Comisiwn Bevan Commission

Doing Things Differently: Supporting Service Development in the Community

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Over half a million people are now waiting for treatment.

Health and care will never be the same again. What are we going to do differently?

Please note: This paper should be read alongside the Bevan Commission publication **'Doing Things Differently: Tackling the Backlog in the Aftermath of Covid-19'.** Both papers will be followed up with detailed examples of how service change can be achieved and accelerated across Wales through a series of '**How To**' guides.

Content

Executive Summary

Supporting Service Development in the Community

The Covid-19 pandemic has changed the way we access care and services, and forced us all to consider what, how and where services and support should be provided in the future. Pre-Covid-19, there was a drive to provide more services in the community and closer to patients' homes, avoiding admission to hospital where possible. Now providing services in this way is even more important and there is a real opportunity to build on changes made during the pandemic and redesign and mainstream new ways of working that benefit the patient by providing more support in the community.

This paper will consider a number of options and recommendations that will also support the Welsh Government Covid-19 Recovery Plan[1] and National Clinical Framework[2] including:

- **Creating Healthy Communities:** Hospitals have over time become the centre of medical and healthcare services, the 'go to place' where the majority of healthcare is undertaken. Hospital emergency departments have been seen as 24/7 place for rapid treatment but are not necessarily the best option for improving health, for the patient or the system. Some developments have evolved in rebalancing care within communities closer to home, particularly within primary and community settings. Primary care clusters have helped support this shift and some interesting models have been introduced but are not yet systematically mainstreamed.

1. Welsh Government [Online]
2. Welsh Government [Online]

- **Building on what we have:** This paper identifies a number of important opportunities to mainstream or enhance pre-existing services or initiatives across NHS Wales. It also offers the opportunity to harness the considerable range of innovative practices and learning created through over 200 Bevan Exemplar projects, many of which support innovative ideas for out of hospital care. The 'Hospital at Home' concept, enhanced by technological tools and other support, including end of life care, frailty services and advanced paramedic support, provides an exciting opportunity. As does transferring and expanding Community Eye Care /Optometry Services, building upon the expertise and services already in the High St. and expanding services and support within local Pharmacies for minor ailments/ injury/ immunisation /advice and testing services.

- **Strengthening Allied Health Professional (AHP) Services in Communities:** Considerable potential exists to further establish direct access to a wide range of therapies provided by AHPs within community settings whether; integrated on the High St, in Leisure Centres, in other community settings or within primary care clusters. These include services such as community-based Physiotherapy, Podiatry, Occupational Therapy, Psychologists, Speech and Language Therapists, and Dietetics which also offer opportunities to support prevention and early intervention.

- **Transforming Prehabilitation and Rehabilitation:** To help tackle the backlog of people waiting for elective care and long Covid, existing pathways, services and support will need to be redesigned, particularly around prehabilitation and rehabilitation. This should be re-orientated around maintaining healthy lifestyles and self-management through home or community-based rehabilitation, supported by technological apps, self-help and online group support. Rehabilitation should be based on

'home first' principles, in line with the Discharge to Recover and Assess guidance supported by referral to more specialist care / rehabilitation centres as needed.

- **Point of Care Testing (POCT):** Technological developments have enabled many tests, previously taken place in hospitals, to be undertaken earlier and more rapidly in the community, by a range of health professionals. In particular, the following offer immediate opportunities but will undoubtedly be added to in time: Rapid antigen testing for streptococcal infections, continuous glucose monitoring for managing diabetes in pregnant women and freestyle libre flash glucose monitoring for type 1 or type 2 diabetes.

- **National Technology Enabled Self-Management:** Enabling people to self-manage and remotely monitor their conditions whether pain, respiratory, cardiology or psychological conditions, and avoid the need to visit hospitals unnecessarily, will become increasingly important as demand outstrips supply. In Wales, there is a large variation in the range of patient education programmes available, many of which have now been adapted for online access due to Covid-19. A National Technology Enabled Self-Management and Telemonitoring programme would help ensure these support tools are more systematically developed, promoted, supported, and accessed across Wales.

1. Introduction

The changes necessitated in response to the Covid-19 pandemic in health and care have been on a scale and speed not seen before[3]. There is a growing body of evidence demonstrating benefits for patients and the health and care system, if their needs are managed outside hospital settings wherever possible[4]. Such services include primary and secondary prevention, and care management for people living with long term conditions, which can reduce complications and avoid unplanned utilisation[5,6] of care in both hospital and out-of-hospital settings.

This paper highlights:

- How out-of-hospital services have evolved over time and how new, innovative out-of-hospital services have developed, some in response to the pandemic.
- Evidence and opportunities for specific acute care services to be transferred into community settings and existing services which could be strengthened.
- The role of digital solutions in new service delivery models and pathways.
- Priorities based on best value and impact in the short and medium term.

3. The Health Foundation [Online]

4. Government of the United Kingdom [Online]

5. Jonkman, Nini H et al. "Do self-management interventions in COPD patients work and which patients benefit most? An individual patient data meta-analysis." International journal of chronic obstructive pulmonary disease vol. 11 2063-74. 31 Aug. 2016, doi:10.2147/COPD.S107884

6. Welsh Government CCM Demonstrators 2011. Final (Year 3) Report from the Chronic Conditions Management (CCM) Demonstrators: Learning to support integrated primary and community care across Wales. CCM Demonstrators.com. 2011.

