire. The changes within these clinical reconfiguration programmes present opportunities to strengthen service provision within the Newtown area, presenting opportunities to provide surgical day case and chemotherapy services. The current hospital site has inpatient services, maternity services and outpatient services, but currently does not provide any theatres or a minor injury service. There is a need to review minor injury services for this population area, considering potential options for central provision, as well as looking at broader opportunities to strengthen primary care service provision within an integrated health and care building.

Within Newtown, there are a number of health and care buildings, some of which are in poor condition and need significant investment. This presents the need to look at the options for a new build development, which would consolidate many services provided from multiple

buildings which are not fit for purpose such as the Children's Centre within Ynys Y Plant and Mental Health Services within Bro Hafren. In the broader context, Newtown has been awarded funding under the 21st Century Schools Programme to develop education provision within the area. This is part of a broader partnership development opportunity which is looking at the potential of a campus style approach that could integrate health, social care, housing, education and other provision.

#### 6.2.3.4 REGIONAL RURAL CENTRE – LLANDRINDOD WELLS

Llandrindod Wells sits within the Mid-West Powys region which has a population of 19,505. While it is not as deprived as other areas of Powys, the area still scores poorly in relation to the economic measures. The current hospital is undergoing a significant refurbishment largely driven by the current condition of the estate, opportunities to expand services and increase care locally within the Powys. The refurbished building offers inpatient services, theatres, birthing services, renal services and other health and care services.

The nearest District General Hospital for this population base is Wye Valley Trust in Hereford. Under the Sustainability Transformation Planning process, this hospital is merging with South Warwickshire NHS Foundation Trust .The potential impact is unknown, but could result in some services moving further away. Developing a Regional Rural Centre within this area presents opportunities to further integrate health and care services, strengthen local service provision and reduce the impact of service change across the border.

#### 6.2.3.4 REGIONAL RURAL CENTRE – BRECON

The South Central Powys region include Brecon, Hay & Talgarth and Crickhowell, the wellbeing assessment identified a population of 29,658. The major towns within this region are Brecon and Crickhowell. The Welsh Index of Multiple Deprivation (WIMD) gives a low score to this area, based on the economy and health factors. This is particularly the case around Brecon and the St. Johns localities. Brecon itself has also seen a sharp increase in the number of homeless presentations.

Brecon Hospital site has been expanded over the years and has repatriated activity from neighbouring health boards to strength local service provision. Amongst other services, it provides theatres, inpatient services, minor injuries, treatment and diagnostics. It has well developed partnership arrangements with Cwm Taf Health Board who are increasingly supporting more services locally which would have otherwise been provided out of county. This area accesses secondary care services from Wye Valley Trust and Neville Hall Hospital. We are awaiting the outcome of the clinical service strategy work as part of the Clinical Futures Programme to ascertain what future services will be from provided Neville Hall Hospital following the new SCCC development. Continuing to strengthening local service provision within this area through the development of a Regional Rural Centre will be important in developing and sustaining local integrated health and social care services.

### 6.2.4 CORE COMPONENTS OF THE MODEL OF CARE

The engagement events identified the following areas as being important components in the model of care as illustrated in the diagram on page 55. These are linked to the four enablers.

#### 6.2.4.1 WHOLE SYSTEM COMMISSIONED CARE PATHWAYS

Ensure high quality commissioned services, which are safe, effective and efficient. Pathways which joins up services, deliver services more locally and provides access to specialist care

outside of Powys. These pathways will be available electronically for people to help them to understand what outcomes they should expect and how to live with their condition.

#### 6.2.4.2 CARE CO-ORDINATED APPROACH

This works on a scale of need i.e. increases if people have complex needs. This will help people to navigate through the health and care system and a timely and effective way - accessing the right level of support based on their needs.

#### 6.2.4.3 ELECTRONIC RECORDS AND HEALTH CARE INTERFACES

Electronic records are supported with handheld devices and enable sharing of information more easily between health and care professionals as well as real time access to test results.

#### 6.2.4.3 INTEGRATED TEAMS

Working within local communities to support care closer to home, agile and responsive to meet individuals future needs. The Buurtzorg Model (from Netherlands) is an example which promotes self managed teams working in neighbourhoods, it starts from the individual's perspective and works outwards to assemble solutions that bring independence and improved quality of life. It achieves this through utilizing informal networks, the Buurtzorg team, and then more formal networks. Powys has been given money by Welsh Government as one of the three test sites, to explore this approach.

#### 6.2.4.4 PARTNERSHIPS AND COLLABERATIVE WORKING

The Health and Care Strategy has enabled a shared vision for a 'Healthy Caring Powys'. Under this umbrella, partnership working is key to ensuring the best interests of the local population, utilising the Third Sector and the Social Value Forum.

#### 6.2.4.5 SPECIALIST ACCESS TO ADVICE AND GUIDANCE

Commissioning advice and guidance services from professionals in secondary care will be crucial in enabling reduced demand on secondary care services and enabling the provision of seamless care across organisational boundaries.

# 6.3 HEALTH AND CARE STRATEGY AND JOINT AREA PLAN PRIORITIES

## 6.3.1 WELLBEING PRIORITIES


A focus on well-being is the essential foundation for ensuring a healthy, caring Powys. Promoting, supporting and facilitating the physical and mental well-being of people across the life course is about reducing ill-health and enabling people to manage their health and ill-health.

Below are some examples of how people's wellbeing will be supported through the life course:

START WELL

- Integrated Wellbeing Community Hubs will be provided with education, communities and voluntary sector, ensuring local accessible services.
- A holistic programme will be developed with communities to support play, work, mental and physical activity utilising outdoor green space of Powys.

LIVE WELL

- Empowering people to make informed choices based on tailored information that enables management of their own health and well-being, and focus on creating an environment that makes the healthier choice an easier choice.
- Making the best use of community strengths and the physical environment to support people to maintain their health and wellbeing.

AGE WELL

- Supporting older people to be as active as possible, through volunteering, physical and mental exercise.
- Encouraging people to plan for their future, and to take action that reduces the incidence and progression of life-limiting conditions such as dementia.
- Supporting a range of accommodation options and access to them for people in older life.

### PRIORITY 1: COMMUNITY DEVELOPMENT

Working with strongly connected local communities to develop and strengthen community resources that support people to feel safe, with opportunities to benefit from and take part in neighbourhood based schemes, live healthily for longer and contribute to their communities for the benefit of all.

### PRIORITY 2: SUPPORTING UNPAID CARER

Ensuring the well-being of unpaid carers before, during and after caring through information, advice and assistance, supporting education, skills and training development, opportunities for employment, respite, transport and community support.

### PRIORITY 3: PREVENTION AND HEALTH IMPROVEMENT

Enabling and supporting people to make decisions and take actions to improve their health and well-being and avoid or reduce ill health through, for example, stopping smoking or increasing physical activity. Whilst the majority of this work is to be led by the Health Board, there is a joint responsibility for both organisations to ensure commissioning services supports prevention and health improvement.

## 6.3.2 EARLY HELP AND SUPPORT PRIORITIES


Providing early help and support in an integrated way is vital to support people across the life course to manage ill health, improve well-being and to enable people to live fulfilled lives. Maximum positive impact will be made within the first 1000 days of a child's life, focusing on preventing adverse childhood experiences. Resources will be targeted towards disadvantaged families, with delivery of responsive and coordinated services as early as possible.

Below are some examples of how early help and support through the life course will be provided:

START WELL

- Investing in emotional and behavioural support for families, children and young people to build resilience and support transition to adulthood.
- Making the maximum positive impact within the first 1000 days of a child's life, focusing on preventing adverse childhood experiences.
- Targeting resources towards disadvantaged families.
- Supporting and assisting young carers.
- Making sure the transition in to adulthood for young people is well manged and minimises anxiety.

LIVE WELL

- Focusing on early intervention to support the independence and participation of people with sensory loss, physical disabilities, learning difficulties and other conditions.
- Supporting people to be independent and active in their communities.
- Identifying people earlier who are at risk of developing a disease, and we will help them to reduce the risk and impact.
- Focusing on activities which reduce the need for operations and improve post-operative outcomes.

AGE WELL

- Utilising technology so older people can self-care and remain independent, and to encourage greater social inclusion.
- For carers, continuing to develop services to meet the holistic needs of the family and provide adequate respite care.
- Helping people to overcome loneliness and social isolation and be an active member of their community.

## PRIOIRITY 1 TACKLING ADVERSE CHILDHOOD EXPERIENCES

Working with families to make the maximum positive impact within the first 1000 days of a child's life, focusing on preventing adverse childhood experiences, through a joint plan to implement good practice guidance:

- Focus efforts in communities and areas where multiple ACEs are likely to be present.
- Ensure the workforce is ACE-informed.
- Provide programmes which seek to improve parenting skills.
- Screen for ACEs in the antenatal and early years settings.
- Screen for ACEs among adults in contact with public services.
- Ensure local implementation of national programmes designed to address ACEs.
- Deliver resilience programmes in schools and youth settings.

## PRIORITY 2 PRIMARY AND COMMUNITY CARE

Sustainable Primary Care services are vital to the identifying, providing and signposting people to the early help and support they need, therefore there is a need to continue to improve the sustainability of GP Practices across Powys and has developed a Sustainability Toolkit that can be deployed to support Practices that find themselves at risk.

