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Rural Health Innovation Local Projects

Summary of reports

October 2011

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Executive Summary

The Rural Health Innovation Programme has provided an opportunity to initiate innovative health and social care practice for rural communities in Wales. This report outlines the work of Local Innovation fund projects undertaken during the first implementation phase of the Rural Health Plan in 2010-2011.

The Local Innovation Fund projects were launched in August 2010 and address the key issues raised in the Rural Health Plan of access, integration and community cohesion. The projects are wide ranging and deliver to a broad cross section of client groups as well as addressing acute to long term conditions and engage volunteers and professionals across the board.

A key theme within the projects has been the use of ICT. The IT Paramedics project has enabled Specialist Practitioners to see and treat a wider range of clinical presentations in situ. This has further potential to reduce transfer to hospital and so reduce travel for patients. The Telerehabilitation work aims to use videoconferencing in a wide range of clinical specialities from speech and language therapy to audiology. These projects bring services closer to patients, reducing travel time for service users and clinical staff and improving access for remote communities.

The Voluntary Sector has played a key role in service provision ranging from non emergency transport provision, advocacy services and Investors in Carers. This breadth of service delivery demonstrates the potential the Third Sector has.

Some projects have required service redesign, for example, the Palliative Care project has restructured its service provision engaging with the Third Sector to enable hospice at home care. Designed for Competence has developed three new roles to improve care for patients and released clinical time for senior staff to attend to complex cases. These projects have demanded integrated working which will reduce duplication of work and improve care for patients.

Several projects showed the benefit of extending the roles of health professionals. The community pharmacy projects demonstrate this, for example in the heart failure management work. The nurse led Minor Injuries Unit also extended the practitioner's role bringing emergency care closer to patients. These models have particular potential for rural communities where access to specialist services can be difficult.

These differing approaches have offered opportunities to improve health and social care provision against the three key themes of the Rural Health Plan of access, integration and community cohesion and engagement. It is vital the lessons learnt from this work are taken forward by sharing the learning, embedding projects locally or diffusing models out across different clinical specialities and/or geographical areas to continue to improve the health and wellbeing of the rural communities in Wales.

Introduction

Over a third of the population of Wales lives in a rural community. Following widespread engagement with rural communities and health and social care practitioners throughout Wales, the Rural Health Plan - Improving Service Delivery across Wales (2009) was developed. It highlighted many potential areas for progress in health and social care provision in rural Wales under its three key themes of access, integration and community cohesion and engagement.

The Rural Health Plan's overarching aim is "To focus on the health of people living in rural communities - their wellbeing, their healthcare and health and social care needs to enable them to live happy and fulfilled lives as independently as possible".

To support delivery of this agenda the Rural Health Implementation Group (RHIG) was set up in 2010. During the first implementation phase the portfolio has included two development sites, two work streams and also 15 Rural Health Local Innovation Projects. These local projects were funded short term and their purpose was to:

- Stimulate and support innovative and sustainable solutions supporting the key themes outlined in the Rural Health Plan;
- Develop and test new models of integrated, sustainable working across health and social care addressing integrated systems, service delivery, planning and workforce development;
- Strengthen local ownership, engagement and rural networks supporting health and wellbeing in rural communities;
- Support joint workforce training and developments planning which support new skills, roles and responsibilities;
- Identify and share examples of good practice to inform service delivery.

This report is a summary of the work these projects have undertaken to date.

Methodology

There was a call for innovative health and social care projects for rural communities in Wales in April 2010. In total 15 projects were supported across a range of service providers and client groups. The timescales were extremely tight and implementation has been challenging.

Each proposal needed to be sustainable, affordable and transferable and be able to demonstrate partnership working as well as impact and outcomes against the key themes of the Rural Health Plan and the local aims and objectives for the project.

Rural Health Innovation Local Projects

1. Community Support Networks and Building Capacity in Primary Care.
2. Telerehabilitation via videoconferencing. Plus Sp< clinic in a bag.
3. Palliative Care in Powys.
4. Nurse led MIU linking with a DGH.
5. Electronic x-ray link.
6. Capable Coping Communities.
7. IT Support for Paramedic referrals in rural areas.
8. Improving Access and Integration for Rural Carers across Hywel Dda.
9. Designed for Competence.
10. Community Outreach Bus:
    - DORIS (Denbighshire Outreach Rural Information Service);
    - Mantell Gwynedd Mobile Unit;
11. Rural Carers Survey - Health and Social Care Agencies;

12. Innovative Rural Community Pharmacies:
    - Cognitive Behavioural Therapy - Gwynedd.
    - Heart Failure - HDHB.
    - Smoking Cessation - Powys.
13. Third Sector Co-ordination in Rural Areas:
    - Transport - Ceredigion.
    - Long Term Conditions - Powys.
    - Access to Health and Well Being Information - South Gwynedd.
14. Taking Care Farming Forward across Wales;
15. Telemedicine.

List of Abbreviations

Abbreviation	Descriptor
ABHB	Aneurin Bevan Health Board
ASIST	Applied Suicide Intervention Skills Training
BCuHB	Betsi Cadwaladr University Local Health Board
CALL	Community Advice and Listening Line
CCBT	Computerised Cognitive Behavioural Therapy
COPD	Chronic Obstructive Pulmonary Disease
CAVO	Ceredigion Association of Voluntary Organisations
DGH	District General Hospital
ENP	Emergency Nurse Practitioner
GAVO	Gwent Associations of Voluntary Organisations
GPOOH	GP Out of Hours service
HDHB	Hywel Dda Health Board
HF	Heart Failure
LHB	Local Health Board
LTC	Long Term Condition
MIU	Minor Injuries Unit
NHSDW	National Health Service Direct Wales
PAVO	Powys Association of Voluntary Organisations
PFI	Private Finance Initiative
RHIG	Rural Health Implementation Group
SLA	Service Level Agreement
Sp<	Speech and Language Therapy
VVW	Volunteer Village Wardens
WAST	Welsh Ambulance Service Trust

1. Developing Community Support Networks

Aim

To reduce suicide and self harm, by building on the strength of existing communities and building capacity.

Summary of Projects

The rationale for the project was better integration of statutory, third sector and community networks as the key to improving the support available to people experiencing suicidal thoughts and those caring for them.

Project i) Community Networks. Development of an improved integrated network of community bases support for service users experiencing suicidal thoughts or following self-harm. This network will include third sector organisations and ASIST trained community support volunteers to provide support to lower risk service users.

Project ii) Build Primary Care Practitioners Capability to train. Creating Healthier Communities - training programme for primary care practitioners in rural communities.

Objectives

- Investigate and address the problems that people living in rural areas have in accessing support when they self harm or have suicidal thoughts.
- Increase options for service users.
- Increase awareness of options available for service users.
- Increase take up rates for community services for service users experiencing suicidal thoughts or self harm.

Methodology and report of activity

- Initial preparation included collating and reviewing national, regional and local data, identifying the key stakeholders, designing the engagement workshops.
- Initial engagement and design included engaging with key community influencers, GP practices, and strategic groups' feedback was analysed and an implementation plan designed.

Implementation

Project i) Community Networks programme: training undertaken in the community to disseminate training. Planned implementation of network delayed by governance issues. Recruiting volunteers to man phones or visit people at a "place of safety" should now be taking place.

Project ii) Primary Care Practitioners Capability to Train: Practices engaged and trained to deliver "Connecting with People Suicide Awareness Session and Suicide Response".

