SUMMARY REPORT	ABM University Health Board

ABMU Health Board	**Date: 25th May 2017** **Agenda Item: 3 (i)**

Subject	**Primary and Community Strategy**
Prepared by	**Hilary Dover Director Primary and Community Services** **Dr Alastair Roeves, Unit Medical Director Primary and Community Services**
Approved by	**Siân Harrop-Griffiths Director of Strategy**
Presented by	**Hilary Dover, Director Primary and Community Services**

Purpose

To present the draft Five Year Strategy for Primary and Community Services for discussion and to receive comments.	**Decision**	
	Approval	X
	Information	X
	Other	

Promoting and Enabling Healthier Communities	**Delivering Excellent Population Outcomes**	**Demonstrating Value and Sustainability**	**Securing a Fully Engaged and Skilled Workforce**	**Providing Effective Governance and Partnerships**
x	**x**	**x**	**x**	**x**

Executive Summary:

The Strategy aims to be aspirational and vision setting and sets out the direction for a range of services for the next 5 years. The development of the strategy has engaged with the local population, contractor services (including GPs, Dentist, Pharmacists and optometrists), community nursing, integrated care teams, Hospital Units, Mental Health and Learning Disability Services, Local Authorities and Third Sector services to seek views and to determine priorities.

The Strategy sets out our ambition and provides an overarching direction for primary and community services operating within the wider Health Board context. The document cannot summarise everything we aim to do over the next five years but represents the outcome of the discussions that have taken place to date with stakeholders, provides a background to the current services, looks at the challenges ahead and aims to provide a vision for the future. It recognises that the status quo is no longer an option.

Key Recommendations

The Health Board is recommended to:

- **CONSIDER** the Draft Strategy
- **APPROVE** the Draft Strategy for implementation

Next Steps

The Strategy will be shared with the wide range of stakeholders who have provided feedback and comments throughout the engagement process. Once agreed the final document will be made widely available. On approval, a detailed implementation plan will be developed which will support the Primary and Community Services Unit and the Health Boards IMTP.

MAIN REPORT		ABM University Health Board
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Approved by	**Siân Harrop-Griffiths Director of Strategy**	
Presented by	**Hilary Dover**	

1. Purpose

Primary care and community services are a fundamental part of the ABMU Health Care system and creating a sustainable future for these services is a high priority. The draft Primary and Community Strategy sets out the direction for a range of services for the next 5 years.

2. Background

The Health Board has recognised that the status quo of provision of primary and community services is no longer an option. In the face of rising demand and austerity the traditional model of services provided will have to change if the challenges of preventing ill health, easier access to healthcare and the rising demand of complex technological healthcare are to be met. 90% of care takes place in the community and there are good opportunities to influence, change and improve models of care.

Whilst the Health Board has a clear strategic intent to strengthen primary and community services it Health Board has not previously had a strategy for primary care and community services. However, with the growing maturity of the new clinical and management structures within the Health Board it is felt to be the right time to ensure that the priorities for these services and the recognition of the important role they hold in the wider health and social care environment are clearly articulated. The development of the strategy has been led by the Primary and Community Services Unit which has engaged with key stakeholders over the last few months to bring together views to inform the direction of travel for primary care and community services over the next 5 years. The strategy aims to be aspirational and vision setting and provides a direction of travel for services delivered in the community.

3. Approach and Timelines for the Strategy Development

Recognising that primary and community services are so broad and cover such a significant element of care, the Unit has sought to develop the Strategy through a highly engaged approach. The main timelines are set out below:

February/March

Shared understanding, sought views and further developed the scope of the strategy through workshops and meetings held:

- Primary and Community Services Workshop
- Executive Strategy Group
- Primary Care Development Board
- Cluster Network Meetings
- Local Medical Committee
- Staff Side
- Senior team meetings with other Units
- Patient and Carer groups
- Third sector services
- Local Authorities
- Community Health Council

Literature review, review of alternative models of care

Mid-March

- Developed the draft strategy based on feedback/discussions held, co-produced with patients and carers

End March

- Primary Care and Community Services workshop held for all stakeholders to feedback key findings to check understanding and to feed into the strategy to further shape the draft.

April 2017

- Presented the draft Primary and Community Services Strategy to the Executive Team and changes made following feedback received.

May 2017

- Presented the 'vision' to staff at the Primary and Community Services Team brief and further comments received to update the final draft.
- Provided a verbal update on the progress of the the draft Primary and Community Services Strategy to the Executive Strategy Group.
- Present final draft to the Health Board meeting.

June 2017

- Make required changes to the final draft.
- Share the final version with stakeholders
- Develop a detailed implementation plan with a clear communications plan and key milestones and share widely.

4. Scope of the Strategy

This strategy describes the development of primary care and community services across Bridgend, Neath Port Talbot and Swansea for the next five years. There are huge challenges to provide healthcare to a growing population, which is living longer with complex needs, whilst at the same time addressing issues in preventative healthcare and maximizing the opportunities available in the community.

The Strategy outlines:

- The vision for Primary and Community Services
- The strategic and policy context
- An outline of new models of care (including outcomes from Pacesetters in Wales, Cluster developments and integrated models of care)

The Component elements address the future of primary and community care in relation to:

- Improving Patient Access
- Workforce
- Quality
- Information Technology
- Estates.

5. Key Benefits

A significant range of benefits have been identified if the strategy is delivered. In developing the implementation plan, these benefits will be quantified to support ongoing measurement and reporting.

The benefits to patients & carers will be:

- Improved outcomes of care
- Wider range of services offered close to home
- Standardised service provision, doing only what is necessary
- Consistency of delivery
- Greater continuity of relationships
- Seen/treated by the right person at the right time
- Ensuring local needs addressed
- Streamlined, easily accessible services

To clinicians will be:

- Working at upper end of licence
- Greater support to teams
- Enhanced learning opportunities
- Greater continuity of relationships
- Improved communication

To the Health Board will be:

- Improved outcomes for our patients and citizens
- Quality Standardisation and more appropriate benchmarking
- Greater value for money
- Sustainability improved
- Prudent delivery

5. Recommendations

The Health Board is recommended to:

- **CONSIDER** the Draft Strategy
- **APPROVE** the Draft Strategy for implementation

Abertawe Bro Morgannwg
University Health Board

THE PRIMARY AND COMMUNITY STRATEGY 2017-2022

A vision for a vibrant and sustainable future for primary and community services

Contents **Pages**

Our Values

'Caring for each other, Working together, Always improving.'

Our Values are important. They define what we do and how we should do it. They should be as true now as they will be in 5 years, when this strategic vision is achieved.

Executive Summary

This strategy document sets out our ambition and provides an overarching direction for primary and community services operating within the wider Health Board context. The document cannot summarise everything we aim to do over the next five years but represents the outcome of the discussions which have taken place to date with stakeholders, provides a background to the current services, looks at the challenges ahead and provides a vision for the future. It recognises that the status quo is no longer an option. In the face of rising demand and austerity, the model of general practice and delivery of community services must change if the challenges of preventing ill health, easier access to healthcare and the rising demand of complex technological healthcare are to be met. There are significant opportunities afforded to implement some radical changes to the delivery of primary and community services through: changing roles, changes in technology to provide more care closer to home, integration and joint working across partner agencies and maximizing the use of community assets. The strategy discusses initiatives designed to improve provision in a number of key areas and has been designed under the overarching principle of delivering safe and effective health services which patients value and trust.

The aim is that staff will be working in practices and services that they are proud of, delivering care to patients in truly integrated teams. The key components of the strategy are:

Improving patient access: The strategy proposes the delivery of primary and community care at scale through the development of a seven-day access model via primary care 'hubs'. The hubs will need to be slightly different across the three counties but core components and standards of access will be the same across each. The model sees a full range of clinical and social care practitioners including nurse practitioners, clinical pharmacists, therapists and health scientists, and community paramedics working more closely with GP practices, releasing more GP time to deliver care for complex patients. More people currently receiving oral health care in hospital settings will be able to access general and specialist services in the community with an environment encouraging a more preventive care approach.

Workforce: The strategy considers this a key area for development and seeks to blur the traditional healthcare professional boundaries. GPs will have a clear understanding of their role in the future and there will be new innovative roles for other health and social care professionals working closely alongside GPs. This will create more capacity to look after patients in the community, provide continuity of care and timely access. There will be an emphasis to further develop enhanced skills

and roles for dental care professionals and general dentists, therapists and health scientists.

Quality: The current pressures on General Practice and community services need to be addressed. Focusing on a smaller number of substantial change programmes may be the key that is needed to unlock the required transformation. Another important aspect of our strategy is to take active steps to improve the quality of patients' experience by ensuring we are more pro-active in identifying and meeting the cultural, language and mobility needs of patients who need our help.

Information Technology: Joined up communication between different healthcare providers and the wider social care system is of critical importance to an integrated healthcare model. Significant work is being undertaken to develop a digitalisation strategy that aims to eradicate waste, reduces duplication, and maximises the time spent by GPs and other health care professionals with their patients. The introduction of e referral systems will help to transform care pathways e.g., oral health and eye care pathways.

Estates: Operating under the banner of 'first class buildings for world class services' the strategy seeks to develop and deliver a physical environment that matches the service aspirations of the future.

The Abertawe Bro Morgannwg University Health Board (ABMU) population has benefitted from a strong primary care provision across its 72 GP practices and 77 dental practices. ABMU GPs have long been leaders in primary care development, innovation, education and research. For the last few years, there has been a growing culture of collaboration between practices and with the wider health care system through Cluster Networks. In addition, ABMU Health Board has the only two dental contract prototypes in Wales.

FORWARDS:

Andrew Davies

Chair, ABMU Health Board

I very much welcome and support the development of our Primary and Community Strategy. I recognise the significant difficulties and challenges facing primary care across ABMU Health Board as well as the opportunities we have within our grasp. I also recognise that as an integrated health care organisation we need both a clear vision for primary and community services and also a plan on how to deliver that vision for the benefit of the citizens and communities we serve.

