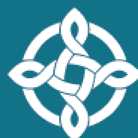
Better Together
System Level Models of Care



Gwella Gyda'n Gilydd
Llunio dyfodol gwasanaethau iechyd diogel, o ansawdd uchel i Bowys

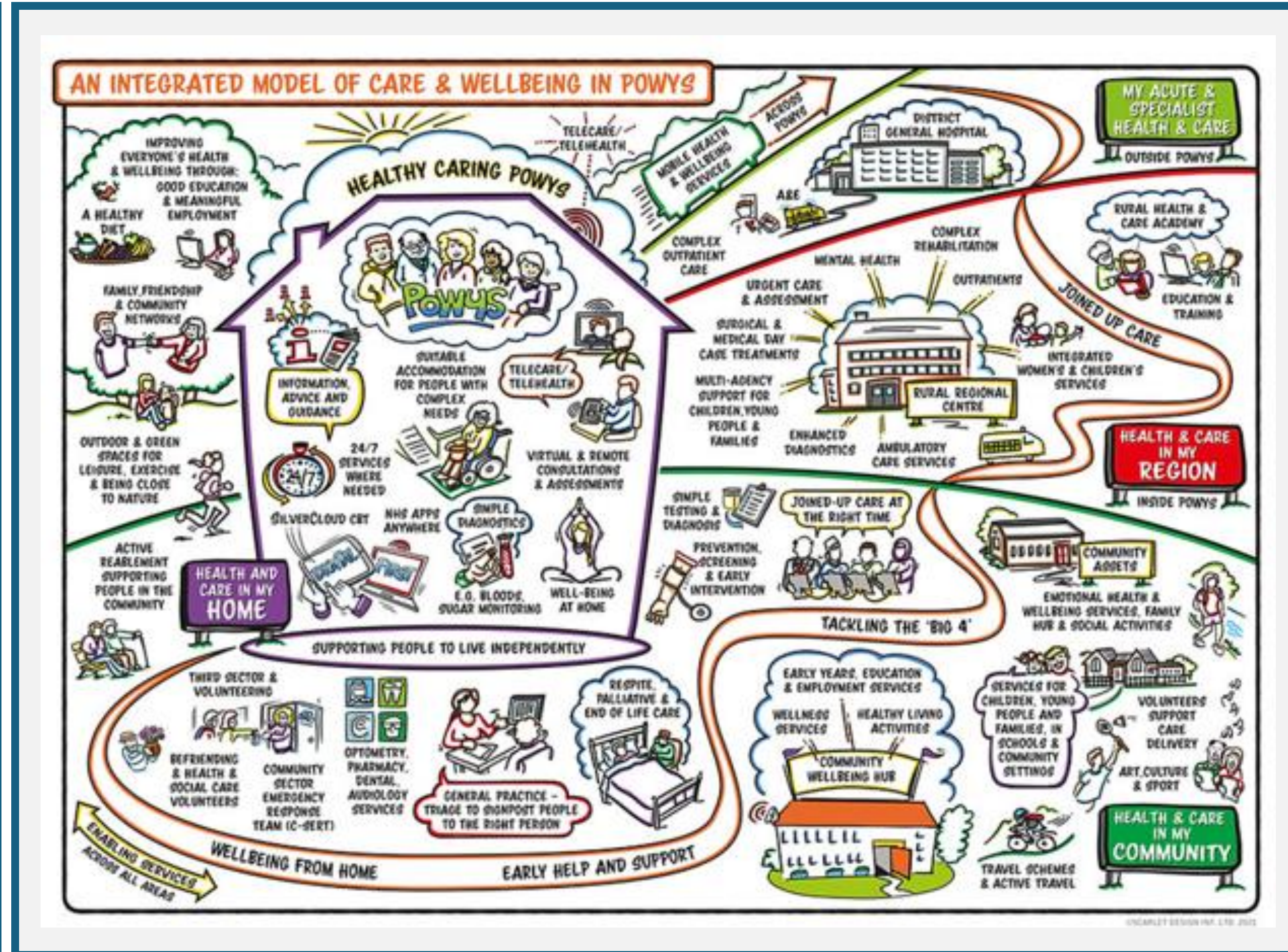
Better Together
Shaping the future of safe, quality health services for Powys

Background: Our Health & Care Strategy

Core to the model of care is:

- **Home**
- **Neighbourhood approach / community wellbeing hubs**
- **Regional Rural Centres**

