Introduction

This report updates and further informs progress in stabilising and strengthening some key elements of health services in Pembrokeshire. The principles outlined in the paper are based on the need to maintain a viable rural district general hospital service at Withybush General Hospital.

Acute Inpatient Care

The Pembrokeshire catchment area changes were implemented in August 2015 in order to maintain a 24/7 acute medical service following the loss of Core Medical Trainees (CMTs) earlier in the year. The changes were due to be reversed in December 2015, however due to continued shortages of appointable medical staff and nursing staff, it was not possible to re-open all of the beds and reverse the boundary changes at that time. However, on 1st September 2016, the boundary changes were reversed and the bed numbers reinstated at Withybush General Hospital.

Additional Commissioned Beds

The provision of additional beds will support Winter Planning. Commissioning additional community beds will allow us to ensure that patients who no longer require acute inpatient care but need a further period of intermediate care and or assessment can be safely discharged to the community. These beds will also be used as an alternative to an acute inpatient hospital admission.

Recruitment and Future Model for Withybush General Hospital

The future plan for the Consultant model at WGH is to move from a 1 in 8 rota to a 1 in 12. This will also support the ongoing management of oncology as well as General Medicine patients at WGH. Currently there are 10 consultants in post of which two are long term agency who are working as effective team members and colleagues. The Health Board have been successful in recruiting a Consultant Ortho-geriatrician, this provides a third Consultant for Care of the elderly. Additionally a Consultant in Palliative Medicine has also been recruited and will take up post in the New Year, and the advertisement for a Specialist Clinician in End of Life and Palliative Medicine is currently live.

Development of Pembrokeshire Haematology and Oncology Unit at WGH

Our plans to upgrade facilities for haematology and oncology patients continue to progress well with a wider improvement planned for Withybush Hospital. The much needed facility to provide a better environment for patients undergoing chemotherapy is aimed to be completed by the end of the year offering new facilities (including a larger treatment area, a quiet room and a multi-disciplinary team room) not currently available in the hospital. The much needed facility will provide a better environment for patients undergoing chemotherapy is aimed to be open by the early January 2017 offering new facilities not currently available in the hospital.

The floor plans were designed by our staff and shaped by key stakeholders including patients. The plans will provide an appropriate environment to deliver care at different stages of the disease and protect prime medical space next to Ward 10 for medical services.
The scheme, when combined with the refurbishment of Ward 10 during a later phase, will improve the overall space for oncology services and improve the experience overall for our patients.

For the Ward 10 refurbishment, a Project Group has been established, planning is underway and a business justification case will be developed. An estimated £1.5 million will be required. We are presently recruiting a consultant in Palliative Medicine to support inpatient care and an additional specialist post to support community.

The plans are in the context of a wider hospital reconfiguration which will eventually see the expansion of medical beds in the hospital, however it is unlikely that these beds will be available until Spring 2017. Additionally, these plans will subsequently support improvements to the medical day unit, discharge lounge and surgical facilities and provide wide reaching benefits for patients of Pembrokeshire and attracting clinical staff to the hospital.

To progress the development at the earliest opportunity, Hywel Dda University Health Board is providing a new Chemotherapy Day Unit in the current Ward 5 - former Special Care Baby Unit. The newly proposed scheme will provide enough space to improve facilities for cancer patients undergoing chemotherapy.

**Community Services**

The Overarching Principles which underpin the development of Community Services within Pembrokeshire are:

- Future models are built around the patients needs not around existing service boundaries.
- Future models should aim to provide care within the home or as close to home as possible where it is both safe and practicable to do so.
- Traditional clinical roles should be challenged and innovation encouraged.
- Future models must be sustainable both in terms of recruitment and costs.

**Care Closer to Home Integrated Plan 2015 -2018**

The ability to enact service re-design within primary and community services in Pembrokeshire is dependent of whole sale service transformation. Without service transformation there is limited ability to release cash savings / cost avoidance as a part of a whole-sale strategic realignment of service priorities. The review of community hospital services in Pembrokeshire will provide an opportunity to evidence and support a service model that will provide and accord with the delivery of Care Closer to Home.