We are serious about change in order to deliver the vibrant, sustainable, high quality primary and community services we all aspire to and that the population of Swansea, Neath Port Talbot and Bridgend deserve. As Chair of the Health Board I recognise that providing great care comes down to a combination of many factors, many of which are complex, and as a health board we are wholly committed to supporting services in the community to deliver the vision outlined in this strategy

Alex Howells

Interim Chief Executive, ABMU Health Board

Primary and community services are the foundation of health care delivery in the NHS and the key to a sustainable service for the future. The particular health challenges we face mean that it is essential we bring care closer to home, support patients to play an active role in their own care and health conditions, and prevent avoidable use of hospital, institutional or specialist care. The need to develop and strengthen primary and community services was a key driver for the establishment of integrated Local Health Boards, and has long been embedded as a central tenet of our clinical strategy 'Changing for the Better'. I welcome this specific strategy for primary and community services which I am confident, will help us make a reality of our vision for the future, through innovative and creative development of new models and ways of working which we have tried and tested. We have some excellent examples of new approaches and successful improvements, supported by excellent local leadership and fantastic commitment from staff. We want to see this grow and expand. We are confident that this is not just a catalyst for new models of primary and community services which can help address the immediate challenges and pressures, but should also act as a catalyst to stimulate the transformation of pathways into and out of hospital services. It needs to be an integrated part of our strategy for the future.

1. Introduction

The aim of our five year strategy is to make a positive difference to the people that come into contact with our services. It has been informed by feedback from staff, patients and other stakeholders. This strategy outlines the development of primary care and community services across Bridgend, Neath Port Talbot and Swansea.

Primary Care is the foundation stone of the NHS in Wales. As many people's first point of contact with the NHS, around 90 per cent of patient interaction is with primary care services (**http://content.digital.nhs.uk/primary-care)** these services therefore have the ability to be leading care and change.

The Strategy is written in the context of The Social Services and Well-being (Wales) Act, which came into force on 6 April 2016. The Act provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales. It also recognises the influence of the Wellbeing of Future Generations Act, which is about improving the social, economic, environmental and cultural well-being of Wales. The Act requires public bodies to think more about the long term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach to do things in a more sustainable way.

To respond to the requirements of the Act and to ensure maximum involvement with stakeholders, the development of this strategy has involved a wide range of people. By involving people in helping to set the direction of travel, we have aimed for the strategy to take into account the impact changes could have on people living their lives in ABMU Health Board area in the future. This has included being aware of the Well Being of Future Generations Act requirements to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place

"This strategy sets out the direction in clearly defined areas of care provided to the population. It is underpinned by the continued commitment to improve outcomes across the age spectrum meeting all current and future Welsh Government and Public Health Wales aims regarding reducing inequalities and improving health for all working collaboratively with Public Health Wales.

We will achieve this via a rights based approach in line with the Health Board's Children's Charter by robust and prudent delivery of the early year's agenda via the Health Visiting and School Nursing Services in line with the Healthy Child (Wales) Programme (2016) and the refreshed School Nursing Framework (2017)."

2. The Case for Change

ABMU Health Board covers a population of approximately 500,000, making up around 17% of the total population in Wales. The population is projected to increase by approximately 42,000 people (8.1%) between 2013 and 2036. The biggest increase projected is in the older age bands with the over 85 population predicted to more than double by 2036. An ageing population is likely to represent a significant increase in the demand for health and social care services.

An increasing overall population will mean an increase in the demand and need for health care, putting pressure on already limited resources (JSNA 2013). (http://www.wales.nhs.uk/sitesplus/863/opendoc/224685)

- ABMU Health Board has a growing and ageing population with increasing numbers of people experiencing dementia and chronic conditions.
- Life expectancy continues to increase and the inequality between male and female life expectancy is getting smaller
- As our population gets older more retain their teeth longer and their mouths become affected by wider general health problems. These place different pressures and demands on services
- As our population gets older and advances in health technology increase the demand and complexity of care also increases.
- The chances of living a long life in good health vary across the ABMU Health Board area and are linked to levels of deprivation
- ABMU Health Board area can be split into 327 areas called Lower Super Output areas (LSOAs). In ABMU Health Board areas 83 out of the 327 areas are ranked as the most deprived 20% areas nationally
- On survey measures of personal well being ABMU Health Boards population score similar to the Wales and England averages
- The health assets of our communities are strongly associated with deprivation.

2.1 Children and Young people

It is now increasingly realised that a large body of work is required by a wide range of professionals within health and social care to prevent the descent into ill health. That descent starts very early in life.

The rate of low birth weight babies is 1.7 times higher in our most deprived communities compared to our least deprived communities. Infant mortality rates have stabilised in recent years. ABMU Health Board has higher levels of overweight and obesity in children aged 4 – 5 years. The Health Board has seen an increase in the uptake of routine vaccinations for children aged 1 – 5 years however; the uptake of routine childhood vaccinations is lower in our most deprived communities.

Poor oral health starts early in childhood. In ABMU Health Board, nearly 1 in 5 of 3-year-olds have at least one tooth affected by decay. Good oral health impacts on wellbeing and can be an indicator of poverty as well as uninformed parenting, general hygiene, diet and lifestyle. It can also reflect the impact of common health

risk factors and can be the first manifestation of systemic disease. Poor oral health impacts on readiness for school as well as absenteeism, employability, sickness rates, obesity, self-esteem and wellbeing. Poor oral health can place significant pressure on health and social services e.g. the most common reason people contacted the former NHS Direct Wales and new 111 service in the ABMU area is due to dental pain.

3. The Policy Context

'Our Plan for Primary Care Service for Wales' up to March 2018, published by Welsh Government in November 2014, set out the vision for primary care at the heart of the NHS, driving transformational change and ensuring patients' needs are met through a prudent approach to healthcare.

The Nuffield Trust produced a report entitled 'Securing the future of general practice' (2013), which has made a number of important points:

- 'Primary care is under significant strain. GPs and their teams are caught on a treadmill of trying to meet demand from patients whilst lacking time to reflect on how they provide and organise care.'
- 'New models of care organisation are emerging organically in some areas to meet the challenges facing primary care.'
- There is a need to 'balance the benefits of organisational scale with preservation of the local nature of general practice.'.
- Whilst the ability to extend the scope and scale of primary care is important, no one organisational model of primary care should be advocated.'

Local context will play an important role in determining organisational form and the precise mix of services will depend upon the nature and priorities of the local population. It is inevitable that practices will need to work in federations, networks or merged partnerships in order to increase their scale, scope and organisational capacity. However, patient outcomes need to be the same regardless of how the services are delivered.

Change at this level will require support and incentives, as well as permission for GPs and other primary care practitioners to test out new approaches to the delivery and organisation of care. It is likely that the pressure to change how primary care is delivered will persist into the future, and determine the speed of travel.

This is echoed in the Royal College of General Practitioners (RCGP) 2020 Vision for Primary Care document that outlines six steps in an action plan for primary care.

1) Promote greater understanding of the value that generalist care brings to the health service
2) Develop new generalist – led integrated services to deliver personalized cost effective care
3) Expand the capacity of the general practice workforce to meet population and service needs
4) Enhance the skills of the general practice workforce to provide complex care

5) Support the organizational development of community based practices, teams and networks
6) Increased community based academic activity to improve effectiveness, research and quality.

The 'Emerging model of Primary Care', written by Dr Jane Harrison in 2016/17., came about through the evaluation of pacesetters across Wales. The new models include super practices, cooperatives, corporate partnerships, social enterprises, limited companies and federations – with differing levels of integration, staff employment, contractual arrangements, economies of scale, financial control, flexibilities and internal support mechanisms.

'Delivery of care through cluster networks is a key component of the new approach with the mature cluster providing holistic care for their community by offering a range of generalist skills in house and bringing specialist skills into the team when needed. The model supports coordinated care for the entire population, making referrals only when necessary and returning people to the care of the primary care team as soon as possible. New professional roles, therefore, have the potential to not only contribute significantly to the sustainability of primary care, but also to impact on the unprecedented demand and pressure on unscheduled and scheduled care services in the acute setting.' (Berwick 2013)

In the development of this strategy we have involved patients through engagement and hearing their voice, have engaged staff to ensure that they have been able to improve the services and environment in which they work and have aimed to embrace transparency in the service to trust and the growth of knowledge.

'Together for Health: A National Oral Health Plan for Wales' (2013-18) described the priorities for oral health services in Wales and was reflected in our Local Oral Health Plan (2013). Our strategy will also be informed by a new national Oral Health Plan which is due to be published in 2017/18 and is likely to stress the importance of developing options to reform the primary care dental contract, revising dental pathways and increasing connectivity and implementing e-referrals. In the interim, the 2017 Welsh Government's publication 'Strengthening and refocusing the national preventive programme 'Designed to Smile' seeks a shift towards improving oral health in younger children and integrated work with dentists and other health professionals.

The health and wellbeing of children will be promoted through the Healthy Child Wales Programme (HCWP) - the universal health programme for all families with 0 – 7 year old children. It will include a consistent range of evidence based preventative and early intervention measures, and advice and guidance to support parenting and healthy lifestyle choices. The HCWP sets out what planned contacts children and their families can expect from their Health Boards from maternity service handover to the first years of schooling. These universal contacts cover three areas of intervention: screening, immunisation, and monitoring/supporting child development.