Working within the Primary Care Clusters, the development of a population based approach will be taken to planning and delivery of the health and social care model, supporting development of shared services across GP cluster areas, to provide wider access to scarcer skills and the continued development of enhanced service arrangements. This work will:

- Further integrate primary care with community based services to ensure equity, early help and support and sustainability of services.
- Continue to strengthen local delivery of optometry and community dental services, avoiding unnecessary travel out of county to District General Hospitals.
- Provide mobile services across Powys to improve access to dental care for hard to reach groups and reduce inequity of service.

## PRIORITY 3 MANAGING LONG TERM CONDITIONS

We will support people to identify if they are at risk of developing a disease, and help them to reduce the risk and its impact by taking a wider, whole system approach to risk reduction and chronic condition management. Ensuring those people with long term conditions are able to live well.

People will be better informed regarding their conditions and options for treatment; through shared decision making and active co-production of treatment and care plans. Everyone will have a self management plan which supports multiple co-morbidities. This is developed in collaboration between individual and health and care professionals. More emphasis on self care through education, increased use of technology, and through changing the culture of the way care is currently provided will empower individuals.

### 6.3.3 TACKING THE BIG FOUR


Effective services will be developed to treat and support people with the four main causes of ill health and premature mortality in Powys. This means focusing on prevention of the big four conditions by supporting children, families and adults to create the foundations of good health throughout their life, including healthy weights, positive diet and activity, personal resilience and relationships. Focus on early help and support, and improving outcomes for people who develop any of the big four conditions,

Below are some examples of how the big four will be tackled throughout the life course:

START WELL

- Supporting children and families to create the foundations of good health throughout their life. This includes healthy weights, positive diet and activity, personal resilience and relationships and other steps that will reduce the risk of developing the main four causes of ill health and premature mortality in their later life.

LIVE WELL AGE WELL

- Developing effective services to treat and support people suffering from the four main causes of ill health and premature mortality in Powys.
- Developing support to reduce the incidence and impact of the diseases in later life.

#### PRIORITY 1 MENTAL HEALTH

Hearts and Minds: Together for Mental Health in Powys is the strategy for improving the mental health and emotional well-being of the people of Powys. It is delivered through a multi-agency Partnership Board known as the Mental Health Planning and Development Partnership. Its aim is to improve the mental well-being of all residents in Powys and to support those people with a severe and enduring mental illness.

Across all tiers, from health promotion through to specialist services, focus will be on further improving integrated working arrangements, increasing focus on wellbeing, early help and support and improving quality and effectiveness of services.

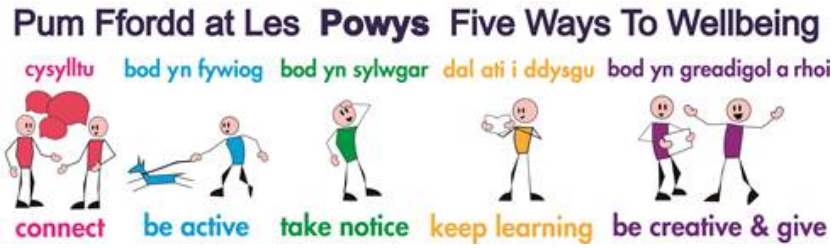
A holistic approach to support families with mental health issues is crucial. All support services will be adaptable and flexible to meet the needs of individuals; by ensuring the right level of training is in place.

Integration of physical and mental health care is key in reducing stigma, and embedding this within existing services is important, some identified areas for opportunity include public health, primary care, chronic conditions, perinatal and community and social care.

Key areas of focus will include:

- Continue to engage with our stakeholders to develop sustainable models and pathways of care suitable for the needs of adults and older adults living in Powys.
- Deliver the priorities outlined in the Dementia Plan.

- Improve mental health, resilience and emotional health of the people of Powys through delivering the priorities in the mental health delivery plan.
- Support families and carers' of people living with mental health issues that impact daily living and quality of life.
- Ensure services are accessible and appropriate to the population they serve addressing the needs of those whose first language is Welsh and the needs of people with protected characteristics.
- Continue to embed the five ways to well–being across services and communities:




Key areas of work are:

- Integrate of NHS and Social Care Mental Health services across Powys, at each level including leadership and management as well as front-line provision to provide a seamless mental health service that supports the mental well-being and recovery of patients.
- Enhance Primary Care outcomes, co-locating mental health practitioners and services wherever possible; promoting collaboration through shared / care /co-management arrangements between GPs/primary care practitioners and 'secondary' care and providing flexible local solutions.
- Implement of the key findings from the Child and Adolescent Mental Health Services (CAMHS) review.
- Develop of Acute Care in the Community to form one holistic and joined up service.
- Develop of perinatal services to improve wellbeing, develop pathways and improve skills of midwives, health visitors and nursery nurses to address mild to moderate perinatal ill health.

## PRIORITY 2 CANCER

There is a strategic commitment to supporting activities that reduce the incidence of cancer through wider work to improve health and well-being, improving timely detection of cancer through screening and early diagnosis, ensuring fast and effective care and treatment through managing effective commissioning; and supporting those diagnosed with cancer and those who care for them in the community throughout their cancer journey.

A multi-agency Cancer Partnership Group leads the work to improve cancer services for the people of Powys.

Key work areas include:

- Continued focus on improving wellbeing, prevention of disease and providing early help and support to reduce impact and improve survival rates.

- Initiate a programme of work in partnership with Macmillan and other Third Sector partners to develop an integrated model between health and social care which delivers a proactive community response to the needs of people with cancer. This service will offer holistic needs assessment and an identified link officer able to signpost or refer to existing local agencies to provide appropriate support for the person and their individual needs.
- Continue to explore the feasibility study of establishing chemotherapy outreach services in Powys and work with Hywel Dda UHB and Shrewsbury and Telford NHS Trust to develop service options in North Powys.
- Explore opportunities to implement telehealth opportunities into cancer pathways in Powys.
- Secure and deliver well coordinated palliative and end of life care on a 24/7 basis in line with published standards and guidance.
- Address health inequalities through analysis of cancer pathways and outcomes to identify and address inequalities and targeting of cancer screening.
- Robustly and effectively performance manage commissioned cancer services through the Commissioning Assurance Framework.

### PRIORITY 3 RESPIRATORY

There is a strategic commitment to improving clinical outcomes and experience for people affected by Respiratory conditions. This means supporting activities which will prevent respiratory diseases through improving health and well-being and targeting efforts with at risk groups, improving early diagnosis, and supporting those with respiratory conditions to effectively and proactively manage their conditions through effective rehabilitation and self-management programmes.

People will be better informed regarding their conditions and options for treatment; through shared decision making and active co-production of treatment and care plans. Everyone will have a self management plan. This will be developed in collaboration between individual and health and care professionals.

There will be more emphasis on self care through education and through changing the culture of the way care is currently provided. This will enable respiratory nurse's to focus more on complex needs to avoid unnecessary admissions and support exacerbation.

Key work areas include:

- Continued focus on improving wellbeing, prevention of disease and providing early help and support to reduce impact and improve survival rates – with particular focus on reducing the number of people who smoke and increasing uptake to pulmonary rehabilitation programmes and the National Exercise Referral Scheme programme.
- Ensure all respiratory patients have key measurements taken annually to identify early decline and prompt intervention.
- Ensure all people with chronic respiratory conditions have a personalised self-management plan in place within three months of diagnosis.
- Ensure that crisis management packs are available to the whole of the population of Powys.

- Develop pathways to manage acute conditions across an enhanced primary/secondary care interface.
- Develop initiatives to promote the management of acute respiratory conditions in the patient's home and in intermediate care settings.
- Ensure adequate and equitable access to palliative care services for end-stage respiratory disease care.
- Work with WAST to explore and scope improvements to respiratory pathways.

## PRIORITY 4 CIRCULATORY

There is a strategic commitment to improving clinical outcomes and experience for people affected by circulatory conditions. This includes diabetes, heart disease and stroke. The aim is to reduce the incidence of circulatory conditions through the wider work to improve health and well-being, improve the timely detection of circulatory conditions through increasing awareness, ensuring effective treatment though robust commissioning, strengthening community services and enable people to confidently self-manage their conditions.

Partnership groups are established and lead the work to improve diabetes, heart disease and circulatory condition services for the people of Powys.

The aim is to reduce the rise in rates of type two diabetes and continue to improve key outcomes and complication rates for all people with diabetes. This will be achieved through effective management of the condition which can increase life expectancy and reduce risk of complications and through enabling self-management.

Changes to stroke service provision from neighbouring health boards has resulted in a review of the pathway and changes to commissioning to ensure that patients access the required services within the recommended time. The aim is to increase and strengthen the care provided locally.

Using information on premature mortality from coronary heart disease as a proxy for need, there is some high level evidence from Public Health Wales that the relatively low emergency admission and intervention (angiography; revascularisation) rates for coronary heart disease in the Powys population are in line with local need. However, there is also anecdotal evidence within Powys that patients with coronary heart disease present late to primary care including after acute events.

Key work areas include:

- Continued focus on improving wellbeing, prevention of disease and providing early help and support to reduce impact and improve survival rates – to include working with GP practices to optimise opportunities for secondary prevention e.g. optimising blood pressure or reducing cholesterol levels in patients with coronary heart disease.
- Introduce a Cardio Vascular Disease risk assessment programme in deprived areas of Powys to improve the detection and management of cardiovascular disease.
- Ensure all Powys residents have access to 24/7 thrombolysis within an 80 minute travel time from their home.
- Undertake work to review existing community heart disease services and analyse rates of diagnosis of coronary heart disease in GP practices.

- Develop local one stop clinic services, including psychology support, to improve early help and support, and improve the experience for people diabetes, heart and stroke services.
- Review and develop provision of community stroke rehabilitation to increase equity across Powys and increase intensity of stroke therapy in the community.