Key scheduled deliverables achieved in 2010-11:

- Programme Design workshop delivered.
- Draft report on existing data.
- Contact made with GP leads and briefing note for GP practices.
- Meetings and report of findings from strategic groups.
- Project implementation plan presented to Project Board.
- Schedule and prepare delivery of Community Volunteer Training.
- Schedule and prepare delivery of Train the Trainer Programme for Primary Care Practitioners.
- Design of Train the Trainer Programme for Community Volunteers completed.
- Design of Train the Trainer Programme for Primary Care Practitioners completed.
- Set up peer learning set framework for Primary Care Practitioners and Community Volunteers.

- List of resources to signpost service users.
- Delivery of Train the Trainer Primary Care Programme.
- Delivery of Train the Trainer Community Volunteer Programme.
- Web material with information about the support network for BCUHB to upload.
- Full consultation with community based organisations and representatives.
- Design of project in response to their input and feedback.
- Design of a suicide prevention training course "Emotional CPR" in collaboration with STORM, Manchester University specifically for community members.
- Design of a Train the Trainer training course to enable a team in the locality to train unlimited numbers within their own organisations and communities in "Emotional CPR".
- Delivery of Train the Trainer to people in the community who are well placed to disseminate the training. Those trained included: Community Mental Health Teams representative, Mental Health Resource Centre representative, St John's Ambulance national trainer, Barmouth First Responders, CALL mental health helpline, HAFAL Charity supporting people with severe mental health problems.

Outcomes/Findings

Project i) Nine community based trainers are now trained (see final bullet point of key deliverables). There are plans to follow these trainers up. This has facilitated linking up existing telephone services between GP OOH and CALL. The planned network of 28 volunteers has not yet occurred but should be recruiting now.

Project ii) There was difficulty engaging with practices (many reported being too busy or too small to have time to take part in the training). 8 out of 9 trained reported the training has increased their belief that they have a role in trying to prevent an individual committing suicide and the tools have increased their knowledge.

Follow up on service users was not undertaken for this client group.

Conclusion

Project i) Delays in governance and development of second training programme from the two day ASIST to the two half day emotional CPR training limits the conclusions that can be drawn from this aspect of the programme. Additional information will be gained from ongoing monitoring of this programme.

Project ii) Immediate feedback from Primary Care Practitioners is positive but the project leads note "there is also a culture that unless people are being paid to do something directly, they do not see it as their responsibility".

These projects have been designed and delivered a potentially sustainable programme which can build capacity in the local community. Barriers were encountered on engagement, concern about any change and working across borders.

The early results from this project suggest it could be of benefit to embed this project within other voluntary sector organisations to ensure sustainability and promote integration - potentially through the community hubs.

2. Telerehabilitation via videoconferencing

Aim

To improve access to health care services into the heart of the community, by increasing access to expertise, reducing staff and patient transportation time, reducing costs, staff travel time and CO_2 emissions using secure videoconferencing.

Project ii) Sp< "clinic" in a bag: To provide more effective community based Speech and Language Therapy services.

Summary of Project

Roll out of a Telerehabilitation video conferencing system in North Wales, based on standard commercially available broadband and low cost video conference equipment. The system would be used to enhance the delivery and maintenance of wheelchairs and special seating.

Project ii) Sp< "Clinic in a bag" aims at improving access to services for Sp< in rural areas.

Objectives

- Installation of 10 videoconference units.
- Train staff (includes Sp< Posture and Mobility Services, Rehab engineering services). Develop protocol.

Methodology and report of activity

Negotiation and provision of a secure server (Codian MCU) (with additional funding) to increase number of channels available. Planning stages to move the unit to NWIS.

Prototype testing of Videoconferencing systems - Dell laptops with four different configured designs.

Negotiation with IT to provide six medical physics staff access rights (which has reduced the cost of the units and enabled more units to be purchased).

- 40 units procured and delivered.
- Configuration of software.
- Demonstrations undertaken.
- Promotion of service in local press, BBC TV and radio.
- Additional specialities have now been engaged:
    - Wheelchair Special Seating (Posture and Mobility Directorate).
    - Wheelchair Approved Repairer service.
    - Community Palliative Care support.
    - Community Volunteer Support Audiology.
    - Remote Cochlear Implant Programming Audiology.
    - COPD remote support.
    - Lymphodaema remote support.
    - Speech and Language Therapy remote support .
    - (Home Haemodialysis - not yet confirmed).

Project ii) One adult bag and two childrens Sp< bags have been developed, procured and issued.

Outcomes/Findings

1. Provision of videoconference units (10)
    1. Number of videoconference (VC) units 40 with 7 additional units for training and replacements.
    2. Four types of VC units have been developed all around a standard unit to allow for uniform training and repair/ support protocols. This approach was developed in collaboration with the BCU HB IT after testing a variety of systems showed the complications which could result in the field if a standard approach was not used. This has resulted in IT support being made available for the project.

iii. A secure VC "app" (ConferenceMe) has also been identified and tested which will allow community users to access the TeleRehab service using their own computers - with appropriate permissions to remotely set up their own "home/community" computers with a webcam and headset.

2. Train staff

   i. One member of staff has been identified for training, in addition to the author with a training unit ready for use.

   ii. A training room has been developed, equipped and demonstrated.

   iii. A training TeleRehab Unit will be delivered to the trainer in Bangor by the end of September 2011 with train the trainer support.

   iv. The Rehab Engineering Unit which provides specialised seating/wheelchair systems for individuals with disabilities will have their definitive unit delivered by the end of September 2011 with training.

   v. Ysgol Gogarth will be the first external (to the NHS) site for TeleRehab. A unit is ready for delivery and staff training once 2.3 and 2.4 are completed. (October 2011).

3. Protocol and operational policy have yet to be developed as there are a number of variables which are still being explored.

   i. The funding to upgrade a secure server to accommodate 10 channels (10 point to point VC calls) has been successful (£27,000 notification 08/09/2011). Potentially each sub project will have a dedicated channel which will significantly simplify protocols and policies. Now that notification of funding has been received this portion of the work can now be carried out. (October 2011).

   ii. VC units will be set up with two different operational systems for use in the community and NHS settings - these are currently being tested. Four units have been set up by BCU IT and tested, this required a small amount of remedial work by IT now completed - and a request for another 10 units to be set up has been submitted.

   iii. 6 staff members involved with the project have been set up with Administrative Rights for the VC units to enable them to set up and first line troubleshoot systems.

Project ii) Sp< Clinicians have access to assessment and intervention resources in schools and homes.

Conclusion

To date the project has been proven to be technically feasible across a wide range of broadband and NHS connections. Pilot use between a local school for children with disabilities has worked well. Findings to date are limited to technical achievements, clinical impact will be available from April with informal feedback sought before then.

The early results from this project should be shared.

As the project has grown and broadened out from its original plan it would benefit from a secondment opportunity to push forwards an implementation timeline and support early adopters to the new way of working.

Project ii) As a result of the RH Innovation project it will be rolled out across BCuHB with a further 50 bags planned. There are also plans to incorporate Clinic in a Bag into the Therapy Manager software. The results shared from this project have been limited to date and more detail would be required before conclusions around rolling out this programme nationally could be drawn.

3. Palliative Care in Powys

Aim

To improve and increase the palliative care provision for the population of Powys.