4. The Strategy

This strategy describes the development of primary care and community services across Bridgend, Neath Port Talbot and Swansea for the next five years. There are huge challenges to provide healthcare to a growing population, which is living longer with complex needs, whilst at the same time addressing issues in preventative healthcare and maximizing the opportunities available in the community. It is equally important that, particularly in an area of relatively high deprivation, that we are ensuring that children have a healthy start in life, beginning with the education and support to their parents at individual and population level before they are born. Patients and carers are also rightly expecting more from their NHS. Our strategy must fit the over-riding principles of delivering safe, effective and sustainable health services that patients value and trust. The strategy recognizes the need to meet the considerable recovery and sustainability challenges that the Health Board faces.

Services within primary care are traditionally provided through General Dental and Medical Practitioners [GPs], Opticians and Community Pharmacists who are independent practitioners, and the staff they employ. Community services are directly managed by the Health Board and cover a range of public health and community nursing, community hospitals, therapy and health science services as well as specialist dental services in the community.

It is recognised that the problems facing primary and community services are significant with difficulties in recruitment and retention of GPs and members of the community teams. Individual practices or community teams will not be able to solve these problems alone. However, there are also opportunities emerging.

We intend to scale up and integrate primary care and community services working across the three counties to meet the needs of the population to:

a) improve outcomes

b) achieve efficiencies and

c) provide responsive care that meets the needs of the population.

(For a description of how services may look in five years' time see Annex 1)

In ABMU Health Board the community nursing teams have identified six priority areas for the strategy

1. Maximising health and wellbeing
    - Providing comprehensive early years support to increase health literacy across our communities
    - Leading care nearer to home
    - Leading an holistic assessment and providing care in any community environment
    - Co-production with individuals and across clusters

2. Working with people to provide a positive experience
    - Identifying the need for early help and managing crisis intervention
    - Using the relationship as a therapeutic tool

- Leading transition between care settings and championing discharge from hospitals
- Measuring impact of service delivery through feedback

3. Delivering care and measuring impact
    - Use professional expertise and business acumen to influence and direct commissioning of care
    - Use population and benchmarking/best practice data to inform delivery of services
    - Always use the evidence base to report outcomes
    - Identify and measure harm to improve service delivery

4. Building leadership
    - Empowerment through role models and supervision
    - Maximising use of technology to support care at home and mobilise the workforce
    - Using all opportunities to develop care skills across the whole workforce regardless of setting or employer
    - Proactively protect and advocate for the vulnerable and safeguard to prevent harm

5. Right staff in the right place
    - Multi-agency development of teams
    - Skill sharing and development of trusted assessor roles
    - Integration to support people to navigate through care systems
    - Development of advanced practice skills across the workforce

6. Positive staff experience
    - Growing the workforce through models of apprenticeship
    - Developing the workforce with mentorship and supervision
    - Providing excellent practice placements for students at all levels across all disciplines (Annex 2)

In 2016/17 we were successful in achieving funding for seven pacesetter projects to be undertaken which allowed us to implement and evaluate changes in primary and community services. This knowledge has been enhanced by the evaluation of other pacesetter models across Wales. The learning from the evaluation has been modelled into an 'Emerging Model for Primary Care for Wales.'(Annex 3) Groups of practices working closely together in Cluster Networks have already demonstrated that real progress can be made. Cluster Networks are delivering innovative front line services, with widening of primary care and community service teams offering new roles for nurses, clinical pharmacists and community paramedics working closely with GPs. These projects are often enabled by integrated clinical IT systems and workforce development programmes.

ABMU Health Board is the only Health Board in Wales where the dental contract prototypes exist and these are now informing the development of contract reform throughout Wales.

Supporting the strategy will continue to be the implementation of the Health Board's six strategic aims. The focus for primary and community services within the ABMU Health Board is to:

- Work with partners to support individuals to achieve and maintain the best level of health across the lifespan by facilitating the best start in life, reducing inequalities and increasing immunization rates
- Ensure the delivery of excellent, safe, sustainable primary and community services across the whole Health Board area to ensure excellent patient outcomes and experience.
- Support the delivery of accessible and sustainable services closer to patients' own homes and communities
- Ensure that the workforce delivering care is of the right number and have the right skills for people in the right roles.
- Ensure that services are delivered within a strong governance framework providing assurance to our citizens, Board, partners and Welsh Government that we are using the resources allocated to us to best effect.
- Put patients at the health of service delivery; working with patients and carers to promote self-care and support the maintenance of independence for as long as possible through integrated service provision.

5. Our Vision

In five years, we expect that there will be key benefits for our patients and for those delivering services:

Always Caring:

- Patients and carers will feel heard, feel cared for, and feel **happily independent** and have access to the appropriate tools and information to promote and maximise self-care.
- **People will achieve health and wellbeing** with the public, patients and professionals as equal partners through **co-production**. Health Board professionals will **care for those with the greatest health need first**, making the most effective use of all skills and resources. We will **do only what is needed**, no more, no less; and **do no harm**.

Working Together:

- Clinicians will be working in **sustainable, effective and efficient practices/teams** of which they are proud, delivering care to patients in a wider truly integrated team; always listening, always caring, and always improving.
- General Medical Practices will be working together in **cluster networks** integrated with care teams from the community, secondary care, social care and the third sector - as well as with primary care optometry, community

pharmacy and dental colleagues - so that people feel they can access care which is appropriate to their need and which is well coordinated.

- **New structure and workforce models** will be in place to allow clinicians to spend more time with their patients, with greater continuity of care and high quality care for their patients.
- The services will be delivered in line with **Prudent Healthcare** Principles to ensure the cost effectiveness of service change is measured and maximised
- All this will be underpinned by a **shared clinical record** with an integrated health and social care record, and appropriate 21st century digital technology.

Always Improving

- We will have **reduced unwarranted variation** using evidence-based practices consistently and transparently. In times of severe financial challenge, patients, carers and professionals will be confident that every pound that is spent on health care in our area is spent on **the type of care agreed because it most likely to be of benefit to them**.

Cluster Networks

The benefits of building integrated health and social care services around the patient on a population base of around 30-50,000 has been espoused in Wales for a number of years. Great progress has been made but the pace and effort needs to accelerate to achieve the vision espoused then, and ever more urgently needed now.

In five years, patients will receive services in the community from individuals who are part of teams that are organised at cluster network level. This will provide the economy of scale, wider range of professionals needed and sustainability of community services. However, within that cluster network, there will be micro-teams that work around the patient and allow greater continuity of valuable relationships between professionals, and the professionals and patients.

The 11 **cluster network teams will be the default unit for planning, managing and delivering community services**. New services will be delivered on the basis of these cluster networks, however where these services can only be delivered at a larger footprint, cluster networks will work together to ensure the service is delivered safely, effectively and sustainable. This may mean that two smaller cluster are merged to form a total of ten Clusters Networks.

The benefits to patients & carers will be:

- Improved outcomes of care
- Wider range of services offered close to home
- Standardised service provision, doing only what is necessary
- Consistency of delivery
- Greater continuity of relationships
- Seen/treated by the right person at the right time

- Ensuring local needs addressed
- Streamlined, easily accessible services

To clinicians will be:

- Working at upper end of licence
- Greater support to teams
- Enhanced learning opportunities
- Greater continuity of relationships
- Improved communication

To the Health Board will be:

- Improved outcomes for our patients and citizens
- Quality Standardisation and more appropriate benchmarking
- Greater value for money
- Sustainability improved
- Prudent delivery

Resilient Communities

Working closely with Local Authorities and Education Authorities, Housing Associations, Police, third sector, public health and voluntary organisations, we will work in partnership to **create resilient communities** that will support citizens to build and strengthen wellbeing. This will help reduce the risk of ill health and **reduce the need to access statutory health and social care services**.

We will build on the **community assets** that already exist to help keep people from becoming patients and to enable them to have the best outcomes. However, when citizens need more, we will build **support and reference groups** for patients and carers **to help citizens to keep control and responsibility for maintaining their health**. We will support the development of **online health apps and websites** that empower and activate patients to take control of their condition. This includes supporting patients to access their own **online medical records**.

Care Closer to Home

When this is not enough, patients will be able to access services as close to their homes as possible where this is safe and appropriate. The Health Board will design and deliver services using the new structures and organisations that are developing in the community. This may mean that **health and social care professionals and other partners** e.g. Third sector partners, Housing and volunteers work with patients in their home, GP Practices, community pharmacies, dental surgeries, high street opticians, venues in their neighbourhoods (in 'cluster networks') such as health or resource centres, schools, leisure centres or hospitals.

We will deliver some health services, previously only accessed in hospitals, in the community. This **transfer of traditional secondary health care to a community setting** will occur only where this is safe and cost-effective to do so, and without destabilisation of existing primary care services. This may mean that some of these services will be delivered in the community across groups of cluster networks.

These services will be designed and managed to ensure they are **safe, effective and sustainable**. This may mean services are delivered by larger providers formed from the merger of existing bodies, e.g. a merger of several small GP practices, or new organisations formed by formal collaborations, e.g. a GP Federation providing services to a cluster of 50,000 patients. Patients will be able to access a wide range of **primary care services 24 hours a day, 7 days a week where there is a demonstrable patient demand or need**

During the time frame of this strategy, the implementation of several major national initiatives will change the focus of **community pharmacies** in a way that will support the new vision for primary and community care and the cluster working concept. The community pharmacy contract is, from September onwards, moving from an item-based dispensing model to be more focused on provision of specific services and outcomes, requiring collaboration within cluster networks. This is likely to be supported by a Welsh Government requirement (first raised in the Public Health Bill proposed in 2015) that pharmaceutical health needs assessment needs to be undertaken to ensure where and how services are commissioned reflects health rather than business needs. In the interim, the Wales-wide roll out of the Choose Pharmacy IT platform will support these and other changes, such as Common Ailments enhanced Service that will provide good opportunities to create a more integrated primary care model.

Early Years

We know that **investment in the early years of life** can have a significant impact on health, social and educational development. Working in **close collaboration with our colleagues in local authorities, communities, education and the third sector** we will work to address health inequalities by utilizing the opportunities that arise through the Healthy Child Wales and Flying Start. We will **support parents and communities** to prepare children for school and maintain the delivery of key public health messages throughout the school years and during transition into adulthood.