### 6.3.4 JOINED UP CARE


Providing joined up care means people are at the centre of health and care services, minimising and eliminating barriers, duplication and complications between organisations and teams. Health and care teams work seamlessly to get things right first time and minimise needs from escalating. Services will be reviewed in line with new developments to ensure choice, accessibility and coordinated services, working with partners to safeguard residents.

Below are some examples of how care will be joined up support people through the life course:

START WELL

- Young people and families will have a fully integrated experience of health and care.
- Health and care will work closely with education providers to support young people and develop healthy behaviours.
- Work with partners to ensure young people are safeguarded and resilient.

LIVE WELL

- Offer a more co-ordinated approach to managing long term conditions that gives everyone an opportunity to build on their strengths;
- Develop services that fit around peoples' busy lives – providing choice, accessible and equitable services more locally;
- Work with partners to safeguard residents;

AGE WELL

- Support health and care teams to work seamlessly with older people to get things right first time and prevent needs from escalating;
- Review existing health and care services and invest in health and care environments that meet future needs – providing choice, accessibility & co-ordinated services.

### PRIORITY 1 CARE CO-ORDINATION

During 2016/17, the Council and the Health Board have been focussing on the development of two Integrated Team pilot sites in South Powys, in Ystradgynlais and Brecon. Considerable achievements in the delivery of care have been gained, through improved communication, coordination, knowledge and skills. It is widely acknowledged that integrated care is highly beneficial to the individual in receipt of services and carers, and remains the model by which

both the Council and the Health Board wish to operate. It is recognised that there is great potential to deliver further improvements, and a qualitative review has recently been completed to assess the current pilots and support the next phases of development.

A Care Coordination Hub will be developed to ensure a more efficient way of managing the timely repatriation of people from other health board's District General Hospitals / acute hospital beds in Wales and England and manage flow in and out of community hospitals.

This will support a 'home first' ethos and a 'discharge to assess' model of care, it will hold and manage bed and service capacity data from across the health and social care system in Powys and will act as the central point for referral and allocation of community hospital beds, assessments of need, packages of care in the community and residential and nursing home beds, for those who are currently in a District General Hospital /acute care bed in Wales and England.

Ensuring access to services such as reablement that offer intensive support to help people who are recovering from an illness or injury to regain their maximum level of independence at home will be essential in supporting the 'home first' and a 'discharge to assess' model of care.

## PRIORITY 2 UNSCHEDULED CARE

Reducing more avoidable emergency admissions and re-admissions to hospital of people (all age) with chronic disease and other health issues such as people prone to falling, is a priority to improve outcomes and reduce the costs of unscheduled care.

Key areas of work:

- A review of the Virtual Ward will be undertaken to further develop an integrated approach to address people's holistic needs across health and social care to prevent crises from occurring; reduce duplication, improve continuity and the quality of care across providers and ensure that resources in the community are used efficiently by targeting additional services to those most at risk.
- Explore opportunities to reduce admissions to hospital through re-development of pathways to provide more diagnostics and interventions in a primary and community care setting.
- Develop urgent care services including the development of paramedics in the community, joint initiatives with WAST and improvements to the out of hours care to reduce sustainability risks and implement the All Wales NHS 111 service. The 111 service will provide one stop shop for health information and advice including access to GP out of hours services.

## PRIORITY 3 NEW MODEL OF CARE FOR LLANDRINDOD – REGIONAL CENTRE

Over the last 3 years Welsh Government have invested £6.5m specifically to support major capital works to reconfigure the layout of Llandrindod War Memorial Hospital in Mid Powys. Some of the works that have already been completed to enable refurbishment of departments; this also includes a brand new Birth Centre which opened in 2017.

Work on the next phase is currently underway, with a very large programme of work due for completion by May 2019 to extend the use of the building through increasing services delivered from within the hospital, as well as offering the potential to deliver new services.

For the longer term, further work is required to look more broadly at the population and future health and care model within this area to strengthen Llandrindod War Memorial Hospital as a Regional Rural Centre. This will involve an assessment of current service provision, as well as working with the community to further develop a potential of the Regional Rural Centre which delivers integrated health and care for the population of the Llandrindod Wells area.

## PRIORITY 4 NEW MODEL OF CARE FOR MACHYNLLETH – COMMUNITY HUB

There is a growing emphasis on asset-based approaches to promoting health and wellbeing in communities that utilise the capacity, skills, knowledge, connections and potential within the community, rather than focusing on the needs and problems. Wellbeing Community hubs can provide a means for alternative approaches to service delivery underpinned by the principles of community involvement and partnership.

An Outline Business Case for the development at Bro Ddyfi Hospital was submitted to Welsh Government in 2017. This scheme will integrate primary care services onto the site and establish Bro Ddyfi Hospital as a Wellbeing Community Hub for the local community. The facility will provide a base for health, local authority and Third Sector teams, encouraging integration and efficiency and will create a 'hub' to improve access to health and social care, well-being, prevention and health promotion facilities. Working with the Mid Wales Collaborative, BCUHB and HDUHB we will be looking at what services can be repatriated to Machynlleth to provide care closer to home.

The Full Business Case will be aligned with the Health and Care Strategy outcomes and new model of care, and further work will be undertaken with the community to develop the model of care and to create a 'Wellbeing Community Hub'.

## PRIORITY 5 PLANNED CARE CLOSER TO HOME

Outside of Powys a wide range of planned care services are commissioned from local, regional and specialist hospitals and healthcare providers, such as major surgery, cancer care and specialist tests and investigations. In addition, there are also a number of placements for disabled people with complex needs out of county.

The key aim is to ensure that commissioned services are high quality, effective and timely elective care that meets or exceeds targets. We are seeking to shift the balance of outpatient, day care, diagnostic and elective inpatient services to community settings to improve access and quality of care within Powys, and to reduce demand on acute services. People will continue to have rapid access to specialist services and expertise where they, in discussion with their GP, think it necessary. This work will include transforming outpatient services across Powys and improving existing theatre utilisation.

For disabled people with complex needs we aim to create a flexible range of appropriate, effective and efficient accommodation options locally within Powys.

## 6.3.5 WORKFORCE FUTURES


An effective workforce is about ensuring the right people in the right roles, effective professionally and clinically led structures, robust and efficient processes and a culture of engagement and innovation. All of which enables and supports people to thrive, delivering the best possible care for the people of Powys.

This will require all employees in public, independent and voluntary sector to come together to deliver a cross sector workforce strategy and organisational development plan.

We will:

- Support people to work longer, ensuring transfer of knowledge, skills and experience.
- Support our workforce to develop innovative models of care in a rural setting through education, research, training and technology.
- Support a thriving Third Sector and core economy.
- Grow the Powys workforce through local training and development.
- The health and care workforce will be agile to respond to people's needs in a timely way.
- Promote well-being within the workplace.

The aim is to create a workforce which is agile, flexible and responsive.

### PRIORITY 1 STAFFING MODEL

Opportunities to provide integrated care via integrated teams, using resources most efficiently is the underlying principle of any workforce model or approach.

Develop and implement an Integrated Joint Workforce Plan to ensure a whole system approach to delivering the future model of care, to ensure highly skilled and effective workforce to support good outcomes across the 'Start Well', 'Live Well, 'Age Well'.

Maximising the role of the workforce across all sectors through an integrated approach will be fundamental to delivering the new model of care. New innovative models will be based on multi-skilled roles ensuring a shift to prevention and early intervention. This will require workforce plans to cover the whole health and care system.

Key areas of work:

- Develop a cross sector workforce strategy and organisational plan that ensures the cultures, systems, structures, staff engagement mechanisms and people are aligned to deliver the Health and Care Strategy.
- Develop and agree overall culture necessary for shared workforce plan to be delivered.
- Develop joint approach to education, commissioning for health and care.
- Further build on excellence in leadership and management at all levels of system to develop staff from within our organisations, as well as developing our apprenticeship schemes to offer further opportunities for young people to train and work within Powys.

### PRIORITY 2 PARTNER ENGAGEMENT

We will develop an overarching engagement plan to ensure that we share resource and provide effective mechanisms for people to play an active role in the development and implementation of health and care services.

## 6.3.6 INNOVATIVE ENVIRONMENT


It is important that in order to deliver safe, effective, and sustainable services the right environments are created for our staff, the public and our partners. This means an appropriate environment which promotes innovation, research and development across all aspects of the health and care system.

We will:

- Develop integrated and technologically-enabled Regional Rural Centres and "Wellbeing Community Hubs" that provide a "one stop shop" for local people, also using community facilities and resources to strengthen local health and care delivery.
- Provide accommodation that is appropriate and meets need.
- Tackle poor quality facilities for health and care services, providing a modern care environment and working environment that makes people proud.

### PRIORITY 1 REGIONAL RURAL CENTRE IN NEWTOWN

We will look at the options for developing a Regional Rural Centre in Newtown to address the issues around the ageing estate, support the future population needs and mitigate against the potential shift of services away from north Powys.

Newtown has been awarded funding under the 21st Century Schools Programme to develop education provision within the area. This is part of a broader partnership development opportunity which is looking at the potential of a campus style approach that could integrate health, housing, education, police and other provision. This is a unique opportunity which we have an ambition to work with the local community and our partners to develop and test a fully integrated model of a Regional Rural Centre that secures the triple integration aims in relation to integrating physical and mental health; health and social care; primary and secondary care within this region of Powys. This scheme will require capital funding which will be discussed with Welsh Government in 2018/19.