2. Context in Wales

As population health focused organisations, Health Boards are responsible for the healthcare of their resident populations and must plan and commission services and care based on their population's needs and outcome analysis. Regional Partnership Boards have an important role to play, bringing together a range of stakeholders, including health, social care, the third sector, the independent sector, education, housing, service users and carers, to develop innovative collaborative approaches to commissioning across sectors and geographies. This is very necessary if the integration agenda as set out in 'A Healthier Wales' is to be progressed.

Value Based and Prudent Health and Social Care go hand-in-hand with quality when measuring the effectiveness of services provided. They continue to be important in underpinning future service changes to achieve outcomes that matter to individuals whilst considering the impact and cost that achieving those outcomes would have.

Primary and community health services make up the largest percentage of the overall NHS activity statistics but with less than 9% of the NHS total expenditure spent on GP primary care. GP Clusters across Wales facilitate further integration of primary and community health and care services, enabling care models to move from being largely reactive, to ones that are proactive and based on prevention and early intervention. This model enabled a more streamlined response to the Covid-19 pandemic as stakeholders already had well established collaborative relationships.

Furthermore, early discharge from hospital following treatment, reduces the risk of further complications, particularly for older people and those with disabilities. It also leads to higher rates of patient satisfaction with care experiences [7,8].This is also true for people undergoing keyhole and other increasingly common day-case surgical procedures such as total hip and knee replacements [9].

Most recently, many clusters have further collaborated with other sectors to design and administer the Covid-19 vaccination programme.

7. Gonçalves-Bradley DC, Iliffe S, Doll HA, Broad J, Gladman J, Langhorne P, Richards SH, Shepperd S. Early discharge hospital at home. Cochrane Database Syst Rev. 2017 Jun 26;6(6):CD000356. doi: 10.1002/14651858.CD000356.pub4. PMID: 28651296; PMCID: PMC6481686.

8. Department of Health [Online]

9. Pritchard MG, Murphy J, Cheng L, et al. Enhanced recovery following hip and knee arthroplasty: a systematic review of cost-effectiveness evidence. BMJ open 2020;10:e032204. doi: 10.1136/bmjopen-2019-032204.

3. Where are we now in Wales?

In Wales, over the last 15 years or so, there has been effort and resource put into creating community and out-of-hospital multi and interdisciplinary teams, and primary care clusters. These include specialist outreach from hospitals, as well as primary and community in-reach into hospitals, for pre-habilitation, and early discharge and admission avoidance schemes. There is also a need to ensure that patients have access to such service out of hours. 'A Healthier Wales'[10] clearly identifies that further service transformation is required to deliver models of care that "...have a greater emphasis on preventing illness, on supporting people to manage their own health and wellbeing, and on enabling people to live independently for as long as they can, supported by new technologies and by integrated health and social care services which are delivered closer to home." This action is also at the heart of the Primary Care Plan[11] which takes a whole system approach to enable the delivery of seamless care and support closer to people's homes. Both strategic documents reinforced the importance of using digital solutions to enable a greater focus on public health, supported self-management, rehabilitation and recovery interventions and services. Change has however remained slow. Rapid transformation is needed, building upon the experiences and opportunities presented by Covid-19, and other innovative developments to meet health and care needs over the coming years. This is a significant and timely opportunity we should not miss.

Many of the new and enhanced services that have taken place have built upon the existing national and local health board contractual arrangements such as GP practices, dentistry, community pharmacy, community health (nursing and AHPs) and primary and community health and social care clusters. Whilst many

10. Welsh Government [Online]
11. Welsh Government [Online]

changes have progressed with outreach optometry, further opportunities exist to extend community optometry services through the optometry contract[12].

New funding models, such as pooled budgets, together with the targeted Transformation and Integrated Care Funding (ICF) streams from Welsh Government, have also supported transformational approaches to delivering health and social care, including Regional Partnership Boards. However, the extent to which any new funding schemes have really been transformative or industrialised is still limited, often compounded by traditional financial models, performance measures and governance systems which do not always follow the patient and their needs. It will be important to recognise that some of the recommendations in this paper will require these to be addressed.

To help inform this work and its recommendations, we have identified four core areas for out-of-hospital service transformation and how these have changed during Covid-19.

- **Services available on the High Street**
  Community Pharmacies, Optometry services, Dental services, Physiotherapy, Sports Therapy and Podiatry services.
- **Direct access to Health and Care Services**
  Access to Allied Health Professionals, Paramedics and Advanced Paramedic Practitioners.
- **Care in the Community and Close to Home**
  Acute Response Teams, Multidisciplinary Community Health and Social Care Teams, Community Specialist Nursing services, Discharge to Assess, Diabetic Retinopathy, Prehabilitation, Point of Care Testing, one stop shop Diagnostic Clinics and Supported Self-Management.
- **Palliative Care and End of Life**
  Hospice at home, education and training for residential and nursing home care staff.

Please see Appendices 1 and 2 for detail.

12. Welsh Government [Online]

4. What does the evidence tell us?

4.1. National / International journals and reports

The delivery of health and social care has been significantly disrupted both from the direct effect and impact of Covid-19, and the indirect effects that have arisen from the innovative approaches to mitigating actions that have been required to be taken by all parties[13]. Most aspects of the disruption have been addressed through the deployment of digital technology and new models of care that have been rapidly developed and implemented to meet these challenges[14,15,16]. These mainly included remote consultation software, telemonitoring, telehealth and telecare, and associated new ways of working and care pathways. This has been particularly evident in primary and community care, and hospital, outpatient appointments as reported by The King's Fund, Health Foundation and Nuffield Trust[17,18].