Our early years focus will be on encouraging proactive identification of those who are vulnerable and at risk to reduce the harmful effects of adverse childhood experiences. We will also focus on understanding the needs of the different sections of the child population and their families in order to **strengthen early and easy access from primary care into specialist services** when appropriate. This will be underpinned by a better understanding of how children and their families use the healthcare system. Working with children and their families to design and improve the quality of services we aim to provide the **right support to children and their families** to enable them to make long-term health enhancing choices

Place-based Care

The Health Board will recognise the benefits of providing '**place-based services'** rather than profession-centred services with a 'fortress mentality'. Patients will experience **seamless care** provided by a few professionals, instead of multiple providers working without coordination. This means that health and social care

professionals will work in **closely integrated teams**, using pooled resources, under shared management and agreed governance. As a result, the **right care will be provided, at the right place, at the right time and by the right person**. We will work with colleagues in social care to identify joint initiatives where we can bring together our expertise to **keep people well and out of hospital for longer.**

New ways to contact a Clinician

When required, **patients will be able to contact an appropriate primary healthcare professional in a timely manner.** This maybe by speaking to a GP or nurse over the telephone using NHS111, GP Out-of-Hours, the ***Telephone First*** **access model** for in-hours General Practice, or *Skype*/*Facetime* **video consultations**. Patients will also routinely use online services, such as *Patient Knows Best,* or a mobile phone App or an online website algorithm, such as *askmygp.com*. All practices will provide **online appointment booking** and online or centralised repeat prescription requesting. Respecting the busy lives our patients lead, we will only cancel appointments where it cannot be avoided. **Continuity of relationship** between patient and professional will be a challenge with the wider range of access and professionals, and services will be expected to maximize continuity.

Clinicians doing what they do best

Health Care Professionals will work at the top of their license, by practicing to the full extent of their education and training, instead of spending time doing something that could be effectively done by someone else. The Health Board will support professionals through training to extend their roles to be able to provide **more personalized care to patients**, such as through non-medical prescribing qualifications. We will support creation of dedicated **clinical care pathways** allowing professionals and patients to know what is expected at any point in the patient journey, especially with chronic conditions. GPs will receive prompt **advice and support from specialists** if they need it using secure electronic communication or by telephone.

Health and Social Care professionals will work in **multi-disciplinary primary care and community teams** whose membership is far wider than at present. For example, a team may include doctors, nurses, dentists, health care support workers, pharmacists, physiotherapists, occupational therapists, social workers and social prescribers, as well as the existing strong links to geographically/cluster-based community staff such as midwives, health visitors, therapists, mental health support teams, and third sector employees and volunteers.

The Health Board will strive to maintain **meaningful personal relationships between GPs and community service professionals, such as District Nurses**, therapists and health scientists, whilst recognising the economies of scale needed to **ensure continuity of an excellent sustainable service over a geographical area**.

Strong and effective leadership of these multi-disciplinary teams will be essential. These teams will be led by the most appropriate professional lead. The Health Board will develop these leadership skills in the workforce. As a result of GPs being able to

delegate, signpost or transfer responsibility for tasks to other professionals, **patients with complex needs will be able to have longer consultations with their GPs.**

Vulnerable Groups will particularly benefit from this coordinated and planned approach by the team.

- The **health and wellbeing of children** will be promoted, through the Healthy Child Wales Programme, with public health nurses and practitioners playing key roles alongside Flying Start and local authority and educational colleagues.
- The **health and wellbeing of young people** will also be addressed, especially through improved access for appropriate local mental health and sexual health services.
- **The residents in care homes** at risk of avoidable admissions to hospital, will receive enhanced care provided by GPs and multi-disciplinary teams supported by Community Resource Teams
- **Carers' needs** will be will be considered and where possible addressed, as their essential and growing role in delivery care and support is continually acknowledged.
- **Those patients who frequently attend** primary and secondary care services, or ambulance services, will be identified and offered sensitive and personalised support, which may include mental health support.
- **People with long term conditions** will receive more specialised care in the community and will be able to agree **personalised care plans** in a form they can readily access. For example; people with **type 2 diabetes mellitus and chronic respiratory diseases**, such as asthma and Chronic Obstructive Airways Disease (COPD), will have access to trained clinicians based in the community rather than travel to hospital.
- **The population in prisons** will receive health care of the same standard as if the prisoners were in the community.
- **Asylum seekers** will receive enhanced primary care services where necessary to address any extra need
- **Traveller Communities** will be have services delivered without discrimination
- **Patients at the end of life** will have their wishes and preferences for type and place of care acknowledged and respected through **advance care plans shared with clinicians and care givers**.

Quality Improvement

With our partners we will **be recognised as a leading provider of primary and community care**. We will actively seek **feedback from patients and carers** on their experiences and outcomes achieved from contact with our services.

The Health Board will promote a **culture of continuous learning**. We will systematically measure how well our services are meeting the needs of our patients and communities. We will actively encourage professionals to provide feedback on their level of engagement in their workplace. **Quality and safety will be the responsibility and priority of every member of staff** – both clinical and non-clinical – and we will have a clear set of measures for ensuring that we deliver high quality care across every service. Using the data from patients, staff and services, we will use **continuous quality improvement methodology** to change the design and delivery of services to increase quality and safety, ensuring lessons learned are systematically shared to minimize the risk of repeating mistakes.

Building our Futures with Partners

We will work with partners to maximise the use of co-located services from a wide range of community assets and where needed we will seek to **design and build new buildings** to provide accommodation for the larger provider organisations that will be required to deliver the wider range of services in the community. Where possible we will work with local authorities, universities and third sector organisations **to co-locate services**, e.g. as in the planned **ARCH Wellness Centres** and Villages. Where a new build is not feasible, we will improve premises to ensure safe, effective and healing environments exist for patients and professionals. People who cannot currently access primary or community services in the community because of mobility, sensory or other disabilities will have their requirements acknowledged and addressed, avoiding the need for unnecessary hospital attendances.

We will actively promote the ABMU area as an ideal place **to train, work and live** as a student or qualified professional. We will facilitate **recruitment** to hard pressed professions, such as GPs and District Nurses, and support schemes to incentivise **retention** of professionals, such as portfolio careers and fellowships. We will support Swansea University in the development of a **Primary Care Academy**, and specialist training pathways within medical degree programmes.

As a University Health Board, we will **promote academic research** in primary care and community services in collaboration with local universities. We expect to publish our innovative services and developments, and **disseminate our learning** nationally and internationally.

6. Components of the Primary and Community Strategy

These sections address the future of primary and community care in relation to access, workforce, quality, information technology and estates, underpinned by these principles:

- People living longer, healthy lives independently at homes for as long as possible, with their complex needs addressed

- Emphasis on health promotion, patient responsibility, self-care and self-management, and avoidance of professional creating dependent relationships
- Sustainable workforce, higher staff satisfaction, spending more time with patients
- Making the most of our resources, sharing whenever possible between organisations, creating a sustainable future for health and care delivery
- Continuity of care, better access, experience, and high quality delivery of care
- Delivery of the strategy's objectives will be monitored through the development and implementation of a detailed, outcome based action plan
- The Primary and Community Services Unit must become functionally more dynamic – with increased flexibility and speed to respond to the continually changing health and social care environment, especially in recruitment and retention of the workforce.

6.1 Access to Services

Traditional access to GPs has involved physically going to the surgery and waiting in the queue to see a GP, or repeatedly telephoning to speak to a receptionist. Many patients complain that they feel that have to fight to get an appointment. Many practice appointment systems are still based on a 'shop front' model of general practice where the only clinician was the GP. This model is outdated and does not reflect the wide range of professionals and wide range of treatments now available in modern primary care. Practices are able now to operate different models of care which will reflect the needs of their registered populations.

The RCGP has stated that we need to exercise care when trying to develop a simple definition of access as this can imply that there is only one model of GP access when we know that there are a number of models being used. However, good access is recognised widely as having three essential components:

- Timeliness
- Accessibility (including language and mobility issues)
- Quality Service

Patients will not be satisfied if at least one of these features is unsatisfactory. For example, a person with hearing problems will not be satisfied with a good practice offering same day appointments if the *only* way to book an appointment is by telephone. Alternatively, a GP walk-in service, sited close to the home of a patient with diabetes, is unsatisfactory if the GP is unskilled in managing that long term condition. There is also a need to ensure we secure greater compliance with the Welsh Government requirement[18] that our services can be 'actively offered' through the Welsh language rather than wait for a patient to ask to be provided with that service in their first language., as set out in *More than Just Words 2012*.

Practices around the UK have innovated and developed new ways of providing timed access to skilled clinicians. The most successful new models have used formal quality improvement methodologies to test and measure interventions. They measured demand from patients and consequently matched supply of appointments,

and increased capacity to cope with surges in demand. Some practices widened the range of professionals available. Others changed to a default first offer of a timely telephone call with a GP (the *Telephone First model)* rather than a face-to-face consultations. Others are using online algorithms to prioritise by whom patients are seen and how quickly. As part of improving access there are opportunities to further roll out community cardiology services providing quick access to diagnostic and treatment in primary care, access to audiology for hearing test in GP practices instead of needing to go to hospital, local access to services which previously needed hospital care such as vasectomy services.

Many of the structural issues that reduce access can be dealt with by merging smaller practices either physically or functionally. Physical mergers will create one organisation to deliver access. However sharing resources between practices with integrated IT systems provides a functional alternative allowing existing practices to survive with their separate identities. An example of a new service delivery model is the Neath Pacesetter Hub.

