Meeting Date	**26 September 2019**	**Agenda Item**	**4.1**
Report Title	Primary and Community Strategic Reflection Reports 2018/19		
Report Author	Andy Griffiths, Interim Head of Primary and Community Service Development Hilary Dover, Director Primary and Community Services Unit		
Report Sponsor	Chris White, Chief Operating Officer		
Presented by	Hilary Dover, Director Primary and Community Services Unit		
Freedom of Information	Open		
Purpose of the Report	The (All Wales) 2018/2019 Strategic Reflections report has been developed by the Directors of Primary and Community Care (DPCC). The DPCC covers all Health Boards in Wales and is jointly chaired by Alan Lawrie, Cwm Taff Morgannwg University Health Board and Hilary Dover, Swansea Bay University Health Board The achievements of the DPCC, and the Strategic Programme continue to be overseen by the National Primary Care Board (NPCB) with clinical engagement and expertise sought from the Primary and Community Care Reference Group (PCCRG). The Report provides an overview of progress based on the draft forward work plan 2018 / 2019 included as part of the 2017 / 2018 annual report which identified 2 main priorities; 1. Supporting sustainability and facilitating progress of clusters. 2. Ensuring that enabling activities prioritise and support strategic primary care development. The Strategic Reflections paper is a stock take before moving into the formal communications from the National Strategic Programme for Primary Care. The report was approved by the National Primary Care Board on the 12th July 2019. The second report presents the ABMU University Health Board, Primary and Community Services, Strategic Reflections Report for 2018/19 which can be read		

<table>
<tr><td></td><td colspan="4">alongside the National ‘Strategic Reflections 2018-2019’ report.</td></tr>
<tr><td>Key Issues</td><td colspan="4">The ABMU Health Board Strategic Reflections Report demonstrates how the Primary and Community Services Unit progressed with a number of priority projects In line with the Health Boards Primary and Community Strategy achieving a range of outcomes and highlights the innovations which have taken place. It demonstrates the good work which continues in the contracted and directly managed community services and the impact that a number of pathways are having in helping to support people to remain in their own homes where appropriate through utilisation of appropriate care and technology.</td></tr>
<tr><td rowspan="2">Specific Action Required
(please choose one only)</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
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<tr><td>Recommendations</td><td colspan="4">Members are asked to:
NOTE and discuss the 2018/2019 Strategic Reflections report developed by the DPCC, and
APPROVE the Primary and Community Services Strategic Reflections Report for 2018/19</td></tr>
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ABMU UNIVERSITY HEALTH BOARD PRIMARY AND COMMUNITY SERVICES STRATEGIC REFLECTIONS REPORT 2018/19

1. INTRODUCTION

The purpose of the ABMU Health Board Primary and Community Services Strategic Reflections report is to describe the how Primary and Community Services operated and developed during 2018/19. The report has been compiled within the context of the ABMU Health Board Primary and Community Strategy **(**May 2017**).**

At a National level, the All Wales Directors of Primary and Community Care in Wales (DPCC) decided that for 2018/19 instead of producing an annual report (as per previous years) it would be more appropriate to develop a strategic reflection document of the key achievements across Wales.

This decision by the DPCC has been mirrored by the Primary and Community Services Delivery Unit (PCS) within Swansea Bay University Health Board (SBU) with the production of the ABMU Health Board 2018/19 report.

This report covers the period of 2018/19 and as such refers to the services that were provided by the former organisation, Abertawe Bro Morgannwg University Health Board (ABMU) and thus reference is made to this organisation throughout the report.

2. BACKGROUND

The Primary and Community Services Unit has responsibility for the delivery and management of a wide range of services, via contracted services (eg General Practice, Dental services and community pharmacies) and through a wide range of directly provided community services (eg Community Nursing, Therapies and Health Science and integrated teams).

In 2017/2018 ABMU Health Board approved and launched its five year Primary and Community Services strategy. The strategy outlined the development of primary care and community services across ABMU Health Board and recognised Primary Care services as the foundation stone of the NHS where 90% of all patient interaction took place. The strategy had five key areas that would support the provision of improved services:-

- Improving access.
- Workforce
- Quality
- Information Technology
- Estates

Services were mainly delivered within 11 Clusters which cover a defined geographical area. These Cluster have continued to strengthen and develop during 2018/19 as well as being the organisational platform for delivery of a range of services and are now further developing as innovative agents to drive service delivery and change.

The Strategic Reflections Report demonstrates how the PCS Unit has delivered against the Health Board's Primary and Community Services Strategy and progressed

with a number of priority projects achieving a range of outcomes and also highlights the innovations which have taken place. It demonstrates the good work which continues in the contracted and directly managed community services and the impact that a number of pathways are having in helping to support people to remain in their own home where appropriate through utilisation of appropriate care and technology.

3. GOVERNANCE AND RISK ISSUES

The Strategic Reflections Report provides a summary to the Board of key areas of work taken forward in 2018/19 across primary and community services and demonstrates the effectiveness and breadth of the service delivery.

4. FINANCIAL IMPLICATIONS

None noted

5. RECOMMENDATION

Members are asked to:

- **NOTE** and discuss the 2018/2019 Strategic Reflections report developed by the DPCC, and
- **APPROVE** the Primary and Community Services Strategic Reflections Report for 2018/19

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

The Strategic Reflections Report provides a summary to the Senior Leadership Team of key areas of work taken forward in 2018/19 and demonstrates the effectiveness and breadth of the service delivery.

Financial Implications

There are no financial implications

Legal Implications (including equality and diversity assessment)

There are no legal implications

Staffing Implications

There are no staffing implications

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The ABMU University Health Board, Primary and Community Services, Strategic Reflections Report for 2018/19 will influence future direction of travel for primary and community services and highlights examples of actions that support the delivery of the Act, such as **:-**

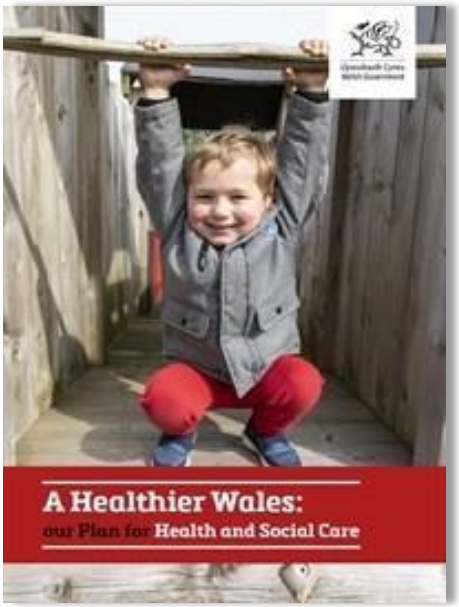
- **Long Term** – Demonstrating the Health Boards continuing progress to delivering the Primary and Community Services Strategy and providing sustainable primary and community services.
- **Prevention** – Improving provision of preventative health actions through immunisation and vaccination programmes.
- **Integration –** working with Local Authorities to deliver integrated Community Services to support frail or elderly patients to regain independence as soon as possible.

○ **Collaboration –** Across the Health Board to deliver the Mobilisation project. ○ **Involvement –** Patient involvement in the development of the Whole System Cluster Transformation programme.	
Report History	
Appendices	• Appendix 1 - Directors of Primary and Community Care 2018/2019 Strategic Reflections • Appendix 2 - ABMU University Health Board, Primary and Community Services, Strategic Reflections Report for 2018/19

Strategic Reflections

2018-2019

Abertawe BroMorgannwg University Health Board – Primary and Community Services Strategic Reflections 2018/19



Background

In June 2018 Welsh Government published 'A Healthier Wales - Our Plan for Health and Social Care'. The previous strategy/plan for Primary Care 'Our Plan for a Primary Care Service for Wales' concluded in March 2018.

The All Wales Directors of Primary and Community Care in Wales (DPCC) decided that for 2018/19 instead of producing an annual report (as per previous years) it would be more appropriate to develop a strategic reflection document of the key achievements across within and across Wales.

This decision by the DPCC has been mirrored by the Primary and Community Services Delivery Unit (PCS) within Swansea Bay University Health Board (SBU) with the production of this report.

This report covers the period of 2018/19 and as such refers to the services that were provided by the former organisation Abertawe Bro Morgannwg University Health Board (ABMU). It should be noted that the service developments with PCS occurred throughout the year in which the Welsh Government consultation exercise and subsequent implementation of the change in boundary of health care services for the county of Bridgend took place. The change saw a significant number of services transferring to Cwm Taff Morgannwg University Health Board.

The PCS Unit has responsibility for the wide range of directly managed services listed in Table below as well as contractual arrangements with independent primary care providers and Care Home providers approximately 1800 nursing home beds,

Primary Care	**Community Services**
Primary Care Clusters	Community cardiology
Community Pharmacies	Community dentistry, including oral health education
General Medical Services	Pulmonary Rehabilitation
GP Out of Hours Service	Continuing Health Care
General Dental Services, in and out of hours	District nursing
Optometrists	Sexual Health Services
Postgraduate Dental Training Unit Cymmer GP Managed Practice.	Asylum Seekers Project
	Community Wound Clinic
	Community Continence Service
	Health visiting and Flying Start Teams
	Public health nursing – safeguarding,

	School Health Nursing. 'Looked After Children' Health Team Prison Health Care Health Psychology
Therapies and Health Sciences	**Intermediate/hospital services**
Audiology Chronic Pain Podiatry & Orthotics MCAS Speech and Language	Gorseinon Community hospital and Day Hospital Restorative dentistry Intergrated Community Resource Teams including Acute Clinical Teams Deprivation of Liberty Safeguards (DOLS) – Supervisory Body Team

Introduction

'A Healthier Wales' sets out a long-term vision for a whole system approach to health and social care. It focuses on health & well-being as well as prevention of illness across the whole system. It emphasises multiagency multisector partnership approach to the provision of health and social care and has strengthened the role of the Regional Partnership Boards (RPB) as the key focal point for service change.

To support the implementation, significant funding was made available through the 'Transformation Fund'. The Transformation fund will support the delivery of new models of service provision that will allow health boards and partners to deliver on the strategic intention of 'A Healthier Wales' and enable them to make the necessary changes with the desired increased scale and pace.

In 2017/18 ABMU Health Board approved and launched its five year Primary and Community Services strategy. The strategy outlined the development of primary care and community services across ABMU Health Board and recognised Primary Care services as the foundation stone of the NHS where 90% of all patient interaction took place. The strategy had five key areas that would support the provision of improved services:-

- Improving access.
- Workforce
- Quality
- Information Technology
- Estates

2018/19 saw the 2nd year of the strategy, which remains consistent with 'A Healthier Wales' in its desire and drive to provide high quality services as close to people's home as possible.

This report sets out the key actions delivered through the ABMU Health Board Primary and Community Services (PCS) during 2018/19 that have supported the ongoing development of primary care and community services within the health board region. It provides an overview of service development for 2018/19 and focusses on key areas within the PCS Unit, specifically -

- Primary Care Sustainability
- Cluster Development
- Pacesetter and Delivery Plan Programme
- Whole System Cluster Transformation Programme,
- GP Out of Hours service,
- Primary Care Measures

The report concludes with a collation of the key service achievements that have been implemented across the full range of services provided via the PCS Unit and identifies the relevant links to the Primary and Community Services Strategy.

Primary Care Sustainability

The primary care and practice support team have worked pro-actively to support and improve sustainability of general medical practices. This has assisted in maintaining the provision of general medical services to the local population.

A pro-active visiting programme has been undertaken to all GP practices who are highlighted as red/ amber (on risk matrix) to offer formal/ informal support and encouragement and if appropriate to formally apply for assistance.

Through 20 **local sustainability assessment panels** attended by both the Community Health Council and Local Medical Committee consideration of 17 applications which have been formally made by practices. Panels have granted a range of additional practical or financial support on a case by case basis.

During 2018/19 the primary care team and practice support team have supported/assisted 22 practices across Swansea/NPT/Bridgend.

The development of a **discretionary merger framework** and the Health Board primary care team provided both financial and project support to facilitate practice mergers or potential merger discussions. Five mergers have been successfully completed to date. The last of these mergers was completed in November 2018 forming the Estuary Group Practice. Mergers have proved a successful way to manage acute last person standing situations and ensure the continuity of general medical services provision to the local population. They have also however provided the catalyst however for the remodelling of primary care and the introduction of the new primary care model. This was particularly highlighted when the New Cross, Sway Road and Clydach practices merged in July 2018 to form the largest practice in Wales with an expanded multi -disciplinary team.

8 amber GP practices currently receive support from the Sustainability Team in varying amounts. 2 practices scoring red are working closely with the Sustainability Team and support from the GP Fellowship scheme and Physician Associate programme has acted to strengthen their workforce. Recruitment of 8 Salaried GPs in to Practice Support Team, of which 6 remain in post (4.7 WTE). 5 Practices have been supported to achieve a stabilised position. These are practices who expressed a wish to tender resignation of their GMS contract. Positive feedback received from all practices who have held a SLA with the Practice Support Team.

The development of the **Telephone First framework** – launched in February 2018. Approximately 25% of practices are doing some form of telephone first/ telephone triage and the framework is designed to support and standardise practice to ensure good access. Workshops were held at the time of the launch to promote the framework and training of clinical staff. 17 practices took part in the workshops and further sessions have been sought by sole practices/clusters directly through to the training provider. In addition to this reception staff from 20 practices across Swansea/NPT/Bridgend have been trained to undertake **Non-Clinical Call Handling training** (in support of the Telephone First model) with further sessions scheduled for 2019/20.

Establishment of an innovative **primary care recruitment and networking event** held on the 19th April 2018 aimed at attracting new recruits into practices within ABMUHB and to discuss opportunities for career progression. Seven GP practices took part in the event with 68 attendees on the evening. Feedback of this event was very positive.

Cluster Development

The primary care clusters in ABMU Health Board have now been in place for nearly ten years and involve the third sector, the Health Board, the local authority, primary care contractors and, importantly patients and carers themselves. The Health Board has recognised the maturity of the clusters and the strong platform they provide for positive change. 2018/19 was a year of significant cluster development. Each cluster produced its three year plan and with a range of Health Board support implemented a range of initiatives.