Summary of Project

This is part of a three year long term strategy to build further palliative care capacity linking with Third Sector organisations providing hospice at home services on the borders of Powys. It has involved revision of pathways of care, standardising training and estates management.

Objectives

- Patients whose preferred place of care at the end of life stage have their needs met where practicable.

Methodology and report of activity

- Pathways of care have been revised and agreed between the Hospices and tLHB.
- Training has been standardised across the hospices.
- Agreement has been reached on the care of patients on the borders of each Hospice's patch.
- Severn Hospice, Beacon of Hope and St David's Foundation Hospices to provide at home carers as a key component of the hospice at home offer. This was in place from 18 July 2011 in Severn Hospice and Beacon of Hope, and in place in St David's Foundation 12 September 2011.
- Powys specialist nursing team are planned to transfer to the employment of the three hospices following the statutory period of consultation under TUPE regulation.

Outcomes/Findings

The service has a relatively small client group. Unless it is appropriate, current packages of care will not be altered but as new clients are referred to the programme the care plan will be offered. As a result it may take some time for the caseload to work up to capacity. The evaluation will therefore be undertaken over a 12 month period initially and will include:

- Showing an increased number of patients supported to stay at home;
- The 'I want great care questionnaire';
- CSIW minimum standards;
- Measurement of preferred place of death; and
- Severn Hospice questionnaires to users and referrer.

The data from the hospices will start to be reviewed in September and will need at least a quarter before early feedback can be taken. These initial findings should be available around Christmas 2011.

Conclusion

Outcomes from this project will be shared when available.

Once this project has been embedded locally the next steps for this locality are to review the beds, improve links with the Palliative Care consultants and consider the location of the Macmillan nurses.

4. Nurse led MIU linking with a DGH

Aim

To provide a more accessible and responsive local MIU service for the local population.

Summary

Training to up skill a cohort of current Band 5 nurses to ENP level, and the development of the telemedicine links with Hereford Hospital and Powys Out of Hours provider.

Objectives

- Enable more patients to be assessed and treated by MIU ENPs.

Methodology and report of activity

- The IT side of the project has been identified and procured (though delivery to Hereford Hospital was not proving straightforward).
- Negotiations with Hereford to set up an SLA.
- Negotiations with Hereford to overcome PFI hurdles.
- Link is due to be installed and operational by October 2011.
- Two nurses have been up-skilled with a further three booked for the next course.

Outcomes/Findings

While the MIU service is now enhanced it is too early to provide evaluation outcomes. The project lead intends to evaluate the service after six months of operation around April 2012 by reviewing:

- Activity trend monitoring through service and in DGH;
- Feedback from Community Hospital clinicians otherwise having to refer patients on to DGH;
- Feedback from DGH and Out of Hours clinicians providing a remote assessment of patients; and
- Feedback from patients in receipt of the service.

Conclusion

Negotiations and personnel issues in the partner organisation have led to the delays in implementing this project. As the link becomes operational results should become available. As yet no further evaluation measures are available to determine potential benefits of rolling out this service.

5. Electronic x-ray link

Aim

To provide a local x-ray facility accessible for outreach consultations to ensure a more accessible and responsive service for patients and the clinicians caring for them.

Summary of Project

To establish an electronic link between the x-ray facility at Llandrindod Wells Hospital and the radiography department of a District General Hospital.

Objectives

- Decrease patient travel.
- Decrease x-rays by visiting consultants.
- Improve storage.

Methodology and report of activity

- Planning: Prolonged negotiation with various Welsh Health Boards to instigate the link before returning to connect directly with Hereford. Assistance from Welsh Health Estates has enabled images to be stored in Wales for Welsh residents.
- Procurement and delivery of IT equipment undertaken.
- Work plans have been amended across various staff groups to facilitate the change in working practices the new system will require.

Project went live from 15 August 2011.

Outcomes/Findings

The evaluation plans for this project are still to be clarified. It is due to be undertaken in January 2012 however there may be valuable feedback to be gained before then. An audit of patient records to demonstrate the change in pattern of patients accessing x-rays locally is planned.

Conclusion

The main delay for this project came from the x-ray strategic links in particular with cross border development. This was further complicated by the involvement of PFI which required additional sign off. Once the link is embedded the outcomes from the project can be considered.

6. Capable Coping Communities

Aim

Build capacity for self help and community action to improve and promote the health and wellbeing of their local populations.

Summary

To establish three rural community hubs. The project included Volunteer Village Wardens to assist in social care activities and Dawn Patrol Scheme encouraging children to check the welfare of older people on a daily basis.

Objectives

- Encourage self help.
- Improve community action.
- Promote health and wellbeing.
- Promote intergenerational engagement.

Methodology and report of activity

- Volunteer Village Wardens were recruited, trained and started in their roles acting as centre points for their village.
- Active recruitment to the VVW was undertaken amongst the community and the service was promoted to people likely to signpost to it i.e. community support workers.
- Dawn Patrol. The schools were engaged and training plans developed. Consent for the children to take part was resolved and the programme of training was delivered. A daily indication scheme was established.
- People in the local community were actively sought to utilise the service.

The project leads are seeking Big Lottery funding to continue the scheme.

Outcomes/Findings

The VVW receive an average of 6 new referrals a month which result in an average of 7 visits per person.

Breakdown of Interventions. (Last Quarter)	% of total	Raglan	Magor	Llanvihangel Crucorney	Totals
Initial Visits	4	4	4	1	9
Companionship	23	33	16	4	53
Transport	13	13	15	2	30
Introducing to people	2	3	0	2	5
Access to Social Amenities	36	13	69	2	84
Filling out Forms	7	0	16	0	16
Physical Support	2	0	5	0	5
Household Management	5	5	6	0	11
Help with letter writing	1	0	2	0	2
Phone Call Assistance	3	5	2	0	7
Medical appointments	3	7	0	0	7
Shopping	3	6	0	0	6
Summary		89	135	11	235

The Dawn Patrol had only received two referrals before the end of the school year.

Conclusion

The VVW have been well received by the local communities. The Dawn Patrol works well in urban areas but may not transfer to rural communities. This project is ongoing and will report in November 2011.

The impact of this project has demonstrated the social value of integrated working. The learning from this work is transferable and should be shared to facilitate similar community capacity programmes.

7. IT Support for Paramedic Referrals in rural areas

Aim

Enable provision of alternative pathways of care.

Summary

To provide IT support to enable paramedics to undertake electronic referrals to unscheduled care partners across Powys and Hywel Dda LHB.

Objectives

- Reduce conveyance.
- Improve Quality of Care.
- Increase ambulance availability.
- Decrease admission rates.

Methodology and report of activity

- Paramedics have up-skilled to Specialist Practitioner - independent practitioners.
- Six "Tough" laptops were procured.
- Laptops were configured and issued to independent paramedics in mid and west Wales.

Outcomes/Findings

In the initial phase of this project early signs show the laptops are principally used for health resources. Currently the clinical patient pathways and referral routes are not in place to get full benefit however these should be developed. Functionally the laptops have demonstrated a good battery life lasting a whole shift but there have been software issues which have made them slow and this is being reviewed.

The final phase for this project is to audit the referral rates and efficacy of referrals. Key performance indicators will include:

- Reduced transport to hospital rates for 999 callers.
- Improved quality of care for rural patients.
- Decreased admission rates.
- Improved use of the NHSDW directory of services.
- Increased partnership between WAST, third sector and LHB services.
- Increased ambulance availability within rural areas.
- Plus patient stories.