The Neath Pacesetter Hub project has successfully demonstrated that a cluster of practices can address access issues by working together. Practices in the Neath Cluster Network have adopted the *Telephone First model* and thereby increased the efficiency and effectiveness of their own appointment systems. They have supported the creation of a central multidisciplinary team (the 'Hub') with physiotherapists, wellbeing worker, pharmacist and audiologist that only this cluster can refer to. The GPs have adopted Vision360 software, which they use to book patients into appointments with the Hub clinicians whilst speaking to patients during Telephone First conversations.

The *Telephone First* model has been adopted in other practices and will be encouraged to be adopted all ABMU areas where access is poor. The Hub model can be adapted to work in any cluster network, with practices choosing the professions to be included as part of their local agreed priorities.

Oral Health and Access

The learning gained from the Dental Contract Prototype model will be rolled out in a contract reform programme. Areas of high need will be prioritised to facilitate access and to encourage a preventative and holistic approach to care. This will provide an environment where general health and wellbeing becomes an integral part of oral health services e.g. advice on smoking cessation and diet.

Services for the most vulnerable will be reviewed to ensure they reflect the needs of the population and integrated with partner services whenever possible.

The demand for children's dental general anaesthetics will be reduced by establishing an environment which supports prevention and the development of alternative methods of care. The 'Designed to Smile' programme will be refocused on the 0-5 year olds, with a multi professional integrated approach involving health care visitors, educators and local dental practices.

Dentistry will work within cluster networks to improve access for their local communities, to ensure that services are appropriate for the local population, and patients access the most appropriate care pathway.

Robust, evidence based, integrated care pathways will be developed with the individual's long-term interests as its focus.

A single point of access for dental referrals from primary care to our community and secondary care specialist services will be developed to ensure reduced waiting times and effective and efficient use of resources to inform the Health Board on areas for potential service development.

Policies will be developed to reduce waiting times for specialist services and reduce pressure on our hospitals. There will be a change in emphasis with further development of specialised dental services within the community/primary care settings. We will work across Health Board boundaries where this is in the best interest of our populations we serve.

Expansion of core community teams

The development of the core long term care service teams to meet the demand of the expanding population is recognised. There also needs to be alternative workforce solutions to support patients in the community preventing avoidable admissions into hospital, to help deliver primary care access at scale and also to ensure rapid discharge from hospital with support in the community. The system needs to wrap around patients rather than patients having to fit into the system provided.

A community model could be developed whereby district nurses, nurse practitioners, clinical pharmacists and community paramedics work more closely with GP practices thereby releasing GP time to deliver care for more complex patients and to increase capacity to deliver a seven day service to the local population. Depending on local needs, the community/primary care practitioner could support the routine nursing home caseload and provide a home visiting service to those patients who have an acute, but non serious illness or injury and are unable to attend a GP practice. The style of model will depend on the rurality and demography of each of the three counties and will involve the further development of a new model for rapid response services to respond to urgent demand. This model replicates something seen both in the acute hospital setting and within palliative care services which are currently delivered across the hospital and community. Community Pharmacists and optometrists – particularly those accredited to provide Low Vision Support - could also play an important role in delivering this model in or near the patient's home.

The current hospital model focuses consultant time to see the sickest patients and uses junior doctors and nurse practitioners to deliver more routine work. This model is not entirely transferrable to primary and community services as GPs still need to see patients at the frontline of the NHS, however, other professionals can take on some of the routine work. The capacity created will give GPs more time to care for their sickest patients or those presenting with the most acute and complex conditions in the community.

Integrated Intermediate Care

In the last three years community health services in ABMU Health Board have been engaged in a large scale change programme under the auspices of the Western Bay Partnership. The Western Bay Partnership is a coming together of health, social care and voluntary sector organisations to improve services and outcomes for our population. The community services arm of the Western Bay has been focused on improving services for older people by building capacity within the integrated intermediate tier of care. Evidence from the King's Fund tells us that a service response that is fit for the future requires orientation away from acute and episodic care towards prevention and self-care as well as care that is well coordinated and integrated. Integrated working helps to ensure the right mix of services in the right place at the right time.

A recent evaluation of the Western Bay Integrated Intermediate Care Programme, undertaken by Cordis Bright (2017), shows that there is now much greater integration between health and social care services, an improved culture of collaboration and that the programme has also assisted in changing services to be more commonly available at times when people need them. This provides the opportunity to maintain and where possible reduce demand on unscheduled care.

Over the next five years the capacity in integrated intermediate care services will need to grow to meet the rising demand that is likely to come as a result of ageing in our local population. Older people have told us that they want the opportunity to live as independently as possible with minimal support from statutory services. After a period of acute illness and whilst managing their chronic conditions people want to be given the chance to regain independence. There is evidence from across the United Kingdom, as well as locally, of the effectiveness of services that offer rehabilitation and reablement to people, and support to their carers, on a short term basis whilst they regain the confidence to manage at home. Sometimes these services are provided in a residential setting but more commonly are provided in people's homes. Wherever the setting the principle of supporting people to regain independence will be fundamental to a sustainable care and support sector for the long term. This will require a focus on community therapy services.

In the future we want:

- More frail and older people being cared for at home and not in institutional care
- More people being supported to live independently with the support of technology
- People being supported to live in settings of their own choice, this may mean alternative and flexible housing options
- People receive the support they need from one team compromising health and social care staff

Redesign of pathways for chronic disease management and planned care

Patients at home can manage chronic diseases, such as Diabetes and Chronic Obstructive Pulmonary Disease [COPD] or Asthma, very successfully with support

from primary care teams and specialist advice when necessary. However, there is unwarranted variation in how the support is provided and where it is provided across the ABMU area. Clinical Pathways that describe the journey that a typical patient would expect to take from diagnosis to treatment of complications of the long term condition help clinicians to standardise care. They show patients the standards of care they can expect to be delivered and future care plans. They support patients to self-manage their conditions.

Patients with long term conditions require a different type of access to their GPs and practice teams. These patients live with their conditions every day of the year, so we should focus resources on making available to them the tools and skills to live with and control their condition. Patients and their carers should expect and receive education and support from peers and community based resources, as well as online and telephone services. They should have regular reviews with a clinician, not necessarily their GP, as often as their clinical need determines. The reviews may occur online, in their GP's practice or a cluster network venue. The reviews may occur on a one to one basis or may be held as a group appointment – a new evidence based innovation where a group of up to 10 patients benefit from listening to and sharing the advice received from a clinician. The group appointments are much longer than one patient would require but use less resource than if all patients had a single short appointment. Outcomes are just as good and this model is acceptable to many patients.

When only a one-to-one consultation will do, the patient with a long term condition will be able to access a longer appointment with a clinician for the opportunity to discuss all of their conditions. During phases of serious illness, a team approach will provide the additional intensive support they need, on an 'easy in, easy out' basis.

Opportunities also exist for there to be shifts from secondary to primary care for other planned care pathways such as oral health and eye care pathways. Currently too many patients are receiving screening, assessment or follow up treatment in hospital settings when designated high street optometrists are qualified and able to undertake this work. The Health Board needs to develop new models of care within practices for patients with long term conditions i.e. one stop shops. An example is Type 2 Diabetes. Although current performance in diabetic care in ABMU is good, there is unwarranted variation in how the care is delivered across the Health Board, with much of it based in hospital outpatients. Recruitment and training of Diabetic Specialist Nurses (and/ or transfer of some resources from work currently undertaken in hospital), based in cluster hubs, could help transfer these patients safely to receive their care within the community. Further benefits of this approach would be to increase continuity of care and may reduce access demand through greater patients' self-management and empowerment.

There will be a further promotion of direct access Physiotherapy and Podiatry services; evidence-based self-referral mechanisms to promote self-management and ease of access to avoid the need to see contact a GP.

In summary, therefore we will:

- **Develop new ways of providing timed access to skilled clinicians.**
- **Provide local access to services which previously needed hospital care**
- **Promote the *Telephone First model* and thereby increase the efficiency and effectiveness of appointment systems**
- **Ensure rapid discharge from hospital with support in the community through building capacity to deliver a seven day service and through supporting people to regain independence**

6.2 Workforce

Primary and community care is central to the delivery of a safe and effective health service. National modelling by the RCGP has stated that the number of GPs being trained will not be sufficient in order to meet future demands. The Centre for Workforce Intelligence has said that there will be a significant undersupply of GPs by 2020 unless significant steps are taken to address this imbalance between supply and demand. The predicted numbers of practice nurses due to retire in the near future is also a significant cause for concern.

The Kings Fund has highlighted some key issues with the development of effective workforce planning in primary and community services.

- There are currently no clear ways to measure demand for primary care services.
- There is a distinct absence of any measures of activity and consequently there has been difficulty in establishing a clear view of the pressures that practices and community services are working under.

A clearer view of workload and workforce would allow better planning and more creative use of skill mix in order to deliver primary care on a more sustainable footing. It is clear that a skills review is needed to ensure that professionals are working at the top of their licences.

We have looked at the NUKA Healthcare system in Alaska and see the principles as being key to progressing the 5 year strategy in ABMU Health Board. These principles include the need to focus on the multi-disciplinary approach to the effective delivery of primary care and include:

- Respect and engage the workforce as valuable contributors of new ideas, not just ‘hands’ to follow orders.
- Value interdependency, team work and systems thinking
- Trust intrinsic motivation far more than extrinsic incentives
- Remain relentlessly curious about the needs and experience of customers
- Employ empirical learning cycles pervasively to continually test and learn from changes

Traditional Boundaries

There is a need to develop roles and training across the traditional primary and community nursing boundaries that currently exist. Building capacity within the community may require the development of new nurse practitioner roles and the development of multi skilled community professionals along with support staff who can work across a number of currently distinct roles.

Practice and Community Nursing

As the population ages, there is a pressing need to cost effectively manage the care of increasing numbers of people with long term conditions and prevent unnecessary hospitalization.