The clusters have each produced a yearbook of their key achievements in preparation for the national primary care conference. The cluster yearbooks highlight the breadth of work undertaken to improve services for a number of population groups including older people, children and young people, carers, young carers, asylum seekers and migrants, and women who have suffered domestic violence. There has also been a huge focus on supporting prevention through work on improving screening uptake, reducing smoking, increasing vaccinations and encouraging healthy weight and active lifestyles.

A particular mention should be given to the Bay, City and Cwmtawe clusters who working jointly with the Health Board / Public Health were involved in attracting additional funding through the Health Foundation and the Welsh Government Transformation Programme in excess of 1.9 million.

Pacesetter and Delivery Programme

The Pacesetter and Delivery Plan programme provided ABMU Health Board with an additional financial resource (£662k and £4.295 million) to develop and deliver innovative Primary and Community focussed services.

The Pacesetter programme included:-

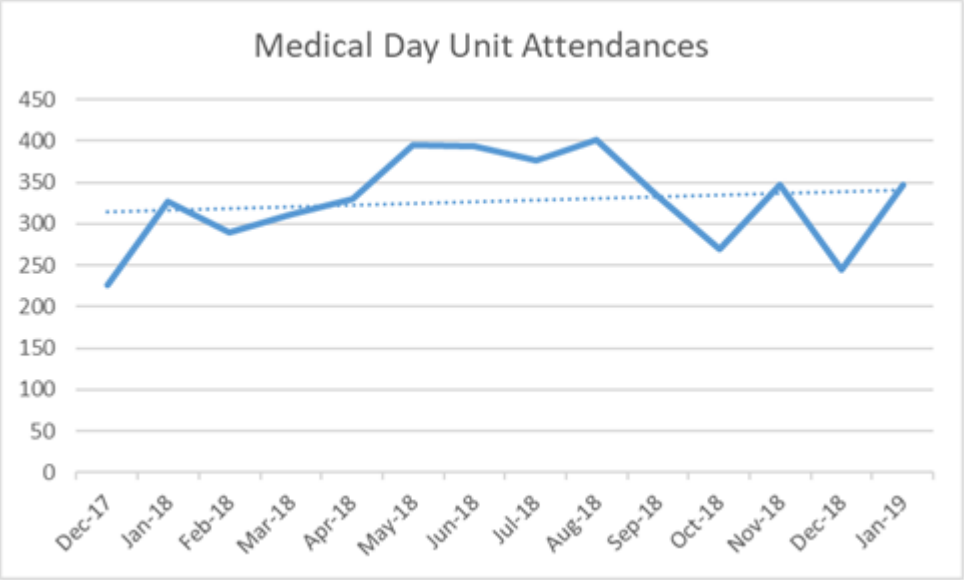
The **Hub and Spoke** project. In 2018/19 the focus was to stabilise and expand on the Hub concept (a Multi disciplinary team of staff supporting patients in primary care), by extending access to more remote areas through the development and provision of spoke services. Spokes have been progressed in two clusters in the Neath Port Talbot Local Authority area (Upper Valleys Cluster and Afan Cluster) to date. The added interface of spoke services at a distance in rural and valley communities has provided increased access and multi disciplinary team solutions in those cluster areas and thus provided increased patient access closer to home and has supported the sustainability issues within General Practices.

The Hub and Spoke services have proven popular with patients with satisfaction rates at 95%.

The Delivery Plan projects included:-

Ambulatory Care in the **Medical Day Unit** (MDU) based in Singleton Hospital. The MDU was able to increase its capacity and expand the operating times (from October 1st 2018) to an 8am to 8pm service and deliver a variety of medical procedures, incorporating various specialties such as Respiratory, Gastroenterology, Haematology and Oncology Medicine. The unit also provides care for patients coming from home and the community requiring Intravenous (IV) therapy and direct primary care referrals. In the latter part of the year the unit has assisted in the development of the pleural service and provides day case support to inpatients requiring bowel prep for endoscopic investigations, liver and lung biopsies. The MDU mainly sees planned admissions, but can facilitate drop-in patients. The Unit was able to support approximately 340 patients per month and reduce the demand for inpatient beds.

The following table illustrates month on month MDU activity in 2018/19. The reduced activity in November and December was due to a temporary move of the MDU, due to significant winter pressures. This recovered in January 2019.



The **Community Respiratory** Team continued to provide excellent service improvements for patients across ABMU Health Board. In 2018/19 the number of patients completing the **Community Pulmonary Rehabilitation Service** improved from 71% to 87%. The collaborative work between the team and the National Exercise Referral Scheme (NERS) led to a three fold increase in referrals to NERS for patients completing and improving long term adherence of the intervention. Value based healthcare work showing trend that those patients who have completed PR have reduced admissions and those that are admitted and have completed PR have reduced length of stay.

The **Early Supported Discharge COPD Team** based in Bridgend had an increase of 28% in referrals and had a mean length of stay with the team of 1.93 days compared to mean length of stay 5.42 days in Princess of Wales Hospital. 23% patients re-admitted (90 day readmission rates) in 2016 and this had reduced to 6% in 2018 demonstrating the improved outcomes for patients.

The Community Nutrition Service have been able to continue to deliver a range of interventions to support patients within the community. This includes a **Structured Diabetes Education Programme** (including via self referral) for patients who needed to improve self management. The service has provided education and support within the Care Home sector regarding **Nutritional Risk (MUST) Training** which has seen improvements in the accuracy of risk assessment for patients in care which has led to improved care planning and interventions.

The **Mental Health Link Worker** provides a triage model of memory assessment, utilising touch screen technology (via the mobilisation project). This was previously supported by the Bevan Commission and is a key project and key member of our workforce that supports the joint working between Mental Health Services and Integrated Community Services.

Whole System Cluster Transformation

The transformation fund launched by Welsh Government to support the implementation of 'A Healthier Wales' has formed a centrepiece of activity for the PCS Unit. In 2018/19 the Cwmtawe cluster in conjunction with Heads of Service and the Area Clinical Director developed plans that were sponsored and supported by the Regional Partnership Board, and applied for transformation funding for a 'Whole System Cluster Transformation' programme. The proposal was agreed at 1.7 million pounds and a formal invitation to extend the Cwmtawe model to other clusters was received. This proposal was developed by the PCS unit and submitted with Health Board and Regional Partnership Board support. This was approved by Welsh Government in March 2019 and a further 8.9 million pounds awarded. The programme will now extend to all 8 Clusters with introduction on a phased basis and each Cluster having an 18 month implementation phase.

This transformation model is aligned to the quadruple aim of improving population health and well-being; having better quality and more accessible health and social care services; providing high-value health and social care and ensuring a motivated and sustainable health and social care workforce. It will help turn the vision of 'A Healthier Wales' into practice for people living within the Health Boards communities.

The programme commenced in 2018/19 in Cwmtawe Cluster and the way services are provided is changing, with more of an emphasis of working with the communities it serves, and keeping people well - not just treating them when they are unwell. This has been achieved by increasing the range and scope of GPs, healthcare professionals, including pharmacists, audiologists, speech and language therapists; who work together with voluntary sector and social services partners to improve patient services. This has seen:-

- Increased focus on a social model of health;
- Better use of skilled workforce;
- Services more accessible and sustainable;
- Closer joint working across disciplines

The service developments being undertaken through this transformation are aligned with the Health Boards Clinical Services Plan with a focus on the chronic conditions management and development of whole system pathways to ensure high quality and more efficient use of resources. This Transformation programme will continue throughout 2019/20 and into 2020/21.

GP Out Of Hours Services

The ABMU GP Out Of Hours Service (GPOoH) implemented changes to its service model in 2018/19. This resulted in the service being able to report a consistent 'Level 1 Green' on Welsh Government weekly position reports, with very few exceptions. This means that it has a GP shift fill rate in excess of 90% (several occasions hitting 100%). There was a marked improvement between Quarters 1 and 2 compared to Quarters 3 and 4 as the programme of change developed. This has included the following: -

- A Service Level Agreement with Welsh Ambulance Service NHS Trust for a rota of paramedics dedicated to ABMU GPOoH to undertake home visits 20:00 – 08:00 7 days a week, 52 weeks of the year began on 5th November 2018. This has stabilised overnight provision of GPOoH allowing GP resources to remain at base and attend to face-to-face appointments, provide telephone triage and provide advice to patients.

- The GPOOH Service has increased the number of GPs equipped with remote access devices. This has enabled GPs to work more flexibly, to provide telephone triage and telephone advice, adding to the overall GP resource available to the service.

- A rotational post between the 111 service and ABMU GPOoH Service was initiated. This supported integration of the range of Out of Hours services available and is designed to support the alignment of services.

- Further additions are to be made to the multidisciplinary workforce. Advanced pharmacists have been trained in minor illness and Health Care Support Workers (HCSWs) have undertaken a bespoke training day. Both groups of staff will support the sustainability and quality of service that patients will receive.

In December 2018 the ABMU GPOoH was subject to a peer review as part of an All Wales programme. The Peer Review Team consisted of doctors and managers from GP OoH Services in Aneurin Bevan, Hywel Dda and Cardiff and Vale Health Boards, the 111 Service and Welsh Government and was chaired by Dr Chris Jones (Chair of Health Education and Improvement Wales).

Feedback from the Peer Review Team was extremely positive and recognised the significant benefit to the wider unscheduled care system the service offers, when it is working well. In particular, the review team felt that ABMU is "…at the vanguard of shaping the urgent care agenda in Wales and should continue to drive the prudent healthcare principles as part of this approach". The feedback commented on the significant improvement in GP shift fill, compared to the previous year, and that the patient experience remained consistently high, with low numbers of complaints.

The peer review feedback was accompanied by an action plan, which has been integrated into the overall change management programme being taken forward.

Primary Care Measures

Phase 2a of the Primary Care Measures (PCM) were implemented in 2018 and Public Health Wales drafted the National Variation Report (NVR) (December 2018). This report provided an overview of service provision against all of the standards on an all Wales basis. The data reported allowed ABMU Health Board to review performance and understand variation between and within Clusters in ABMU Health Board and across Health Boards.

The NVR sought opinion from all Health Boards across Wales on a range of issues including the structure and style of the document and on the creation of three national PCM for an All Wales approach to improvement. Their recommended priorities were based on the measures that had the greatest levels of variation within clusters and across Health Boards.

ABMU primary care services agreed with the principles of developing nationally agreed priorities, however, it was noted that the data that had supported the development of the report was not current and provided feedback that it would lack reliability for our primary community services to support its development.

To implement change based on the PCM, a clinically led implementation group was established and has identified and agreed three key areas for service development in Swansea Bay University health board based on our regional priorities. These are

1. diabetes,
2. Smoking cessation
3. antimicrobial prescribing

2019/20 will see the implementation of actions coordinated across Clusters aimed at improving service provision for these three areas.

Summary of Primary and Community Services Achievements 2018/19

Mobilisation Project

Relevant Primary and Community strategy components:- Improving Patient Access, Workforce, Digital and Quality

Primary and Community Services have worked in partnership with the Mental Health and Learning Disabilities Delivery Unit and the Informatics team to deliver the Mobilisation Project, which empowered over 5,000 staff across the health board to start taking advantage of mobile technology.

This has allowed a range of staff and services within the PCS Unit to deliver digitally enabled health, care, and well-being in our communities. By using mobile technology at the point of care in the community, the following highlights have been achieved:

- Patient **appointments in the community have increased** by 17%, with Neath Port Talbot-based teams **attending 7,900 more appointments** per quarter;
- The number of **returns-to-base during the day has reduced** from eight to two trips per day;
- Staff experience rating improved specifically in areas of **personal value and safety**;
- Improved the **digital skills of our community workforce**, in readiness for the roll-out of the all-Wales community health and social care system (WCCIS).

Digital initiatives make up two of the eight enabling objectives in the health board's organisational strategy; in the areas of digitally enabled health and wellbeing, and digitally enabled care. The achievements of the Mobilisation Project have been just the start, as we work together toward improving outcomes for our patients and citizens, using digital technology, in line with Welsh Government direction set out in "A Healthier Wales".

Therapy and Health Sciences

Relevant Primary and Community strategy components:- Improving Patient Access, Workforce and Quality

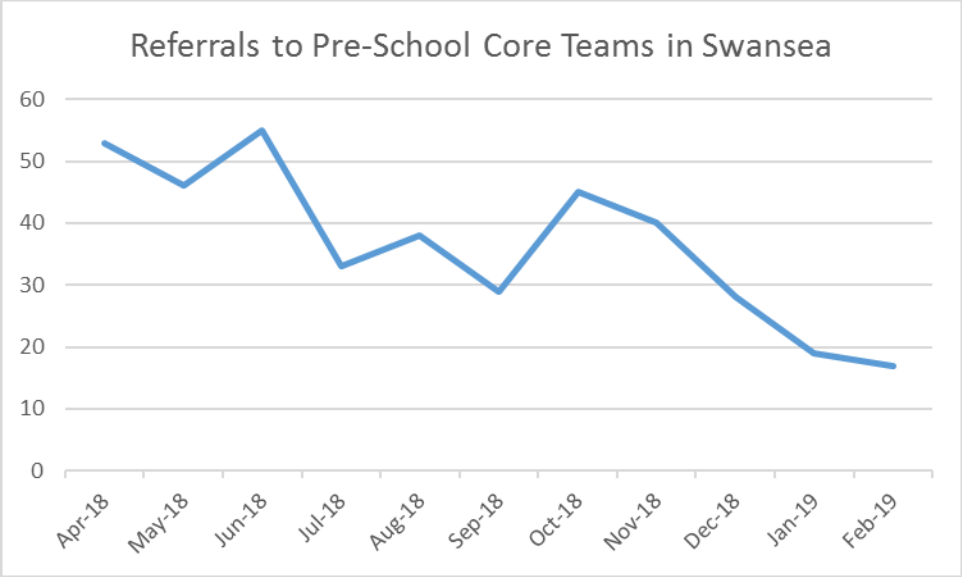
Speech and Language Therapy

As part of a collaborative project with Neath Port Talbot and Swansea Education departments the WellComm Speech & Language Screening and Intervention tool was introduced to all maintained nurseries in the Local Authority areas.