- **Integrated health** and **care services** to meet holistic needs of individuals
- **Moving services (where safe and effective)** from secondary care out of county hospitals into Powys Rural Regional Centres
- **Utilising digital technology** to provide virtual clinics accessing secondary care professionals,
- **Linkage** to and provision of **adequate supported living accommodation**,
- **Community development** and **stakeholder involvement** to **deliver wider community benefits**,
- Offering **one stop services** and delivering as much of the care pathway as locally as possible within Powys,
- **Inter-generational Community Well-being Hubs** providing a means for alternative approaches to service delivery,
- Creating an opportunity to **bring communities together** to enable people to **address the well-being issues** which matter most to them.



Overarching Vision for Physical and Mental Health

Person at home

- 'Maintaining control of my life'
- Wellbeing awareness
- Information, advice & assistance
- In person services depending on need:
- Home based assessment, prevention, diagnosis and treatment
- Community development and connectors – including befriending
- Home support
- Personal care, Rehabilitation
- Respite
- Equipment and adaptations
- Virtual ward / Enhanced community care
- Same day and urgent community response
- Crisis resolution home treatment
- Emergency response
- Palliative and end of life care in the home
- Community transport

Community Solution teams & hubs

- Primary Mental Health Services
- Multi competency teams including third sector
- Virtual & actual MDT's including triage, assessment, planning (including crisis plan)
- Holistic frailty team
- Disability Teams
- Mental Health & shared care
- 111 Press 2
- Sanctuary
- Circle approaches
- Urgent community response (same day)
- Outpatients including virtual & modernised follow-up
- Shared care for frail patients with cognitive impairment
- Palliative care
- Admission avoidance & day case
- Rehab culture
- Deconditioning identified & prevented
- Inpatient optimisation through step up & step down

Rural Regional Centre

- Enhanced Urgent Care including Minor Injury & Illness
- Step up Assess /Treat including back up for virtual wards
- Primary Care OOH including Pharmacy
- Complex Rehabilitation
- Modernised Outpatient
- Diagnostics
- Specialist Community teams e.g. Respiratory, Cardiology

Rural Regional Centre for Mental Health

- In-patient assessment and treatment centre
- Section 136 suite
- Support for crisis and community teams through step up
- Shared care model for physical health needs of mental health patients

Out of County

- Specialist out of county outpatient appointments
- WAST 6-8-minute 'purple' or 'red' response and conveyance
- Emergency Admissions
- Emergency Department and Same Day Emergency Care
- Acute Clinical Unit (e.g. Medical Assessment Unit)
- Low secure, medium secure and mental health rehabilitation
- Tier 4 Eating Disorder Inpatient
- Psychiatric Intensive Care Units
- Private providers

Considerations:

- Community mental health provision needs to be more closely dovetailed into a tiered approach for enhanced community care (including rapid and crisis response in the community)
- A more joined up approach across mental health and physical health
- Sustainable care and support at home
- A tiered approach and response based on severity and urgency ranging from helping to maintain wellbeing through to people who are severely and urgently unwell who may need a crisis or emergency response.

Social Model for Health & Wellbeing

Enable me to start well, live well & age well

- A **single hub** with several ways in to connect people to their community
- Access to **organically grown community led services** so individuals can be creative, learn new hobbies, and meet people of similar interests
- **Social connectedness** for advice, support, health promotion and signposting
- A place to **engage**, **help others / volunteer** and share skills & experiences
- A space to **empower individuals** to recognise their own potential
- Support to deliver **Proactive Health & Wellbeing Interventions** – transforming prevention, Early Help & support at home.
- Accessibility to **community transport**

Enable me to stay well & support myself

- **New front door** – interface between **Primary care**, **Health** and **Social Care, wellbeing activities** and **community assets**
- A place to support specific concerns " **what matters**" – housing, money worries, caring responsibilities, chronic health conditions, disabilities, bereavement.
- **Targeted intervention** - Integrated family centre, Youth club, Powys Living well service
- A place to adopt **healthy lifestyle changes** – e.g. Smoking cessation, weight management programmes
- **Drop-in services** - No eligibility or waiting lists
- Support to deliver **Targeted Support and Intervention**