The workload of practice nurses has changed of the last 10 years with many of them dealing with more complex patients care through chronic disease clinics and health promotion. With the increase in this delegated work it will be increasingly important to ensure that this group are properly supported to fulfil these roles safely.

In the Netherlands, Buurtzorg developed a unique district nursing system which has garnered international acclaim for being entirely nurse led and cost effective. Prior to Buurtzorg, home care services in the Netherlands were fragmented with patients being cared for by multiple practitioners and providers. Ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low paid and poorly skilled workforce who were unable to properly care for patients with co morbidities, leading to a decline in patient health and satisfaction. To address this, Buurtzorg gave his district nurses far greater control over patient care. The nurses now lead the assessment, planning and coordination of patients care with one another. The model consists of small self-managing teams of a maximum of 12 professional (comprising both nurses and other allied health professionals). These teams provide co ordinated care for a specific catchments area, typically consisting of between 40 – 60 patients. In the Netherlands, integrated care has been cited as easier to deliver because district nurses tend to be well known in the small neighbourhood/community they work in. This has helped them to build good working relationships and strong dialogue with GPs, home doctors, police, paramedics and social care providers. We will seek to include key elements of this model in the delivery of our community nursing services.

There are also opportunity to increase the type and number of generic roles across health and social care.

Health Care Support Workers (HCSW)

These workers are now commonly seen in many multi-professional teams and are highly valued for their patient facing and administration roles. They provide opportunities for professionals who are highly trained to perform duties only they can do whilst HCSWs complete more generic tasks. It is important to ensure that their roles and numbers are balanced in children's and adult services.

Advanced Nurse Practitioners (ANP)

The expertise of the ANP in primary care lies in their ability to operate as a 'generalist'. These are nurses working at an advanced level of their professional

practice that encompasses aspects of education, research and management but is firmly grounded in direct care provision. Every day they will be making professionally autonomous decisions, for which they are accountable, perhaps receiving patients with undifferentiated and undiagnosed problems and making an assessment of their health care needs, based on highly-developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination. As well as screening patients for disease risk factors and early signs of illness, they can make differential diagnoses using decision-making and problem-solving skills, developing with the patient an ongoing nursing care plan for health, with an emphasis on health education and preventative measures. They can order necessary investigations, and providing treatment and care both individually, as part of a team, and through referral to other agencies, having a supportive role in helping people to manage and live with illness. They will have the authority to admit or discharge patients from their caseload, and refer patients to other health care providers as appropriate, whilst working collaboratively with other health care professionals and disciplines. They provide leadership consultancy function as required.

Research into the safety and effectiveness of ANPs has provided overwhelmingly positive conclusions regarding the value of the role and the patient satisfaction that arises from ANP care. As part of the implementation we will further develop these roles.

Clinical Pharmacists

This group of professionals have the training and capability to take on more roles within primary care and in particular through current and planned enhanced services, to provide direct support to patients without the need for attendance at their GP. They can provide support to practices to review repeat medication systems, support for practice medicines managers, medicines reconciliation post discharge, nursing home medications review and work to improve anti-microbial stewardship. They can be independent contractors who work at the behest of a local practice, under a service level agreement direct to the practice or be employed directly by practices, cluster networks or the Health Board. Alternatively, they may be independent contractors who work under a service level agreement with a local practice or delivering a nationally agreed enhanced service, such as the Minor Ailments Service, supported by direct access to the clinical records of patients who have signed up for this support.

Community Paramedics

There can be an increasingly important role within primary care for this group of professionals. Community paramedics already provide a role in some of practices in the Valleys where they can undertake home visits, minor injuries and minor illness work. Developing their roles within more urban settings can be explored further.

Advanced practitioner roles are also developing which are made up of experienced nurses and paramedics who can provide higher level diagnostic skills in the community as well as the ability to offer independent prescribing.

When Paramedics are employed directly by WAST they can support both the practice and cluster network and also respond to local Red calls.

Physician Associates (PAs)

These new clinicians are graduates who have undertaken post-graduate training and work under the supervision of a doctor. They are trained to perform a number of day-to-day tasks including: taking medical histories, performing examinations, diagnosing illnesses, analysing test results and developing management plans. They are able to conduct much of the routine work of a GP or community physician, freeing up the doctor to deal with more complex cases. They are already employed in some general practices in Wales and in England. For example one English practice has a team of three PAs who manage a practice's urgent same day requests alongside a single GP.

Swansea Medical School has a set up a Physician Associates course and training is already being provided by ABMU Health Board practices. We will seek to develop supported opportunities for these new additions to the multidisciplinary team.

The Medical Assistant

This is a non-clinical role that is being developed from a scheme originating in Brighton. An administrative officer is trained to process incoming correspondence usually handled by GPs, and safely and accurately deal with it to the same standards as the GP. Evidence from Brighton has shown that this method is safe and 90% of correspondence can be directed away from GPs, leading to freeing typically an extra 40 minutes a day per GP.

Community Therapy and Health Science Workforce

This range of services will develop further to reinforce service models such as in the Musculoskeletal Clinical Assessment Service (MCAS) or the Chronic Pain Service where services are led by therapists such as physiotherapists, podiatrists or psychologists with medical support. The therapy and health science workforce already work across all boundaries and between all services. Further work will be undertaken to embed services within cluster networks with an emphasis on prevention, co-production and providing these specialty services as close to our population's homes where appropriate through working with colleagues to input effectively into all relevant pathways.

The main shift will be to improve and support self-management by co-production and improved health literacy with a focus on those diseases that have life changing or life/limb threatening potential consequences, and where services can support sustainability of primary care.

The role of Health Care Support Workers and support staff will also be developed to ensure a clinician's time is utilised both at the top of their license and in the most effective way. The team's roles will become more consultative and offer leadership in identifying interventions and requirements that others are more appropriate to undertake, and thus releasing more time for diagnosis and planning.

The Future GP

The key feature of being a General Medical Practitioner in the NHS in Wales is the responsibility for provision of primary care services, to a registered population of patients with whom the GP has a continuous relationship. This has helped to make the NHS one of the most cost-effective health care systems in the world. However, with an increasingly part-time and non-permanent GP workforce, this is harder but not impossible to fulfil.

The characteristic features of the traditional Independent Contractor career model of a GP have existed since 1948. This model has delivered a solid and reliable service until recent years. Where GPs are in relatively good supply, the independent contractor model could continue into the future. However, in those increasing numbers of areas with poor recruitment and increased early retirements of GPs, this model is unsustainable. The future GP in these under-doctored areas may have a different contractual arrangement – a salaried GP employed by a practice, cluster or Health Board, working a portfolio career whilst attached to a single practice or group of practices:

The RCGP describe the following characteristics of the future GP. The general practitioner of 2022 will:

- build on his/her core generalist skills to develop as an **expert generalist physician**
- be able to routinely structure care around **multi-morbidity**, as well as individual conditions
- take on **extended roles** in areas of clinical care that require the skills of a generalist practitioner
- work with generalist practitioners from other disciplines, to deliver **co-ordinated** care
- **lead service planning** and **quality improvement**
- develop **extended roles** in areas such as public health, community development, education, training and research.
- offer **continuity of relationship** between the practitioner, the wider healthcare team, the patient and their carers and family, over time
- **coordinate** services around the needs and **shared decisions** of patients and carers
- **deliver health-promotion** and disease-prevention strategies to identified populations
- act as '**gatekeeper'** and '**navigator'** to specialist services, to ensure effective resource utilisation and coordination, (where direct access is inappropriate)
- retain his or her ability to be an **independent advocate** for his or her patients and to meet his or her professional obligations as a doctor first, irrespective of contractual arrangements or commissioning responsibilities
- remain at the heart of his or her patients' communities, systematically **supporting self-sufficiency** and developing communities as health resources in their own right.

The Primary Care Academy

This initiative of Swansea Medical School aims to deliver more of the undergraduate medical curriculum in primary care settings, and in general practices in particular. Medical students who spend longer periods on attachments in primary care in their degree course have been shown to be more likely to become GPs. We also know that when students have excellent experiences in practices they are more inclined to return to that area to practice when qualified. GPs who teach medical students in their practices have been shown to consider it rewarding and stimulating and feel it helps to deliver better care. The Primary Care & Community Services Unit is working with Swansea Medical School to develop the proposal further in the hope it will support recruitment and retention of GPs. There are also opportunities for training a wider range of community practitioners.

The Dental Workforce

The dental workforce will be planned and developed across services and between the Primary and Community Services and Morriston Hospital delivery units. It will reflect the needs of the population, service location and use the appropriate individuals with the appropriate skills.

Over the next five years' oral health services will see a shift from treating disease to prevention with the focus on the most vulnerable. Care will be closer to the homes of patients, provided on a domiciliary basis where needed, and provided by individuals with the most appropriate skills. Closer working with other health providers and nursing homes staff will support this emphasis.

The roles and responsibilities for Dental Care Professionals will be developed and expanded freeing dentists to do only what they can do. Dentists will become leaders and part of teams which includes therapists, nurses, hygienists, oral health educators and clinical dental technologists.

This expanded role will extend to support for non-dental professional to encourage good oral health and screening for their client groups. This will be reflected in the current care homes dental pilot which will be expanded and become integrated with the GMS care homes service**.**

The Community Dental Service will continue to refocus its activity on the most vulnerable in our population with the location of services and workforce developed to reflect the needs of these groups.

In summary, therefore we will:

- **Develop a workforce of multi skilled community professionals**
- **Further develop advanced practitioner roles**
- **Develop the model of the 'Future GP' linking with the development of the Primary Care Academy development.**

6.3 Quality

All of us involved in treating patients and in managing and improving health services understand the importance of providing the best care possible for all our patients. We need to ensure that we are getting it right first time and that where ever possible we do today's work today. Better care and better value can be achieved through the reduction of waste and error. We want to make sure we create an environment in which change, improvement and innovation can flourish.