The Speech and Langauge Therapy department has provided training and support to implement the Toolkit and children with delayed speech, language and communication development now receive early targeted intervention in school and when required referral to specialist services.

Outcomes for the project have been excellent with only 6% of children screened requiring referral to specialist services. The results from 34 schools implementing WellComm has shown an increase in age appropriate language skills and a decrease in the prevalence of language delay from 65% to 34%.

Following on from the Wellcomm project in October 2018 the service piloted a direct access service for pre-school children in Swansea that demonstrated a 51% reduction in numbers of children being escalated for specialist speech and language therapy assessment, thereby releasing additional capacity to deliver therapy sessions. The success of this pilot has subsequently been rolled out to clusters as part of whole system transformation.



In November 2018 the department received temporary funding to provide a new service to Morriston Hospital's Intensive Therapy Unit. This resulted in critical care patients receiving objective instrumental assessments of swallowing, earlier intervention and recovery of function; the introduction of above cuff vocalisation for patients previously unable to communicate whilst ventilated and improved compliance with national critical care standards.

Speech and Language Therapy in ABMU Health Board is leading the way nationally on evaluating the impact of our interventions through the use of Therapy Outcome Measures (Enderby et al, 2015) a standardised outcome measurement. ABMU Health Boards Speech and Language therapists presented at the Royal College of Speech and Language Therapist conference and the National Primary Care conference on the pioneering work in this area.

Audiology

Audiology is now delivering a full Primary Care Audiology Service to the whole Cwmtawe Cluster using a combination of Advanced and Associate practitioners. Plans are also in place to extend this to the Neath and Afan Clusters so that all surgeries will be able to access the same level of service this year. The development of Primary Care Audiology service has been a collaboration between Audiology, GPs and Ear Nose and Throat specialists, and has required Audiologists to develop an extended skill set. It is a good example of clinicians working to the top of their licence, delivering care closer to home, and providing the right care by the right person. This has enabled practices to release GP and Practice nurse appointments so that they can see more people. Plans are in place to see similar developments extending to other Clusters in the near future. In June 2018 this work was nationally recognised at the Transformation in Health Care Awards when the ABMU Health Board Audiology service were highly commended for innovation in Primary Care.

Podiatry & Orthotics

The aim of Making Every Contact Count (MECC) is to use each appropriate contact to offer brief advice or intervention in support of behaviour change. It is a technique that can be used for a range of health behaviours including stopping smoking, healthy eating, getting active, responsible drinking, immunisations and positive mental wellbeing. It is not additional work but a different way of doing what we already do.

Measuring the impact of Podiatry & Orthotic MECC activity is unique in Wales and has been recognised by Pubic Health Wales (PHW) as an exemplar of good practice and demonstrates assurance in line with Health and Care standard 1.1– Health Promotion, Protection and Improvement. PHW have stated that the way MECC has been implemented in the service is seen as a structured tool kit providing great assurance to staff that can and should invite conversations with patients which were previously regarded outside their normal scope of practice. PHW have further advocated the departments methods as best practice and completely in line with the principles of 'up thinking' (it's up to me) rather than historical 'down thinking' (it's down to them).

The Podiatry and Orthotic team MECC training and implementation demonstrated a patient behavioural change across the three primary MECC priorities i.e. Smoking (13.6%) Diet & Exercise (10.2%) and Immunisations (15.3%). A total of 2,908 MECC conversations were held April 2018 to end March 2019. Of these 395 (13.6%) Podiatry patients reported a behavioural change.

Podiatry implementation of co-production training has informed best practice and ongoing health board training. As leads for health board wide coproduction implementation Podiatry has worked closely with the public health department to embed MECC training as part of the new and revised coproduction training which will shortly be launched. The Podiatry model of co-production training has been piloted effectively in service areas including Neath Port Talbot prudent board (Rheumatology), community wound care and rehabilitation engineering.

Primary Care – General Medical Services

Relevant Primary and Community strategy components:- Estates, Improving Patient Access and Quality

The Health Board aims to support service delivery in future-proofed, fit for purpose premises. With this aim in mind, the Health Board was successful in attracting over £1.8m to support the modernisation of **Murton clinic and Penclawdd clinic**. Both Practices were outdated and offered poor environments and had received adverse patient feedback on the facilities. They did not support modern healthcare practice or allow an expansion of services in line with the transformed model of primary care and cluster working.

The practices provide much needed services to the populations of Bishopston (1,901) and Penclawdd (3,354) and further patients in rural Gower. The main practice premises in Mumbles and Gowerton did not have further scope for expansion, and in the case of the Gowerton practice there are housing developments planned in the local area through the Local Development Plan.

Enabling works were completed by the end of March 2019. The investment will significantly improve the physical environment in both clinics and achieve compliance with Welsh Health Technical Memorandum Statutory requirements, helping to support people with their self-care, and helping them remain as well as possible and for as long as possible, within their own homes. They also align with Health Board quality of care objectives and maintain a balance of care between hospital and community settings. They present an opportunity for increased medical training with additional Doctor clinics at Penclawdd, the extension of respiratory and Coronary Heart chronic disease management clinics, increased level of wound care clinics at Murton, the extension of early years services, breast feeding and baby clinics.

Porthcawl Primary Care Centre

Porthcawl Primary Care Centre opened in early 2019 and has provided new, expanded, GP and primary care accommodation for the people of Porthcawl and the surrounding areas. The property, together with all the primary care sites in Bridgend, has subsequently transferred to Cwm Taf Morgannwg University Health Board.

Mountain View Health and Family Centre

The Health Board was delighted to support the development of the ‘first’ integrated primary care and family centre in Mayhill in Swansea. This multi million pound development supported by the health Board, Welsh Government and Swansea Council provided modern purpose built primary care facilities including a new GP practice and a community pharmacy.

The GP Practice accommodation is almost twice the size of the former surgery , with four ground-floor consulting rooms and a further two on the first floor; two treatment rooms; a phlebotomy room; reception; waiting areas; offices; and associated staff rooms.

Integrated Health and Wellbeing Centres

The Welsh Government Primary Care Pipeline funded schemes included the development of two new health and wellbeing centres in Bridgend and Swansea and the refurbishment of two existing health board owned clinics in Murton and Penclawdd (as above).

Bridgend Health and Wellness Centre is continuing development in Partnership with Linc Cymru and will form part of the 'Sunnyside Wellness Village' in Bridgend, a combined health and social housing community. Outline Planning Permission for the scheme was received in March 2019.

The Outline Business Case has was submitted to Welsh Government for approval and the scheme formally transferred to Cwm Taf Morgannwg University Health Board for final development.

Development of the Swansea Wellness Centre continued at pace. The Strategic Outline Case was submitted to Welsh Government for approval and development with potential site users and tenants is ongoing. The development of a City Wellness Centre within Swansea City Centre will provide a wide range of well-being and primary and community services for the population of Swansea. Proposed services for both the Swansea and Bridgend schemes will include GP services, dental services, children services, pharmacy, third sector services, audiology, speech and language, mental health and sexual health services.

Primary Care Hub

Relevant Primary and Community strategy components:- Improving Patient Access, Workforce and Information Technology

The **Primary Care Hub in the Neath Cluster** continued to successfully demonstrate that a cluster of practices can address access issues by working together through a central multidisciplinary team (the 'Hub') with physiotherapists, wellbeing worker, medicines management support and audiologist. The GPs within the Neath Cluster adopted Vision360 software, which use to book patients into appointments with the Hub clinicians whilst speaking to patients during Telephone First conversations. Learning from the Hub has been rolled out across Neath Port Talbot through the development of 'spoke' services in the Afan and Upper Valleys Clusters. The added provision of these services at a distance in rural and valley communities increases access and multi-professional team solutions to bring care closer to home.

Physician Associate GP Internship Programme

Relevant Primary and Community strategy components:- Workforce and Quality

The Sustainability team was successful in securing Welsh Government 'Pacesetter' funding to enable a pilot programme to introduce the Physician Associate (PA) role within General Practice over a two-year period 2018 – 2020. The aim of this programme is to embed this relatively new healthcare role within General Practice by facilitating a structured educational programme to consolidate the skills of newly qualified PAs whilst strengthening and diversifying the Primary Care workforce. PAs will divide their working week between designated General Practice and associated community services to ensure a breadth of opportunity for skills development. Each PA completes three 4-month placements in both General Practice and community services within the 12-month programme to help gain exposure to varied access and workforce models in addition to diverse patient populations.

A professional portfolio has been devised to ensure the learning and development of PAs are both captured and enhanced during every rotational placement within the 12-month programme. This portfolio maps knowledge and skills progress whilst aligning the PAs and mentors to standards set out by the Faculty of Physician Associates to ensure the PAs are confident and competent Primary Care clinicians on completion of their internship.

2018/19 saw recruitment of 2 PAs into the pilot programme, with extremely positive feedback from patients, PAs, mentors and wider multi professional team members received to date. We look forward to welcoming the next cohort of 5 recently recruited PAs for the 12-month pilot programme commencing in October 2019.

Primary Care Non General Medical Services – Dental

Relevant Primary and Community strategy components:- Quality, Information Technology

The roll out of the National General Dentistry Services Reform Programme commenced in October 2017. Dental practices are able to join the scheme in April and October of each year. Since the programme commenced, the health board has 12 practices on the programme, this amounts to 20% of practices which meets the expectations set out for all Health Boards by Welsh Government.

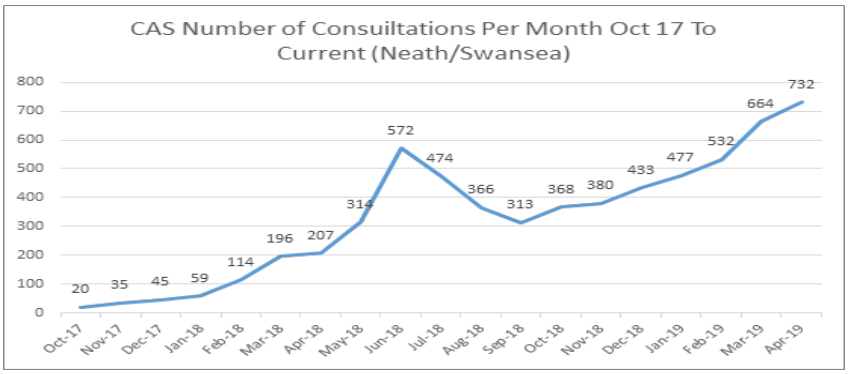
ABMU Health Board had previously had higher than average numbers of children (aged 3-17) receiving general anaesthesia (GA) for dental treatment. A new service pathway was introduced in June 2017, where children referred for a GA by a dentist received an assessment to determine the most appropriate treatment and care setting for their need. The 'pilot' initially targeted routine referrals and due to the significant reduction in number of children requiring a GA for treatment, the service was rolled out in Feb 2018 to encompass urgent referrals into the service. Current data shows a reduction of greater than 50% in the number of dental GAs provided in Feb/March 2019 compared to Feb/March'18, bringing the Health Board in line with the national average.

National Dental E-referral System was successfully launched in March 2018. ABMU and Hywel Dda UHBs were early adopters for the scheme and continue to work with the providers on how the system can but utilised further. The scheme aims to improve the efficiency of how referrals flow between professionals and improve the time it takes for them to be seen. Patients can also 'track' their referrals giving them greater understanding and assurance.

Primary Care – Pharmacy

Relevant Primary and Community strategy components:- Improving Patient access, Quality and Workforce

The Choose Pharmacy platform and Common Ailments Service (CAS) was made available in all pharmacies across the Health Board foot print. In 2018/19, 7052 consultations were delivered directly to citizens. The Health Board has the 3rd highest figures in Wales despite being the last health board to roll out the service.



In 2018/19 -Community Pharmacies also delivered 11,446 flu immunisation vaccines as we continually attempt to increase the level immunised population, this was an increase of 35% being vaccinated within community pharmacy than in 2017/18.

Community Services

Relevant Primary and Community strategy components:- Quality, Improving Patient Access, Workforce and Digital

School Nursing Service

The School Nursing Service continues to work to fully implement all expectations of the Welsh Government's (2017) A School Nursing Framework for Wales alongside delivery of the statutory programmes we deliver across all school settings within the Health Board.

The School Nursing Service provided reception class Height & Weight (screening programme) and related Public Health Wales national Child Measurement Programme (surveillance programme) and the National Vision Screening Pathway programme achieved a 97.7% uptake rate, an increase of 1.9%.

Offering vaccination against flu to all primary school pupils during a very busy ten week timeframe we achieved a 75.3% uptake an increase of 1.3% and top in Wales for a 3rd year running. We have also increased uptake in the Human papillomavirus (HPV) and Teen Booster vaccination programmes.

To meet Welsh Government expectations of the 2017 Framework classroom sessions are offered and delivered including:

- Hand Hygiene (Reception Class ages 4-5 years)
- Nutrition for all classes across all 149 primary schools
- Relationships & Sex Education (specifically puberty) for Year 5 pupils (ages 9-10 years)
- Transition to comprehensive school for Year 6 pupils (ages 10-11 years)
- Relationships & Sex Education Year 9 pupils in the 23 secondary school sites

All of the work within schools has been enhanced through the support of the Mobilisation project, in particular the provision of the IPads, as there has been improved ease of and timeliness of communication between staff.

Health Visiting Service

Following a successful pilot programme being implemented in 2017/18, the Health Visiting (HV) service has continued to work in partnership with the Prison Advice and Care Trust (PACT) in Her Majesty's Prison, Swansea to offer aspects of the Healthy Child Wales Programme to fathers. This innovative partnership approach aims to support positive child parent relationships and mitigate against the impact of incarceration as an Adverse Childhood Experience (ACE).