### PRIORITY 2 EAST RADNORSHIRE & YSTRADGYNLAIS WELLBEING COMMUNITY HUB

There is a need to review service provision in East Radnorshire and Ystradgynlais; this includes reviewing the model of care within Knighton Community Hospital, seeking to build on the existing community led hub within this area.

### PRIORITY 3 DEVELOPMENT OF WELLBEING COMMUNITY HUBS

East Radnorshire and Machynlleth have been identified as the first areas to start work on developing Wellbeing Community Hubs. During 2018/19, we will agree further areas for development. We recognise there is a need to look at the south west Powys region.

Ystradgynlais is amongst the worst 10% of deprived areas in Wales, it has a high percentage of 4-5 year old children who are obese or overweight and it has the highest rates of people regularly drinking above recommended guidelines.

### PRIORITY 4 SUPPORTED HOUSING

Suitable accommodation that is safe and warm is one of the foundations of personal wellbeing, particularly for the people with a disability and older people. It enables people to access basic services, build good relationships with neighbours and others, and maintain their independence, all resulting in an improved quality of life. Helping people to stay well and maintain independence is critical for good health and helps to reduce pressure on health and social care services.

Powys County Council and Powys Teaching Health Board have developed a number of commissioning intentions (Older People's Commissioning Strategy, 2016) which focus on potential accommodation options for older people. These intentions aim to ensure that;

- Older people know and understand what care, support and opportunities are available to them
- Older people have a choice of local accommodation to be able to live independently
- Older people have suitable accommodation that meets their needs.

A review of Older People accommodation has highlighted Brecon, Welshpool and Ystradgynlais as key areas of development.

### PRIORITY 5 INNOVATION, IMPROVEMENT, RESEARCH AND DEVELOPMENT

Areas of focus will include:

- Develop measurement framework to support delivery of the Health and Care Strategy.
- Develop a strategic outline programme to provide framework for delivery of the Health and Care Strategy.
- Identify areas for joint approach ensuring innovation, improvement, research and development are embedded within the delivery of new models of care.
- Development of predictive modelling tools to support ongoing population assessment.

## 6.3.7 DIGITAL


The importance of technology and technologically enabled buildings and services in our estate, in people's own homes, between them and between primary and secondary care providers is a key opportunity to transform the current pattern of service provision and reduce demand on acute services. The potential benefits to improving services, reducing waste and mitigating against the geographic and service access challenges in Powys are tremendous.

Technology solutions and innovations are a key part of the future opportunities for sustainable health and care provision for Powys residents. A digital first approach will enable and promote telehealth, telemedicine, self care and support for people and carers. This will support and enable clinicians, managers and support staff to work more effectively and efficiently whether in community hospitals, primary care facilities or out in the community, it will reduce travel time and miles for people in Powys and allow for more agile working.

We will use:

- Telemedicine and webcam communication (e.g. Skype) will bring specialist skills and expertise remotely to people in Powys.
- Technology and telecare will support people to be independent.
- Knowledge and access to information will enable people to take greater responsibility and make informed choices.
- New advances in technology to enable more local diagnostic tests to be undertaken in Powys.
- Work together to support people to use technology.

### PRIORITY 1 INFORMATION, ADVICE AND ASSISTANCE

Continue to develop Information, Advice and Assistance services including the development of Powys People Direct, Info Engine, Dewis and Community Connectors service to provide up-to-date, accessible information on local community support services.

In line with Social Services and Wellbeing Act – Part 10 Code of Practice (Advocacy Regulations) we are currently co-producing an approach for the delivery of the full range of advocacy including the provision of an Independent Professional Advocacy Service (IAS). Other than the IAS most advocacy support will be developed as a generic approach across our information, advice and assistance services.

### PRIORITY 2 WELSH COMMUNITY CARE INFORMATION SYSTEM (WCCIS)

Continue to implement the WCCIS system across Powys to support joint assessment and care coordination to help ensure that service users do not have to repeat they story. Alongside this work implement electronic referral, discharge and diagnostic information across Powys GP Practices.

### PRIORITY 3 TELECARE AND TELEHEALTH

The Mid Wales Health Care Collaborative has an ambition for Mid Wales to be an exemplar for the deployment of telemedicine. We will promote and roll out telehealth and telemedicine to enable people to self care and to support people to access early help and support.

## 6.3.8 TRANSFORMING IN PARTNERSHIPS


With the increasing complexity of care, the rurality of Powys and current workforce challenges, our ability to work with our communities and partners is paramount in improving the wellbeing of our population and developing our new model of care.

We will:

- Strengthen engagement of individuals, families, communities and partners across the voluntary, statutory and business sectors through area-based planning.
- Remove historic barriers between organisations, working in a more integrated way to respond to people's holistic needs.

- Improve services based on evidence of what works well.
- Improve commissioning to deliver more services in-county, and offer greater continuity of care with services delivered out of county.

### PRIORITY 1 SAFEGUARDING

Continue to work with private, voluntary and independent sectors to ensure that Safeguarding remains every bodies business and that commissioned services are more tightly monitored in relation to safeguarding requirements including implementation of the Threshold Document.

### PRIORITY 2 THIRD SECTOR COMMISSIONING

Develop pooled budgets and joint commissioning and grant arrangements for Third Sector provision with increased focus on wellbeing, early help and support including information, advice and assistance.

### PRIORITY 3 CARE HOME COMMISSIONING

Develop pooled budgets and joint commissioning arrangements for Care Home Commissioning.

### PRIORITY 4 ACCESS AND TRANSPORT: MILES MATTER

Review of non-emergency patient transport and voluntary transport schemes to ensure future provision of community transport.

Access to services will be improved through the introduction of new models of care which deliver care closer to home and through utilisation of digital technology, the actions associated with this are included within other sections of this plan).

### PRIORITY 5 WELSH LANGUAGE

There is a need to improve welsh language offer for the residents of Powys when accessing health and care services.

Undertaking a review of the Welsh Language requirements is required to establish a baseline position and enable consideration as to how the welsh language offer can be improved for the residents of Powys.

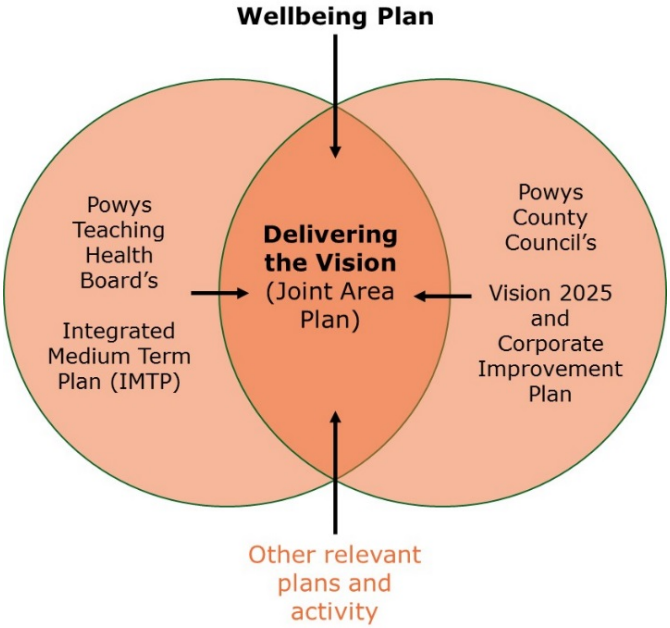
# 7. Joint Area Plan

## 7.1 OVERVIEW

The key areas of work, within this section, are joint areas of work that have been identified as those that will have the greatest impact, in relation to responding to the identified care and support requirements in Powys population assessment and delivering the new integrated health and care model for Powys and its intended outcomes.

It is also driven by the feedback provided by the Regulators in relation to the recommendations made following the review of children services by the Care Inspectorate Wales (CIW, previously CSSIW). It will be further refined in line with the recommendations of the adult's services review following its completion.

The diagram below illustrates this.




In addition to these joint areas of work. Powys County Council and Powys Teaching Health Board have re-aligned their operating plans to the Health and Care Strategy; these plans provide details of the agreed areas of work being undertaken in each respective organisation over the next 1-3 years.

Corporate Improvement Plan http://pstatic.powys.gov.uk/fileadmin/Docs/Democracy/Corporate-Improvement/Powys_Corporate_Plan_2017_v3_English_FINAL.pdf

Integrated Medium Term Plan – currently under development.