Ophthalmology is one speciality which has demonstrated that new models of care have provided benefits for patients and the healthcare system in terms of managing referrals and avoiding visits to hospitals for consultations and some treatments[19]. Furthermore, people living with chronic conditions have been monitored through telehealth technologies on a scale not achieved prior to the pandemic[20].

13. The King's Fund [Online]

14. Vargo, D, Zhu, L, Benwell, B, Yan, Z. Digital technology use during COVID-19 pandemic: A rapid review. Hum Behav & Emerg Tech. 2021; 3: 13– 24. https://doi.org/10.1002/hbe2.242

15. The King's Fund [Online]

16. Nuffield Trust [Online]

17. Health Foundation [Online]

18. Health Foundation [Online]

19. Gunasekeran, D et al, 2021. Digital health during COVID-19: lessons from operationalising new models of care in ophthalmology. The Lancet. [Online] [Accessed 10 March 2021]

20. The King's Fund [Online]

In Wales, there has been a sea change in the scale and pace of innovative practice, much of which has been facilitated through digital technologies, but not all care team members have access to the right tools to deliver virtual services or the associated skills and competencies. Some changes in service delivery provision were already underway prior to the pandemic, particularly innovations funded through the ICF and Transformation Fund which helped the accelerated response needed. It is important that these innovations and changes are further developed, accelerated and 'industrialised' systematically across Wales.

4.2. Evidence from practitioners, consultation events and meetings

The following section provides an insight into which health and care services currently in acute settings, or those with potential for development, could be of benefit and impact if strengthened within the community. This is informed by a range of stakeholders including:

- Public-facing online survey.
- Bevan Exemplars, Adopt & Spread leads, Bevan Advocates and Fellows.
- Meetings with key stakeholders from Welsh Government, Health Boards, Trusts, professional bodies, and patient/citizen advocacy organisations.
- Series of online consultation events.

4.2.1 Technology Enabled Self-management (blended approach)

People living with chronic conditions spend most of the time self-managing their conditions with relatively little contact with health and care professionals. However, many people do not have the knowledge, skills or confidence to optimise their own health and wellbeing on a daily basis. Patient education programmes such as Education for Patients Programme (EPP) (see Appendix 3) and other self-monitoring tools provide an opportunity to support people to self-manage outside of healthcare settings. Across Wales, there is currently a large variation in the range of patient

education programmes available and the tools and technology support for this. Many of the education programmes have been adapted through Covid-19 for use online with some innovative models emerging in some Health Boards. The following are important considerations in moving forward.

- **Self-Management** - Prolonged waiting times across Wales will require a range of options to help patients self-manage. A "blended approach" to patient education is needed, embedded into redesigned care pathways, using technology tailored to meet individual needs. This includes online 1:1 and tech enabled group sessions and face-to-face support provided in a range of community-based and home settings.
- **Physiological measurements and remote consultations** - Both professionals and patients need to be supported to fully maximise the use of simple, low cost, home-based technology including the use of landline telephones, mobile phones, app or web-based interfaces, either alone or in combination with the use of physiological measurement and monitoring equipment such as for Blood Pressure, Pulse Oximetry and ECG.

4.2.2 Prehabilitation, Preoperative Assessment, Rehabilitation and Recovery

Prehabilitation, Preoperative Assessment, Rehabilitation and Recovery will need to be transformed to ensure it is best suited to meet needs within community settings to respond to long Covid, the orthopaedic backlog and other demands. The following will need to be considered:

- **Prehabilitation services** improve post-operative outcomes and, in some cases, provide a more appropriate alternative to surgical intervention. These could be scaled up to offer all people on waiting lists access to online and in-person support to enhance their fitness and functional capacity before surgery. Like self-management, prehabilitation helps people to increase their fitness, stop smoking, or reduce alcohol consumption and has the potential to help prevent other health issues or complications in the longer term.

Programmes usually have multiple components such as nutritional support, exercise and psychological education.

- **Preoperative assessments** are necessary for some types of surgical procedures and digital technologies can reduce the need for patients to attend a hospital appointment for tests and investigations. Pre-operative cardiopulmonary exercise testing for people in whom major abdominal surgery is planned is an example where the data and information required to plan the surgical procedure could have the potential to be obtained using digital technologies in the home or community setting[21].
- **Rehabilitation** The increasing number of people requiring surgical procedures due to the backlog will also require increased rehabilitation and recovery capacity across Wales. There is considerable potential to address this outside of a hospital setting and embedded as part of the redesigned care pathways. Technology-enabled rehabilitation programmes can be tailored to individual needs with varying levels of intensity and could be further integrated with self-management, pre-habilitation and preoperative assessment, and elective surgery, which will allow a high volume of patients to be treated and receive support from a multidisciplinary team of experts[22].

4.2.3 Point of care Testing (POCT)

POCT services are largely offered to patients when they attend appointments in hospitals and GP practices, with some community nursing staff also being able to undertake some tests eg to diagnose a UTI. As technology develops, the potential for these services to be expanded into the community, avoiding the need to attend hospital and providing more rapid and convenient tests, will grow.

21. Health Technology Wales [Online]
22. Welsh Government [Online]

4.2.4 'Hospital @ Home' and Community based Allied Health Professionals (AHPs)

The provision of more digitally-enabled and/ or direct access to community-based therapy / AHP services will be important. This includes new models of working such as the provision of physiotherapy in leisure centres and community enterprise delivery models. Focus areas currently being tested include podiatry services and psychological therapies for people living with low-level depression and anxiety, both of which could improve timeliness of care, lengths of stay in hospital as well as avoid hospital admissions in the first place.