Health Visiting services have been involved with a number of health promotion activities within the Health Board, including :-

- The "Buggy Push" where staff demonstrated baby massage and promoted healthy eating and providing direct support and advice to parents as part of the walk.
- Swansea Teddy Bears picnic, July 2018, had a number of Health visiting manned stalls where healthy eating, childhood immunisations including influenza were promoted.
- The Flying Start HV team have loaned the 'Flu bug' costume, from Public Health Wales, and utilised it at 3 Family Wellbeing days at local primary schools where it was well received.

In order to address the increasing emotional and physical health needs of children ABMU Health Boards Health Visitors trialled the 2nd version of the All Wales Family Resilience Assessment Tool and Instrument. This allows the Health Visiting Service to undertake robust assessments with children and their families and ensure early and targeted support and interventions can be given.

Prison Health Care

The Health Board improved the health of men in HMP Swansea (prison) by introducing a new system for dispensing medication to support prisoners who were receiving care for substance misuse issues. This resulted in improved patient safety and reduced drug dispensing errors.

District Nursing Service

District Nursing services have contributed to the development of the All Wales Levels of Care, in line with the All Wales Staffing Act. Adopting and utilising this will enable District Nursing to better understand the changing needs of the population and to ensure that our resources are targeted in the right place.

In 2018/19 the Health Board implemented a Single Point of Contact for District Nursing Services, which is managing approximately 10,000 contacts per month. This has streamlined the referral process for the public and professionals (eg GPs), has allowed us to prioritise patient contact across the Health Board and has allowed our front line District Nurses to focus on direct patient care.

Community Resource Teams

The integrated Community Resource Teams (ABMU Health Board, Bridgend County Borough Council, Neath Port Talbot County Borough Council and Swansea Council) continued to develop and enhance the range of services that they provided to support people to remain independent at home. In 2018/19 the teams prevented over 3000 hospital admissions and supported over 900 people to be discharged safely from hospital with integrated health and social care support.

Conclusion

In line with other health boards in Wales, the focus on primary and community services is increasing and this Strategic Reflections report provides an overview of some of the key areas of work. Further work is underway to promote the closer alignment of secondary and primary care services.

Strategic Reflections 2018-2019

Directors of Primary & Community Care (DPCC)

BACKGROUND

The implementation plan from '*Our Plan for a Primary Care Service for Wales up to March 2018'* was completed in April 2018 following the publication of the Annual Report 2017 / 2018.

In June 2018, Welsh Government (WG) published '*A Healthier Wales: our Plan for Health and Social Care*'. The Primary Care Strategic Response to '*A Healthier Wales'* was launched in November 2018, followed by the establishment of delivery mechanisms and the setting up of a Programme Management Office to take the new plan forward.

As a result, the period between the end of the previous strategy and commencement of new arrangements focussed on further developing and sharing the good practice that had been led since 2015 and on the full establishment of the new arrangements. It would therefore have been inappropriate to develop an Annual Report at the same stage as previous years. DPCC have therefore developed a Strategic Reflection Report for the period April 2018 to March 2019 summarising key areas of progress and latest achievements including those areas which have been incorporated into the new delivery mechanisms.

INTRODUCTION

'*A Healthier Wales'* sets out a long term vision of a *'whole system approach to health and social care*', which is focussed on health and wellbeing, and on preventing illness. As a result, all parts of health and social care delivery have responded leading to numerous changes and reviews of existing structures. Emphasis on cross sector integration and the value of joint working on initiatives have strengthened the role of Regional Partnership Boards (RPBs), to enable them to be the key drivers of change in health and social care at regional level. For primary care there has been a continuation of the primary care cluster model to promote transformational ways of working with national primary care contracts being reformed to enable delivery of seamless health and social care at local level.

To ensure whole system delivery, the Welsh Government (WG) are leading a Transformation Programme with governance through RPBs supported by a National Transformation Board. To achieve the required change will necessitate an acceleration towards a fully integrated national digital architecture, the roll out of the Wales Community Care Information System (WCCIS), and creating an online digital platform for citizens, alongside other nationally mandated services. The need for a new Workforce Strategy for Health and Social Care which includes planning for new workforce models has become central to the work of the new Health Education and Improvement Wales (HEIW), Special Health Authority, established in September 2018.

Whilst the strategic direction for primary and community care remained the same, the focus, scale and pace of delivery by existing workstreams needed to be increased to develop delivery mechanisms to meet future expectations.

Workstreams set up to take the new programme forward are as follows;

- Prevention and Wellbeing.
- 24/7 Model.
- Data and Digital Technology.

- Workforce and Organisational Development.
- Communication and Engagement.
- Cluster Vision and Transformation.

It should be noted that work during this period has also been affected by planning for Brexit at both National and Local level.

The achievements of the DPCC, and the Strategic Programme continue to be overseen by the National Primary Care Board (NPCB) with clinical engagement and expertise sought from the Primary and Community Care Reference Group (PCCRG).

This Report provides an overview of progress based on the draft forward work plan 2018 / 2019 included as part of the 2017 / 2018 annual report which identified 2 main priorities;

1. Supporting sustainability and facilitating progress of clusters.
2. Ensuring that enabling activities prioritise and support strategic primary care development.

SECTION 1 – SUPPORTING SUSTAINABILITY

VISION FOR CLUSTERS

Primary Care Clusters are central to delivering the Primary Care Model for Wales. In August 2018, DPCC were provided with various interpretations/definitions of 'clusters' and invited to share local understandings alongside their vision for the future.

From the exercise an all Wales definition was reached i.e.

"A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities."

Inevitably, the pace of development and maturity of clusters had been variable across Health Boards (HB), regionally and nationally. However, implementation of the Strategic Programme for Primary and Community Care required a clear understanding of the current intentions for cluster development at local level, to know if there is a consensus on a national vision that is achievable over the next 3 years. DPCC were invited to complete a template to explore;

- the range of maturity of Clusters,
- the future intentions e.g. alternative model.
- What the risks and/or challenges were in the local area.
- The relationship that clusters have with RPBs.
- The vision for the development of Primary Care Clusters at HB level.

Responses were collated and presented at a time out session in April 2019. Actions have been incorporated into the Strategic Programme a number of which form the actions for the Transformation Workstream.

The Primary and Community Care Development and Innovation Hub (PCCDI) Annual Report 2018 / 2019 summarises the Hub's activities which support cluster development including a number of programmes, masterclasses and conferences which

have been well attended throughout the year.

The PCCDI is supporting the work of pertinent new workstreams. Outline plans for all the new workstreams were approved by the NPCB in May 2019. (*See Appendix 1*).

PACESETTERS

The PCCDI support the Pacesetter Programme on behalf of DPCC. The PCCDI Annual Report 2018 / 2019 summarises their activities including the commissioning of a Critical Appraisal of the Pacesetter Programme published in June 2018 and showcased at a stakeholder event in October 2018.

In September 2018, the Deputy Director for Primary Care in Welsh Government wrote to DPCC requesting a review of current pacesetter projects to inform planning for 2019 / 2020.

DPCC coordinated the collection of local information to address the following;

- Which components of the Primary Care Model were being targeted?
- How expected results would address the three aims of the primary care fund (i.e. Sustainability, improved access or more care available in the community).
- How the overall pacesetter programme ensures a strategic and coordinated approach?
- Which components of the Model need the most development, e.g. more services delivered in the community, use of digital technology to improve access or urgent primary care 24/7.

DPCC were asked to assess their pacesetter schemes to suggest if it should be adopted and adapted across Wales, would need further testing and/or evaluation, or should be stopped and why.

As a result, it was agreed that ongoing Pacesetters Programmes that commenced in 2018, would continue until April 2020, and in the meantime, the following recommendations agreed to inform future pacesetter planning. See Box 1.

Box 1 Recommendations

1. Plans for pacesetter projects should be sufficiently developed for approval by all DPCC in the December preceding commencement the following April.
2. DPCC to be cognisant of the need to approve projects based on the national requirements to ensure that all elements of the primary care model are adequately tested and measures demonstrate which element could have the greatest effect.
3. Projects should normally continue for 2 years commencing in the April of year 1, with midterm analysis made available to approve continuation.
4. Project plans must include evidence of cross discipline agreement to continue with and scale up pacesetters that demonstrate positive outcomes. Processes for sharing of learning must also be in place.
5. All members of executive teams would be expected to be aware of new developments on commencement and incorporate proposals as part of IMTP returns. Appropriate links to be made with Integrated Care Fund Projects

aligning with Regional Partnership Board Plans.

6. Learning from all Wales projects should be owned at local level and successful projects adopted as appropriate without re testing. JET meetings would be expected to challenge failure to adopt.

CLINICAL TRIAGE

During 2018, the Transforming Primary Care Group led by DPCC, commissioned the PCCDI to undertake an online survey to better understand the use of information flow services to provide advice, signposting, assessment and treatment within GMS practices.

A total of 47 % (n=199) of practices responded, outlining their experiences of Signposting, Triage and Telephone First approaches based on the shared definitions as follows;

Signposting – Offering information on available services and other resources – mainly used by receptionists and administrative staff.

Triage – The patient is directed to the right service for the right care – i.e. direction to an external professional or service in line with *Choose Well*, e.g. Pharmacist, Optometrist, Dentist, Physiotherapist etc., informed by the service user in response to identifying the reason for needing professional advice or prior to an appointment.

Telephone First – Patients are asked to speak to a clinician on the phone first either a GP and/or Advanced Nurse Practitioner or Triage nurse.

The key message from the survey was the need for greater clarity, understanding and consistency in the definitions of the three approaches to the service. Furthermore, only 11% of respondents applied formal standards although with the exception of call back times. Barriers included a lack of time to set up the approaches and the lack of available education and training for staff including access to up to date directories of local services.

The final report which is available via Primary Care One, continues to be discussed with stakeholders to agree recommendations for a common approach in the future.

FOCUS ON 24/7 CARE OOH/111

Alongside considering the development of the social model of care, the existing actions from a health perspective have continued. Of particular note is the join up of in hours and out of hours primary care services to a 24/7 model. Ensuring access at the right time, particularly for patients presenting with urgent primary care needs is one of the areas of focus for the new 24/7 Model workstream. This workstream will also complement the work being undertake as part of the National Unscheduled Care Board, (USC).

Urgent Primary Care / Out of Hours (OOH) Services have also been transforming at pace with the adoption of 111 roll-out and the development of a Primary Care Model for Wales which is increasingly focused on 24/7 responses to patient need. There is collective agreement across NHS Wales that future OOH services must be sustainable at a local level; are built upon a wider multi-disciplinary workforce; have clear standards for the delivery of care, and can access and integrate with a range of key services across health and social care.

In response to these requirements and the publication of the Welsh Audit

Report on OOH (July 2018), Judith Paget, Chief Executive Officer (CEO) was appointed as CEO lead for OOH and the Urgent Primary Care Group was established.

One of the first actions instigated by the Group was a clinically led, data driven process to peer review each health board's OOH service and to act as 'critical friend' in offering advice and support as part of the Winter Planning process.

The Peer Review Panel was led by an independent chair (Dr CDV Jones) with membership including Clinical Directors and Operational Leads, Associate Medical Directors, DPCC, the 111 Programme team, HEIW, the Royal College of General Practitioners (RCGP) and WG.

The output from each review was a summary report and action plan which was endorsed by local clinical leaders, with full support from the wider corporate and executive team. For wider governance and for assurance purposes, the Peer Review Panel also recommended that the report and action plan were submitted to local Quality and Safety Committees and /or sub-committees of the Board as appropriate and aligned with HBs medium term plans.

Recommendations from the Review have been discussed with the NPCB and will be incorporated into forward work plans as part of the Strategic programme.

SECTION 2 - ENABLING ACTIVITIES

WORKFORCE AND ORGANISATIONAL DEVELOPMENT (OD)

During 2018, DPCC requested the PCCRG to undertake a survey of all professional groups to capture an understanding of the potential of the wider multi-disciplinary roles and the current and potential input to the primary care model. Following a survey of over 25 professional groups working in primary care a report was published entitled: *Multi-Professional Roles within the Transforming Primary Care Model in Wales*, (August 2018).

Findings were shared and presentations made to the national primary care conference in November 2018.

General messages on Cluster Multi-disciplinary Team (MDT) working included;

- Transformation requires support and advocacy for people who have been long-term passive recipients within the traditional care system.
- The multi-professional cluster team offers a holistic approach to care, with expertise in partnership working and co-production.
- Professionals must work to their own level of competence, recognising their limitations. Professionals need training programmes that equip them with the necessary skills for their cluster roles.
- Workforce sustainability is key for these roles and workforce

planning should ensure that skills and expertise are matched to cluster needs.

Recommendations from the report have been incorporated into the new Workforce and OD workstream deliverables.

PRIMARY CARE INFORMATICS

GMS IT

The previous Framework Contract under which General practitioner (GP) systems and services were procured expired in 2016. A procurement process was undertaken to establish a new Framework. The outcome of the procurement process was announced in January 2018. The decision resulted in one of the existing suppliers ceasing to be a provider under the new Framework. This meant that a number of Practices needed to migrate to a new system, provided by one of the successful suppliers.

The DPCC oversaw the process led by NHS Wales Informatics Service (NWIS) to ensure that the core requirements for GP systems functionality and interoperability detailed in the GP Clinical Systems & Services Minimum System Specification Release Strategy could be delivered. Whilst the project has been subject to some delays, work is on target for completion 2019.

My Health On Line (MHOL)

By December 2018, phases 1 & 2 of the MHOL project had been successfully completed with 100% of practices across Wales having the functionality that allows patients to; book and cancel appointments; register for MHOL services online; order repeat prescriptions; view allergies and medications; update contact details, and use MHOL on mobile devices. It remains a practice decision regarding the functions they deploy. Work has continued on improving the uptake and utilisation of the services. New work focussed on the development and implementation of the Detailed Coded Record access. The work has been taken forward by early adopter sites and will be followed by an evaluation phase prior to roll out.