## 7.2 JOINT AREA PLANS

The tables below highlight key areas to integrate and improve services, these will be reviewed annually. The areas of work are linked to the priorities established through the Health and Care Development Programme and other areas of work which are important.

| Wellbeing<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority1] Undertake a local review of community development, working closely with Third Sector provision to assess and develop opportunities to increase wellbeing. Align with Information, Advice and Assistance through Infoengine and DEWIS. Support priority areas- projects for children, young people and families, dementia friendly communities, volunteering, role of community connectors. | All Themes | Cross cutting | Y1 - Y2 | ✓ | ✓ | |
| [Priority1] Develop Day Time Activities for Older People in line with the new model of care linking with the community development work to ensure we have a co-ordinated and accessible range of services for older people, including those with dementia, and their carers. | Older people with complex needs and long term conditions | Age Well | Y1 - Y2 | | | ✓ |
| [Priority1] Create an Integrated Youth Support and Skills Service for young people to ensure that they are able to fulfil their potential, make good life choices, maintain healthy relationships, enter further training or employment and successfully. | Integrated Family Support Services<br>Children with complex needs | Start Well | Y1 | ✓ | ✓ | |
| [Priority2] Implement Everybody's Business Model for Carers so that carers have a good sense of well-being and are able to fulfil the caring responsibilities they chose to undertake:<br>• More carers are identified and their needs assessed.<br>• Access to short breaks for carers. | Carers and Young Carers | Start Well<br>Age Well | Y1 - Y4 | ✓ | ✓ | ✓ |

| Wellbeing<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| • A carers' champion in every GP surgery and school to act as a point of contact and help carers get advice and support.<br>• Strengthened community support for carers.<br>• Carers can access the services they need in a timely manner.<br>• Access to social and leisure opportunities for carers.<br>• Training, information and advice for carers is accessible to support them in their role.<br>Young carers are helped to fulfil their life choices and educational aspirations | | | | | | |
| [Priority3] Deliver the prevention and health improvement programmes set out within the Health Board's IMTP. (insert link) | All Themes | Cross cutting | Y1-Y3 | | ✓ | |
| [Priority 3] Develop and implement a joint statement of intent for adults with Physical Disabilities and/or Sensory Impairment to transform the health, care and wellbeing for people with a physical disability and/or sensory loss and their carers. | People with complex needs and long term conditions.<br><br>Carers. | Live Well<br><br>Age Well | Y1 - Y4 | | ✓ | |
| [Other] Continue to deliver the joint commissioning strategy for protection of violence against women, domestic abuse and sexual violence in order to reduce and prevent. Work with regional partners to develop a local VAWDASV strategy (date for implementation to be confirmed) | Integrated Family Support Services | Start Well | Y1-Y2 | ✓ | ✓ | |

| Early Help and Support<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescale | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 1] Develop ACE's plan in line with national guidance and existing priorities. | Integrated family support services<br>Children with complex needs due to disability or illness. | Start Well | Y1 | ✓ | ✓ | |
| [Priority 1] Develop Integrated Parenting and Family Support Services to provide whole system support that offers wellbeing, early help/support for families across their continuum of need – ranging from Information Advice and Assistance through to support for those children at the 'Edge of Care.' | | | Y1 new service commissioned<br><br>Y1 – Y2 Full completion | ✓ | ✓ | |
| [Priority 2]. Further integrate primary care with community based services to ensure equity, early help and support and sustainability of services. | All groups | Cross cutting | Y1 – Y3 | ✓ | ✓ | ✓ |
| [Priority 3] Develop service models for people living with long term conditions linked to improved health and well-being outcomes with broader use of resources across the whole community rather than just statutory providers i.e. Community Connectors. | All groups | Cross cutting | Y1 – Y3 | | | |
| [Other] Working with our partners, develop wellbeing and early help and support services which promote emotional and mental health and well-being for adults. | All groups | Live Well | Y1 – Y4 | | ✓ | ✓ |

| Big Four<br>Joint Areas of Work | Cross Reference to priority groups<br>(as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 1] In line with Health and Care Strategy develop a joint Dementia Action Plan and implement Together for Dementia Friendly Wales. | Older People with complex needs and long term conditions. | Age Well | Y1-Y3 | | | ✓ |
| [Priority 1] Introduce new approach to the delivery of psychological therapies within communities such as group based talking therapies, peer support and improving links with Community Connectors. | Older People with complex needs and long term conditions.<br>Carers. | Live Well | Y1-Y3 | | ✓ | |
| [Priority 1] Develop a multi-agency prevention and early intervention service to promote emotional and mental health and wellbeing for children and young people. Implement key findings from CAMHS review. | Integrated family support services. Children with complex needs due to disability or illness.<br>Young Carers. | Start Well | Y1-Y2 | ✓ | ✓ | ✓ |
| [Priority 1] Promote wellbeing and aim to reduce perinatal mental health through innovative community based interventions such as bump-to-buggy walks, baby massage and splash a spri. | Integrated family support services.<br>Children with complex needs due to disability or illness. | Start Well | Y1-Y3 | | ✓ | |
| [Priority 2] Initiate a programme of work in partnership with Macmillan and other Third Sector partners to develop an integrated model that delivers a proactive community response to the needs of people with cancer. This will be achieved through the offer of a holistic needs assessment and an identified link officer who is able to signpost or refer people to existing local agencies to provide appropriate support to meet their individual needs. | All Groups | Live Well | Y1-Y3 | | ✓ | |

| Big Four<br>Joint Areas of Work | Cross Reference to priority groups<br>(as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 2] Continue to explore feasibility of Chemotherapy Unit and align with the development of Regional Rural Centres. | All Groups | Cancer Partnership Board | Y1-Y3 | | | ✓ |
| [Priority 2,3,4] Continue to strengthen end of life palliative care on a 24/7 basis. | All Groups | Cross cutting | Y1-Y3 | | | ✓ |
| [Priority 3] Deliver improvements to pathways for people with chronic respiratory conditions, increasing self care and providing enhanced support at home and in the community. | All Groups | Respiratory Partnership Board | Y1-Y3 | | | ✓ |
| [Priority 4] Develop local one stop clinic services, including psychology support, to improve early help and support, and improve the experience for people diabetes, heart and stroke services. | All Groups | Partnership Boards | Y1-Y3 | | | ✓ |
| [Priority 4] Review and develop provision of community stroke rehabilitation to increase equity across Powys and increase intensity of stroke therapy in the community. | | Stroke Partnership Board | | | | |
| [Other] Support implementation of Area Planning Board Substance Mis-use Commissioning Strategy 2015-20 to commission and monitor delivery of high quality substance misuse treatment and prevention services to reduce alcohol and/or drug related harm to individuals, their families and the wider community. | All Groups | Regional Group | Y1-Y3 | | ✓ | ✓ |

| Joined Up Care<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescale | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 1] Develop Care Coordination Hub – to reduce length of stay, prevent DToC, and ensure early escalation at DToC trigger points. This wioll include the review of the joint reablement services. | Older People with complex needs and long term conditions.<br><br>Carers | Cross Cutting | Y1-Y3 | | ✓ | |
| [Priority 1] Develop and implement a joint commissioning plan for the Supporting People programme that focuses on reducing homelessness and improves people's wellbeing. | | Live Well | Y1-Y3 | | ✓ | |
| [Priority 2] Review Virtual Wards and further development of integrated approach. | | Cross Cutting | Y1-Y3 | | ✓ | |
| [Priority 4] Develop Regional Rural Centre for Llandrindod Wells. | All Groups | Project Board | Y1-Y5 | ✓ | ✓ | ✓ |
| [Priority 5] Develop Community Hub for Machynlleth. | All Groups | Project Board | Y1-Y5 | ✓ | ✓ | ✓ |
| [Priority 6] Repatriate activity into Powys through commissioning new pathways of care. | All Groups | Cross Cutting | Y1-Y3 | | | ✓ |
| [Priority 6] Put in place a flexible range of appropriate, effective and efficient accommodation options for people with learning disabilities (to return home) to provide the necessary support arrangements to meet the needs of individuals. | People with Learning Disabilities | Live Well | Y1-Y4 | | ✓ | ✓ |

| Joined Up Care<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescale | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Other] Enhance transition arrangements through improving our understanding of the experiences of young people moving from children to adult services and improve our learning of their experiences. | Integrated family support services.<br>Children with complex needs due to disability or illness. | Start Well<br>Live Well | Y1-Y2 | | ✓ | ✓ |
| [Other] Establish a fully integrated multi agency team to provide a co-ordinated and appropriate support service for children with a disability and additional learning needs, and their families | Integrated family support services.<br>Children with complex needs due to disability or illness. | Start Well | Y1 | ✓ | ✓ | ✓ |

| Workforce Futures<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 1] Develop a cross sector workforce strategy and organisational plan that ensures the cultures, systems, structures, staff engagement mechanisms and people are aligned to deliver the Health and Care Strategy. This will include to agreeing overall culture necessary for shared workforce plan to be delivered, joint approach to education, commissioning for health and care and further building on excellence in leadership and management. | All | Cross Cutting | Y1-Y4 | | | ✓ |
| [Priority 1] Develop and implement an Integrated Joint Workforce Plan to ensure a whole system approach to delivering the future model of care to ensure highly skilled and effective workforce to support good outcomes across the Start well, Live well, Age well. | All | Cross Cutting | Y1-Y4 | | | ✓ |
| [Priority 1] Agree model for Integrated Care Teams and roll out across Powys. | All | Cross Cutting | Y1-Y4 | | | ✓ |
| [Priority 1] Develop and implement apprenticeship scheme for Powys. | All | Cross Cutting | Y1-Y2 | | | |
| [Priority 2] Develop joint engagement plans for partner, key stakeholders, service users and public. | All | Cross Cutting | Y1 | | | |

| Innovative Environment<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 1] Develop the case for change and aim to secure funding to complete a strategic case for investment in a Regional Rural Centre in Newtown. | All groups | Cross cutting | Y1 – Y2 | | | ✓ |
| [Priority 2] Review existing services in East Radnorshire and Ystradgynlais. | All groups | Cross cutting | Y1 | | | |
| [Priority 3] Agree other areas for Community Hub development. | All groups | Cross cutting | Y1 | | | |
| [Priority 4] Develop a flexible range of appropriate, effective and efficient accommodation options for Older People to provide the necessary support arrangements to meet the needs of individuals | Older People with complex needs and long term conditions. | Age Well | Y1 – Y2 | | | ✓ |
| [Priority 5] Develop strategic outline programme to provide framework for delivery of Health and Care Strategy. | | | Y1 | | | |
| [Priority 5] Development of predictive modelling tools to support ongoing population assessment. | All | Cross Cutting | Y1-Y4 | | | ✓ |
| [Other] Develop Home Based Support Model in Ystradgynlais and align with Integrated Care Team, Older People's Accommodation strategy, plans for Domiciliary Care and the review of Day Care Services. | | | Y1-Y3 | | | ✓ |