Unexpected benefits have also included:

- The ability of the practitioners to use the equipment to view all incoming 999 calls in their locality and select appropriate cases thus ensuring the correct response to a call and quicker response times.
- The senior practitioners using this equipment are lone workers and this project has shown the laptops reduce their isolation and improve efficacy of their non direct clinical workload.

Conclusion

Outcomes from this project remain outstanding. While clinician feedback is positive, consideration of further development of this work (e.g. support investment in Adastra to improve the clinical information loop) or extension of this scheme across rural communities can not be made, until this is made available.

8. Designed for Competence in Rural Localities

Aim

Redesign and test an integrated workforce to better support and care for people in rural communities.

Summary

Designed for Competence is a methodology to deliver a skilled and integrated workforce across Health and Social Care within a locality. This project applies this to needs within rural communities where people, where appropriate, will be supported in their own homes in managing their conditions and care needs rather than be admitted to hospital.

Objectives

- Increase capacity and capability of workforce and improve access and service quality and ultimately outcomes for patients.

Methodology and report of activity

Health and Social Care Support Worker

These will be integrated posts working across Health and Social Care organisations to deliver low level health and care tasks. Currently staff are being recruited to undertake this new role within Anglesey, with talks underway to develop the posts in Gwynedd. A small pilot project is underway in Denbighshire with positive outcomes. This is also now being taken forward as part of the Changing Care project and being looked at as best practice across BCUHB.

Job descriptions and KSF profile have been drawn up and agreed by the Operational managers, these now need to be submitted to Agenda for Change for matching.

Denbighshire have drawn up and agreed on a section 33 with Anglesey in the process of developing one. This will enable the transfer of functions for the post, as well as covering the different terms and conditions across Health and Local Authority.

In house training within Health has been identified for the health competences and work is now underway with the workforce and organisational development directorate to develop a formal accredited training programme.

The challenges to developing this post has been:

1. Undergoing the change management process with operational managers from the Local Authority in order for them to see the benefits of the roles.
2. The Local Authority has the money for employing this group of staff and progress with developing them has been slow. However agreement has now been made to develop these posts across Anglesey as part of the locality development.
3. The need for a section 33, and the lack of personnel expertise in being able to develop this has slowed down the process.

Rehabilitation Assistants

The Rehabilitation Assistant will be part of the locality teams, both out on the District and within the Community Hospitals. They will be recruited from existing staff who have an interest in Rehabilitation, enablement and promoting independence. They will work closely with the therapy staff both with Health and Local Authority, taking on lower level rehabilitation tasks. Currently the Local Authority employs reablement workers but they have no links into Therapy and Health does not employ any.

Work is underway to redesign the previously delivered BTEC course for Therapy Assistants within the local colleges as this no longer fits the service need. A lot of training however is delivered within BCUHB and work has commenced to start mapping the identified competences with the identified training. Once this has been completed the training will commence and the Rural Health Funds will be used to either fund the colleges

or provide backfill to allow staff to access the training.

Staff have been identified within two Community hospitals and from the reablement team within the Local Authority (Anglesey) to undertake this new role.

The challenges for developing these posts have been the same as the above mentioned.

Assistant Practitioners

The Assistant Practitioners will work as a member of the Community Resource team in a given locality assisting Nursing Staff in the performance of their duties in organising Patient care and interventions. They will work without direct supervision within specified clinical area/ Patients own homes undertaking tasks that fall within the remit of the non-complex patient.

The post holders will be responsible for their own caseload of non-complex patients, devising and implementing treatment programmes with reference to a qualified Nurse when required. They will be expected to rotate within Community Hospital and District Nursing Service and potentially into other areas as the role develops.

Again the Job description and KSF profile has been completed and the competences have been fed into the local colleges development of the diploma level course. As this course is now being funded nationally for both Community and Primary care staff, funding has been used to provide backfill to enable staff to undertake this course. Nursing home staff and Matrons are also now being contacted across North Wales to develop this role within Nursing homes.

Currently there are 5 nurses in training for their diploma to undertake this role. A further cohort is due to commence in September with applicants from both community and primary care.

Outcomes/Findings

Training programmes developed as a result of the Rural Health component of this project include:

- Diabetes training.
- MUST tool and nutrition.
- POVA training.
- Administration of Influenza and Pneumococcal injections which has assisted in the delivery of the annual influenza immunisation programmes for the over 65 and the “at risk”.
- Monthly update/support sessions held for health care assistants to help provide clinical supervision and support for HCAS taking on extra tasks.
- Dementia training.
- Administration of Insulin within the Health care assistants in the District nursing services across Anglesey and Gwynedd.
- Health Care Assistant 8 day training module arranged for Chronic Conditions, which will allow the health care assistants to be delegated basic Chronic Condition tasks.
- Resulting in release of registered clinicians time for more complex cases.

Conclusion

Skills for Health are completing a formal evaluation of the whole Designed for Competence programme.

Findings from the Rural Health component will continue to present (as to the indicative evaluation plan) as more staff complete training and start their roles in the community. The learning from the impact on local communities will be transferable to other rural settings and should be shared as and when available.

BCUHB have identified this workforce development as Best Practice. The project team are transferring this model of workforce design to registered staff.

9. Designed for Competence

Aim

Develop an innovative infrastructure to stimulate expansion of the Ceredigion Investors in Carers (CIiC) accredited GP Practice Scheme across Hywel Dda.

Summary

This scheme delivers accreditation in recognition of the best standards of practice and support services provided to Carers. It was initially aimed at GPs across Ceredigion and this project planned to facilitate the expansion and development of the programme across all primary care in HDHB and into secondary care.

Objectives

- Recognise the value of carers.
- Support carers.
- Include carers in planning.

Methodology and report of activity

Primary Care Bronze Scheme

- Establishment of Investors in Care working group reporting to Carers Strategy Group.
- Development of detailed Action Plan and agreement of Operational Plan across the three counties.
- Short term agreement with the Voluntary Sector.
- Review the maintenance of the Bronze Award Scheme.

Primary Care Silver Scheme

- Creation of Silver Award framework.
- Silver pilot evidence submitted and assessed (with Carers input).
- Delivery of training to GP Surgery staff.
- Award of Silver Level to 3 GP practices in Ceredigion.

Secondary Care Bronze Scheme

- Developed an action plan.
- Secondary Care Bronze Award framework and training programme developed in partnership with Carers.
- Workshop held on the 18th of July, attended by the three Secondary Care pilot sites.
- Secondary Care training delivered to each pilot site.

Outcomes/Findings

Rural Health Innovation Fund allowed additional capacity to take forward the CIiC across Primary Care and introduce it to Secondary Care resulting in:

- 33 GP Practices attained bronze accreditation, doubling the previous number over the last 12 months.
- Three GP practices were also able to gain the silver award.
- Three secondary care sites are piloting the bronze scheme.
- The number of unpaid carers identified as result of the scheme in the period:

July 2010 - June 2011:	77 (6.5 a month)
July 2011 - Mid August 2011:	15 (10 a month)

Principal findings for carers are:

- Improved access to information.
- Signposting for respite.
- Proactive approach.
- Recognition of their contribution.
- Provides the carer with choice.

Conclusion

Outcomes from the secondary care sites are not yet available but would be of value to follow up. As the Carers Measure rolls out the value of this programme may be further highlighted.