Appointments data

In December 2018 NWIS presented initial work on the collection of appointments data from a number of GP practices**.** Data were collected via Audit Plus, however as no data standards exist, the quality of data was variable and not comparable or complete. It was acknowledged as valuable innovative work that needed to be developed further as it has the potential to provide evidence of workload in primary care. The variability at this stage did not allow for wider circulation and discussions on next steps are ongoing as part of the Strategic Programme.

Telephony

During 2018, it was suggested that telephony systems in GP practices may be improved with a more consistent approach. Initial scoping work was undertaken to establish what good looks like by visiting different practices in Wales and England. Work is ongoing to develop recommendations.

WCCIS

DPCC maintain an oversight of implementation of the WCCIS project. The Data and Digital Technology workstream will continue to receive progress reports against

implementation targets which extend to the end of 2019.

DATA COLLECTION AND INITIATIVES

Quality and Delivery Measures

Phase 2a of the Primary Care Quality and Delivery Measures were implemented in February 2018. Following implementation DPCC commissioned the PCCDI Hub to produce a Primary Care Measures (PCM) national variation report of the new measures using a standardised template methodology.

The final draft report presented in February 2019, demonstrated the variance per Phase 2a Measure by health board, within health boards and between clusters across Wales. The report identifies where the greatest variance exists using arbitrary thresholds which makes comparability less reliable.

The report recommended that results should be used to identify and share good practice and proposes closer focus on a small number of key areas. It was agreed that the value would be at local level and for sharing with executive teams.

The link to the full report is available as part of the PCCDI Annual Report.

Urgent Care Delivery Milestones

An initial set of delivery milestones was issued in March 2018 for the period April to September 2018. A second set was issued in August 2018 for the period October 2018 to March 2019. The first set served to begin a formal process of implementation and contributed to a greater awareness of the Primary Care Model working with the USC Programme. A narrative report was produced to summarise progress.

The second set were developed in partnership with DPCC and were issued by the Minister and focused on urgent care over the winter period. This process has increased awareness of the role that primary care can have as part of a whole system response to winter pressures. Milestones were reported end April 2019 relying on measurable results rather than narrative and have been used to develop milestones for 2019 / 2020.

Key Indicators

During 2018 the DPCC identified a set of high level indicators for primary care as requested by the Minister. The initial phase of the work focussed on a small set of indicators to provide health boards and WG a snapshot of the 'temperature' of GMS.

Indicators were grouped into 3 categories;

- Existing model/contractor status
- Patient experience.
- Transforming primary care status.

Primary care teams were asked to submit the data via the Portal to Cwm Taf Morgannwg UHB with NWIS being responsible for accessing data to indicators sourced from national surveys. A quarterly report was presented in December 2018. This initial work has been further developed and proposals made for a RAG rating of indicators. Work has continued during 2019.

Winter Pressures

Despite both health and social care services experiencing considerable

pressure on a year round basis, winter is often seen as the most challenging period. As a result of the Minister for Health and Social Services, commitment to evaluate the period 2017 / 2018, the DPCC explored how health and care services performed over the period in relation to, the funding allocated, challenges the system experienced, and opportunities to prioritise actions to deliver improvements for winter 2018 / 2019. Lessons and opportunities for changes were taken forward as part of the 24/7 work stream to inform the Unscheduled Care work.

In September 2018 Chief Executives agreed that a proportion of the 111 underspend for 2018 /2019 would be utilised to support the sustainability of OOH services during the winter period. HBs were asked to submit proposals which would either directly support the delivery of the service, improve patient access or instigate initiatives that would enable flexible working for staff.

With support from the DPCC the proposal was extended to include improved access to urgent dental provision during the OOH period as this represents one of the highest presenting conditions to the service. Certain initiatives were also extended into April 2019 to cover the Easter period.

Each HB submitted a range of proposals to improve the local sustainability of their urgent care service based on learning from the previous winter 2017 / 2018.

Similar to previous winter initiatives, the focus was primarily on creating additional workforce capacity to supplement existing staffing levels during known peaks in demand namely weekends and key bank holiday periods plus operational enhancements to support flexible working.

A summary of the key schemes are noted below;

- Swansea Bay UHB - Piloting the introduction of Paramedic Practitioners.
- Hywel Dda UHB - Piloting the introduction of Advanced Paramedic Practitioners.
- Aneurin Bevan and Cwm Taf Morgannwg UHBs – Introducing Mental Health Practitioners.
- Cardiff and Vale UHB - Minor Illness practitioner pilots.
- Swansea Bay, Hywel Dda, and Cardiff and Vale UHBs - Healthcare support worker pilots being progressed across three UHBs.
- Cardiff and Vale and Aneurin Bevan UHBs - Various urgent dental pilots looking to increase triage capacity and /or additional dental sessions on weekends.
- Cardiff and Vale UHB - Regional proposal for coordination of dental calls.

Urgent Care Pilots

Monies were also made available to support a number of Urgent Care Pilots during the winter of 2018/2019. See Appendix 2.

A workshop was held in May 2019 at which the schemes were reviewed and summarised by the six themes of the National Strategic Plan. Some of the findings/conclusions from the pilots were;

- **Digital & Data**

Access to information and the technical solutions to support this across clusters is required both in

and out of hours with a 'once for Wales' approach.

Information governance solutions to schemes such as Skype in Care homes needs to be resolved.

- **24/7**
  There is a need for a definition of urgent care and that Primary Care needs to be championed and senior leadership is required particularly in HBs, otherwise innovation will falter.

  OOHs and primary care need to review access with clusters and monitor patient demand to improve overall access and inform planning. It was also identified that there is a need for an up-to-date directory of services (e.g. pharmacy services etc).

- **Winter Initiatives**
  It was agreed that there is a need to implement these earlier in the year and that there is a requirement for more formal evaluations of schemes moving forward.

- **Workforce and OD**
  The review of the schemes identified the need to ascertain the core skill set of the multidisciplinary team. It also acknowledged the impact and wider skill set of Advanced Nurse Practitioners.

  There is a need to consider an employment vehicle for effective recruitment HB vs Cluster.

- **Communications & Engagement**
  There is a clear need to manage the expectations of the public in terms of public messaging, access, definition of urgent care and the MDT approach to care.

- **Cluster Vision**
  Informal support is required as a foundation for innovation and coping of pressures.

COMMUNICATIONS AND ENGAGEMENT

In May 2018, WG confirmed recurrent funding of £20,000 per HB would be made available to support local communication activity in primary care. The 2018 / 2019 funding was specifically for raising public awareness of how and when to access care and support close to home. Evaluation reports for utilisation of funding 2017 / 2018 were collated to update the national narrative and share good practice. Welsh Government have continued to monitor the utilisation of the funding throughout the year.

The draft forward work plan included in the DPCC Annual Report 2017 / 2018 identified the intention to enhance professional engagement and understanding of the primary care model, increase communications with all stakeholders across health and social care and establish firm arrangements for taking the work forward to engage and increase public awareness.

Professional engagement was achieved via close working with the PCCRG and their survey of all professional groups establishing and sharing their experiences and opportunities for closer working. The new strategic programme delivery mechanisms include a Communications and Engagement Workstream. One of the key deliverables is to increase public

awareness within individuals, parents, family members and carers about the importance of making the right local health service choice. It is hoped that presentations to Regional Partnership Boards during 2019 will help to embed the primary care model across different sectors.

CHIEF EXECUTIVE'S NATIONAL IMPROVEMENT PROGRAMME (NIP)

For the second year the Chief Executive's Management Team have asked all peer groups to work together to deliver a National Improvement Programme based on whole system initiatives. The themes for 2018 / 2019 were;

- Efficiency.
- Value based healthcare.
- Workforce.
- Digital and
- Governance.

All peer groups were invited to set SMART objectives for areas within their specific forward work plans which required joint working across peer groups.

The agreed goals for DPCC were as follows;

Efficiency - Working with the Directors of Finance to develop an approach to demonstrate value in transfer of resources out of hospital. This work was completed early 2018.

Workforce – included GMS negotiations working with Assistant Medical Directors (AMD) and Integrated Workforce Planning, working with Directors of Therapies and Directors of Workforce. This area has been taken forward as part of the workforce workstream.

Governance – goals led by AMDs focussed on streamlining and data gathering within OOH, winter planning and escalation framework, and support of clinical triage. DPCC also led on the roll out of pacesetter projects in partnership with AMDs.

Specific actions agreed for DPCC and reported quarterly were;

- Development of a common vision based on *A Healthier Wales* – launched November 2018.
- Prioritising 24/7 care, communications and engagement and working with unscheduled care – This action also proposed joint working with Directors of Nursing on out of hospital community/complex care, continuing healthcare, and commissioning of residential care. This work has not been concluded and will continue during 2019.
- Sharing of learning from Pacesetter and pathfinder programmes and the external critical appraisal.
- Support of the roll out of clinical triage and the development of a cluster governance good practice guide. Both actions achieved and reported in the PCCDI Hub Annual Report.

Final reports were submitted April 2019. Plans for 2019/2020 are awaited.

CONTRACT NEGOTIATIONS

Changes to the contracts for primary care contractors can help to ensure that activities which support strategic primary care development are prioritised. Hence, DPCC have been central to contract negotiations during 2018 / 2019.

The Strategic Programme for Primary Care outlines how primary care contractors will respond to '*A Healthier Wales'* under the 3 headings;

- Resilience of individual/community.
- Advice/access when required, and
- Supported and delivering workforce.

Details are provided for GMS, Pharmacy, Optometry and Dental.

The GMS Contract and ongoing work in relation to enhanced services were identified as the key priority for 2017 / 2018 and remains ongoing. Priority was initially given to developing and agreeing governance and decision making mechanisms to take forward negotiations. This also included expert training in negotiation skills for DPCC, Heads of Primary Care (HoPC) and AMDs. During 2018 / 2019 processes have facilitated three way working with WG and the General Practitioners Committee Wales (GPCW) ensuring that CEO's are fully supportive of an all Wales approach to negotiations. Negotiations are continuing.

DPCC also received regular updates in relation to the Pharmacy Needs Assessment, changes to eye tests for children and the dental contract.

SECTION 3 - OTHER ALL WALES BUSINESS

ALTERNATIVE PROVIDER MEDICAL SERVICES CONTRACT (APMS)

Whilst APMS is permitted as a contractual model for the provision of general medical services, work to date has only been undertaken at local level and no national contract is available for use across Wales. In November 2017 Capsticks Solicitors were commissioned to draw up a draft APMS contract. Following consultation and amendment DPCC agreed to extend the work to commission Capsticks to provide a suite of schedules/templates to support the draft APMS contract which would safeguard its use in practice.

Mandatory principles within the contract have been determined however, there is freedom to HBs to develop the contract to best meet local need, hence there are flexible parts that require local determination.

Capsticks presented the Contract and Schedules to DPCC in February 2019. Capsticks have been invited to clarify some issues and WG have received the documentation for their review and consideration.

INDEMNITY

Welsh Government agreed to introduce a state backed scheme to provide clinical negligence indemnity for providers of GP services in Wales. WG worked in collaboration with DPCC to negotiate the scheme, which came into force from April 2019. It covers all contracted GPs and other health professionals working in NHS general practice.

A representative from the NHS Wales Shared Services Partnership (NWSSP), Legal and Risk Team who have led the process, attended the DPCC meeting in March 2019 and presented the detail of arrangements. The main changes for primary care providers in indemnity arrangements for incidents occurring after 1st April 2019 were discussed. NWSSP will continue to operate the Scheme from 1

April 2019. The initial arrangement relates only to future liabilities.

PRIMARY MEDICAL CARE ADVISORY TEAM (PMCAT)

In 2017, the Primary Medical Care Advisory Team was transferred from Public Health Wales to NWSSP. As part of the transfer HBs asked PMCAT to review the processes around PMCAT investigations and performance management. A General Medical Practitioner (GMP) Performance Review Task and Finish Group was set up with representation from DPCC. The primary aim was to review and identify improvements to existing GMP performance procedures in order to enable a consistent, proportionate and robust approach to GP performance concerns across Wales.

In June 2018, the draft Framework for the '*Management of Performance Concerns in GPs on the Medical Performers List Wales'* was discussed and approved by DPCC. The Framework identified four management stages culminating in a Reference Panel. DPCC requested NWSSP to explore the feasibility of establishing a National Advisory Panel Unit for Wales. Negotiations are ongoing to address some of the original concerns around variability of process and training although the establishment of a National Advisory Panel Unit will not be considered until 2020/21.

VALUE BASED HEALTHCARE (VBH)

The development of all Wales disease specific pathways of care have inevitably had an impact of primary and community care services. The Respiratory Implementation Group had focused on a VBH approach to improving Chronic Obstructive Pulmonary Disease (COPD) including online training, which was welcomed by one health board with consideration for all Wales adoption. The Clinical Lead was invited to present to DPCC in December 2018. Whilst the approach was well received implementation requires the commitment and agreement of local Clusters and GP practices.

DPCC also suggested that the VBH approach could be applied to other areas of primary care where practice is variable. Discussions are ongoing.

COMPASSIONATE COMMUNITIES

In April 2018 Dr Julian Abel, Director of Compassionate Communities UK, presented the '*Frome Model of Compassionate Communities'* to DPCC. The adoption of such a model needed to be able to align with or enhance current working approaches at local level, hence it was agreed that Dr Abel would be invited to present at local workshops at health board level inviting executive teams and local primary care leaders. The PCCDI coordinated the workshops from July 2018. Following consideration at local level, two health boards agreed to continue to adopt the approach and work is ongoing to establish arrangements.

SECTION 4 - ONGOING CHALLENGES AND CONCLUSIONS

Continuing to deliver wide scale structural and cultural change across health and social care '*at pace'* remains a substantial challenge.

Challenges in relation of workforce, technology, funding and communications are well documented. Competing demands to focus on local

needs whilst contributing to a national agenda continues to be a difficult balance.

Demands upon health and social care are broader than primary and community care and whole system change requires close engagement and commitment from all members of executive teams. As important will be the ability to engage the public and enable them to feel the benefits of a new approach to care.