**Developing Ophthalmology Services for Wet Acute Macular Degeneration (AMD)**

Plans to develop community provision for wet AMD within the county are progressing. In order to take forward the pathfinder for treating wet AMD, injection sites have been identified. This has been developed at the GP practice in Crymych. Additionally suitable injection rooms have been identified at two new sites in Tenby and South Pembrokeshire Hospital Health & Social Care Resource Centre. It is envisaged that the clinics should be starting up in January /February 2017 for South Pembrokeshire Hospital. The rooms are in the process of being updated and we are currently finalising staffing and equipment requirements.
The joint review of South Pembrokeshire Hospital and Social Care resource centre is progressing, although the review has slipped on the timelines established in the Project Initiation Document. Hywel Dda University Health Board and Pembrokeshire County Council are reviewing care and support provided from South Pembrokeshire Hospital Health and Social Care Resource Centre to consider if any improvements or changes are required to meet patient and customer need. The review is considering services and activity that is jointly funded and will talk to staff, patients, partners and stakeholders about their needs and ideas about future service provision. The Community Health Council and staff side representative from health and social care are members of the review group.

It includes a comprehensive review of:

- day care and rehabilitation/reablement for adults, including therapy input
- inpatient services which include 35 health and 5 social beds
- support services including administration, estates, hotel services, transport
- accommodation space for health and social care staff and provision within the area for visiting services

The review is also considering the impact of changes in relation to policy, fair charging and the impact of the Social Services and Well Being Wales Act. At this stage we are not consulting on any service change, but rather taking a close and prudent look at our services to ensure they are working in the best interests of our patients and population and to consider any potential changes and improvements that could be made. Any future models or options considered will need to ensure that services are inclusive and fit for purpose going forward. The three work streams have reported provisionally to the executive team and as a Health Board we are committed to ensuring the review process is thoughtful and inclusive of all stakeholders. We need to ensure where we have got to so far represent the long term need of our communities and we will be thoughtful and inclusive on reviewing the work to date, deciding if it meets these needs or whether we commission more work involving all interested parties.

Although we have recently experienced some nursing staffing difficulties on Sunderland Ward, we will continue to work hard with the hospital staff to ensure the hospital continues to run safely, providing the level of care patients require from our Community Hospitals.

**Intermediate Care Funding (ICF)**

The allocation from Welsh Government to Hywel Dda has been announced as £6,484m total revenue allocation and a further £1,301m Capital allocation. This included a specific element for Frail and Older people, learning disabilities and complex needs. Health Boards and Local Authorities in 2015-16 with a focus to improve outcomes for older people and to reduce pressures on the unscheduled care system by supporting people to remain at home, avoiding unnecessary hospital admissions and also promoting discharges. A further element of funding has been confirmed by Welsh Government and this will be allocated in October 2016 with the full allocation to be spent in the 2016/17 financial year. The Health Board and Local Authority are working collaboratively to identify priority areas in line with the guidance of the Intermediate Care Fund.
Leg Ulcer Clinics Pembrokeshire

District Nursing Teams have developed Leg Ulcer Clinics for ambulatory patients with venous leg ulcers. These patients were previously attended by Practice Nurses in Primary Care. A Community Registered Nurse with a Specialist interest in Leg ulcer Management has recently been appointed to redesign the existing service and facilitate future development. Discussions are taking place around possible alternative models and more optimal approaches to data collection, performance management and service planning. Currently there are Leg Ulcer Clinics held in Yorke Street Health Centre, Meadow Park Day Centre, Narberth Health Centre, Fishguard Health Centre, Solva Surgery, Tenby Cottage Hospital and South Pembs Hospital.
The Clinics are held twice weekly currently with a total of 260 attendances during the month of September.

Care at Home Team

This is a new service being implemented to enhance the delivery of end of life care for patients within their own home.