The project leads are mindful of the potential to commercialise the programme.

The early outcomes reflect a positive community model which could be utilised in other settings e.g. community pharmacies, rural hubs.

10. Community Outreach Bus

i. DORIS (Denbighshire Outreach Rural Information Service)

Aim

Improve access to health social care and wellbeing advocacy and information services.

Summary

The project is an information and advocacy service to be delivered by volunteers and staff, linked to the MIND Doris bus, for the delivery of a range of services for the rural population of Denbighshire; specifically to improve access to health, social care and wellbeing advocacy information within this area.

Objectives

- To enable an advocacy and information service to be delivered by staff and volunteers for the population of rural Denbighshire.

Methodology and report of activity

Development and Implementation: The working group established there were two elements to this project:

i. Information provision, provided by volunteers.

ii. Advocacy and management of the volunteers by the Advocacy Officer.

Information to be provided was agreed on, as was the referral route to Advocacy services.

Volunteers were recruited, underwent CRB checks and trained.

The Advocacy officer researched best practice on demonstrating support outcomes - the outcome star chart was selected.

The volunteers and advocacy officer have delivered the services of:

i. Information provision and

ii. Advocacy.

Outcomes/Findings

Poor weather limited use of the DORIS bus but volunteers went out to community groups from February 2011.

- 185 people were present at the meetings and received information from the volunteers.
- 32 people were referred on to the Advocacy Service.

Of the 32 people receiving advocacy services 25 undertook an outcome star chart assessment. With the following statements scored, out of 10, by the person requesting advocacy. Second outcome star charts need to be undertaken to complete the evaluation. From the four completed case studies received the average change is given below:

Star Chart comment	Average Change over four assessments (scale 0-10)
Staying as well as you can	0.25
Keeping in touch	0.5
Feeling positive	2.5
Being treated with dignity	2.5
Looking after yourself	1
Feeling safe	1
Managing Money	1.75

Conclusion

Due to the weather and long term sickness the full potential of the DORIS bus may not have been seen yet.

A larger sample of completed star charts would give a fuller picture of the value of the advocacy service in this environment.

ii. Gwynedd

Aim

To explore opportunities to test a wider range of integrated services that could be provided including volunteering opportunities to remote and rural communities.

Summary

To develop and implement a Community Mobile Unit Service to take information and raise awareness about Health, Social Care and Third Sector Services (such as Voluntary Organisations and Social Enterprises) into the heart of the local communities; working in Partnership with Health, Social Care and Third Sector to utilise the Unit to improve access to services, enable engagement and consultation at a local level; which will support the sustainability of utilising the Unit beyond the project period.

Objectives

- Purchase outreach bus to enable staff and volunteers to deliver health, social care and volunteering opportunities locally for the population of Gwynedd.

Methodology and report of activity

Development and implementation: Through questionnaires and requesting feedback from locality groups, health and social care professionals and third sector organisations Mantell Gwynedd ascertained the following themes for using the mobile unit:

- Providing information on services - thirdsector, health, social care & wider.
- Promotional events - promoting third sector services.
- Consultation events - health and social care.
- Delivering services - third sector, social care & health.

The option of hiring or purchasing a unit was evaluated with buying proving more cost effective. The mobile unit was purchased, made road worthy (tax and MOT), modified and livery arranged. Additional items such as mobile broadband connectivity, netbook & printer, Citizen's Advice Bureau touch screen console which enables people to search and gain a variety of information, monitor and DVD player for displaying educational/promotional information, 3rd Sector DVD promoting various 3rd sector services available in Gwynedd, exhibition space for posters etc. were organised.

Volunteer drivers were recruited and trained

Hiring out of the unit administration has been established e.g. terms and conditions for hiring; a hire agreement contract (approved by legal services); vehicle check list and mileage log pre & post hire and a booking system were developed.

Launch and promotion: Mary Burrows, BCUHB Chief Executive launched the unit on the 1st March 2011 in Bangor; Mantell Gwynedd also hired a space in the shopping centre for that week for promotional purpose to promote the 3rd Sector and the availability of the Mobile Unit. The Unit is also promoted on Mantell Gwynedd's website, local radio, leaflets; details have been included in newsletters and network mail shots.

Outcomes/Findings

Since the launch of the Unit in March, the unit has been utilised by 3rd Sector and the Gwynedd County Borough Council (up to the last review undertaken in July 2011).

Date	Event	Area visited	Hired by
14/04/2011	Big Screen Aberdaron	Aberdaron	3rd Sector
25/04/2011	Street festival	Tywyn	3rd Sector
02/05/2011	Sioe Nefyn Show	Nefyn	3rd Sector
05/05/2011	Raising Awareness	Bala	3rd Sector
04/06/2011	Young Farmers	Bala	3rd Sector
11/06/2011	Dyffryn Owgen Show	Bethesda	3rd Sector
15/06/2011	European Seniors event	Bangor	Gwynedd County Council
27/06/2011 - 01/07/2011	Men's Health	Various in Gwynedd	Gwynedd County Council
02/07/2011	Caernarfon Show	Caernarfon	3rd Sector
20/07/2011	Caernarfon Festival	Caernarfon	3rd Sector
23/07/2011	Snowdon Race	Llanberis	3rd Sector
24/08/2011	Meirionnydd Show	Bala	3rd Sector

Case studies on utilisation of the unit are in the full report.

Conclusion

Mantell Gwynedd found the largest lesson learnt over the development and implementation of the project was not to under estimate the work involved in setting up and getting a Mobile Unit ready. From finding a suitable vehicle and the modifications required to ensure it confirmed to regulations and standards; to setting up the contractual arrangements and paperwork for hiring the Mobile Unit, which had to be legally ratified.

Mantell Gwynedd have implemented measures to ensure the Mobile Unit is self-sustaining and will generate an income which will then be utilised to fund ongoing costs for maintaining and running the Unit for example with advertising space on the unit and hiring charges for the unit.

The Mobile Unit will continue to be promoted for use by Mantell Gwynedd, in particular with Health to encourage utilisation.

Outreach Conclusion

The original project outline aimed to deliver a combined mobile outreach service for integrated working. This project has provided two units which are utilised by the voluntary sector and local government. There has been disappointing uptake by Health.

11. Rural Carers Survey - Health & Social Care Agencies

Aim

To improve access and integration for rural carers across Hywel Dda health care sector.

Summary

This proposal builds on project no. 8. It will conduct a survey of rural carers in the area. Informal/unpaid carers who presently live in or near to rural communities potentially have a skills set and an understanding of issues that could place them in a favourable position to take up work opportunities in the care sector.

Outcomes/Findings

- To discover the barriers for carers.
- Investigate if transferable carers skills for work within Health and Social Care settings.

Methodology and report of activity

- Questionnaire developed and agreed.
- Voluntary sector organisations engaged in circulation and return of completed questionnaires.
- Sixty one questionnaires returned.
- Analysis of completed questionnaires to be included as part of final evaluation report.

Outcomes/Findings

The responses from the questionnaires demonstrate most carers, who responded to the survey, are not of working age and so would not be in a position to consider a work opportunity in the care sector.

Conclusion

This survey provided additional information which could help inform future strategy development.