Assess & Monitor me closely

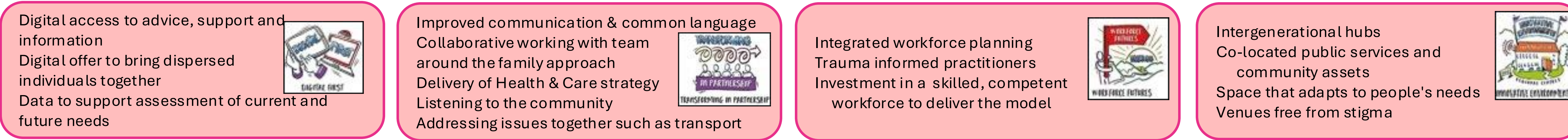
- **"No wrong door"**– professionals **working together** to offer extra support when needed – helps work out what's working well
- **"Holding on"** not "referring on" principle adopting **a holistic seamless offer**
- A place for **individuals** from **stigmatised groups** to engage and **diminish negative perceptions**
- A space to focus on **trust**, **maintaining** and **strengthening relationships**
- **Coaching model** embedded within practice delivered **1:1** or **small groups**
- **Targeted interventions** – Mental & Emotional Health, Frailty, leg clubs etc. for clinicians to connect with a wider range of social issues

Step up my care

- A space for **Health champions** to work at the top of their licence – e.g. dementia navigator role, cancer champion
- A place for **individuals** suffering the **impacts** of **trauma** and **adversity** to receive holistic therapeutic **trauma informed wellness** and **healing**
- **Working together** with **Primary Care involvement**
- **Enhanced Community Care** - **multi agency** working **/ early conversations** to prevent a crisis response and support recovery
- A space to provide **specialist expertise** when needed to ensure needs are met

Goals: short term – reduce demand, long term – improved population health outcomes across the lifespan

Enablers



Integrated Community Model

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Enable me to start well, live well & age well

- **Place-based care** through networked **community hubs and primary care** proving care co-ordination and sign posting
- **Social prescribing** & wellbeing checks
- **Lifestyle support** & **behavioural activation**
- **Trauma Informed** approach
- **Health promotion** and **prevention** informed by population need
- **Vaccinations** & **Immunisation** programmes
- **Education** and **support** for carers and family including focus on **frailty** & **dementia**
- Focus on **current need and future generations**
- Use of **digital technologies** including apps and online resources to support education
- Use of community assets to support **digital inclusion**

Enable me to stay well & support myself

- **Single Point of Access**
- **Case finding** & **Risk stratification** including frailty indices, electronic health records, clinical insights and local intelligence
- **'What matters to me'** conversations, recognising multimorbidity
- **Personalised Care Planning** and **strengths-based assessments**
- **Future Care Planning** started closer to diagnosis to clarify what should happen when my needs escalate
- **Targeted Education** including use of **digital tools** to support **self-management** of **long-term conditions/multi-morbidity** including Living Well Services, prehabilitation and rehabilitation
- **Working together** between partners across Health including primary care, Local Authority and Third Sector to meet the **needs of the person**.

Assess & Monitor me closely

- **Multi agency Enhanced Community Care**
- Access to **diagnostic testing in the community** including **Straight to Test** pathways
- **Case Management** approach around the **needs of the person**
- **Frailty scoring** and **registers** used for monitoring
- **Comprehensive geriatric assessment**
- **Structured medication reviews**
- **Trusted Assessors**
- **Intermediate care** team including D2RA & step-down provision, falls response, rehabilitation & reablement
- **Supplementary Services** at Practice & Cluster level **based on population need**
- **Technology Enabled Care** for **remote monitoring** and **specialist input**, including focus on multimorbidity
- **Improved co-ordination** and **future care planning** for people in their last year of life and end of life

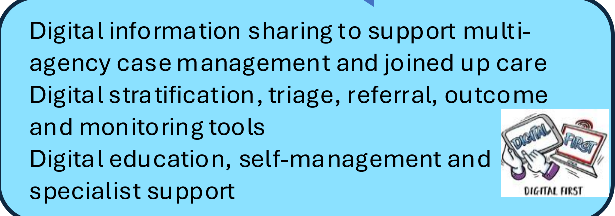
Step up my care

- **Intermediate care** team including **urgent community response** and **end of life care**
- **Enhanced support and treatment at home** including **IV antibiotics**
- Access to **one stop frailty multiagency MDT,** including dementia services
- **Same day** access to **Urgent Care assessment, diagnostic and treatment** either at home, in the community or in a health setting including **short stay inpatient admission**
- **Supplementary services** at Cluster level based on population need
- **Referral pathway optimisation** including timely access to specialist support through GPwER, Advanced Clinical Practitioners and specialist teams in and out of county