A Care at Home Co-ordinator has recently been appointed to lead a team of Health Care Support Workers to provide care in the patient’s own home. The role will provide Leadership, management and supervision ensuring standards of care are met. They will liaise with GPs, Consultants, Nursing Colleagues, Allied Health Professionals, Social Services, Voluntary Agencies, Patient’s, Carers and their families.

Interviews take place 17/18\textsuperscript{th} October to appoint ten WTE Senior Health Care Support Workers.

British Heart Foundation Educational Programme

HDUHB Pembrokeshire Locality Managers and Primary Care Locality Development Managers are currently in discussion with the British Heart Foundation (BHF) regarding its offer of a free cardiovascular disease (CVD) and care educational programme for Primary and Community healthcare and administrative staff across Pembrokeshire. The proposed programme would see the delivery of 3 educational packages each tailored to the educational needs and remit of ‘registered staff’, ‘health care support workers’ and ‘admin, clerical and reception staff’.

Sessions would run from Winter 2016, be delivered at a central location for ease of access and would also have educational input from local professionals (Frailty ANP, Heart Failure CNS, Cardiac Rehabilitation CNS, Chronic Condition Nurse Practitioners, etc) to provide a local service context. Programme attendees would be developed as ‘CVD Champions’ in teams for the purpose of cascade training/awareness, on-going liaison with BHF trainers and maintenance of knowledge/ awareness gained through the ‘BHF Alliance’ educational support scheme.

Community Resource Teams

HDUHB Pembrokeshire Locality Managers and PCC Service Manager are working collaboratively in the re-development of Community Resource Teams (CRTs) across Pembrokeshire. With the objective of pursuing an inclusive and engaging approach, two ‘CRT Scoping Workshops’ hosted over the summer 2016 saw good attendance with broad professional and multi-agency representation. Building upon this work, an initial ‘CRT Steering Group’ meeting is scheduled for October 2016 with a view to reviewing workshop outcomes, developing the draft operational policy and overseeing the initiation of CRTs. The CRTs will closely align to the GP clusters.
The Older Adults Assessment and Liaison (Frailty) Service - Pembrokeshire

The Older Adults Assessment and Liaison (Frailty) Service in Pembrokeshire has been operational since February 2016.

Aims/Objectives of the service

The aims/objectives of the service is to provide holistic comprehensive geriatric assessments to frail older adults to prevent avoidable hospital admissions and proactively maintain patients' independence with the support of a multi-disciplinary team.

Clinics

Clinics in South Pembrokeshire are run every Tuesday morning between 9am and 1pm across two locations on alternative weeks.

  a. Tenby Cottage Hospital (TCH) Frailty Clinic  -  2nd and 4th Tuesdays of each month
  b. South Pembrokeshire Hospital (SPH) Frailty Clinic – 1st and 3rd Tuesdays of each month

Each clinic has capacity to see 4 patients per session with the current format allowing for 3 routine appointments and 1 urgent / rapid access appointment. There is currently no waiting list for clinic appointments and all urgent patients can be offered an appointment within 1 week of referral.

Comprehensive Geriatric Assessment / Documentation

All patients who attend clinic are provided with holistic and comprehensive geriatric assessment looking at all aspects of health and social care needs with the emphasis on early identification of issues relating to frailty and provision of detailed clinical management plans to the patients general practitioner.

Patients are discussed by the multidisciplinary team (MDT) at the end of clinics and identified needs, problem list and management plans are made with agreement of the whole team and then communicated to the wider health and social care teams.

The type of patient that is typically seen at the clinic are those who will be able to be discharged from care at the end of the assessment with a clear plan in place, not those patients who will need an immediate hospital admission or referral on to another specialty. The whole focus of the clinics is on working proactively with patients to prevent unnecessary admissions to hospital and maintain patients’ independence as much as possible.

Home visits / Domiciliary

Patients who are housebound or those that are unable to attend clinic for any reason are offered a domiciliary visit by the Advanced Nurse Practitioner (ANP). They receive the same comprehensive geriatric assessment as patients attending clinic and any patients requiring more specific occupational therapy or physiotherapy input are referred into the services as required. The ANP can contact the Medical Consultant for advice or support for patients seen at home and also discuss these patients at the weekly clinic MDT where necessary.