Inevitably, the new few years will be marked by Brexit and political change, however, *A Healthier Wales* sets a cross party supported policy for Wales for the longer term.

As the current policy builds on and extends the work of '*Our Plan for a Primary Care Service for Wales up to March 2018'* (2015), the direction of travel has already been set and tested. We have over the past 4 years collected examples as well as hard evidence of the innovations and improvements in primary and community care. The approach of the DPCC has already demonstrated our commitment to implementing the new Strategic Programme for Primary Care.

SECTION 5 – REFLECTIONS AND EVIDENCE OF PROGRESS

Five years after the top priorities for Primary and Communuity care were identified (Box 2), it is noteworthy that all have been achieved to a greater or lesser extent.

Box 2

Top priorities identified 2014:

1. The need for a clearer strategy and vision at all levels
2. Primary and community care to become a higher priority for NHS organisations
3. The need to do things differently through a better understanding of the workforce, data collections and use of a wider skill mix
4. Local mapping of resources, services and infrastructure to inform service planning
5. Better measurement of the effectiveness of primary care and more use of outcome data to inform change
6. Integration of planning, finance, estates, health board structures and leadership
7. Better communication, use of IT and information sharing,
8. Alignment of finance and resources around the patient and
9. Co-production

Whilst the pace of change during that time may have seemed relentless at times, it has achieved the rewards of being able to evidence improvements in primary and community care for service users and has resulted in the development of a significant programme of work to take the agenda forward into the next 5 years.

As outlined in Section 4 there remain hard challenges to be overcome in the future, however, building on the successes over the past 5 years, DPCC remain committed to the effective leadership that has significantly transformed the aim of *'moving primary and community care centre stage'*

The paragraphs below provide some examples of new achievements since April 2018.

ACHIEVEMENTS 2018/2019

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Intergenerational Practice

In 2017, an inquiry into loneliness and isolation recognised the benefits of intergenerational contact. Over the past year the Health Board and its partners have been working with organisations and communities in an attempt to combat social isolation and loneliness through the Ffrind i mi/Friend of mine® initiative (www.ffrindimi.co.uk). Recent partnerships with schools/school children, college students, and police/volunteer cadets has resulted in increased intergenerational befriending in care homes, sheltered accommodation and on hospital wards. This has identified positive benefits for both children and older people.

An Intergenerational Practice Strategy *Building Bridges Across the Generations* was launched on 20th December 2018. The strategy is supported by electronic practice toolkits and case studies. 52 partners have signed up to this strategy, including Gwent Police, Care Homes, Schools, Older Persons Commissioner, Cardiff and the Vale Partnership Board and Bangor University.

ABUHB have worked with Petra Publishing, story tellers and illustrators to produced *Billy the Superhero.* This **bilingual** book, written by children for children, which hopes to introduce the topic of health and social care to children, encourage them to reach their potential and spark interest into its rewarding career prospects.

Aneurin Bevan Care Academy (ABCa)

Across Wales a shortage of GPs and practice nurses, an ageing workforce compounded by recruitment and retention difficulties has resulted in significant pressures within primary care. General practice is evolving and the workforce of the future needs to incorporate a range of professionals supporting GPs to improve the health and wellbeing of the population.

Welsh Government transformation funding has been utilised to develop ABCa. The priority is to recruit, train and retain nurses, pharmacists and pre-registration pharmacy technicians (PRPTs) focusing on vulnerable localities.

The aim is to produce nurses and pharmacists that are fit for purpose and employment by independent general practices and offer an opportunity for PRPT's to work in multi-sector roles. The expectation is to improve service sustainability as well as aligning with National Primary Care Sustainability Transformation, Care Closer to Home and Clinical Futures.

Since March 2019, 10 nurses, 7 pharmacists and 11 multi-sector PRPT's joined ABCa. This innovative educational programme encompasses an accelerated training and assessment curriculum (based on RCGP/GPhC competency framework) as well as multisector training events. Accredited education includes the nurses completing a

Foundation Diploma in Community and Practice Nursing, pharmacists a Clinical Diploma/Independent Prescribing qualification and PRPTs an accredited GPhC course.

A Graduated Approach to Care

A 'Graduated Care' approach means that ward criteria / specifications are clearly defined to reflect the categories of patients and their care needs. As a result, ward models can be aligned more closely to patient need which, in turn allows for patients with similar needs to be grouped together and for staff resources to be utilised to provide more effective care. This means that patients can either be admitted directly to a ward which provides the appropriate level of non-acute care (i.e. avoiding unnecessary admission to acute inpatient unit) or, as part of their recovery from ill health, step down to a more appropriate setting.

The model describes a graduation of care from acute through to care that could be received at home and clearly articulates each level based on the support that would be required from professionals. It also acknowledges that there are a number of pathways (stroke, palliative etc) that transect graduation and in some instances result in patients deemed to be at different levels being cared for in the same area due to prudency.

The following benefits have been realised:

- Patients receive the right care in the right place and the right time.
- Resources are directed and concentrated according to need, ensuring appropriate staffing levels and skill mix.
- Patients experience more positive outcomes with a higher proportion of patients returning to their usual place of residence.
- Reduction in agency and locum expenditure due to more prudent use of resources.

BETSI CADWALLADER UNIVERSITY HEALTH BOARD

Primary Care SITREPs

A tool has been developed for GP practices to report weekly the level of pressure in the service, relating to demand, capacity and access. Depending on the levels reported, the Area team contact practices to discuss actions including what individual practices can do to support themselves, actions on a cluster basis to support the local area and actions for the HB to be able to provide support to practices for home visits etc. This allows a 'whole system' view of unscheduled care pressures. This is being rolled out across N. Wales and shared with other HBs.

North Denbighshire (ND) Cluster Minor Ailments Scheme

WG funding was received to support the ND Winter Pressures pilot, providing a cluster minor ailments service to relieve pressure in GP practices, out of hours services and ED. Funding came to an end in April, however, the service continues to run following successful appointment of 2 ANPs, supporting local practices and the wider USC agenda by treating patients with low level presenting conditions, changing the culture

of inappropriate ED and OOHs usage. This will also continue to support North Denbighshire practice sustainability through challenging summer demands.

Healthy Prestatyn Iach (HPL)

This managed practice was established in April 2016 with a multi-professional approach a focus on de-medicalistion and social prescribing. HPI is also focusing on the development and mentoring of advanced practitioners across various professions, and has led the introduction of the Primary Care Nurse Consultant role.
Other Managed Practice initiatives include:

- Joint initiative with Mental Health with CPN joining the HPI Brenig Team, caring for the frail elderly/housebound patients. There are also Joint Care Home Ward Rounds.
- Patient Engagement Group / Patient Council now established within HPI.
- Primary Care Paediatric ANP with a complex needs caseload based at HPI working jointly with Community Paeds Team.
- Joint Care Home service being developed supporting 550 patients in care homes.
- Year of Care MDT process with joint working with therapies and medicines management to review out of range Diabetes patients.

Development of Practice Nurses

- **Practice Nurse trainees -** A programme continues with non-primary care nurses taking up posts within independent and managed practices. This offers the nurses an opportunity to upskill and develop in a safe clinical environment, and is supported by clinical skills training.
- **Student nurse placements-** Promotion of general practice as a suitable learning experience for student nurse placements continues. Close working with the placement allocation team and GP practices has ensured student placements remain well supported.
- **Nurse education – post registration-** Ongoing discussions with universities is underway, to raise awareness for courses to have a better primary care fit, particularly with a gap in respiratory care, and other chronic disease courses.
- **Workflow Optimisation-** to safely hand over the processing of clinical correspondence to other members of practice staff, practices that have adopted this way of working have created up to an average of 8 hours per week of GP time. Through advances in technology to streamline 'admin' work non clinical staff are being enabled to action and file clinical correspondence.
- **CAMHS Family Wellbeing Practitioner (FPWP) -** The FPWP supports families and young people with low level mental health and behavioural issues to support the growing need of contacts to practices in North Denbighshire. The aim is to provide early access to advice and appropriate signposting for families through training and consultation to staff in North Denbighshire cluster of surgeries in addition to face to face consultations with children, families and young people to offer advice and brief intervention to improve the wellbeing of the individual and family as a whole.

Addressing sustainability through provision of MSK and Mental Health Support in Primary Care

Following the successful roll out and evaluation of MSK clinics at a cluster level in one cluster, and roll out of Mental Health Liaison (MHL) in another cluster, C&VUHB committed to mainstreaming and rolling out these successful initiatives across all nine clusters on a recurrent basis to help address some of the GMS sustainability and resilience issues.

MSK clinics are now operational, hosted in four cluster hubs. By December 2019 all nine clusters will have access to cluster hub based MSK clinics. Over 650 patients have been seen by a first contact physiotherapist between 1st February – 30th April 2019, the majority of these patients would otherwise had been seen by a GP.

MHL clinics are being rolled out at a practice level. MHL staff will work from General Practice to provide this service. MHL clinics are operational in all the practices in the two clusters. By March 2020 all nine clusters in Cardiff and Vale will have access to practice based MHL clinics.

To complement the MHL service, a procurement exercise has been undertaken to ensure all nine clusters have access to Tier 0 Mental Health services provided by third sector providers in each cluster.

Care Home Integrated Support Team (CHIST)

Members of the Cardiff CRT undertook a quality improvement Project in 2016, in conjunction with WAST, the key aim of this project was to attempt to reduce unnecessary calls to WAST and reduce hospital admissions, and unnecessary calls to OOHs and in-hours GP calls. As a result a Care Home Integrated Support Team was developed (CHIST). This team has access and works in conjunction with a CRT consultant, District Nursing Teams and GP Practice/cluster based staff e.g. Cluster Pharmacists.

The CHIST staff agreed a programme of education and training with the care home manager including;

- Appropriate use of WAST resources
- Provision of patient lifting equipment and use of risk assessment tools
- Advanced Care Planning
- Falls Prevention and Management/Walking Aid clinics
- Diet and Speech and Language management
- Accessing specialist Gerontology and CRT Support
- Specialist Seating Assessment and Advice

which is delivered to staff over an agreed period of time and modified based on the identified needs of the care home. The training programme has been offered to those homes (Nursing and Residential) who were high users of WAST services and where emergency admissions are high.

The initial quality improvement project involving one care home indicated that the CHIST approach could have an impact on both WAST and emergency admissions, with the results (over a 12 month period) indicating:

- OOHs GP Call Outs reduced by 21% (2 visits per month)
- WAST incidents/call outs reduced by 31% (5 call outs per month)
- EU attendances reduced by 22% (2 attendances per month)
- EU duration reduced by 42% (3 days less a month in the EU)
- Number of Emergency Admissions, reduced by 8%

Social Prescribing in South West Cardiff Cluster leading to transformation

Cardiff SW Cluster have developed a strong ethos for collaborative working since it was first established in 2014. A range of projects have focussed on supporting members of the community through multi disciplinary working. Collaboration has been established with health care professionals within both primary and secondary care. Close working relationships have been developed with members of local community organisations and social prescribing has become embedded in the model of primary care within the cluster.
The successful bid to the Transformation Fund has allowed the cluster to develop the model of working at pace, with a basis in learning from the Frome model of compassionate communities.

First steps were to set up a project group to allow rapid decisions about how to adopt the model.

The model developed by the cluster has four main elements being tested:

- Community development and support for individuals through wellbeing connectors
- MDT approach to support vulnerable members of the community
- A discharge liaison hub to support people when they are discharged from hospital and support them to stay at home
- Care plans to support seamless care across systems focusing on the needs of the individual 'What matters to me'

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

The Advanced Training Practices (ATP) Hub and Spoke Model

The original scope of this scheme focused on the development of a sustainable nurse workforce. However, due to the role of the pharmacist becoming essential to the multidisciplinary team, trainee pharmacists have also been incorporated. The model is based on the premise that GP practices are experienced in offering high quality training places to postgraduate doctors and medical students. This model puts GPs in control of their future multidisciplinary workforce, allowing practices to work together and the clusters to 'grow their own'.

The multi-professional training environments and training frameworks have been achieved through the development of Advanced Training Practices.

As of January 2018, 23 pre-registration nurses have been placed within the hub or spoke practices, and three nurses have cited their positive experience within the GP practice during their 6 week placement as the reason for returning to complete their consolidation. Four Advanced Nurse Practitioner (ANP) trainees were appointed in September 2017, have all completed their six week induction programme and have been allocated a Designated Supervisory Medical Practitioner (DSMP). Each practice has completed the Batchelor of Nursing Education Audit - Practice Learning Environment and all four trainees are enrolled on the MSC in Advanced clinical practice and undertake a minimum of two days per week clinical training under the supervision of their DSMP and a minimum of one day per week training with their Advanced Nurse Practitioner Mentor.

There has been overwhelmingly positive student evaluation with feedback from the University of South Wales showing students rate their time with the hub and spoke model within the top 5% of placements.

Neighbourhood District Nursing Teams

The Neighbourhood District Nursing Teams continue to make positive progress in terms of providing “all care” interventions from within the teams’ resources for end of life care patients. Delivering this care has been a challenge for the teams as it has been additional activity, but this has been achieved through the realisation of efficiency benefits through the use of Malinko and the Community Navigator role.

Anecdotal evidence remains positive from both the patient/family perspective and staff perspective and this allows the teams freedom to provide care in partnership with the patient and family in order to tailor the care to each patient/family’s needs.

CTMUBH has been successful in recruiting to the Care Navigator roles and this has supported the implementation of the Malinko “intelligent scheduling software” system. There are plans afoot to focus on the broader development of the role and the link to our Sector partners.

The Neighbourhood District Nursing Teams have received comprehensive training with regard to Advanced Care Planning and have begun to initiate a number of ACP’s for palliative patients on their caseload.

The Neighbourhood District Nursing Teams continue to strengthen their engagement within the virtual ward hosted at St John’s Medical Practice and receive timely referrals and access to other professionals to benefit patients on their caseload. The Virtual Ward has now been opened to neighbouring Practices within the cluster which is extending this working practice further than the Neighbourhood District Nursing Teams.