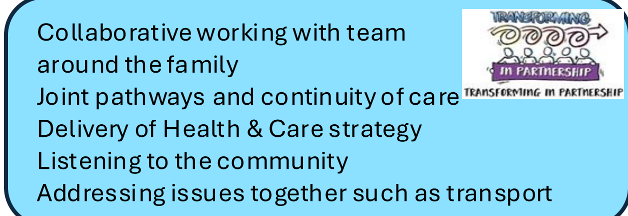
Goals – To provide integrated place-based, person-centred, digitally enabled and proactive care
Prevention of unnecessary hospital admission and supporting timely discharge
more seamless care & treatment

Enablers

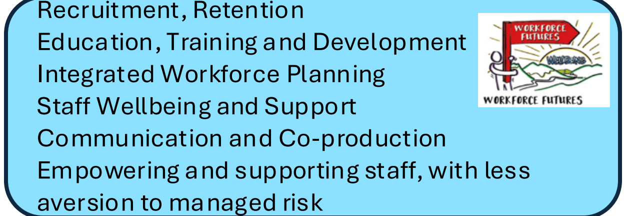
Digital information sharing to support multi-agency case management and joined up care
Digital stratification, triage, referral, outcome and monitoring tools
Digital education, self-management and specialist support



Collaborative working with team around the family
Joint pathways and continuity of care
Delivery of Health & Care strategy
Listening to the community
Addressing issues together such as transport



Recruitment, Retention
Education, Training and Development
Integrated Workforce Planning
Staff Wellbeing and Support
Communication and Co-production
Empowering and supporting staff, with less aversion to managed risk



Co-located services
Age friendly environments
Intergenerational hubs
Fit for purpose, therapeutic spaces

Mental Health

Core Offer 1 – Thriving

Self Help and Community Based Support

- Building and Supporting inclusive communities
- **Self Help/Self Care** awareness and information
- **Community Based Support** including social and leisure activities that promote wellbeing
- Promote **self-referral** to **Online CBT**
- Promotion of **111(2)**
- **Tackling Stigma**
- **Joint working** and **co- location** – health, social care and third sector

Core Offer 2 – Getting Help

Timely Support and Intervention

- Developing the 'front door' - the **single point of open access** to direct patients to appropriate care aligned with 111p2
- Improved **pathways** and modelling care with **third sector partners**
- Development of a **holistic assessment** and **navigation** service
- Working with **Primary Care** to improve pathways aligned to single point of access
- **Peer support** and **recovery college** approach

Core Offer 3 – Care and Treatment

Community based Mental Health and Social Care Services

- **Community Teams** work seamlessly
- **Primary peer support** designed by people with lived experience
- **Safe space to assess, de-escalate** and **support** (Sanctuary model)
- Sufficient **time to assess** mental health patients in primary care settings
- Sustainable **specialist** and where appropriate, **recovery focussed multi-disciplinary** mental health support for people with higher level mental health needs
- **Person Centred Care** and **Treatment**

Core offer 4 – Breaking the Cycle

Crisis Intervention and Acute Care

- Strengthened pathway on admission in **commissioned providers**
- **Fit for purpose Inpatient Environments**
- Increased options for **enhanced care**
- **Reviewed** and **improved pathways** for commissioned care
- Increasing **Trauma Informed** approaches
- **Agile** and **rapid response** and improved **Shared Care arrangements** with **physical health**
- **Seamless support** on discharge

PEOPLE IN POWYS WILL EASILY ACCESS AND RECEIVE A TIMELY, SEAMLESS, HOLISTIC MENTAL HEALTH SERVICE CENTERED AROUND THEIR NEEDS. THE SERVICE WILL BE MODERN, SAFE SUSTAINABLE AND DELIVERED BY A SKILLED, INTEGRATED, MULTIDISCIPLINARY WORKFORCE WHO PROMOTE HOPE, CHOICE AND EMPOWER PATIENTS TO BE AT THE HEART OF THEIR CARE AND TREATMENT.

Enablers

Explore and incorporate future digital technologies
Robust case management system
Improved data, performance and outcomes system
Systems rationalised and aligned better joined up care

Collaborative working with team around the family approach
Joint pathways and continuity of care
Delivery of Health & Care strategy
Listening to the community
Addressing issues together such as transport

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