| Innovative Environment<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Other] Commission a flexible range of appropriate, effective and efficient accommodation options to provide the necessary support arrangements to meet the bespoke needs of our individual children, including looked after children. | Children with complex needs due to disability or illness. | Start Well | Y2 | | ✓ | ✓ |

| Digital<br>Joint Areas of Work | Cross Reference to priority groups (as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 1] Develop Information, Advice and Assistance services including the development of Info Engine, Dewis and Community Connectors service. | All | Cross Cutting | Y1-Y2 | ✓ | | |
| [Priority 2] Roll out of WCCIS implementation. | All | WCCIS Project | Y1-Y3 | | | |
| [Priority 3] Technology Enabled Care | All | Cross Cutting | Y1-Y2 | | ✓ | ✓ |
| [Priority 3] Further develop and roll out Florence (text messaging) to enable people to increase their involvement in the management of their treatment, condition or lifestyle | All | Cross Cutting | Y1-Y3 | ✓ | ✓ | |
| [Priority 3] Develop and expand the number of Invest in your Health group sessions via Skype to support individuals to manage their long term conditions. | All | Cross Cutting | Y1-Y3 | ✓ | | |
| [Priority 3] Develop specialist consultant in reach services, clinician outreach, supporting primary and secondary care joint working through the use of telemedicine via the Mid Wales Health Care Collaborative. | All | Cross Cutting | Y1-Y3 | | | ✓ |
| [Priority 3] Evaluate and continue to roll out CBT intervention for people with depression to aid improved rural access to care. | All | Cross Cutting | Y1-Y3 | | ✓ | |

| Transforming Partnerships<br><br>Joint Areas of Work | Cross Reference to priority groups<br>(as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Priority 1] Work with private, voluntary and independent sectors to ensure Safeguarding remains every bodies business. Implement monitoring arrangements in relation to safeguarding requirements including the Threshold Document. | All | Cross Cutting | Y1-Y2 | | ✓ | |
| [Priority 2 and 3] Pooled Funding - We will work together to pool funding across Health and Social Care in relation to:-<br>• Residential and Nursing Care.<br>• 3rd sector grants and small contracts (PCC & PTHB) to enable the commissioning of the preventative elements of the new model of care. | Older People with complex needs and long term conditions. | Age Well | Y1-Y2 | | | ✓ |
| [Priority 4] Review of non emergency patient transport and voluntary transport schemes to ensure future provision of community transport. | All | Cross Cutting | Y1-Y3 | | | |
| [Priority 5] Maximise the Active Offer to speak Welsh, ensuring people can secure their rights and entitlements by using their own language to communicate and participate in their care as equal. | All | Cross Cutting | Y1-Y4 | ✓ | | |

| Transforming Partnerships<br><br>Joint Areas of Work | Cross Reference to priority groups<br>(as per area planning guidance) | Delivery Mechanism | Indicative Timescales | IAA | Prevention | Alternative Models |
|---|---|---|---|---|---|---|
| [Other] Developing the Market in a rural economy is essential. This includes developing and encouraging social value sector to fulfil service delivery opportunities. | All | Cross Cutting | Y1-Y3 | | | ✓ |
| [Other] We will develop an Advocacy Plan to support a whole system approach to the provision of advocacy which is aligned to the RPB key themes, ensures all types of advocacy are available and supported across the model of care and continuum of care. We will support the commissioning process around a range of services including the Independent Professional Advocacy Service. | Older People with complex needs and long term conditions.<br><br>People with learning disabilities<br><br>Carers, including young carers | Cross Cutting | Y1-Y2 | | | ✓ |
| [Other] Review Domiciliary Care Delivery Model, identify whether there are opportunities to broaden and integrate roles to support improved outcomes. | Older People with complex needs and long term conditions. People with learning disabilities;<br><br>Carers, including young carers; | Age Well | Y1 | | | ✓ |

# 8. Measuring Impact

Key to delivering the Health and Care Strategy and Joint Area Plan will be measuring the impact of the intended change and tracking progress against the intended outcomes.

A matrix has been drafted in appendix A with some health and care indicators that will inform whether the evidence based interventions are having an impact on the wellbeing and quality of health and care in Powys. This will be further developed during quarter 1 of 2018/19, along with quantifiable measures that demonstrate the level of intended impact i.e.

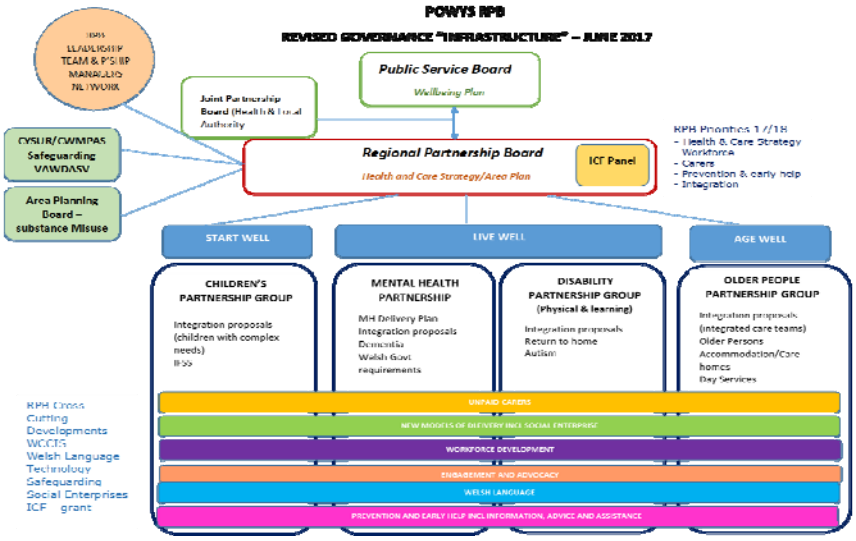
# 9. Governance

## 9.1 REGIONAL PARTNERSHIP BOARD

The role of the Regional Partnership is to improve the outcomes and wellbeing of people, as well as improve the effectiveness of service delivery.

In line with the requirements outlined in Part 2 of the SS&WB Act, the RPB ensures that all work will be co-produced, requiring practitioners and people to work together as equal partners to plan and deliver care and support. The RPB will facilitate a balanced representation from the full range of public services and provide targeted support (via Powys Association for Voluntary Organisations) to ensure citizen including carer engagement at all levels of the RPB infrastructure. The Joint Area Plan will take a Results Based Accountability approach to measuring impact and not just measure how much or how well we do. We will measure impact via the outcomes aligned to the SS&WB Act.

The Regional Partnership Governance structure is as follows:-




Strategic Leads have been identified across the key agencies and will have responsibility for overseeing the delivery of the Joint Area Plan.

Each Partnership Group will report to the RPB on a regular basis in relation to progress and or identifying any barriers to achieving the identified priorities.

The RPB will also produce an annual report that shares more widely the achievements being made against the Joint Area Plan.

## 9.2 INTERDEPENDENCIES

### 9.2.1 HOUSING

Housing is fundamental to achieving wellbeing and the intended outcomes. There are key areas identified within the Joint Area Plan such as supported accommodation which support these wellbeing outcomes, however there is also a need to ensure alignment with the County Council's Affordable Housing Programme. This is a phased five year programme for the development of new council homes and homes for low cost home ownership. The plan will look to build around 250 properties during this period.

### 9.2.2 EDUCATION

Education is crucial in achieving the outcome ' As a child and young person I have the opportunity to experience the best start in life' There is a critical interdependency with in the following areas that will be managed via the Children and Young People Partnership:

- Strengthen learning and skills in Powys, infrastructure and resource via 21st Century schools programme, resource management and shaping the schools infrastructure.
- Developing the post-16 sector.

### 9.2.3 PUBIC SERVICE BOARD - WELLBEING PLAN

There is a key interdependency with all aspects of the wellbeing plan. The Delivering the Vision and Joint Area Plan under the Public Service Board Wellbeing Plan will be delivering on many of the health and social care aspects of wellbeing in Powys, including the safeguarding of vulnerable people, prevention, action on adverse childhood experiences and the needs of carers.

### 9.2.4 COUNTRYSIDE SERVICES

Connecting people with the outdoor environment can improve mental and physical wellbeing. Opportunities to work with countryside services will be utilised to improve wellbeing and prevention.

### 9.2.5 FIRE SERVICE

In the delivery of health and wellbeing services within local communities, the Fire Service can play a crucial role in assessing risk and vulnerability within the home, particularly in cases involving the elderly and those considered at risk or vulnerable.

The sharing of information between partners when doing home visits is vitally important in improving the safety and well-being of our citizens, and a collective approach in sharing information; skills and resources, is the sufficient yet most effective approach in moving forward in a holistic way.

These is a need to identify interdependencies with existing and future work with the fire service to ensure the future health and care system is fully aligned and benefits are maximised.

## 9.3 FUNDING

There is a commitment in principle to pooling some of our Third sector grants and small Third Sector contracts between the Local Authority and Powys Teaching Health Board to ensure a consistent approach to meeting outcomes and supporting the future model of care.

In addition there are opportunities to align existing Welsh Government flexibilities with the Health and Care Strategy and Joint Area Plan. This includes Supporting People Grant, Flying Start, Families First and the new Employability Grant.

