PC 07

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Response from: Abertawe Bro Morgannwg University Health Board

Welsh Government Health, Social Care nd Sport Committee:

Enquiry into Primary Care

Submission from

Abertawe Bro Morgnnwg University Health Board

Overview of ABMU HB Cluster Networks

Introduction

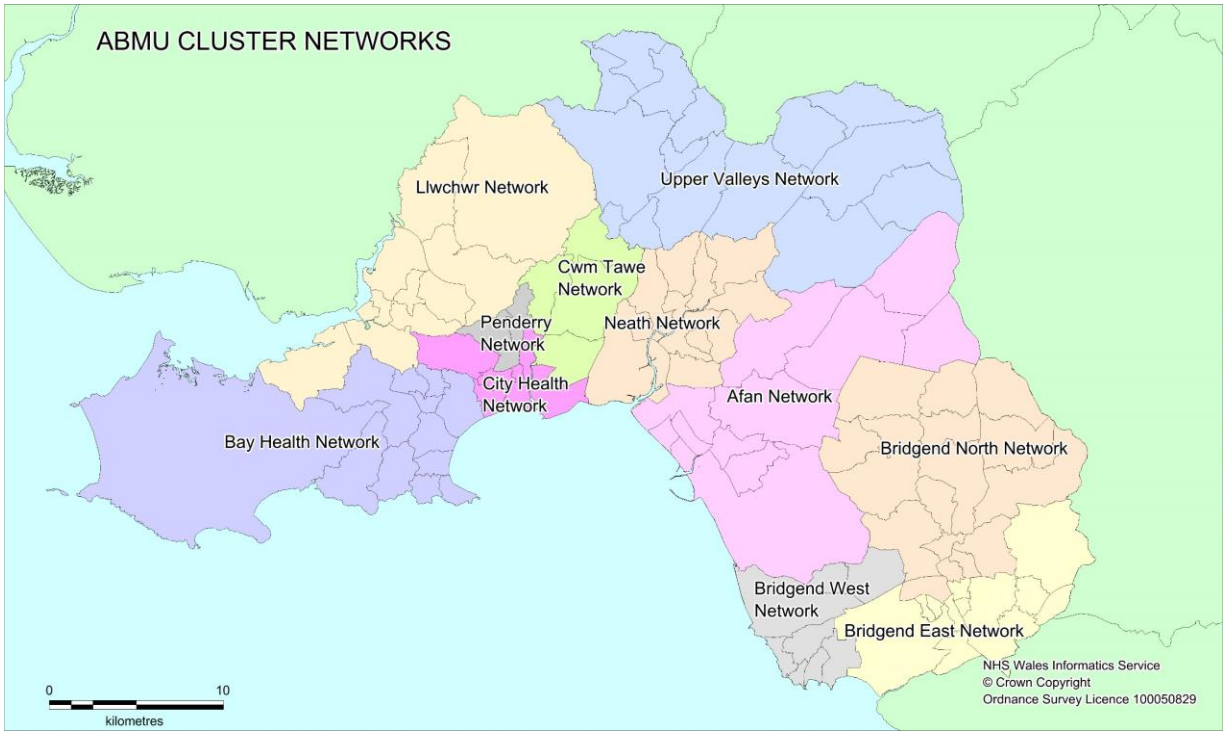
The development of primary and community services is a fundamental plank of the Health Board's clinical service strategy "Changing for the Better", and the National Primary Care Plan for Wales has created a welcome catalyst to accelerate the changes needed to create a more sustainable health and social care system across ABMU HB.

The Health Board is currently in the process of developing its five year forward strategy for Primary and Community Services which will layout the future strategic direction for maturing our cluster networks from late 2017 and beyond.

Responsibility for developing our cluster networks in ABMU HB sits within our Primary and Community Services Delivery Unit (PCS), which is one of six operating delivery units across the Health Board. The PCS Unit is led by a triumvirate team of a Service Director, Nurse Director and Medical Director. Additionally, the PCS Unit has a Unit Dental Director and an Optometric Advisor. The benefits of this organisational structure is to provide clear devolved leadership for embedding the Health Board values, quality and safety, operational management and performance improvement across all of our sites and services, and ensuring these values are translated through our cluster working.