Across Wales there are a number of different 'Hospital @ Home' care models (Virtual Wards, Stay Well @ Home) which focus on supporting early discharge from a hospital admission or hospital avoidance. During the pandemic, remote consultations and telemonitoring technologies have been introduced into care pathways. For people who are frail or at end of life, the Hospital @ Home model has considerable potential to provide a package of out of hospital services at home in communities. Further innovative opportunities exist to address the needs of these groups of patients with minor adaptations, technologies and enhanced care team skills and competencies.

All the service transformation and enhancements outlined above not only enable care to be provided in communities but would provide the 'integrated wrap-around' to waiting list management and enable more surgical procedures to have shorter lengths of stay or be undertaken as day cases. They are also more convenient, less disruptive for patients and may also reduce other risks such as infections.

5. Analysis and Discussion

At a time when many people in Wales will be waiting much longer for specialist consultations, diagnostics and surgical procedures, it will be important to co-design innovative care pathways that support people to help them manage their symptoms and underlying conditions. This will also optimise their recovery following intervention, be it a diagnostic procedure, treatment or surgery.

Many of the changes over the last 12 months have highlighted the potential to truly redesign and transform some services and care pathways at speed. In particular, the work undertaken by Bevan Exemplars[23] clearly indicates the wide range of innovative solutions and opportunities to move services into communities that have already been tried and tested. These could be built upon immediately to ensure rapid adaptation, adoption and spread across Wales (Appendix 4). The following summarises some innovative opportunities to move services out of hospital care and to develop further, initiatives already within communities.

5.1. Remote consultations with physiological measurements and psychological and psychotherapy tools

Widespread roll-out of technologies and software will be needed to facilitate the delivery of remote consultations[24]. Primary care services will continue to be delivered in a blended way with Covid-safe face-to-face services being offered for those in need, complemented by sustainable remote consultation care delivery models. Further resources and guidance may be needed to ensure both care team members and patients are comfortable using the digital solutions in order to fully maximise the opportunities.

23. Bevan Commission [Online]
24. Digital Health.Wales [Online]

Innovative Practice: TEC Cymru, NHS Wales Video Consulting (VC) Service

The first phase of TEC Cymru evidence[24], based on 10,000 patient survey responses and 300 user interviews, demonstrates that:

- Very high in patient and clinician satisfaction (slightly higher in patients).
- Clinically suitable across a wide range of specialties, care sectors and Health Boards.
- High acceptability of VC, which is believed to be associated with the 'Welsh Way' of digital implementation processes.
- Consistent data patterns across patient demographics (age, gender, urban/rural location) and across clinical settings and Health Boards.
- Large appetite for VC in Wales, with high potential of sustainability and long-term use beyond COVID-19.

5.2. Integrated Prehabilitation, Preoperative assessment, Rehabilitation and Recovery pathway

The advancements in AHP practice over recent years, provide significant opportunities to establish out of hospital services. These include; end-to-end prevention, self-management, prehabilitation, preoperative assessment, rehabilitation and recovery pathway, with each supported by technology enabled self-management at its core. Virtual prehabilitation delivery models have arisen from Covid-19[25]. The comprehensive and integrated asset, place-based model such as that designed and implemented in Wigan[26], together with the Ysbyty'r Seren 'Dragon' rehabilitation field hospital in Bridgend and the integrated approach to deliver supported self-management and rehabilitation (launched by Cardiff & Vale University Health Board in early 2020) are examples of moving in

25. Kent and Medway CCG [Online]
26. Wigan Council [Online]

this direction. These align to the National Rehabilitation Framework and guidance published this year[27].

From an out-of-hospital perspective, it is clear that the pandemic has forced many Health Boards to invest in more innovative approaches to support self-management, rehabilitation for Covid-19 patients, living with long-term, complex conditions and/or awaiting diagnostic or surgical procedures.

I**nnovative Practice**: Ysbyty'r Seren Rehabilitation Hospital

- Ysbyty'r Seren is Cwm Taf Morgannwg UHB's field hospital which was developed in response to the COVID-19 pandemic.
- Ysbyty'r Seren provies clinical care, wellbeing and therapy support for patients away from the district general hospital setting.

5.3 Point of Care Testing (POCT)

As is the case with digital solutions, there have been many advances in Point of Care Testing technologies which can be used to redesign some care processes and improve and optimise treatments sooner and without unnecessary touchpoints with the health system.

With training, others such as Pharmacists, Paramedics, Nurses, Psychologists, Physiotherapists and Occupational Therapists will be able to undertake POCT. In particular, the following could be actioned immediately:

- Through the community pharmacy contract the use of rapid antigen detection tests (RADT) for diagnosing and managing people with group A streptococcal infections has been demonstrated on a small scale and could be further tested[28].

27. Welsh Government [Online]
28. Health Technology Wales [Online]

- People living with diabetes and pregnant women with Type 1 diabetes can also benefit from tele-monitoring self-management technologies, particularly those whose diabetes is frequently unstable and are likely to require emergency admission to hospital[29,30].

Innovative Practice: Cardiopulmonary exercise testing (CPET)

- Cardiopulmonary exercise testing (CPET) is a way of measuring the performance of the heart and lungs at rest and when exercising.
- It can be implemented as part of remote prehabilitation and preoperative assessments.
- The measurements can be used to help plan a patient's care in recovery and optimise clinical outcomes.