During quarter 1 of 2018/19, more detailed plans will be developed and projects will be established for new areas of work. Business case development will be key in securing funding.

Potential sources of funding to be explored include:

- Integrated care funds.
- Transformation funds (under the Parliamentary review).
- Innovative or Technical funds
- WG capital funding.

Both the Regional Rural Centre in Newtown and the potential development of Wellbeing Community Hub in East Radnorshire, are areas where resources will be targeted to deliver a new model of care as per the Parliamentary Review. The Parliamentary Review suggests that Regional Partnership Boards "develop and implement substantial seamless locality model in at least two new localities in their region". We will be looking at opportunities to access the Transformation Funds to enable us to proceed at pace.

## 9. 4 REPORTING

The reporting arrangements for this plan will be developed during quarter 1 of 2018. Each area will be required to establish detailed plans and regular reports on benefit and progress.

## 9.5 ENGAGEMENT AND COMMUNICATION

An engagement and communication plan will be developed for RPB and a partnership journal will be produced outlining progress and good practice in relation to integrated work undertaken. This will ensure that people are supported to design, develop and delivery of health and wellbeing services.

## 9.6 INFORMATION SHARING

The RPB Information Sharing Protocol will be developed to include a training plan to ensure that all partners are clear on their duties in relation to the sharing and security of data.

## 9.7 POPULATION ASSESSMENT

The Powys population assessment will be regularly reviewed and updated, based on evidence and systems to enable prediction and targeted intervention for individuals with additional and complex needs, at the end of life and sensory.

# 10. Supporting Strategies

The following strategies and plans support the Joint Area Plan.

Joint Strategy for Carers

http://pstatic.powys.gov.uk/fileadmin/Docs/Adults/Joint_Commissioning_Strategy_for_Carers_in_Powys_2016-18_-_FINAL.pdf

Older People Commissioning Strategy
http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Older%20People%20Strategy%20EZread%20Version.pdf

Supporting People Programme - Local Commissioning Plan April 2018- March 2021
http://pstatic.powys.gov.uk/fileadmin/Docs/Adults/Joint_Commissioning_Strategy_for_Carers_in_Powys_2016-18_-_FINAL.pdf

Joint Strategy for Mental Health - Hearts and Minds.
http://www.powysmentalhealth.org.uk/fileadmin/PAMH/docs/Mental_Health_Vision/Hearts_and_Minds_-_final_version.pdf

Joint Dementia Plan.
http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/MH%26LD_Item_3.1_Dementia%20Plan%20%282016-2019%29%20-%20Progress%20Update_Update%20Report.pdf

Joint Commissioning Strategy for adults with learning disabilities in Powys.
http://pstatic.powys.gov.uk/fileadmin/Docs/Consultations/Joint_LD_strategy_2015-2020_en.pdf

Substance Misuse and Mental Health Plan (2017).
http://pstatic.powys.gov.uk/fileadmin/Docs/CSP/CSP_Commissioning_Strategy_2015-2020_Final_en.pdf

Joint Commissioning Strategy for Older People

http://pstatic.powys.gov.uk/fileadmin/Docs/Comms/Older_People_strat_and_plan_2016_en.pdf

Regional Safeguarding Plans (CYSUR and CWMPAS)

http://powys.moderngov.co.uk/documents/s21059/Powys%20County%20Council%20Draft%20Improvement%20Plan.pdf

Full Business Case for Llandrindod Wells

http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_2.3_%28Llandrindod%20Wells%20-%20FBC%29Version%202.pdf

Outline Business Case for Machynlleth

Currently in development.

Older People Accommodation Market Position Statement and Future Vision
http://pstatic.powys.gov.uk/fileadmin/Docs/Adults/Integration/Planning_for_the_future_of_older_people_accommodation_in_Powys_A_Case_Study.pdf

Powys Joint ICT strategy

http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_2.4_ICT%20Strategy%202015-2018_Draft%20Strategy.pdf

# 11. Stay Involved

More information is also available at www.powysthb.wales.nhs.uk/health-and-care-strategy

- You can get involved in the debate on Twitter via @PTHB Health @PowysCC #PowysHCS
- You can follow us on Facebook at www.facebook.com/PTHBhealth or www.facebook.com/PowysCC
- You can email us at powys.engagement@wales.nhs.uk
- You can write to us at Engagement Team, Powys Teaching Health Board, Bronllys Hospital, Bronllys, Brecon, Powys LD3 0LU
- You can invite a representative from the Health and Care Strategy Programme to your group or meeting to update you on progress and listen to your views.

We welcome your views on an ongoing basis to help us to translate our strategy into reality.






# Appendix A – Draft Measures

# Delivering the Vision - Health and Care Strategy

| KEY MEASURES (ANNUAL) | OUTCOMES | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Wellbeing | | | | | | Early Help and Support | | | Big Four | | | Joined Up Care | | | | | |
| | I am responsible for my own health and wellbeing | I am able to lead a fulfilled life. | make healthy lifestyle choices about my mental and physical health, and wellbeing, for myself and my family. | As a carer I am able to live a fulfilled life and feel supported. | whoever I am and wherever I live in Powys. | live in supports me to be connected and to maintain my health and well being | I can easily access information, advice and assistance to inform myself and remain active and independent | As a child and young person I have the opportunity to experience the best start in life. | I have easy access, advice and support to help me live well with my chronic condition. | I have easy access to support, information and early diagnosis. | I have early intervention and treatment | My treatment and support is high quality, evidence based and timely as locally as possible | I have timely access to equitable services as locally as possible | I am treated as an individual with dignity and respect | My care and support are focused around what matters most to me | I receive continuity of care which is safe and meets my needs | I am safe and supported to live a fulfilled life | I receive end of life care that respects what is important to |
| Life satisfaction among working adults and older people | | X | | X | X | X | | | X | | | | | | | | X | |
| Number of people supported to live in their home of choice | | | | | | X | | | | | | | | | X | | | |
| Healthy life expectancy at birth including the gap between the least and most deprived. | | X | X | | X | | | X | | | | | | | | | | |
| People reporting they feel safe | | X | | | | X | | X | | | | | | | | | X | |
| People reporting they live in the right home for them | | X | | | | X | | | | | | | | | X | | X | |
| People reporting they feel part of the community | | X | X | | | X | | | | | | | | | | | X | |
| Working age adults and older people in good health | X | X | X | | | | | | | | | | | | | | | |
| Average capped points score at year 11, including the gap between those eligible and not eligible for free school meals. | | | X | | X | | | X | | | | | | | | | | |
| Life expectancy at birth and Low birth weight | | | X | | | | | X | | | | | | | | | | |
| Measurement of development of young children | | | X | | | X | | X | | | | | | | | | | |
| Children age 5 of a healthy weight | X | | X | | | | | X | | | | | | | | | | |
| Mental well being amongst children and young people | X | | X | | | X | | X | | | | | | | | | | |
| Mental well being amongst adults/older people | X | | X | | | X | | | | X | X | X | | | | | | |
| Children and Young People have improved learner qualifications/standards | | X | X | | X | | | X | | | | | | | | | | |
| Number of Looked after children | | | | | | | | X | | | | | | | | | X | |
| Number of children on the child protection register | | | | | | | | X | | | | | | | | | X | |
| Working age adults and older people free from life limiting long term illness. | | | X | | | | | | X | | | | | | | | | |
| Carers reporting that they feel supported to continue in their caring role | | | X | X | | | | | | | | | | | | | | |
| People reporting they have received the right information or advice when they needed it | | | X | X | | | X | | X | X | X | | | | | | | |
| Adults who smoke | | | | | | | | | | X | X | X | | | | | | |
| Adults and older people of a healthy weight | | | | | | | | | | X | X | X | | | | | | |
| Premature mortality <75 years | | | | | | | | | | X | X | X | | | | | | |
| Cancer incidents and 5 year survival | | | | | | | | | | X | X | X | | | | | | |
| People reporting they have received care and support through their language of choice | | | | X | | | | | X | | | | | | | | | |
| People reporting they were treated with dignity and respect. | | | | X | | | | | X | | | | | X | | | | |
| People reporting that they felt involved in any decisions made about their care and support | | | | X | | | | | X | | | | | | X | | | |
| People who are satisfied with care and support that they received | | | | X | | | | | X | | | X | | | X | | | |
| The number of persons (per 1000 population) aged 75 and over who experience a delay in return to their own home or social care setting following | | | | | | | | | | | | | X | | | X | | |
| The percentage (n=) of enquiries resulting in safeguarding intervention | | | | | | | | | | | | | | | | | X | |
| Percentage of people satisfied with their ability to get to/access the facilities and services they need. | | | | X | | | | | X | X | X | X | X | | | X | | |
| The rate of emergency hospital admissions for basket 8 chronic conditions per 100,000 of the health board population | | | | | | | | | X | | | | | | | | | |
| Number of adult clients supported to live in their own home through assistive technology | | | | | | X | | | | | | | | | | | X | |
| Number of Pooled Budgets | | | | | | | | | | | | | | | | X | | |
| % of Staff Working in Integrated Multi-Disciplinary Teams | | | | | | | | | | | | | | | | X | | |
| Care Closer to home measures - The number of service users with Learning Disabilities receiving residential care or supported tenancies outside of Powys and | | | | | | X | | | | | | | X | | | | | |

# Appendix B – Model of Care Personas

The personas describe the future model of care. Following approval of the document, these will be developed into visuals.