Our strategy fully reflects the Health Board Quality Strategy and embraces the core values of Abertawe Bro Morgannwg University Health Board:

Caring for each other, working together and always improving

***"*We will respect people's rights in all that we do and plan our services and their care with them. Wherever and by whom it is provided, care will be safe and compassionate, meeting agreed national standards, providing excellent outcomes and an experience that is as good as it could be."**

The Primary and Community Strategy aims to deliver excellent health services and improve the quality of patient care. Strong primary and community based care has been widely recognized as being a bedrock of high performing healthcare systems. UK general practice is regarded highly internationally as being highly accessible and well-coordinated however, it has also been recognised that all community based care will have to evolve and grow in order to meet the growing needs and expectation of the population.

The strategic quality objectives of ABMUHB provide the cornerstone for the quality objectives within this strategy:

- **Patient centeredness**: health services that are responsive to the needs and requirements of the individual and are guided by the values of the individual
- **Safe**: health services that take all possible steps to avoid injury or harm
- **Effective**: services that are based on best practice and evidence
- **Efficient**: services that do not waste resources
- **Equitable**: services that do not vary due to personal characteristics
- **Timely**: services that are provided when they are needed and where there is no delay in the delivery of care and treatment that is needed.

Our aspiration is to ensure that high quality, innovative, cost effective and compassionate care is consistently delivered by a primary and community care workforce, which comprises the right people with the right skills in the right place at the right time. The thread running throughout the strategy is the desire to enhance the quality of patient care and experience in the long-term; eliminating waste, reducing variation and delivering better value for money. We will only know if we are achieving these goals if we measure outcomes and listen to the experiences of our patients, service users and staff.

This strategy supports the delivery of these goals through the provision of multi-disciplinary teams of primary, community and social care services and supports the

aim of ensuring the patient is at the heart of everything we do by **delivering a holistic service, wrapped around the needs of the patient,** thus delivering a high quality experience for patients.

Although General Medical Practices were early adopters of IT and have a sophisticated data collection and extraction service to support the General Medical Contract payment systems, there is little sharing of data to support quality improvement activities. ABMU Health Board will work with practices and the Local Medical Committee to develop a Quality Improvement mechanism, and facilitate sharing of data with the Cluster networks and the Health Board where this helps to improve the quality of service or redirection of resources to needier communities or practices. There is far less integration and compatibility between the IT systems in use in other primary care professions but several national initiatives seek to improve this over the course of this strategy. These include the roll out of the Choose Pharmacy IT platform which will enable access to patients Individual Health Record (IHR) to accredited community pharmacies, planned e-referral for several specific eye and oral health care pathways.

Further development and implementation of the action plan to delivery '*More than Just Words'* will be a key aspect of the strategy, notably the 'active offer' through which our services and those we commission from primary care, independent and third sector contractors, should be offered for delivery through the medium of Welsh.

In summary, therefore we will:

- **Ensure that high quality, innovative, cost effective and compassionate care is consistently delivered**
- **Create an environment in which change, improvement and innovation can flourish**

6.4 Information Technology

The Health Board has launched a digitalisation strategy which provides significant opportunities for enhancing service delivery in primary and community services. Particularly relevant to these services are the sections reproduced below:

The aims of improved use of digital health and care systems are to:

- Enable our health and care teams to use digital to spend more time on their core competency – working with people to improve outcomes- not managing digital processes
- Realise the 'efficient productivity' benefits of digital technology investments already made and to come - actually doing more at the same or higher quality level with the same or fewer resources
- Better position this health economy to influence, drive and benefit from new digital technology, achieving the required ongoing cost economies.

The characteristics we will see through the introduction of a digital health and care system are:

- Increased participation by people in their health and wellbeing, and reduction in number of times they miss appointments
- More effective self-care for people experiencing frailty and mental health self-care and long term self-management
- Improvements in care coordination, reduced variation, waste and harm and safer handovers between health and care professionals
- Improved point of care decision support and management of acutely ill or deteriorating patients
- Accurate, agile analysis of population health data at community level for service commissioning and research
- Improvements across the whole system of care and improvements in system analysis and innovation
- The ability to measure health outcomes

In summary, therefore we will:

- **Adopt the characteristics of the digitalization strategy maximizing opportunities within the community**

6.5 Estates

The ABMU Primary and Community Estates Position Statement (2016) provided the outcome of a comprehensive review of all the primary care estates across the three counties and included the conditions of the buildings. Following the completion of this primary and community strategy, the existing estate will need to be reviewed once more and a strategic plan developed to ensure that the premises are modern and fit for purpose. Aspects of this will include their functional suitability, how well space is used, and the quality of the environment as well as health and safety. Stronger linkages need to be created with the Local Authority and local planning departments as they develop their plans for new housing developments to also consider how these will impact upon the existing primary care services.

The balance of freehold to leasehold properties and the options available for the future need to be considered. The current GP workforce who own their own buildings will have genuine concern about the valuation of their premises if new models develop which want to rationalise the existing estate and develop new premises. Younger GPs may not choose the option of owning their own premises and this will have an impact upon those practices who want to recruit in the future.

ARCH (A Regional Collaborative for Healthcare) and the Swansea Bay City Deal provide unique opportunities for significant development of Estates in the region.

ARCH is a world-class, visionary project created by a collaboration between two university Health Boards, Abertawe Bro Morgannwg (ABMU) and Hywel Dda; and Swansea University. It is health and science working together, to improve the health, wealth and wellbeing of the people of South West Wales. It will generate a future for the people of South West Wales which delivers better health, skills and economic outcomes. One key component is the development of additional Integrated Primary Care Resource Centres, (Wellbeing/Wellness Centres) designed to operate by holistic principles, to take care closer to people. There will be new and improved facilities for educating the future workforce alongside patients in modern facilities. New facilities will be developed to house increased R&D, knowledge and science opportunities alongside life science-based businesses.

This means that several practices could move into and share accommodation in purpose state of the art facilities, alongside community services, educational venues, research facilities and social prescribing resources.

The City Deal is a bespoke, trilateral arrangement between the UK and Welsh Governments and the Swansea Bay City Region worth circa £500 million over 20 years. It is designed to dramatically improve economic performance (with allied economic and social benefits) by 2035. The Wellness Centres, such as those planned for the centres of Swansea, Neath and Bridgend could provide excellent quality premises for multiple practices, community services and social prescribing services to work alongside each other.

As we improve our estates we will heed the needs to people with impaired mobility, noting that failure to do so in many cases results in people either not receiving treatment or receiving it inappropriately, within hospitals which are equipped with the means to ensure they can access services.

We will also review our non-GP buildings portfolio, and ensure that premises are used as effectively and efficiently as possible. New GP developments will be favoured where they can offer accommodation to community services thus supporting the creation of multi-use and multi-agency buildings that can benefit the entire community.

In summary, therefore we will:

- **Develop a strategic plan to ensure that the premises are modern and fit for purpose.**
- **Develop strong linkages with the Local Authority to maximize opportunities across organisations and plan for future population growth**
- **Maximise opportunities for further developments through the ARCH programme**

7. Conclusion

Primary and community services in ABMU Health Board and nationally are at a significant crossroads. There is appetite for change as well as an opportunity within some funding though the primary care funds from Welsh Government. General practice is struggling to keep up with the demands being placed upon it, greater integration within healthcare could be the solution. Too much care is being provided in secondary care and there are significant cultural issues which we will need to tackle.

For new models of care to emerge we have to provide the time and space for our clinical leaders to think and plan as well as to receive the training they need to fulfill these roles.

The challenge for ABMU Health Board is to create the permissions, the incentives and the support needed to create these new models of care. The challenge for those working within the primary and community services to adapt and innovate.

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7. RCGP position statement '24/7 Integrated GP services'. Sept 2014
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16. WHC(2015) 01 Improving oral health for older people living in care homes in Wales , January 2015
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Annex 1.

Five years from now – what could primary and community services look like:

Patients still belong to their own local practice list and their own team of doctors and nurses. Patients and their carers have a 'voice' which is listened to and which is highly influential in the way that services are developed and delivered. They are aware of how much resource is available to the cluster network and patient participation group are key to the development of the cluster plans in shaping the delivery of care provision in their local area.

Patients and carers know that they will have quick access to appropriate care from the right person, at the right place and at the right time and that this is very likely to not be a GP but to be the person best skilled to meet their needs. They know that they can access this support over 7 days a week. All patients and their carers are aware of the patient contract they have agreed to which means that they commit to health improvement goals at the same time as expecting to access healthcare as needed to ensure that the population as a whole understands the greater focus on prevention, public health and wellbeing.

They are pleased that they don't need to travel to the GP practice as they used to or to the hospital for care but that much of this is now available to them through their mobile devices having skype enabled consultations with a health or social care professional. They know that when they can't access these devices that a health or social care professional will visit them at home with mobile technology to show them educational support videos through their mobile device and that they can use this one to one visit to ask questions about how to self-manage their own care as well as possible. Patients know that when they experience mental health issues that they can have quick and easy access to support with an 'easy in, easy out' approach having been adopted so that they only need to be in touch with this support at times they need it and not otherwise.

Carers know how to access support in a way which meets their needs so that they can access support as and when they need it.

Children and young people can access information easily through mobile phone apps and have accessible links to child friendly information developed with children and young people. They can also access information for young carers and have access to chat rooms with other young carers through supported young carers 'chat line.' They know that they only have one phone number to ring or one touch of their phone app and they can be signposted quickly to information and advice when and how they want it.

Patients and their carers are pleased to be able to access services delivered through the third (voluntary) sector as these ae providing local support to local communities and helping people access transport more easily when they do need to attend a clinic or hospital. They also know that these services can help support them come home quickly once they have that care.