12. Innovative Rural Community Pharmacies

Summary of Projects

The proposal sets out to pilot in three community pharmacies (one in South Gwynedd, Hywel Dda and Powys) a range of innovative services that could be provided to meet needs in rural communities, maximising the role of local community pharmacists. Services to include use of CBT, smoking cessation and monitoring for heart failure patients.

Objectives

1. To identify how pharmacy can contribute to improved patient services within rural areas.
2. To establish how services would work differently at community pharmacies within rural communities.
3. To evaluate the contribution of such community pharmacy services to the three key themes of the Rural Health Plan.

i. CCBT Gwynedd

Aim

To increase access to cognitive behavioural therapy (CBT) across Gwynedd locality by piloting delivery of computerised CBT from community pharmacies in rural areas.

Summary

Provision of computerised CBT (CCBT) from community pharmacies in South Gwynedd to form a new link to mental health referral pathway in rural communities.

Objectives

- To fill highlighted gap in service for delivering CBT.
- To create and explore referral pathway between GP and pharmacist.
- To integrate pharmacy service with Community Mental Health Teams (CMHT).
- To scope new ways for supporting continued reduction in use of antidepressants.

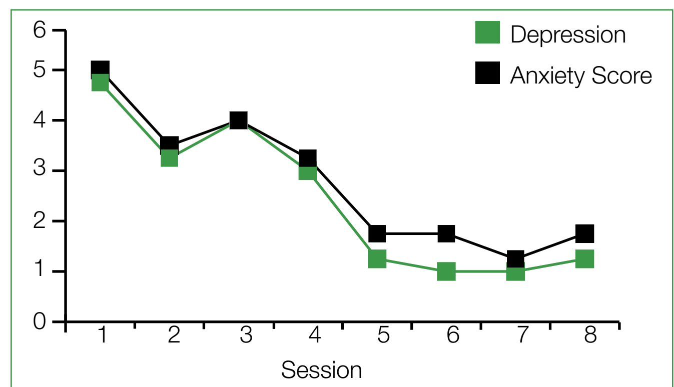
Methodology and report of activity

- Liaison with local GPs and CMHT across three rural sites in BCUHB.
- Software procured.
- Pharmacists trained.
- Patients referred and started treatment.

Outcomes/Findings

These finding show the outcomes for first three patients who have completed the programme July 2011.

Anxiety/Depression Levels



Distress Levels

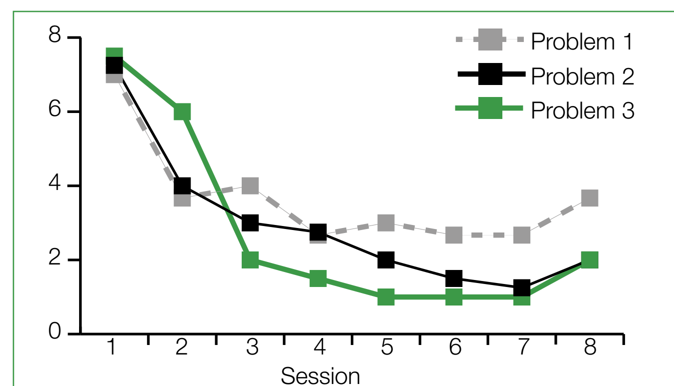


Table 1: Validated questionnaire scores from patients completing 8 session programme

	Score at session 1	Score at session 4	Score at session 8
PHQ-9	13.5	n/a	4
GAD-7	6.75	5	3.67

The PHQ-9 and GAD-7 are widely used validated questionnaires used to measure depression scores.

Patient stories can be found in the full evaluation.

Although this pilot was set up as a three month programme it continues to accept patients until the 16 places available have been utilised.

Conclusion

The results of this pilot are with the LHB to consider ongoing funding. While the patient feedback has been positive the referral rate has been slow. The numbers are too small to support decisions to either develop or roll out across rural Wales.

ii. Heart Failure HDHB

Aim

To improve health related care in line with best practice for patients with heart failure (HF) by utilising community pharmacist specialist as part of integrated pathway.

Summary

Provision of pharmacist led heart failure clinics to meet needs in the rural communities of Pembrokeshire.

Objectives

- To establish and integrate community pharmacist specialist clinics as part of integrated referral pathway for patients in rural areas.
- To train and provide experiential learning for pharmacist working with CHF nurse at local clinic sites to become part of referral team.
- To improve patient care in HF, utilising available best practice e.g. NICE, NSF, 1000 lives etc.
- To optimise treatment of identified HF patients by titrating doses up to the maximum tolerated.

Methodology and report of activity

- Liaison with the LHB and identification of GP practice.
- Local cardiac clinicians engaged.
- The pharmacist delivering this service was already an independent prescriber and no additional training was required.
- Triage of GP list to identify those with heart failure and those on sub optimal treatment.
- Heart failure clinics were run in the GP practice over the pilot period.

Outcomes/Findings

The table below shows activity data for the pilot period and demonstrates that of the 26 patients identified for the review clinic 69% (18) required further intervention.

Table 2: Activity and medicine dose outcomes by patient group (January 1st-March 31st 2011)

	No. of patients on GP list with relevant diagnosis	No. of patients identified for review clinic	No. of patients requiring dose changes	No. of patients referred on for testing/ GP	Patients reviewed with no changes	Patients who did not attend
Group 1	74	10	6	2	2	0
Group 2	14	4	2	0	0	2
Group 3	9	2	0	2	0	0
Group 4	41	10	3	3	0	4
Total	**138**	**26**	**11**	**7**	**2**	**6**

Qualitative data was also obtained from the questionnaire that was designed and distributed by the pharmacist who held the clinic. 10 of the 15 questionnaires were returned with the following results:

- 5 felt the standard of care was better in the pharmacy clinic than that received previously and 5 felt it was the same.
- 9 of the 10 felt they understood more about heart failure since attending the clinic.
- 9 of the 10 felt they were more involved in decisions about their treatment.
- 9 of the 10 would attend the clinic if it was held in a consulting room in the pharmacy rather than the surgery.

Additional patient comments are in the full evaluation.

Conclusion

The results of this pilot are with the LHB to consider ongoing funding. The evaluation for this pilot has demonstrated an effective model of care which could be transferred to other long term conditions requiring monitoring of medication and patient wellbeing for example asthma. This model has potential particularly in rural settings where follow up care can be difficult to access due to distance to specialist facilities and number of specialist staff available to provide a service.

iii. Smoking Cessation Powys

Aim

To improve access to smoking cessation service(s) across rural parts of Powys by extending provision to community pharmacy.

Summary

Provision of Smoking Cessation from community pharmacies to improve access within rural communities of Powys.

Objectives

- To develop community pharmacist as part of referral care pathway for smoking cessation by those unwilling or unable to access current service.
- To complement and work with existing Stop Smoking Wales (SSW) NHS service.
- To integrate service as core element of rural community provision and assist delivery of Health, Social Care and Wellbeing strategy.
- To facilitate participation in health service activity by hard-to-reach groups.

Methodology and report of activity

- Seven pharmacies in four locations identified to participate in the pilot.
- Service level agreement set up by LHB to work alongside the Stop Smoking Wales service.
- Local GPs and SSW engaged.
- Training received by pharmacists and pharmacy assistants.
- Service delivered over pilot period.

Outcomes/Findings

This table shows the activity and outcomes by pharmacy. The mean validated quit rate (% quit at 4 weeks) is 43.3%. The NICE minimum performance target is 35%.