Admission avoidance visits can usually be provided within 1-2 working days, however, patients seen at home are not case managed on a regular basis, rather crisis intervention is provided.
when needed on a short term basis to avoid a crisis or admission and then the patient is discharged with a clear and detailed clinical management plan.

Data

The data range for this update covers from February 1st 2016 until 31st July 2016, i.e. the first six months. A total of 104 patients were referred into the service from both the North and the South of the County with 91 patients being suitable to be seen.

Reason for referral

The majority of patients referred into the Frailty service had more than one reason for referral which highlights the need for holistic and comprehensive geriatric assessment using an MDT approach for frail older adults.

Most common reason for primary referral was falls, followed by concerns relating to immobility.

Cognition (confusion, delirium, dementia) accounted overall for the 3rd most common reason for referral.

Social issues for referral such as carer breakdown, carer crisis, patients not coping accounted for a large number of second referral reasons and again were associated with cognitive concerns or immobility issues.

Future developments and actions

Over the last 6 months there has been an increasing awareness of the Frailty service and the benefits this service can provide to patients, carers and their families. We were aware that there was a disparity in provision of services across Pembrokeshire with clinics only initially being provided in the South. This has now been addressed with clinics having commenced in North Pembrokeshire in September.

Primary Care

Provision of a Nurse Led ‘Walk’ In Service in Tenby Cottage Hospital.

A ‘walk-in’ nurse led service for residents and visitors who require treatment for minor ailments was piloted this Easter in Tenby. The service was based at Tenby Cottage Hospital and run by a team of advanced nurse practitioners and healthcare assistants to give top quality care to people visiting the hospital. Based on the outcomes of the Pilot Service the Health Board have developed a draft Business Case to support a permanent service. The service will provide access to on the day services for local residents and visitors. The service will be provide for minor ailments, minor injuries and conditions that can be most effectively managed by Nurse Practitioners. The Business case for the Walk-in Nurse Led Unscheduled Care service at Tenby Hospital will be considered at BP&PAC prior to the IMTP process as part of any ongoing investment in 2016/17/18.

Primary Care Cluster Funding

During 2016/17 investment in primary care and community services has been provided through a number of sources, one of these being the Primary Care Cluster funding. Pembrokeshire has benefited from investment from Welsh Government to support the development of the GP Clusters. This investment has been targeted at the specific plans and initiatives identified in the Cluster Meetings but aimed at addressing the Ministerial priorities identified within the Primary Care Plan for Wales.
This new investment provides a framework to ensure that primary care and community services align to deliver improved access to services and provide greater synergy across and between services. Additional fund also enabled greater flexibility in the delivery of local initiatives to meet assessed local need and improve access to a range of services. Increasingly the Health Board is viewing the Clusters as delivery units and working in collaboration the Clusters are gaining momentum. The following offers an overview of the work programme being developed by the North and South Pembrokeshire Clusters.

**North Cluster Update**

**Employment of Community Phlebotomists** – The cluster agreed to fund this project for the second year. In year one, the original twelve month funding allocation had been utilised over eight months providing 3.5 whole time equivalent - wte posts in the first year rather than the original planned 2.5 wte.

**Paul Sartori Foundation Advanced Care Planning Nurses** – The Cluster has commissioned Paul Satori foundation to provide Advanced Care Planning advice and support. The nurses are working with GPs, District Nurse teams and care homes to explain the service and the benefits of ACP. Links have also been made with specialist nurses, Chronic Condition Nurse Practitioners and hospital staff. 38 referrals have been made in the first four months of the pilot resulting in 172 contacts with patients. The greatest number of referrals have been received from GP Practices (37%). Self and family referrals were also high at 29%.

The pilot will be fully evaluated however early indications are very positive.

**Pembrokeshire Counselling Services** - Funding for Pembrokeshire Counselling Service to improve access to patients referred was agreed for 2016/17.