HYWEL DDA UNIVERSITY HEALTH BOARD

Community Pharmacy Walk In Centres

The Delivery Agreement set out a plan to develop Community Pharmacy-led NHS Walk in Centres. This development involved asking Community Pharmacies, GP Practice staff and the public about what they felt a Pharmacy Walk-in Centre should include. The feedback from this was shared with the Community Health Council, GP practices and Community Pharmacies. Six Community Pharmacy sites became Pharmacy Walk-in Centres on the 1 March 2019, and a further four became Pharmacy Walk-in Centres on the 1 April 2019. A video has been developed bilingually by the Communications Team which is being shared on social media and across the Health Board website.

Implementing the Primary Care Model for Wales in Managed Practices

Recognising that like most of our workforce challenges, recruitment and retention across Primary Care is a challenge particularly in the more rural areas, the need for a stable Primary Care workforce is paramount to successful transformation. We will use our UHB GP managed practices as the 'test bed' for how the Primary Care Model for Wales can be transacted. A locally developed workforce planning tool has been designed to assist in mapping the most appropriate workforce for each of the Managed Practices. Whilst there has continued to be a reliance on locum GPs a locally agreed cap has been put in place and recruitment into more salaried posts has seen the practices become more stable over the last 12 months. Work is also ongoing to seek the appointment of Pharmacy Technicians and Advanced Nurse Practitioners/Nurse Practitioners to further develop the model across the Managed Practices.

Dental

The Health Board was successful in being awarded non-recurrent, time limited funding (until 31 March 2019) as part of the Winter Pressures scheme to improve access to urgent dental care, particularly over the weekend period. The Health Board commissioned additional services on a sessional basis for those residents in South Ceredigion and East Carmarthenshire, where access to NHS dental services is most challenging. This improved access has resulted in the HB having less pressure on the week day access service for patients needing to access urgent care. The HB has continued to fund this service from April 2019 and has expanded the remit to include cover for Bank Holidays. After collating data across a six month period, which has included an analysis of any patients seeking dental treatment at the Minor Injuries Unit in Prince Phillip Hospital during this time period, consideration will be given as to how this model can be rolled out and expanded across the Hywel Dda footprint.

POWYS TEACHING HEALTH BOARD

Further Development of the Community Resource Team

Additional roles being deployed at Cluster and Practice levels. These complement the increased use of clinical triage that is streamlining access pathways to ensure that people get the right care from the most appropriate person to meet their needs as quickly as possible.

Roles include:

a. Pharmacists and Pharmacy Technicians.
b. Physiotherapists.
c. Physicians Associates.
d. Community Connectors.
e. Mental Health Counselling.
f. Social Workers.

Improved use of Telephone Triage

Telephone triage is now in operation in over 75% of Practices. This has resulted in improved access for patients, with around 50% of callers being supported to self-manage their care. This has resulted in longer appointment times for those who need a face to face appointment and less handoffs as they are able to see the most appropriate person to meet their needs directly.

SWANSEA BAY UNIVERSITY HEALTH BOARD

Implementation of Whole System Transformation of Health Care.

Initiation of the transformation programme (supported by the Welsh Government transformation fund) that will extend across all 8 Clusters within SBU HB. The transformation funding will help turn the vision of *A Healthier Wales* into practice for people living within the HBs communities over an 18 month period. This commenced in 2018/19 in Cwmtawe Cluster and the way services are provided is changing, with more of an emphasis of working with the communities it serves, and keeping people well - not just treating them when they are unwell. This has been achieved by increasing the range and scope of GPs, healthcare professionals, including pharmacists, audiologists, speech and language therapists; who work together with voluntary sector and social services partners to improve patient services. This has seen:-

- Increased focus on a social model of health;
- Better use of skilled workforce;
- Services more accessible and sustainable;
- Closer joint working across disciplines and agencies;
- Improved patient experience.

Estate Strategy

The continued implementation of the HBs Primary and Community Services estates strategy has seen significant developments in 2018/19. The developments have been made possible thanks to the Welsh Government Primary Care Pipeline funding has supported development plans for two Wellbeing Centres and has also enabled the refurbishment of two existing ABMU Health Board owned clinics.

The HB also supported the development of the 'first' **integrated primary care and family centre in Swansea**. This multi million pound development supported by the HB, WG and Swansea Council provides modern purpose built primary care facilities

including a new GP practice and a community pharmacy. The GP Practice accommodation is almost twice the size of the former surgery , with four ground-floor consulting rooms and a further two on the first floor; two treatment rooms; a phlebotomy room; reception; waiting areas; offices; and associated staff rooms.

The development of improved community services estates will provide estates infrastructure that will support the delivery of a wide range of well-being and primary and community services for the population as outlined within '*A Healthier Wales'*. Proposed services for both the Swansea and Bridgend schemes will include GP services, dental services, children services, pharmacy, third sector services, audiology, speech and language, mental health and sexual health services.

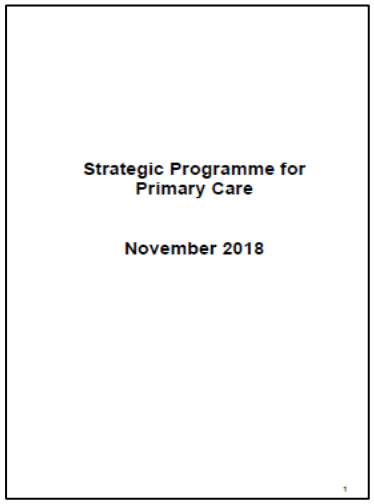
Mobilisation

ABMU Health Board completed a roll out of digital communication devices (Ipads) to circa 1,300 members of Primary and Community Service staff (over 95%). Implementation of this programme has brought a range of benefits to staff, patients and the HB. Tasks such as, the need to telephone the office, search for paper based information (e.g. in filing cabinets or check desk diaries), is a thing of the past as everything from digital notetaking to secure photography, and searching patient records to accessing a personal diary, can now be carried out electronically and remotely.

We have seen the 'return trips to base' reduced from 8 to 2 per day and HCSWs in community nursing teams saving over 2 hours per day in travel and administrative time. This has seen the total number of patient contacts increased on average by 17% - an increase of 8,000 appointments per quarter (32,000 per year estimate).

Appendix I

Plan on a Page



Workstreams 1 – 6:

1. Prevention and wellbeing
2. 27/7 Model
3. Data and Digital Technology
4. Workforce and Organisational Development
5. Communication and Engagement
6. Transformation and the Vision for Clusters.

Prevention and wellbeing

"Acting to reduce risk before something happens."

Work stream 1/6: National Strategic Programme for Primary Care, 2018.

Why is the project needed?

There is a pressing need to transform the health and care system, of which primary care is a key component, towards an approach that prioritises prevention.

A focus on prevention is prioritised in a number of key strategic documents including *A Healthier Wales, Building a Healthier Wales* and in legislation including *The Social Services and Well-being Act* and *The Well-being of Future Generations Act.*

What is the scope of the project?

Due to the breadth of Prevention and Wellbeing activities across Wales, this work stream is within scoping stage. However it has been successful in identifying a number of staged deliverables in order to demonstrate pace and scale in specific areas.

Initial scoping to date has identified the following areas to be progressed:

- Prevention in clinical settings
- Prevention in non-clinical settings
- Compassionate communities or equivalent
- Maximising opportunities to support national programmes
- Social prescribing
- Vaccination and screening

Who will be delivering the project?

DPCC Lead: Hilary Dover
Co-Lead: Sarah Aitken
Named Project Manager: Russell Dyer

What are the key deliverables?

Initial, staged deliverables include:

1. ***Prevention in clinical settings***
   Production of a framework to support a coordinated approach to prevention in clinical settings.

2. ***Prevention in non-clinical settings***
   The programme will explore opportunities to work with system-wide partners in order to improve prevention and wellbeing activity within the community.

3. ***Maximise opportunities to support the delivery of national programmes***

   To actively explore best practice in addressing obesity, physical inactivity and disease avoidance; enabling a framework to be developed which can be used across Wales.

4. ***Social prescribing***
   To increase the range and coverage of social prescribing activity across Wales.

5. ***Vaccination and screening***
   Work with clusters to increase vaccination and screening uptake.

Outcome / Success criteria:

- Production and adoption of the framework for prevention in clinical settings across the wider system.
- Increase in referral activity /uptake/effectiveness of national and local initiatives and programmes.
- Evidence of improved vaccination and screening uptake (e.g. via Primary Care Measures data)

When will the project be delivered?

- Prevention in clinical settings framework to be delivered December 2019.
- Milestones/completion dates for other deliverables to be produced as part of the 'Project Initiation Document' stage. Next meeting planned for 22/05/19.

24/7 Model

Work stream 2/6: National Strategic Programme for Primary Care, 2018.

Why is the project needed?

There is a recognition that across Wales the urgent care services offered to the public from primary and community care (PCC) are very different depending upon the time of day, and often, the location of the prospective patient.

This work stream looks to ensure that as far as possible the service offer is consistent and appropriate both in and out of hours and geography.

What is the scope of the project?

This work stream is concerned with urgent care services within PCC and should complement the work of the National Unscheduled Care Board.

Scope will include:

- actions associated with the recent OOHs Peer Reviews,
- recent investments in PCC services associated with the Winter period,
- escalation metrics and tools,
- access to and use of the totality of independent contractor footprint within a cluster or locality; and
- success of and options for the delivery of clinical triage through in hours GMS services.

The work stream will also take responsibility for a peer review of urgent community type services across health and social care at RPB level and will have a watching brief on the development of the population segmentation and risk stratification at cluster level.

Who will be delivering the project?

DPCC Lead: Alan Lawrie

Co Lead: Nick Wood

Project Manager: Cath Quarrell

When will the project be delivered?

Evaluation of winter plans and production of schemes to adopt = end of June 19.
Escalation Tool = end of September 19.
Other milestones and completion dates will be formalised into a PID as part of the Working Group meeting 17/05/19.

What are the key deliverables?

1. Adoption of OOH Peer Review National Action Plan and follow through to ensure all actions are delivered on time across Wales.
2. Evaluation of all PCC winter plan initiatives and production of mandated schemes that each HB must adopt or justify (as linked to USC Board).
3. Clear and consistent All Wales agreed pathways within OOHs services for disposition to Palliative Care, Paediatrics and MH services; ensuring that (where appropriate) this work inform in-hours delivery.
4. Escalation Tool to ensure that HBs are cognisant of pressures in the wider system and have agreed actions on escalation between practices and HBs.
5. Map of all Independent Contract services in a cluster or locality, identification of any gaps for the local population & GMS Practices to access, along with standardised appropriate access routes which are well known locally.
6. A toolkit showing the positive benefits of implementing clinical triage at practice level including a 'how to', the environment required and the expected results.
7. To produce an agreed RPB level peer review process for urgent community services (by 31 March 2020). Peer reviews would be launched/commence across Wales in 2020/21; resulting in a set of agreed RPB actions linked to output of the Delivery Unit's rightsizing project in terms of right sized community teams and service specifications.

Outcome / Success criteria:

- A series of sustainable HB & Regional OOHs services fully compliant with national standards and in line with WG policy on 111.
- A suite of no more than 10 investments in PCC services that add significant value to the whole system in terms of demand management and supply capacity at times of peak demand such that patient safety and experience of USC improves.
- Easy to use Escalation tool which allows rapid assessment of capacity issues in primary care with resultant support mechanisms.
- Consistent Independent Contract service access at locality level appropriate for the population served.
- A benefits driven toolkit to allow clinical triage at GMS level to be introduced supporting delivery of GP Access Standards.
- Consistent and standardised community service responses across health and social care which prevent avoidable emergency admission to hospital.

Data & Digital Technology

Work stream 3/6:

National Strategic Programme for Primary Care, 2018.

Why is the project needed?

To maximise systems and information, as well as technology, to support the delivery of care at home and in the community setting. This includes identifying priorities for inclusion in the National Informatics Plan.

What is the scope of the project?

There are three main components, these include:

1. **SYSTEMS** - Maximising existing systems (e.g. MHOL) and ensuring new systems (e.g. WCCIS) enable access to and sharing of data and information, to support the delivery of care in the community (including MDT working).

2. **INFORMATION** - Ensuring key data is available to monitor and report on progress against national standards and targets.

3. **TECHNOLOGY** - Identification of technology that can support delivery of new models of care at home or in the community setting.

Who will be delivering the project?

DPCC Lead: Lisa Dunsford, Cardiff and Vale UHB
Co-Lead: Helen Thomas, NWIS
Named Project Manager: Cath Quarrell

What are the key deliverables?

1. SYSTEMS - Identify primary care priorities (as well as Information Governance and data sharing requirements) for inclusion in the National Informatics Plan – including development of high level requirements/specification. High level oversight and tracking of delivery of primary care projects in the National informatics Plan to ensure benefits are realised.

2. INFORMATION - Complete roll out of work on current measures (including appointments data). Develop templates for reporting against new standards (access, 111/OOH) and ensure systems developed to enable monitoring and reporting (including Time spent at home). Scope additional/new primary care measures for consideration.

3. TECHNOLOGY – To assess local good practice/local projects and develop recommendations for wider roll out.

When will the project be delivered?

- SYSTEMS – this will be on a rolling annual basis. Timeline determined by that of National Informatics Plan.

- INFORMATION – Roll out of current measures (Aug 2019). Template for reporting on new standards (Dec 2019), systems developed (Mar 2020). Scope new measures (Mar 2020).

- TECHNOLOGY – Develop recommendations for consideration for roll out (mobile devices and video/skype - Dec 2019). Identify other potential technology for consideration (Aug 2020).

Outcome / Success criteria:

- Clinicians and members of MDT able to access information to support provision of care in the community.
- Key data measures captured and reported on a consistent basis and used to improve quality of care.
- Technology supporting delivery of improved care in the community setting.

Workforce and Organisational Development

Work stream 4/6: National Strategic Programme for Primary Care, 2018.