Activity and outcomes at 4 weeks by pharmacy (January 1st-March 31st 2011)

Pharmacy	No. clients agreeing quit dates	No. clients with data outstanding of pilot	Actual numbers of clients in pilot treatment programme	No. of clients quit at 4 weeks		Total 4 weeks quit	% quit at 4 weeks	No. lost to follow up
				Validated by CO	Self reported			
Davies, Ystradgynlais	33	1	32	12	0	12	37.5%	5
Davies, Gurnos	44	15	29	17	0	17	58.6%	0
Jones, Hay	15	2	13	6	0	6	46.2%	0
Primrose, Talgarth	6	0	6	1	0	1	16.7%	4
Dudley Taylor, Llanidloes	13	4	9	5	0	5	55.6%	2
Boots, Welshpool	7	2	5	0	0	0	0	5
Rowlands, Welshpool	28	11	17	6	2	8	47.1%	4
Total	**146**	**35**	**111**	**47**	**2**	**49**	**44.1%**	**20**

Additional feedback:

- 37% of clients heard about the pharmacy scheme from their GP or nurse.
- 78% of clients had not accessed smoking cessation services before.
- 15% of clients had not used any form of NRT previously.
- 100% of available client feedback stated that clients would recommend the pharmacy service to other smokers who want to quit and over 90% of clients said they would use the service again if they ever returned to smoking.

Conclusion

The evidence for Pharmacists providing smoking cessation services already exists. This pilot has shown it is a model which can be accepted by the rural communities of mid Wales. It is a model of care that would be transferable to other client groups requiring support and supervision during a behaviour change management programme, for example obesity. Powys tLHB has continued funding this programme in the short term.

Final Pharmacy Conclusion

The pharmacy projects have demonstrated the impact of the extended role of the community pharmacist in rural areas and have the potential to undertake further projects. The learning from this work should be shared as examples of good practice. It should be taken into consideration with the current review of needs and developments in relation to MIU and MURS.

13. Third Sector Co-ordination in Rural Areas

This proposal builds on the ability of Third Sector organisations to be flexible and responsive to rural health needs and the strong tradition of self help which exists in isolated areas. Local communities and Third Sector organisations will be encouraged to work together to form more integrated service models in rural communities by:

- Making the maximum use of existing community skills and resources.
- Working together in rural areas in order to achieve efficiencies within local communities which might be made by sharing facilities such as vehicles or by teams co-operating and undertaking some of another organisation's duties to save on time and travelling.
- Diversifying in order to fill gaps in services available within a given area.

Each project was driven locally by the Health and Social Care Facilitator for CAVO, PAVO and Mantell Gwynedd respectively who worked on the project one day a week over the project period November 2010-March 2011.

i. Ceredigion

Aim

To increase the number of health and social care and wellbeing transport services for those who live in rural areas and have no means of independent transport.

Summary

The Ceredigion project intended to increase the number of health and social care and wellbeing (non-emergency) transport services for those who live in rural areas and have no independent transport.

Objectives

- To improve the availability of transport so that those who had problems before: can more easily access health and social services, can more easily attend OP appointments, journeys home following discharge to be easier and more comfortable.

Methodology and report of activity

- Clarification of aims definable outcomes and activities.
- Age Concern engaged.
- Scoping of existing transport services.
- Improved links with other transport service providers.
- Development of database for journey bookings.
- Refinement of original aim to increasing utilisation of existing services - development of pathfinder system.

Outcomes/Findings

- Improved utilisation of resources.
- Anecdotal reports of improved volunteer job satisfaction and better retention.
- Service user comments in full report.

Conclusion

This project has enabled the acquisition of information and the refinement of an existing system that now:

- Maximises the use of existing non-emergency transport services.
- Has resulted in increased utilisation of existing resources.
- Has encouraged effective partnership working between CAVO, HDHB, Local Authority, and Age Concern.

ii. Powys

Aim

Improve access to condition specific services for rural Powys.

Summary

A series of projects to encourage integration of the third sector and health communities of Powys. Improving access to condition specific support for people with LTCs by:

- Improving communication between the Community Voluntary Council (CVC) and national organisations.
- Brokering links between national organisations and their corresponding representatives in rural Powys.
- Gaining a wider understanding to what national services find when delivering to rural areas.

Objectives

- To improve communication between the CVC and national organisation, to broker links between national organisations and their corresponding representatives in rural Powys, to gain wider understanding to what national services find when delivering to rural areas.

Methodology and report of activity

- Desk research with the purpose of placing the research within the context of strategic policies and initiatives.
- Questionnaires were circulated electronically to national voluntary organisations within the National Health and Social Care Network facilitated by WCVA.
- Semi-structured interviews with Powys tLHB with three senior managers.
- Meetings/conversations with representatives of four national voluntary organisations providing services for people with chronic conditions.
- A stakeholder event.

Outcomes/Findings

- Baseline of current services and activities by national organisations in Powys.
- Identification of needs (to broker local and national organisations).
- Identification of solutions focusing on the brokering role of CVC e.g.:
    - To build on the relationships established by this study; to facilitate the engagement of national organisations in Powys strategic initiatives by looking into needs and into projects; to nurture communication channels and work with WCVA to facilitate links and greater information exchange with national organisations; to strengthen the brokerage role of the CVC and to encourage greater collaboration between national organisations working in Powys at a local level, for example the Red Cross outreach service.
- Development of Infoengine database - no new registrations at time of report.

Conclusion

This project facilitated and informed the early stages of grass roots activities and strategic planning due to increase cooperation between national agencies and local initiatives.

iii. S. Gwynedd

Aim

To encourage third sector communities to work together to ensure a better integrated service model in rural communities.

Summary

A series of projects to encourage integration of the third sector and health communities of Gwynedd - encourage third sector organisations and local communities to work collaboratively to ensure integrated service models.

Objectives

- To increase the knowledge of third sector services by health service and social service personnel and of those living in the rural community.
- To enable those living in the rural community to make better use of third sector services.
- To improve access to health and wellbeing information for people with long term conditions.

Methodology and report of activity

- South Gwynedd Long Term Conditions Alliance engaged.
- "Information events" for the voluntary and statutory sectors were held between October 2010 and February 2011. A health event was held in October at Dolgellau (leisure centre and fire station) to engage with the local population. Three third sector awareness-raising events were held in the South Gwynedd area (Dolgellau, Tywyn, Blaenau Ffestiniog) predominantly for health and social care professional workers, volunteers and carers.
- Development and production of a promotional DVD.

Outcomes/Findings

- Enhanced knowledge of the third sector demonstrated, for example, with increased referrals to CAB and Carers Outreach following promotional events (though care must be taken in evaluating this due to multifactorial impacts on these services).
- The project coordinator reports that the Mobile Unit purchased by Mantell Gwynedd via Betsi Cadwaladr University Health Board, has played a crucial role in enabling communities to access information and it will inevitably continue to be pivotal in the provision of information to those residing in rural areas.

Conclusion

Potential efficiencies linked with this work show improved working between the third sector and health and social care professionals can ensure access to health and well being information is improved.

Third Sector Coordination Conclusion

The learning from these projects should be disseminated as case studies of the potential impact of voluntary sector involvement. Support may be required to publicise this work.

14. Taking Care Farming Forward across Wales

Aim

Undertake an evaluation of care farming today and the needs for the future development.

Summary of Project

This scoping study on Care Farming aims to highlight its role for the therapeutic use of farming practices to provide health, social or educational care services for one or a range of vulnerable groups of people.