**Cluster Pharmacists** – The cluster have appointed 1.8 wte Cluster Pharmacists to assist in providing sustainable support to GP practices. The Pharmacists work as part of a multi-disciplinary team across the cluster providing expert pharmaceutical advice to all health professionals and patients, undertake medication reviews for an agreed cohort of patients in line with Prudent Prescribing principles.

**Home visiting service** – A three month pilot is planned to support alternatives to GP home visits thus reducing an element of GP workload. It is anticipated this will release practice capacity for other work, and develop shared clinical services across practices. Home visiting is a demanding part of GPs current role, this will allow improved use of practice resources and better manage the emerging pressures caused in part by rurality and an ageing population.

**Frailty** – Community Frailty Clinics held jointly with Consultant & GP – A community frailty clinic is due to be established within the cluster in the autumn of 2016. The cluster has funded the addition of a GP to the current team, initially referrals will be seen jointly by Consultant and GP. A comprehensive geriatric assessment will be undertaken, it is anticipated that the GP would see patients independently but discuss all cases in the multidisciplinary meeting.

**IT** – The Cluster has invested in the implementation of Vision 360 a comprehensive operating system for GP practices, additionally the installation of WiFi at all practices and provision of iPads to promote portability. These projects will integrally to support practices to share patient records and appointment details across practices. This initiative also links with the Cluster Pharmacist, the Home Visiting pilot and the frailty proposal as they will allow access to records from any location and will also allow consultation details to be reported directly to the patient’s registered practice.
Pembrokeshire Young Person’s Counselling Service – The Cluster has supported work with the Third Sector to provide funding in 2016/17 to support the development of an App to provide a direct appointment booking service with electronic referral and information for their clients.

Screening uptake – working with Public Health Wales and the Third Sector to increase the uptake in screening focusing on bowel screening but also including breast, AAA and cervical screening.

South Cluster Update

Cluster Pharmacist - The Cluster Pharmacist is working with all practices within the cluster. She has visited nursing homes within the practices boundaries who are pleased to have support with their patients from a medicine/pharmacy perspective. The cluster has agreed that we will support and fund the Cluster Pharmacist with her Independent Prescribing course at Cardiff University and she will be mentored by GPs from Argyle Surgery. This will add more scope to her skills for the cluster when out visiting nursing homes or within practice.

Occupational Therapists - A joint pilot project between Hywel Dda University Health Board and Argyle Street Practice in Pembroke Dock has been undertaken where an Occupational Therapist was based within the Practice. The OT was deployed to the practice to introducing an alternative proactive model of care. The project was successful and the cluster has therefore agreed to fund two fulltime Advance Occupational Therapists to work with the South Cluster practices. The OT who was part of the initial project was successful in the interview process and a second Occupational therapist has been appointed.

Healthy Lifestyle Advisor - The Cluster is also investing in a Band 5 Healthy Lifestyle Advisor which will be a full time post. The role of the Healthy Lifestyle Advisor will be to manage a caseload of clients who require support to make changes to their lifestyle that will improve their health. The vision is that the adviser will support the client (and their family where appropriate) to make positive and sustained changes towards healthier lifestyle choices.

The main focus of the Advisers caseload will be on weight management (including diet and physical activity) and smoking cessation, with additional input to the Immunisation and Vaccination agenda for both seasonal campaigns (e.g. season flu vaccination) and targeted interventions (childhood immunisations). Additional support will be provided to patients around improving their mental well being, and to support healthy ageing. The Healthy Lifestyle Advisor will also work closely with the Advocates within practice and will be supported through Public Health Wales.

The Healthy Lifestyle Advisor will start in post on the 1st November 2016; there is also the option to recruit a second Healthy Lifestyle Advisor for an additional 15 hrs a week.

Lifestyle Advocates Programme - All practices are involved in this programme supported by Public Health Wales.

Employment of Community Phlebotomists - The cluster has agreed to fund the phlebotomist service for another year.