Emma is a 27 year old healthy mother of two, Elin who is seven and Eddie who is 4 months. She takes a proactive approach to managing her individual and family's health and care needs. She is very used to searching for information on the website, picking up literature at her local health and wellbeing hub which includes the local library, knows where to go for local services on infoengine and Dewis and is very well connected and active in her community. She has also met the local Community Connector via her Health Visitor and has received good advice and support from them, including specific support within her local community for families and children.

Emma is interested in utilising the technology available. Her eldest, Elin, has respiratory problems, developed from a very early age which was diagnosed very early. Elin has been used to positively managing her condition from an early age and uses game based supportive apps. Elin has positive role models in her family, her Nan and school friends, and her best friend Sian also has asthma so they help each other. She knows everyone in her community as they play in the local play grounds and she's in the local Rainbows and just moved up to Brownies. Her family, teachers and Brownie leader(s) all have access to information, advice and guidance on well-being and long term conditions management and have been released to train by a commissioned community service specialising in "Children with Additional Needs" (CAN) so they can support Elin's wellbeing and help her to lead a healthy and fulfilled life.

Elin has a new brother, Eddie. Throughout her pregnancy with Eddie, Emma felt in control as she was able to monitor her own pregnancy, access real time advice and raise concerns with her community midwife through the electronic tablet provided to her. She was able to choose whether to have her baby at home, assisted by her Midwife with a GP or Consultant on hand via video link or to give birth in a local modern birthing suite with expert support on hand if needed.

She was also put in touch by the Midwife with the Community Connector and they helped her access local voluntary health and care services such as advice and guidance on parenting support, parent and baby social activities and other services like the Health Visitor, Library and also the Credit Union. Emma as a new Mum was a bit nervous to begin with and so she was supported by a volunteer Befriender to access the new parent and baby social group. A café is run by local volunteers and has an outdoor area where the kids can play. Emma finds this environment provides a great peer support network. She also meets her gran there

once a week when she's attending for older people's activities. As her gran's unpaid carer, Emma also has access to carer respite and enjoys their information and pamper days. There's great intergenerational fun happening, with lots of joint activities and they all love the singing, story-telling, dancing and balance exercises provided by a professional trainer with the local extra care facility. During school holidays, Emma is able to access local Play Network activities which helps her keep Elin active and happy.

Emma is able to access medical support for the whole family through her GP or via telemedicine links to specialist care. She can book appointments online and talk with the team or her GP, if necessary, over a video app on her mobile or watch face. She can book in directly into her personal GP's calendar. The family are able to receive the majority of their health and care services within the home, but occasionally they need to travel to the Rural Regional Centre when Elin needs more specialist diagnostic tests for her condition, and often they link up to the Consultant in the nearby hospital as part of a one stop service. They get community transport to and from their appointment as Emma doesn't drive. Emma feels they are well supported to both self-manage their health and wellbeing needs but also feels secure in knowing specialist services are accessible locally, if needed.


Ethan is 55 and lives with his wife and two sons. All of the family, friends and neighbours support his mental health needs, as Ethan, who is ex-forces has PTSD and struggles with anxiety. Linked with this, Ethan has also experienced substance misuse in his past and has recently been diagnosed with Type 2 Diabetes. Ethan does not work at the moment, although he does volunteer at the local British Legion and gives some time at the Military Museum and the Wellbeing Mobile Unit. He does want to work again, but is fearful that a potential employer won't understand his needs and also doesn't think he can do what is needed, he worries about his PTSD. He's also concerned about his family and wants to support them in the way he did when he was in the forces.

Ethan's GP works within an integrated team which includes a care co-ordinator who spends time with him, focusing on what really matters to him in his life, his aspirations and identifies his holistic needs (and those of his family). The care co-ordinator pulls in various members of the integrated team who have expertise in different areas such as local community services (Community Connector), Occupational Therapy, Psychology including Trauma specialism and specific ex-military support.

Ethan has made the choice of who he wishes to support him and this includes an ex-forces chaplain who is his Befriending Volunteer and an "Anchor Buddy". Together they have created an electronic personalised plan to help him achieve his health and well-being goals which they share with the integrated team. He has built up incredible strong relationships with the people who support him, they are consistently there for him, when he needs them. His personal electronic device also prompts him each day on what he wishes to do and this all helps ensure Ethan meets his short and long term aspirations and goals. One of his key choices is exploring alternatives to medical treatment, focusing on his aims to achieve health

and well-being and finding a job locally that will embrace his needs whilst providing meaningful employment so he can support his family.

Services which support clinical, emotional and psychological needs are all tailored to meet Ethan and his family's needs locally in his Community Hub. Private and public employers are committed to working as part of Community Hubs and frequently have staff volunteering as part of local community action. In this way, Ethan is gradually getting to know what employers are in his local area, what they value most and building relationships with them all on an equal footing, as volunteers.

Ethan and his family are offered respite, he can pull on this as often as he feels he needs it, at the time that suits him. This is partly paid for by his time-banking as a volunteer, but also through his choice of how his well-being needs are funded. Ethan's volunteering with the Well-being Mobile Unit really helps him get out and around other parts of the community and he finds this very rewarding and is a valued member of the team.

He helps inform people that most health and care services are accessible seven days a week in local community hubs and the bigger Regional Centres in Brecon (near where he lives), Llandrindod and Newtown. This includes diagnostics of illness or disease, specific injuries, home care, treatment and support, tele-links to specialist consultants, a wide range of assistive technologies and mobile applications as well as a range of community well-being services.

He can show people how to do this via an app on his phone that is free as it's part of the free Wi-Fi in each community and the Well-Being Mobile Unit. Assistive technology does help Ethan to manage his own health and well-being at home. This includes an app providing him with access to his own health records, up-to-date information on his test results which allows him to self-monitor and manage his medication. He is also able to book and have virtual appointments with his GP or the Integrated Health and Care Team to maintain his even keel and ensure early intervention and appropriate treatment where necessary – everyone is working to a shared plan to ensure continuity of his care.

Ethan's family, his wife Amena and their two children's needs are of equal importance and they also are receiving bespoke support for their own needs, including respite and access to a local carer's group for Amena. She has settled very well into Powys, still attends a local group/class for advanced English speakers with local college students, both virtually via video link and in the local Regional Centre's library. She has been supported by "Workforce Futures", a well-established "Access Local Work" social enterprise co-funded by local businesses and public services to access part-time work in a local opticians. Amena also volunteers with a group of local women on her community safety partnership board, providing not only victim led support and advice but also user led service development.


Seren is 87, she lives alone up in the hills in North Powys and access to her farm house can be difficult. There is a good broadband connection which Seren uses to keep socially active (using the Farming Well-Being Link), she gets her groceries delivered each week and a hot meal from the local pub every day. She makes good use of her "keeping active monitor" which prompts her to get up and move every two hours. She also uses her wireless link on her TV to have a shared falls prevention balance session with her friend Jolene who lives in

the next valley. These daily sessions are a real tonic for one another. Despite not being able to drive, Seren gets out and about regularly by using her local community transport service, with a regular volunteer driver, which links her to the wider public transport network when she needs it. She goes into her local big market town once a week. Sometimes her daughter visits, but she lives a couple of hours away. Seren's main sources of support are in the vibrant and resilient community in which she lives. There has been a good deal of investment in developing voluntary and local social enterprise based community services to support people living independently, – she often visits the Wellbeing Community Hub where she does activities with her friends, including Jolene. She attends a special group for people living with Dementia each week, led by a Welsh speaker, and she loves the activities she does with the local children in their school and joins in with all the singing, dancing and storytelling activities. Seren likes her Befriending volunteer, Bronwen, who speaks with her in Welsh. Bronwen also provides a "Sitting Service" in the local village with other people who can't easily get out of their homes and sometimes she takes Seren with her so she also joins in with the tea and chat.

Seren has been able to anticipate her future needs and choose how she wants to access support to live independently. She has also made her wishes clear if her Dementia gets worse and circumstances change. Her wishes have been clear documented and agreed and are aligned to her health record, accessible by her Integrated Health and Care team, herself and her family. To make her feel safe, she has been able to make some adaptations to her house to ensure she has no trip hazards, but also a remote monitoring device which sounds an alert automatically if there has not been any movement in her house. This gives Seren confidence that when she needs support someone will be there to help or check on her, like the time she fell on a Saturday night - the local first responder assessed Seren and asked for a visit from the integrated health and social care team, who arrived within the hour. They discussed her needs with her and jointly agreed a personalised plan which included some short term support – preventing the need to admit Seren to hospital. She was very happy about this as she didn't want to leave her home and had made this clear.

As Seren is living with Dementia and can be quite forgetful, particularly when taking her medications, she has the help of her personal medication plan and a TV or sound application that reminds her when to take her medication and is programmed to come on at the right time wherever she is in her house. Her daughter's voice tells her she needs to take her medication now and Jolene her friend checks when they have their sessions together. Seren's local community pharmacist provides advice and guidance and sometimes she accesses this via skype. The pharmacy team are linked to outreach health and care volunteers who are well trained to provide active checks on her every so often and they can deliver medication to her when she is not able to collect it in person.

Whilst Seren is most happy being in her own home and wants to stay there, she can't look after her garden so well now and also can't keep her house clean and decorated. Seren belongs to a local social enterprise, set up like a Local Exchange Trading Scheme, where the time she devotes to the "Sitting Service" with others enables others in the local community to give her an exchange of doing her garden or decorating. She pays a local student to clean her house and the student earns credits for community service as part of her college education and also gets a discount at the local cinema.

Seren is so busy with different people and activities in her local community, she has a real feeling of well-being, doesn't feel isolated or lonely and is living well with her dementia.