Why is the project needed?

The multidisciplinary team approach is acknowledged as the common characteristic of the best new models for primary care. On this basis, primary care workforce transformation requires effective:

- workforce data and planning;
- address issues around employment and retention;
- role development (where identified) as required to strengthen the MDT;
- education that increases exposure to primary care, and ongoing fit-for-purpose training;
- means of sharing best practice that is evidence based.

What is the scope of the project?

Between the Strategic Programme for Primary Care and HEIW's 2019-20 work plan, scope will include:

- Supporting Health Boards to develop Workforce Plans for Primary Care, including demand/capacity analysis, introduction of a web-based workforce tool and cluster workforce planning.
- Developing roles and skill mix for MDT development in primary care, including GP education, pharmacy pre-registration training, non-medical education and training, enhanced community eye care, leadership and dental developments.
- Pay and employment; recruitment and retention eg Train, Work, Live.
- Compendium of roles and models.

Who will be delivering the project?

DPCC Lead: Sian Millar, Divisional Director, P&CC, ABUHB
Co-Lead: Lisa Gostling, Director of Workforce and OD, HD UHB
Project Manager: Krysia Groves, Programme Manager (Primary Care), HEIW

What are the key deliverables?

1. To increase evidence and improve workforce intelligence to support changes in workforce planning and education.
2. Launch and implementation of National Workforce Reporting Tool.
3. Development of a tool/minimum specification to assess Demand and Capacity
4. Production of a Workforce Plan template (first iteration) for Clusters; ready to support the next round of IMTPs and to inform more robust commissioning for training places.
5. Development and improvement of the education and training available in primary care to health professionals and healthcare staff (e.g. pharmacists and doctors in training).
6. Framework to expand education and training in primary and community settings.
7. An increase in the number of GP training places offered in Wales.
8. Workforce solutions to support NHS organisations in improving access to eye care.
9. Development of the Train, Work, Live.
10. To share good practice via a refreshed, web-based 'Compendium of roles and models'.

Outcome / Success criteria:

- Implementation of the tools and resources to successfully support workforce planning in primary care.
- Early and visible improvements and extensions to HEIW's educational offer; developed through a process of engagement with NHS colleagues, academic providers and awarding bodies.
- A fully resourced training infrastructure in place with exposure to primary care settings.
- Increased GP trainee places available, supported by successful recruitment and retention rates.

When will the project be delivered?

The work schedule has been initially mapped up to April 2020 and will consist of varying milestones and completion dates relevant to each deliverable.
To demonstrate pace and scale, specific products will be available in Sept 2019:

- National Workforce Reporting Tool
- Demand and capacity tool / specification
- Template (first iteration) to support a cluster workforce plan

Other delivery dates to be defined as per the Project Initiation stage.

Communication & Engagement

Work stream 5/6: National Strategic Programme for Primary Care, 2018.

Why is the project needed?

As recognised within A Healthier Wales (2018) and evidence such as HIW's General Medical Practice (GP) Inspections Annual Report 2016-17 there is a need to raise public awareness of how services across Wales are changing, what is available locally; and how and when to access them.

This project will specifically respond and contribute to these issues as set out within the National Strategic Programme for Primary Care (Nov 2018) which states:
"The communication and engagement on the primary care model for Wales needs careful consideration and dedicated expertise to ensure understanding by all stakeholders and the public are clear on what this means going forward."

What is the scope of the project?

The project will be managed in two phases:

1. (2019-20) - raise awareness of the changes to local health and wellbeing services being developed under the Primary Care Model for Wales
2. (2019-21) - promote behaviour change in accessing the new wider model of primary care services

Phase 1 initially scoped to include:

- User friendly articulation of the whole and different elements of the model for stakeholders (e.g. social care, third sector, secondary care).
- Forming the basis of how staff are trained to manage this message (e.g. receptionist/navigator role).
- Create public awareness and information/education campaign to promote and embed the model with citizens across Wales.

Who will be delivering the project?

DPCC Lead: Chris Stockport
Co-Lead: Chief Officer, CHC.
Project Manager: Catherine Quarrell

What are the key deliverables?

1. To promote and highlight the range of health and wellbeing services within the community and what is changing.
2. To increase public awareness of primary and community care providers, including the different functions they perform, such as opticians providing hearing tests and pharmacists holding patient consultations, to enable people to make good choices of where to get the right help, advice or treatment.
3. Raise public awareness with individuals, parents, family members and carers about the importance of making the right local health service choice
4. Increase awareness and understanding of the Primary Care Model within the workforce and stakeholders, such as the third sector.

Outcome / Success criteria:

- Production of a robust and well-thought out communications strategy.
- A 'Primary Care Model' communications toolkit for use by health boards and partners (including local authorities). This will provide narrative that has been tested with citizens, graphics and video media, with cumulative value arising from consistency of approach and multiple points of exposure.
- Success will be measured by way of evaluation; using existing tools to measure success of the campaign, which could include obtaining feedback from service providers.

When will the project be delivered?

- Communications strategy to be produced and stakeholder endorsed - June 2019.
- Nationally agreed narrative for health boards and partners to use – July 19
- A bilingual set of national design materials and resources for adaption locally – Sept 19.
- Launch national digital and social media campaign to promote Your Local Provider – Sept 19.

Transformation & the Vision for Clusters

Work stream 6/6: National Strategic Programme for Primary Care, 2018.

Why is the project needed?

The case for change as set out in *The Parliamentary Review* and the required 'revolution from within' is fully recognised by the National Primary Care Board. *A Healthier Wales* provides a clear plan for progressing this, with a clear reinforcement of cluster working as part of the national model for local health and care.

Whilst significant progress has been made through implementing the recommendations set out in the *Primary Care Plan for Wales 2015 – 2018*, there is still much to do to fully implement the Primary Care Model for Wales and also ensure full alignment with other actions set out in *A Healthier Wales* including the National Transformational Programme and the National Clinical Plan.

What is the scope of the project?

- To understand the challenges and barriers that clusters experience and identify solutions at both a national and local level.
- To work with other national programmes to ensure seamless working.
- To work with external stakeholders to develop the place-based care approach.
- To align with relevant work as set out in *A Healthier Wales.*

Who will be delivering the project?

DPCC Lead: Sue Morgan, National Director of Primary Care.
Co-Lead: TBC
Named Project Manager: TBC

What are the key deliverables?

1. To identify challenges that clusters are experiencing that hinder them from progressing at pace. To understand whether these need a local or national solution and put actions in place accordingly.
2. To work with the National Programmes of unscheduled care, planned care and mental health to ensure an understanding of the contribution that primary care can make in these areas.
3. To socialise the Primary Care Model for Wales with key external stakeholders (such as social services, WLGA and the third sector) identifying areas of alignment.
4. To inform the Transformation Programme, Clinical Plan and Value Based Healthcare of the contribution of the Primary Care Model for Wales.

Outcome / Success criteria:

- Actions to remove barriers to cluster development.
- Increasingly profile of primary care in National Programmes to ensure alignment.
- Identified areas of alignment with external stakeholders that progress the place-based care approach.
- The Primary Care Model for Wales (and therefore clusters) included as a key component in other programmes arising from *A Healthier Wales.*

When will the project be delivered?

- Cluster development action plan endorsed - June 2019
- Milestones/completion dates for other deliverables to be produced as part of the 'Project Initiation Document' stage.

Jul

PTHB	**ABUHB**
Discharge to Recover and Assess North East Powys	Staff Flu vaccine incentives
Increased Therapy Input into Community and DGHs	Additional HCSW triage nurse - Additional Funding
Support Primary Care across Mid, South and North Cluster areas during the Winter	Additional band 5 Registered Nurse to support ED triage - Additional Funding
Increase Adult Social Care Capacity to assist Patient Flow	Additional Band 5 Registered Nurses ambulatory - Additional Funding
HALO (Shropshire & Telford NHS Hospital Trust and Wye Valley NHS Trust)	Additional pharmacy
Discharge to Assess Neville Hall Model	Extension of contract for additional senior manager support - Additional Funding
CTMUHB	Two WAST Band 6 paramedics 24/7 at Royal Gwent Hospital - Additional Funding
Stay Well @ Home Services	Elderly Frail Unit (EFU) assessment and streaming
Escalation Procedures and Control and Command	T&O capacity and step down
Maintaining GP Out of Hours Services	T&O Receiving Unit
Maintaining Elective Activity	Revised SAU model
Adverse Weather Plans	Additional Bed capacity acute and community care
Maintaining Patient Flow	Discharge and patient flow co-ordinators
Managing Demand at the Front Door	Additional site management support during the evening and twilights - Additional Funding
Phlebotomy Cover	Additional front door therapy support
Medical staffing by night	OOH Support for WAST Stack Allocation
Locum Consultants in Respiratory and Cardiology Services	Home First
Ward 7 New Model - Additional Medical Staff	Frequent attenders
Additional Portering Services	Care Home Step down capacity
Additional MTA Cover	Purchase of 20 Nursing Home beds - Additional Funding
Additional Administration Officers	Infection Control - Funding for IP nurses on call during winter period
Increased Weekend Scanning Capacity	Facilities infrastructure
Additional Pharmacy Cover	Workforce Incentives
Additional Administrative Officer in Acute Medicine Team	Clinical Practitioners in ED
Additional Receptionist Staff	Additional middle grade doctors to support across ED - Additional Funding
Additional Ward Clerk CDU	Community step up capacity
Intermediate Care Services	BCUHB
Residential Placements	Improved Flow

Additional Social Workers	Improved flow/ Safe care: Additional external improvement and change management support extended beyond the winter period.
CTMUHB Continued	**ABUHB Continued**
Domiciliary Care providers	Discharge: Commissioning of additional spot purchase capacity with the Independent Sector. Enhanced community support teams focused on Care Homes
Interim Placements - Care Homes	Demand management: Increase OOH provision at weekends supported by multi disciplinary staff
Additional Residential Placements	Improved Flow: Enhance admission and discharge team support (ADT) in ED
Additional Funding for Domiciliary Care	Improved flow: Additional therapy support staff including enhanced extended scope physios / NIV physio / therapy
CAVUHB	Discharge: Commissioning of weekend NEPTS Capacity to support 7 day discharge
Consultant Connect Implementation	Safety and resilience: Enhanced on call and site based clinical support over the winter period.
Therapies support at the front door	Improved flow/Safe patient care: In patient capacity to support site and community hospital escalation
Additional inpatient diagnostic capacity	Improved flow: Creation of pre-identified additional isolation capacity across North Wales. Provision of Local Rapid Testing for suspected Influenza
7/7 Therapies and support services	Admission avoidance
Point of care flu testing	Meds Management nurse to support the discharge of patients on IV therapy
Surgery co-ordinators	**SBUHB**
Dedicated General Surgery and Trauma SpR in the Emergency Unit	Surge capacity Singleton
Additional Surgical beds to maintain planned care activity	Development of patient flow team Singleton
Increase number of beds overnight in SAU	ANP for patient flow band 7 - Singleton
Flex beds in SSSU	Discharge vehicle - Singleton
HCSW Out of Hours & Transfer Team	Additional Phlebotomy support - Singleton
OOHS GP Clinical Practitioner	Additional portering - Singleton
GP OOHs Increase Triage Capacity	Creation of 10 Green to Go beds on Morriston Hospital site
CRT	Frequent Users Service (ED) - Morriston
Additional Discharge to Assess	Expansion of the Older Persons Assessment Service - Morriston
Paeditric Consultant in Childrens Assessment Unit (CAU)	Acute Cardiology Service - Morriston
Extend FOPAL UHW	ED Additional Winter staffing - Morriston

Extend Co-ordinators Working Hours - EU/AU	ED additional winter staffing - OT support - Morriston
Additional Nursing Support for MEACU	Additional Capacity - Additional Funding proposal
CAVUHB Continued	**SBUHB Continued**
UHL Flow Management	MRI additional mobile capacity- Morriston
Enhanced ECAS UHL	Additional ECHO diagnostic capacity - Morriston
Additional Emergency Unit Decision Makers	Respiratory CNS at the front door - Morriston
Outlier Team	Enhanced Medical workforce (Medicine) - Morriston
Replace Trolleys in MEAU	Enhanced nursing levels in ED - PoW
Additional Medical Consultant Ward Rounds	Enhancement of ENP service in ED - PoW
Therapies front door support	Increase staffing levels to support Medical outliers - PoW
inpatient diagnostic capcity increase	Flexible use of SSU/Bridgend Clinic for surge capacity - PoW
Consultant Connect	Daily cardiology inreach into ED and AMU - PoW
HDUHB	Pharmacy services
Increasing community service provision	Equipment for discharge - Neath Port Talbot
Acute Flow Additional Resources	ESD - frailty - NPT
delay in reducing the medical bed capacity as part of the operational effectiveness / turnaround plan	pre -weekend and/or weekend ward rounds in care homes to address urgent issues and avoid admissions - Primary care
Improved community flow	Morriston Hospital Community In-Reach Flow Co-ordinators- Primary care
Spot purchase of community care beds	GPs working in Minor Stream of ED / A&E - Primary care
Acute Flow Improvements	On site flu testing - Microbiology
Increased Medical IP Capacity in Surgical areas (additional beds)	Community Resource Team at A&E, POWH - Bridgend LA
Acute Flow Improvements - Cardiac transfers to ABMU	Convalescence beds - Bridgend LA
Acute Flow Improvements	Community Equipment - Bridgend LA
Increasing community service provision	Swansea Community Equipment Service - Swansea LA
Spot purchase of community care beds	Non-weight bearing pathway - Bonymaen House- Swansea LA
Increasing community equipement	OT agency costs for the Plas Bryn Rhosyn beds for 14 weeks . NPT LA
Improved community flow	Community Wellbeing Officer - NPT LA
GP OOH capacity - on 111 tel service	Surge Capacity NPT Hospital
Point of care flu testing	Additional ED staffing at times of peak demand - Additional Funding proposal
Acute Flow Improvements -out of hours	

Acute Flow Improvements