5.4 Community-based Allied Health Professionals (AHPs) and 'Hospital @ Home'

A number of Bevan Exemplar projects have focused on testing innovative approaches to Allied Health Professional services including the following from Exemplar Showcase events:

1. PACE Podiatry: Accessible Care for Everyone - Social Enterprise Model in ABUHB.
2. Advanced Practitioner Physiotherapists (APP) in Primary Care and Community Services in BCUHB.
3. Evaluating the Value and Impact of Occupational Therapy in Primary Care in HDUHB.

29. Health Technology Wales [Online]
30. Health Technology Wales [Online]

Optometry

Whilst there have been some service improvements to optometry services in parts of Wales, particularly in relation to retinal screening, Wet age-related macular degeneration (AMD) and other drug-related treatments, the Optometry Contract could be leveraged further to ensure that such innovative approaches are mainstreamed into 'High Street Opticians' where appropriate as this would provide much improved access for patients to such ongoing treatments. This model could also be applicable to other clinical areas.

Innovative Practice: Expanding High Street Optician services

The Optometry contract has been used to provide direct access to appropriate and timely care in some areas of the UK.

- Minor Eye Conditions Service (MECS) can deflect significant numbers of people seeking GP and A&E consultations: 25% reduction in GP referrals and 80% discharged from optical practice after one intervention (Lambeth)
- 5800 out of 6000 care navigation calls directed to more appropriate local services: 25% to optical practices in West Wakefield and saving more than 185 hours of GP appointments.
- Post-diagnosis care for people with glaucoma by suitably qualified optometrist.
- Pre and post-operative cataract care delivered via community optical practice: 90% post-cataract patient care can be managed in the community.

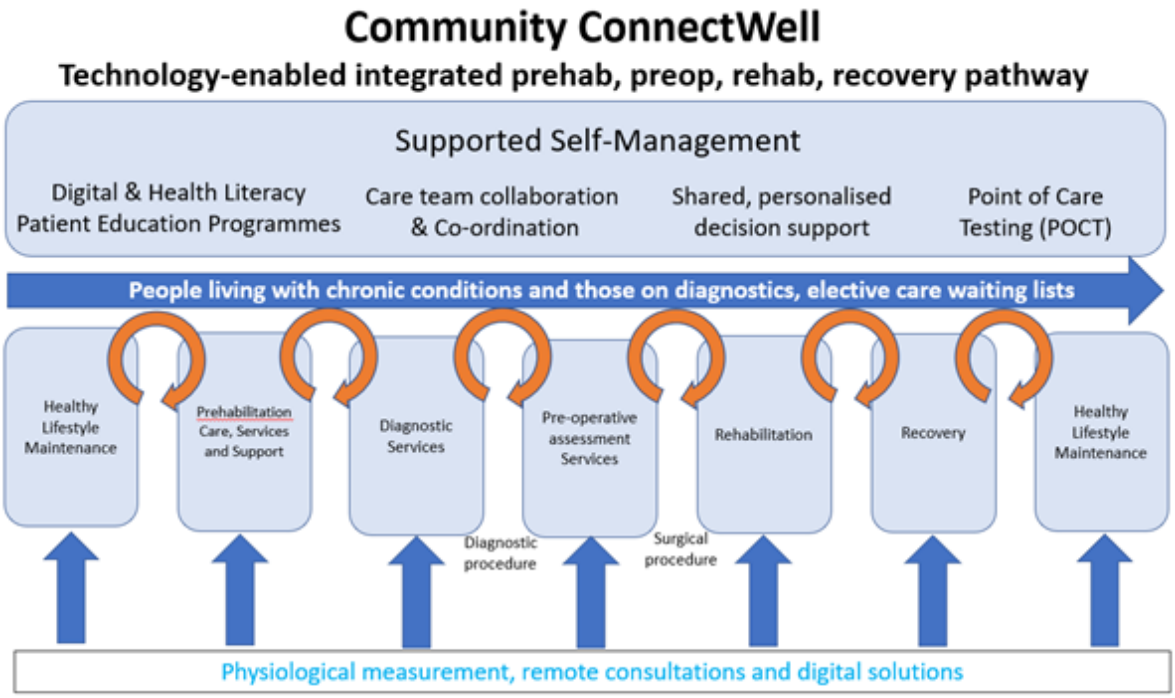
Community Pharmacy

NHS Wales does not yet have an electronic prescription system so community pharmacies are not yet able to fully optimise the value of remote consultations with patients. There is also the opportunity to involve community pharmacies in POCT service developments and telemonitoring of people living with long-term conditions. The Community Pharmacy contract facilitates the delivery of a minor ailments/injury scheme and this could be further enhanced to include other health problems.

6. Options and Recommendations

The options for transferring acute hospital services into community-based services broadly includes; building upon what already exists, is being developed, and continued innovative approaches.

The diagram below sets out a generic care pathway to illustrate how the following key components can be aligned into an over-arching care model 'bundle', designed to enable people to keep themselves healthy: supported self-management, prehabilitation, preoperative assessment, rehabilitation, reablement and recovery.



This 'bundle' needs to be seen as a whole-system approach, supporting people to live well within communities and avoid the need to go into hospital. It will enable people to more easily access and engage in a range of services within local communities, whether in the High St, Leisure Centres or Health Centres and at different levels and intensity, as and when they need to.

Further consideration will need to be given on how this transition is balanced, managed and supported over time, recognising that some may be cost neutral whilst others may need additional resources or training. Some examples have already been tried and tested and are ready to go, whilst others may need extra work or adaptation.