Patients know that with their permission, all who are involved in their care will know about them and that all clinical systems are fully integrated between primary care, secondary care and community services. They have been reassured that all clinical guidelines are collated and disseminated through the organisation so that they can expect to receive the best standards of care wherever they access this. They know that this will be available to them even if they need to move into a supported care environment even if this is only for a short period of time.

All the practices premises have been updated and are modern, clean and efficiently run. Each practice retains it's identify but also belongs to a wider cluster network with a clear 'brand' and uniform access arrangements.

GPs work the majority of their time in their own practice but can also choose to spend some time in other practices in their cluster network by doing weekend and out of hours work. Practice nurses and healthcare assistants also work in this way. All clinicians have job plans and they are given protected time for continuing professional development and quality improvement work. Opportunities are available to develop specialist interests and to work alongside specialists both in the community and in hospital.

GPs now only visit those patients who have complex problems or who need end of life care. Routine visits are now performed by a team made up of nurses, clinical pharmacists and community paramedics who can diagnose and treat a number of common sub-acute medical conditions, Social care provide a rapid response service as part of the integrated team and work closely with GPs and those community visiting teams. GPs have oversight of this team and will only visit if a hospital admission can be avoided, Hospital consultants are often in the community and ambulatory care has been rolled out to seven days a week to keep patients within complex health needs out of hospital.

Patients with long term chronic illnesses have an annual health review with their practice nurse and GP. Together a healthcare plan is agreed which patients can access at all times. In their care plan, patients can review their health goals and they can access links which will advise them about what to do should they become ill. Those patients who struggle to cope with their long term conditions have access to support from the third sector. High risk patients with chronic illnesses are case managed by a long term conditions team who can ring the named GP for advice regarding management decisions or liaise directly with the hospital.

GPs now spend on average 30 minutes with patients with long term conditions and will spend several days a week doing this kind of work. During other days of the week GPs and nurses deal with the workload generated by same day demand. All patients who attend A&E are flagged for the practice and within 24 hours patients receive a telephone call from their GP to review the reasons for that attendance and to learn any lessons. A large number of routine hypertensive patients are now given portable BP machines for home use. They email the practice every three to six months, these emails being reviewed by the most appropriate clinician.

*The outcome of these changes are that patients can obtain same day appointments when needed whilst patients with long-term illness can be better looked after as they receive regular planned coordinated care visits whilst knowing their GP has oversight and control of their medical plan.. Patients have a care plan booklet given to them each year which explains the nature of their conditions, what each medication is for and advice about what to do if they are not feeling well. Patients can also access this on line or via their phone app which is a useful option for some patients***.**

I***n summary, in five years' time***

- ***Clinicians will be working in practices or teams of which they are proud, delivering care to patients in a wider truly integrated team***
- ***Practices will be working together in cluster networks integrated with care teams from the community, secondary care, social care and the third sector.***
- ***New structure and workforce models will be in place to allow clinicians to spend more time with their patients, with greater continuity of care and high quality care for their patients***
- ***The systems will allow easy access to the right clinician at the right time, whist patients with complex needs are managed proactively in the community by a wider multidisciplinary team headed up by their GP and appropriate specialist.***
- ***All this will be underpinned by a shared integrated record, accessible across all services through IM&T systems.***
- ***We will be able to demonstrate our success by measuring and sharing the outcomes of our services with the communities we serve.***

PRIMARY AND COMMUNITY SERVICES STRATEGY: A VISION FOR COMMUNITY SERVICES

Early Years | **School Age** | **Adult** | **Older Adult**

Public Health | Health Literacy | AcuteCare | Reablement | Long Term Conditions | Frailty | End of Life Care

Six Priority Areas for Community Services

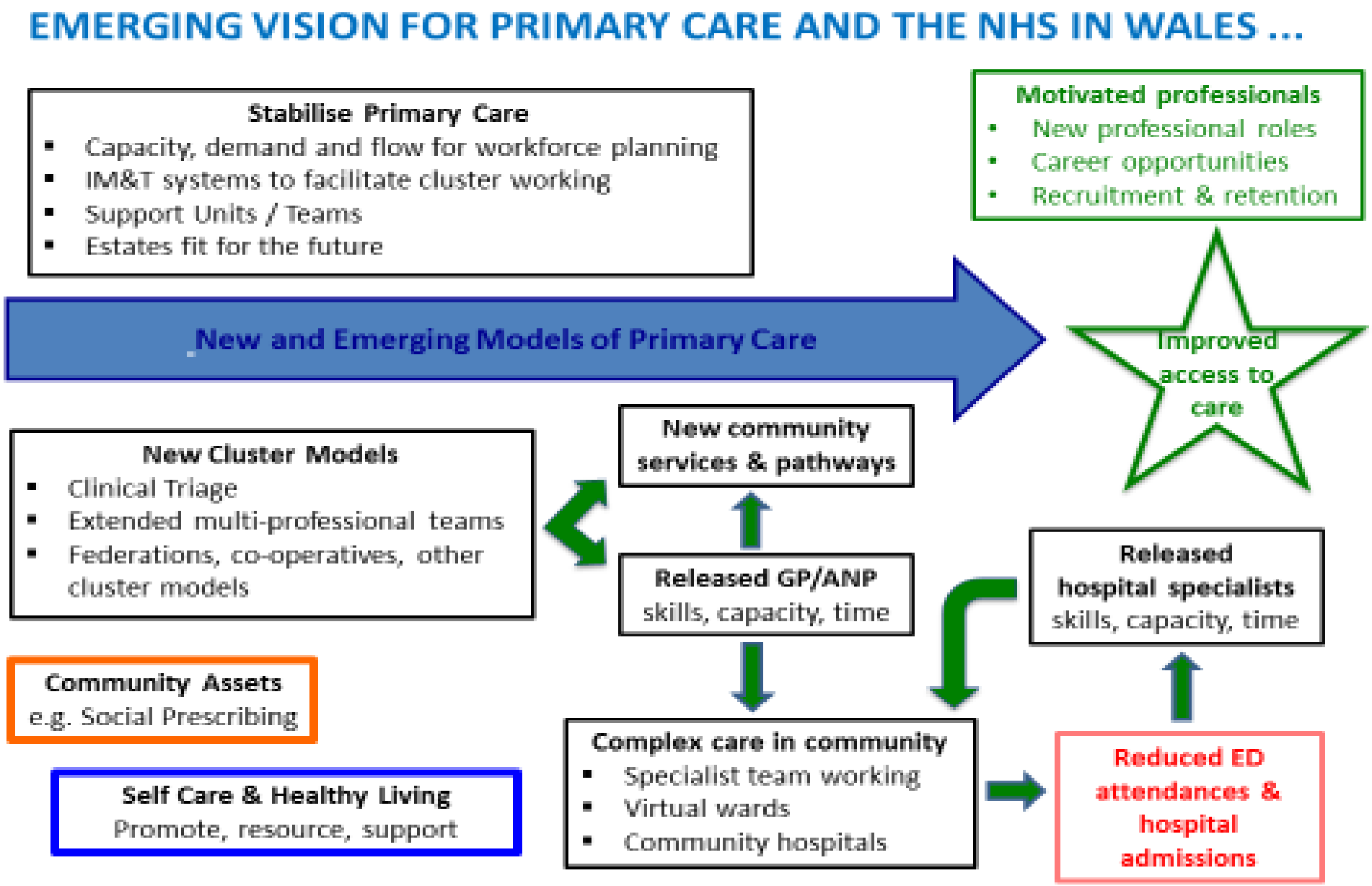
Maximising health and wellbeing	• Providing comprehensive early years support to increase health literacy across our communities • Leading care nearer to home	• Leading an holistic assessment and providing care in any community environment • Co-production with individuals and across clusters
Working with people to provide a positive experience	• Identifying the need for early help and managing crisis intervention • Using the relationship as a therapeutic tool	• Leading transition between care settings and championing discharge from hospitals • Measuring impact of service delivery through feedback
Delivering care and measuring impact	• Use professional expertise and business acumen to influence and direct commissioning of care • Use population and benchmarking/best practice data to inform delivery of services	• Always use the evidence base to report outcomes • Identify and measure harm to improve service delivery
Building leadership	• Empowerment through role models and supervision • Maximising use of technology to support care at home and mobilise the workforce	• Using all opportunities to develop care skills across the whole workforce regardless of setting or employer • Proactively protect and advocate for the vulnerable and safeguard to prevent harm
Right staff in the right place	• Multi-agency development of teams • Skill sharing and development of trusted assessor roles • Integration to support people to navigate through care systems	• Development of advanced practice skills across the workforce
Positive staff experience	• Growing the workforce through models of apprenticeship • Developing the workforce with mentorship and supervision	• Providing excellent practice placements for students at all levels across all disciplines

Fully integrated, co-ordinated model for health and social care, delivering 7 day services that put people's needs at the centre

People will understand how their behaviour impacts on their health and will use self management wherever possible

Outcome focussed measures will demonstrate success in moving services into community settings with positive experience for service users and staff

Sustainable and affordable services as a result of shifting from a reliance on unscheduled care pathways to planned models of care


EMERGING VISION FOR PRIMARY CARE AND THE NHS IN WALES ...
Stabilise Primary Care
Capacity, demand and flow for workforce planning
IM&T systems to facilitate cluster working
Support Units / Teams
Estates fit for the future
Motivated professionals
New professional roles
Career opportunities
Recruitment & retention
New and Emerging Models of Primary Care
Improved access to care
New Cluster Models
Clinical Triage
Extended multi-professional teams
Federations, co-operatives, other cluster models
New community services & pathways
Released GP/ANP
skills, capacity, time
Released hospital specialists
skills, capacity, time
Community Assets
e.g. Social Prescribing
Self Care & Healthy Living
Promote, resource, support
Complex care in community
Specialist team working
Virtual wards
Community hospitals
Reduced ED attendances & hospital admissions