Paul Sartori Foundation Advanced Care Planning Project - The cluster agreed to fund this project for another 6 months from September 2016 to March 2017. Awareness raising tea parties have been held in various Nursing Homes within the cluster area and they also took part with a stand at Argyle Practice Carers’ Day during Dying Matters Week. Each of these has generated referrals for one to one advance care planning.
Screening Project - This is a screening project with Public Health Wales to increase the uptake of screening particularly bowel, but also breast, AAA and cervical screening.

Extra Project - The Extra Project focused on reducing childhood obesity and will be offered to children who attend Pembroke School. It is a new initiative designed to get teenagers active and will provided a focussed 12-month pilot programme undertaken at Pembroke Leisure Centre. The project will be run by PCC (Pembrokeshire Leisure) in collaboration with Communities First and the South Cluster. The Programme is designed to help increase activity levels in 11-15 year olds who may be inactive and/or over-weight with the aim to increase their activity levels in a non-competitive, fun and sociable environment.

Scope Project - This is a Joint project with PCC and the South Cluster to fund a delivery of evidence based exercise into Day and Residential Care Homes in Pembrokeshire addressing the Frailer Older Adult agenda. The project will use qualified members of NERS to deliver an eight week evidence based exercise that will evaluate levels of exercise and emotional response. This project has been implemented in three care homes to date and will commence in a fourth home shortly. They will feedback to the cluster in December 2016

EMIS or Vision 360 - Similar to the North Cluster, the cluster is in the process at looking at working with either EMIS mobile / Anywhere or Vision 360 to look at more robust ways of working with practices when clinical professionals are out visiting patients within the practice population to deliver care closer to home. This would allow medical records to be updated and provide up to date information when visiting patients. Clinicians would be able to securely access patient records and share records between practices, book appointments, plan visits effectively, add consultations look at x-rays, test results, prescribe medications and access real time patient alerts and warnings. Vision visited the cluster meeting in September 2016 and EMIS are attending in November 2016 meeting. The cluster is also in talks with NWIS in regards to IT systems.

C-Reactive Protein Machines Purchased in 2015 – 2016 - The Cluster is working with Public Health Wales to provide a evaluation of CRP testing in the Cluster. To date, the Cluster has purchased 7 machines. Measurement of CRP can be helpful in the clinical management of patients with infection symptoms, the results are available during the consultation and can, therefore, guide antibiotic prescribing.

GP Continuous Professional Development - Two clinical talks provided by Mr Will Bracken – Ortho Geriatrician for all GPs and Advanced Nurse Practitioners. The talks were focused on the improved management and care of the frail elderly and in particular those vulnerable to falls and fractures. GPs from the 5 practices within the South Pembrokeshire Cluster attended.

Flu Talks - Two dates were set for lunch time flu talks in two practices Saundersfoot Practice and Argyle Medical Group. Improving Flu management and the uptake of the Flu vaccine are crucial for the winter period.

Goodwick Surgery

Goodwick Surgery is now a ‘managed practice’ managed by the Health Board directly. The practice is still experiencing difficulty in the recruitment and retention of General Practitioners. The Health Board is working with the Practice to ensure that services to patients are available, access to appointments have been problematic and the practice is not routinely operating a bookable appointment system but offering on the day appointments. The practice has successfully recruited an Advanced Nurse Practitioner, a Practice Nurse, a Practice Manager and two Receptionists. A triage system was implemented in the practice at the beginning of
October 2016 which will, it is estimated, reduce the number of patients presenting at the practice by up to 40%. The Health Board will continue to work closely with the practice and patients to improve access and stabilise the situation.

**Out of Hours / 111 Project**

HDUHB is working closely with ABMU, who are due to “go live” with 111 this month. The 111 programme is to be firstly implemented in Carmarthenshire spring 2017, with a view to then roll out across the other 2 counties. Monthly implementation board meetings are in place to ensure targets are met and are in line with national guidance.

The Out Of Hours team in Pembrokeshire will provide cover for Carmarthenshire patients from November to the “go live” date. Additional support, including staff and telephony and IT infrastructure is being secured.