The following recommendations should all be actively enabled by digital solutions, but not exclude the digitally disadvantaged. Where people feel uncomfortable using technology or there is a lack of Broadband or mobile phone signal, 'multi use' community settings such as GP practices, schools, leisure centres and community halls, all offer considerable potential.

Maximise the potential of Community-based Allied Health Professionals and High Street services by:

1. Transferring some ophthalmology care to community treatment centres and opticians.
2. Expanding direct access to new models of community-based therapy services including Podiatry, Physiotherapy, Occupational Therapy Speech and Language Therapies, Dietetics and Psychology services delivered in community settings.
3. Enhancing minor ailments/ injuries role for community pharmacies.
4. Explore options to develop hospital services as part of High Street regeneration.

Transform Prehabilitation, Preoperative Assessment, Rehabilitation and Recovery Services and Support by:

1. Redesigning pathways, services and support around prehabilitation, preoperative assessment and rehabilitation, supporting people to maintain healthy lifestyles through exercise at home, Leisure Centres and other community settings.
2. Support the development of services enabled by technological apps,

online group support sessions etc.

3. Embedding rehabilitation based on 'home first' principles (wherever possible) supported by tools and as needs be onward referral to new delivery models for specialist care/ rehabilitation.

Create innovative 'Hospital @ Home' models by:

1. Further exploring and testing Innovative Hospital @ Home' models to inform widespread application across Wales.
2. Developing and supporting Hospital @ Home models (including frailty and EOL care) enhanced by digital solutions (video conferencing, physiological measurements, telehealth).

Expand Point of Care Testing by:

1. Exploring wider opportunities to increase POCT with support from other community professionals.
2. Redesigning some care processes and improved/optimised treatments sooner and without unnecessary touchpoints.
3. Using self management technologies for people living with diabetes and pregnant women with Type 1 diabetes particularly those who are frequently unstable and are likely to require emergency admission to hospital[29,30].
4. Exploring the potential to expand the following:

- rapid antigen detection tests (RADT) for diagnosing and managing people with group A streptococcal infections[28].
- using Cardiopulmonary exercise testing (CPET) as part of remote prehabilitation and preoperative assessments.

Establish a National Technology Enabled Self-Management Service by:

1. Establishing and supporting a National Technology Enabled Self-Management Service to help people self-manage and remotely monitor their own health and well being, and chronic conditions including pain, respiratory, cardiology or psychological conditions.
2. Building upon and expanding the Education for Patients Programme and other developments and tools adapted for online access including, Apps and Virtual Group session software.
3. Encouraging innovative developments of remote monitoring and self-help tools, and promote amongst the public and professionals.

7. Conclusion

The pandemic has changed the relationship between health and care practitioners and patients. It has forced all parties to ask fundamental questions about what, how and where health and care, services and support can best provided and accessed.

Covid-19 forced the hand of change, driven by urgent needs and in many cases supported by the use of technology. A number of innovative opportunities to take some services out of hospitals were exposed, which also provided more effective and efficient use of skills, resources and timeliness. This included online support services, remote consultations and services such as podiatry and ophthalmology that need not be undertaken within hospitals settings. It reinforced the importance, potential and readiness of the innovative work already being developed by schemes such as the Bevan Exemplars.

It also highlighted a considerable co-production potential, working with patients themselves as true partners in their own health and wellbeing, building greater confidence in remote consultations, self-monitoring and accessing information online. Getting the balance right between a combination of virtual and in-person care will need to be undertaken with people, including the trade-offs that this new way of working and delivering care[31] and support will force us to consider and address.

We have a great opportunity to transform the way we work which we all need to grasp. Redesigning and mainstreaming new ways of delivering services closer to home will bring many benefits; reducing unnecessary appointments, journeys and costs, work or child care disruption and easier and more timely access.

We still have much more to learn about how the valued patient-clinician relationship is likely to change[31] and how we can ensure that alongside any changes people's physical and emotional well-being remains at the heart of any transformational change.

31. Shapiro SD , Rothman PB . How academic health systems can move forward once COVID-19 Wanes. JAMA 2020;323:2377–8.doi:10.1001/jama.2020.8002

Appendices

Appendix i – Pre Covid-19 - Out of hospital services available in Wales[32]

Services on the High Street

1. Community Pharmacies

- Minor Ailments Scheme with direct access for patients seeking advice and care management for 26 minor ailments.
- Medication reviews – Community Pharmacies.

2. Optometry services

Most opticians across Wales provide standard optometry contractual services.

3. Dental services

Most dentists accepting NHS-funded patients do so in line with the standard dental contractual services.

4.Physiotherapy and Sports Therapy

These services are generally provided by private practitioners and are not reimbursed by the NHS.

5.Podiatry services

As well as podiatry services provided by the NHS, particularly for the elderly, people living with disabilities or diabetes, private practice is available across Wales.

Direct Access to Health and Care Services

6. Direct access to AHPs

Health Boards have been transforming access to allied health professional services, particularly Physiotherapy and Occupational Therapy provided in GP practices, and in some instances, other community settings such as leisure and sports centres and this includes the National Exercise Referral Scheme; community mental health and dementia services, speech and language therapy and dietetics as part of Flying start.

7. Direct access to Paramedics and Advanced Paramedic Practitioners

Advance Paramedic Practitioner – specially trained paramedics who are able to treat patients in the community, refer them to a GP or decide whether they need to be taken to hospital.

Care in the Community and Close to Home

8. Acute Response Teams

Nursing, AHPs, psychosocial, social work.