Objectives

- Investigate current care farming activity in Wales.
- Explore the reported benefits of care farming in the Welsh context.
- Identify barriers hindering the progress of care farming in Wales.
- Outline potential next steps for the development of the care farming concept in Wales.

Methodology and report of activity

- In conjunction with the Amelia Trust and UWIC, event undertaken in May 2011 at the Copthorne Hotel.
- Brought together stakeholders.
- Established a care farming database.
- Literature review/secondary data.
- Acquired opinions from existing care farmers (1st All Wales conference).
- Received enquiries from potential care farmers.
- Engaged with potential commissioners (informal interviews/commissioners meeting).
- Engaged with policy briefs/individuals (health/rural policy).
- Promoted the concept of care farming in Wales (press coverage).

Outcomes/Findings

- Care farming database developed
- Identification of Health/wellbeing benefits (service users/provider):
  - Mental health
  - Employment
  - Young people/older people
  - Preventative (early intervention)
  - Help tackle rural isolation
- Identification of Farm diversification/ sustainability opportunities.
- Collating of individual (commissioners/ potential provider) interest and willingness to progress - ‘coalition of the willing’.
- Potential opportunities for development of care farms are given for example:
  - Maintain contact/awareness of farmers who are looking to develop care farming activity.
  - To monitor progress of care farms whose development is facilitated to capture lessons learned and benefits gained.

Conclusion

This project has delivered on its aims and objectives. Recommendations from the project lead to deliver the potential opportunities include facilitating a Care Farming Network, development of a “toolkit” and a coordinator. The learning from this work including the key messages and full recommendations are in the full report. This learning should be shared especially with Rural Affairs.

15. Telemedicine

Aim

The initial aim of this project was to develop specific telemedicine projects, for example Teledermatology. However it rapidly became apparent that the remit of the work required further intervention. This project has developed from a Local Innovation into a Wales wide workstream.

Summary of Project

This project has been exploring the potential for further applications and encouraging new developments of telemedicine across rural Wales for identified health boards (HDHB, Powys tHB and BCuHB). It has been raising awareness of rural health telemedicine services in Wales, assessing the capability of primary care network bandwidth to support videoconferencing and facilitating a videoconference training programme for NHS staff.

Objectives

- Identify current successfully implemented telemedicine services as models for development/replication.
- Share good practice using implemented telemedicine services as exemplars to adopt/adapt.
- Provide videoconferencing training workshops for all healthcare staff.
- Provide advice/support to health boards, clinicians and health professionals to encourage them to set up/develop telemedicine applications within their own service.
- Create and maintain a web based electronic map of existing rural health telemedicine services in Wales to provide a reference tool and raise awareness of telemedicine services across Wales.
- Conduct a feasibility study by installing and monitoring the use of web cameras at four pilot GP practices in order to assess the capability of primary care network infrastructure to sustain videoconferencing technology.

Methodology and report of activity

- Scoping by subgroup of current activity within telecare and telemedicine which identified successful projects that had positive impact/benefits on health care delivery.
- Information collated to form Telemedicine Proposal - Rural Health Plan.
- Recommendations to report on telemedicine, with particular emphasis on key telemedicine areas - Teledermatology, Rehabilitation Services, Paediatric Cardiology, Palliative Care, Neurology, Minor Injury Units, Teleophthalmology and provide evidence on capability of primary care bandwidth to support videoconferencing.

Outcomes/Findings

- Identified current successfully implemented telemedicine services as models for development/replication.
- Shared good practice using implemented telemedicine services as exemplars to adopt/adapt.
- Provided videoconferencing training workshops for all healthcare staff.
- Provided advice/support to health boards, clinicians and health professionals to encourage them to set up/develop telemedicine applications within their own service.

- Created web based electronic map of existing rural health telemedicine services in Wales to provide a reference tool and raise awareness of telemedicine services across Wales.
- Conducting a feasibility study by installing and monitoring the use of web cameras at four pilot GP practices in order to assess the capability of primary care network infrastructure to sustain videoconferencing technology.

The location of the current Telemedicine activity can be found on this Google Map: http://maps.google.co.uk/maps/ms?msid=211497540860849954742.000498f3b78c6be5028cd&msa=0

Conclusion

Significant developments in telemedicine have been facilitated during the last year. However, there remains considerable scope for further development of telemedicine services across rural Wales. Ongoing work is required to ensure that this initial work can be sustained and developed to the benefit of patients and NHS staff in Wales. Long Term Vision is that telemedicine features in each of the health boards' strategy and should become an accepted rather than a novel way of delivering services.

It is therefore recommended that the work from the original time-limited project be continued to ensure that this initial work can be sustained and developed to the benefit of patients and NHS staff in Wales.

Additional Learning

The Rural Health Innovation projects have been diverse in their mode of service delivery and range of client groups. Not all of the projects have run to plan and many have had hurdles to surmount. Those which have reported to date demonstrate specific learning and there have been a number of common themes which have featured across several projects either during the initial set up, the operational phase or from the assessment.

Set up

Procurement:

One of the recurrent themes in the initiation of many of the projects has been delays with procurement. This has been for two reasons either the procurement process or the identification and development needs to exactly fit the project needs.

Time frames:

The majority of projects have found the tight timescales challenging and in some cases there has been some miscalculation as to how long it would take to initiate, run and evaluate the programme. The need for a clear evaluation framework at the inception of the project is vital.

Operational Phase

Referral routes:

Most of the projects were new to their area so they did not have long standing and clearly defined referral routes. This combined with the tough timescales did not facilitate maximising of referral numbers.

Professional networks:

Many project leads noted specific aspects of the model of care working well due to their own network in the area for example referrals from GP practices where the clinician/lead had had previous professional contact.

Integration:

Many of the projects worked across professional boundaries and while not without teething problems, when it worked it worked well. Spanning this boundary successfully was usually dependent on joint ownership and responsibility for the running and outcome of the project and enhanced where the professional network was already developed.

Evaluation

Measuring the unquantifiable:

Some of the projects address areas which are difficult to measure, such as wellbeing or avoiding family breakdown. This may be as they are either broad concepts (without common definition) or are multifactorial. Measurement is made trickier when this is an additional outcome to a project rather than the main focus.

Small numbers:

All the projects were for rural residents which by their nature denote a small population. In some cases this has led to difficulty forming conclusions from the project.

Potential for further study:

All of the projects have proved fascinating for differing reasons and many highlight potential rich veins for further analysis, for example: the impact of the professional networks on project outcome, impact of culture on service take up (by clinicians and patients), impact of geographical proximity of H&SC professional to client group.

Conclusion

The Rural Health Local Innovation Projects have provided an opportunity to identify and implement innovative health and social care practice across Rural Wales. The timeframes have been challenging but the project teams have shown what it is possible to achieve and some projects have still to realise their full potential. The innovative practice highlighted in this report has been demonstrated across the key areas of Access, Integration and Community Cohesion and Engagement.

Whether or not a project has had limited impact or demonstrated measureable outcomes they have all produced learning points. Some are specific to the individual programme and for others it is transferable. This now needs to be disseminated as the projects reflect, embed in their community, extend their practice locally or diffuse across Rural Wales.

It is important that focus is retained on what is possible to achieve as the Rural Health Plan moves into the second implementation phase, with ongoing attention to improving the health and wellbeing for rural communities in Wales.