9. Multidisciplinary Community Health and Social Care Teams

Aligned or linked to GP clusters where relevant:

- Hospital at Home – earlier discharge from inpatient episode for people with ongoing health and care needs
- Virtual Wards – multidisciplinary care team approach to support early discharge and admission avoidance for those people who are frail or living with chronic conditions, but not exclusively
- Stay well @ Home – Service preventing hospital admission and facilitating discharge by integration of health and social care services at the critical interface during presentation at A&E in Cwm Taf
- Mental Health, learning disability and Dementia care and services in schools and care homes – multidisciplinary care teams often comprising care practitioners from secondary, community and primary care and leisure sectors.

10. Community specialist nursing services

All the main chronic and long-term conditions have specialist nursing service support.Some

are entirely community oriented; others have roles and responsibilities that cover services delivered in primary, community and secondary/tertiary care settings.

11. Discharge to Assess
Early discharge from inpatient episode or A&E attendance when medically fit with assessment of any ongoing health and care needs. The foundations of the discharge to assess model are trust, collaboration and flexibility, and provide the opportunity to benefit local residents as they have the time to recover/rehabilitate in their own home, before any decisions are made with them about their long-term health and social care needs.

12. Diabetic Retinopathy
Eye screening is undertaken in over 130 community venues across Wales, such as hospitals, health centres, GP practices, or a DESW mobile unit.

13. Prehabilitation
Some surgical care pathways, particularly cancer (Pre-Treatment and Optimisation rehabilitation – POP).

14. Point of Care Testing (POCT)
This is the performance of diagnostic tests by non-laboratory staff within a near-patient setting, producing essential test results in a timely manner, allowing speedy diagnosis and treatment.

15. One stop Shop Diagnostics Clinics
Established as part of cancer care pathways in some health boards to reduce referral to treatment time.

16. Supported Self-Management
A range of self-management educational programmes, including the Expert Patient Programme, to support people living with chronic conditions and their families delivered in hospital and community settings utilising care team members from secondary, primary, and community care services. Appendix 3 provides the latest summary of the self-management programmes available across NHS Wales.

Palliative Care and End of Life

17. Palliative Care
Hospice at home, hospice care provided by third sector organisations and supported by the NHS. Education and training for residential and nursing home care staff.

32. Bernadette Sewell, Mari Jones, Helen Gray, Heather Wilkes, Catherine Lloyd-Bennett, Kim Beddow, Martin Bevan, Deborah Fitzsimmons. Rapid cancer diagnosis for patients with vague symptoms: a cost-effectiveness study. British Journal of General Practice 2020; 70 (692): e186-e192. DOI: 10.3399/bjgp20X708077

Appendix ii - Changes during Covid-19 - Out of Hospital and Community Services[33, 34]

Services on the High Street
Telephone calls and face-to-face in pharmacies.
Remote consultations (telephone, mobile phone, video, email) for GP face-to-face appointment triage.
Emergency optometry services until social distancing measures implemented.
Emergency dental services until social distancing measures implemented.
Direct Access to Healthcare Services
Direct access schemes now include an online self-assessment/referral form that patients are encouraged to complete. Telephone access is also available.
Care in the Community and Closer to Home
More remote consultations, particularly telephone, and sometimes augmented with physiological measurements, have been undertaken where an actual intervention, eg IV antibiotics or wound care is not necessary. Some patients have been followed-up and supported in groups using video conferencing technology and been signposted to 'Patient Knows Best' web interactive support.
The capability to undertake POCT on an unprecedented scale has been demonstrated through Coronavirus testing and this has been predicated on the involvement of a much wider range of healthcare professionals than prior to the pandemic.
Most Health Boards in Wales have converted their self-management Patient Education Programmes to be available online with self-referrals in addition to referrals from care team members.
Palliative Care and End of Life
Guidance to support family carers developed by Professor Ilora Finlay has enabled many people to spend their last days at home during the pandemic. The guidance includes the care and services that the carer should expect from the professional healthcare team. Continued roll-out of the Bevan Commission Adopt & Spread Exemplar project - Six Steps education programme for supporting Palliative and End of Life Care.

33. Patient Knows Best [Online]

34. WiredGov [Online]

Appendix iii - Self-Management in NHS Wales

Self-management courses have been provided for the past 17 years in Wales under the brand of Education Programmes for Patients (EPP) Cymru. Courses support individuals with a long-term condition to:

- Develop skills to help them to manage their health and well-being.
- Make best use of health services.
- Work in partnership with health and social care professionals.
- Make positive behaviour changes to improve their lifestyle.
- Take control of their health and well-being.

This in turn should improve the quality of life of individuals with a chronic condition and reduce pressure on NHS services.

Building on the success of recent years, the programme aims to continue working towards improving the number of individuals with a long-term condition in Wales that complete a self-management course.

EPP Cymru currently delivers the following courses: -

- Chronic Disease Self-Management Programme (CDSMP); a 6 week course.
- Caring for me and You - a course for carers; a 6 week course.
- Introduction to Self-Management (ISM); a three hour taster session.
- Living with Breathlessness/COPD; a 7 week course.
- Diabetes Self-Management Programme (DSMP); a 6 week course.
- 50+ Introduction to Self-Management (ISM); a 3 hour taster session.
- Cancer: Thriving and Surviving Programme.
- Persistent/Chronic Pain Self-Management Programme.
- Workplace, Chronic Disease Self-Management Programme; a 6 week course (over 12 sessions for those employed/sickness) and delivered onsite.

Most of the above are now being delivered virtually (due to Covid-19) but of course we are not reaching those who do not have internet access (mostly in deprived areas of Wales).

List of Self-Management courses now available on the (EPP) Database

There are a further 22 courses that are delivered by HB's/3rd Sector but still under the Self-Management EPP banner. However, the extent to which people have access to the wider range of courses varies across Wales.

Self- Management Teams in HB's are all employed by the NHS with the exception of ABUHB. The Self-Management Programme runs from the 3rd Sector (GAVO) where staff are salaried on a lower level but do exactly the same role. The staffing levels differ considerably between HBs and are not based on the prevalence of the local chronic condition population.

Appendix iv. Highlighting some of the relevant Bevan Exemplars services provided in communities

Cohorts 5 and 6

1. Implementation of a Family Wellbeing Practitioner Service in Primary Care GP Practices.
2. Malignancy Of Unknown Origin (MUO) Primary Care Access and Supported Toolkit.
3. Get up and dance!
4. PACE Project - NHS Podiatry Access serviCe for Everyone.
5. Foodwise in Pregnancy: Improving access to evidence based nutrition and healthy weight gain information in pregnancy.
6. Café Care Project - A project to co-produce and evaluate an Advance Care Planning (ACP) café, targeted in the novel area of nursing and residential homes.
7. Using population segmentation and risk stratification to deliver asthma care where it's needed most.
8. A pilot to explore the adaptability of the Hafal Recovery Programme in supporting mental health inpatients transition to community discharge.
9. Using Narrative Therapy with Healthcare Professionals and Patients and Patients to Improve Self Management of Diabetes.
10. Supporting Carers to identify physical causes for behaviours that challenge.
11. An Intensive Community Support Team – Preventing Inappropriate / Unnecessary Admissions to Learning Disability Inpatient Wards.
12. Evaluating the Value and Impact of Occupational Therapy in Primary Care.
13. Super-Agers - Transforming the Lives of Older Adults.
14. Telehealth platform for cleft lip and palate/ velopharyngeal dysfunction.
15. The Grow Well Project.
16. CYSGU - “Help Me Sleep”.
17. Pop to Hop.
18. Validation of rapid gene test to guide treatment options for certain cancer patients whose diagnosis may have been delayed by Covid 19: this new service to be delivered through a hub and spoke model with the aim to improve turnaround time to improve patients prognosis.
19. Virtual pain management programme for osteroarthritis patients waiting for surgery.
20. Making getting treated easier: sexual health services partnering with community pharmacies to enable patients to collect medication closer to home.
21. Immersive environment/ VR to manage chronic pain in a primary care setting.
22. Recovery through activity- implementation and evaluation of an online occupational therapy intervention across Wales.
23. Secure services referral and step down pathway.
24. Virtual Covid-19 Ward.
25. Increasing time spent at home, well and independent - a new campaign improving whole system unscheduled care.
26. A digital first approach to patient correspondence.
27. Urgent GP response unit for acute medical care in the community.
28. Pembrokeshire 'blue team' advice line.

29. Transfer of care and liaison service preventative screening project.
30. Hywel Health Hub.
31. Vascular Catheter Preservation Initiative (PICC & Midline Virtual Ward).
32. Digital education for non clinical staff to promote the use of virtual consultations for people with persistent pain and fatique in rural Powys.

Earlier Cohorts

1. Implementation of a new innovative service whereby Advanced Physiotherapy Musculoskeletal (MSK) Practitioners are deployed into Primary Care. To allow people presenting with musculoskeletal problems to be seen in their local General Practice by an Advanced Physiotherapy Practitioner as an alternative to seeing their General Practitioner.
2. The idea is to develop an innovative Physiotherapy Practitioner-led pathway designed to reduce the pressures on secondary care Orthopaedic out–patients by providing patients with early access to specialist opinion in a local community setting.
3. To develop the pharmacists contribution to encouraging a greater focus on addressing non-adherence.
4. Utilising a combination of remote healthcare monitoring and supported intervention. It enables the local management of patients presenting with Obstructive Sleep Apnoea (OSA).
5. Improving the outcome for IBS (irritable bowel syndrome) patients in Primary Care using the low FODMAP diet approach.
6. Diabetes foot health engagement and empowerment to self-care.
7. Development of a virtual ward supported by community paramedic practitioners.
8. Improving dementia diagnosis in primary care.
9. Developing the role of the Dietetic Assistant Practitioner in delivering an education and dietetic assessment service to manage malnutrition in nursing homes.
10. 'Be Here, Be Clear': a preventative intervention to address communication and behaviour in the early years.
11. Tele-ophthalmology in North Wales using smart phone adaptors to improve management of acute eye disease.
12. Evaluating the delivery of Pulmonary Rehabilitation via Video-conferencing in rural settings.
13. My COPD Nurse is essentially an e-diary aimed at sufferers of Chronic Obstructive Pulmonary Disease (COPD).
14. Conversations about Cancer - an automated cancer advice service, for patients and carers.
15. The development of a new model for optimising the care of vulnerable people in Primary Care through developing Safeguarding Supervision Groups.
16. Virtual Inpatient Care for Hand Trauma
17. Digital Companions : improving health and wellbeing in a digital age.
18. QR Info Pods – communicating digitally with patients.
19. Use of AliveCor smart ECG monitors in the development of the new IP pharmacist role to improve the early detection of atrial fibrillation.
20. Implementing a virtual clinic for People with Parkinson's with the aid of wearable technology.
21. Digital Companions: improving health and wellbeing in a digital age.

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