Cluster Networks in ABMU Health Board

There are eleven cluster networks within the ABMU Health Board area and the populations vary from about 30,000 to over 75,000:

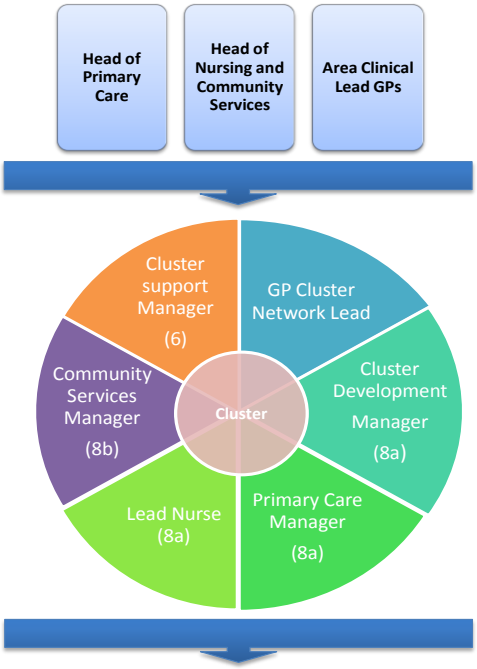


The 11 cluster networks are currently divided into two operational units: the five cluster networks covering the City and County of Swansea Local Authority footprint (Bay Health Llwchwr, Cwm Tawe, Penderry and City Health); and the six cluster networks covering the footprints of Neath Port Talbot and Bridgend County Borough council areas (Neath, Afan, Upper Valleys, Bridgend North, East and West).

Within each of the 5 cluster / 6 cluster operational units there is a senior leadership team which is comprised of a Area Clinical Director (GP), Head of Community Nursing, Head of Primary Care, Primary Care Manager and Cluster Development Manager.

There is clear leadership within each of the 11 cluster network teams from GPs in particular; and, the networks have been developed on a multi professional and multi agency basis. They now form the basis for organising and delivering many community health and social care services, and have developed strong links with the third sector.

Health Board Support to Cluster Networks



NB: Whilst not all posts will be part of this consultation the diagram demonstrates the health board support which will be available to cluster networks

Bridgend East, Bridgend North, Bridgend West, Neath, Afan, Upper Valleys, Bay, Penderi, City, Llwchwr, Cwmtawe

During the autumn of 2013, we engaged widely on a plan to develop the following functions within our cluster networks:

- Improving population health
- Developing and strengthening primary care services
- Delivering & managing community health services
- Joining up health and social care
- Reshaping pathways between secondary and primary care.

Much of this agenda is still work in progress with some significant achievements being realised over the last three years. We are nearing the end of the third year of the GMS contract QOF domain for cluster working and will shortly be producing our third series of cluster annual reports and risk registers.

Within our cluster network areas we have been working through the Western Bay partnership to integrate our community health and social care teams and develop and expand our Intermediate tier services that are organized on a Local Authority footprint. Key features include a multi-disciplinary single access point including the third sector, an acute clinical response service to avoid hospital admissions and promote timely discharge, reshaping re-ablement services to promote independence, provision of step up and down facilities for community based re-ablement.

Item 1

How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).

Reducing variation, improving consistency and embedding innovation that's worked at pace

Pacesetter projects:

The Pacesetter projects have provided an important step forward in supporting innovation in primary care across Wales, and providing an opportunity to learn lessons across Health Board boundaries and work at scales within clusters. ABMU are pleased to be hosting 8 of the national pacesetters and the ABMU contribution to the All Wales programme is summarised below:

Referral and Demand - Acute Clinical Outreach – the aim of this pacesetter is to avoid people from going into hospital unnecessarily and avoiding care home placements. A team of 4 GP's led by a Care of the Elderly Consultant and explores a model of 'hospital at home' at the interface of primary and secondary care providing a 4 hour response on an outreach basis. The pacesetter is still developing however initial results have been extremely positive with good feedback on relationship building across the interface and up-skilling of General Practitioners and the acute nursing team and a saving of '1310' bed days through providing care in the community as opposed to a hospital admission. It will inform future models of care in the community.

Neath Primary Care Hub Pacesetter – The aim of the pacesetter is to channel patient demand for primary care through telephone triage and to more appropriately manage demand by accessing a wider range of share professionals within the cluster ie physiotherapists, pharmacists, mental health support worker (*see feature below*).

111 Pathfinder – this includes a range of schemes such as incorporating a pharmacist in the OOH team, establishing a clinical support team to provide better assessment of complex patients, and improving communication about complex patients between GPs in hours and out of hours.

Pharmacy Roles - Emerging from cluster network discussions, with which ABMU's community pharmacy leads participate, the Health Board is at the forefront of testing out new models for pharmacy roles utilising Health-Board employed community pharmacists. These include pacesetter projects for:

- The role of the **Pharmacists in preventing Acute Kidney Injury** in the community through improving the prevention, detection and management of community acquired acute kidney injury (AKI)

- **Tackling high rates of antibiotic prescribing** – Specialist antimicrobial pharmacists review and advise on practice prescribing. Improves the quality of antibiotic prescribing and minimises the risks of antibiotic resistance through increased awareness of the risks associated with antibiotic use.

- **Palliative Care Pharmacists** – to support the GP workforce to improve care for palliative patients and deliver better outcomes for both cancer and non-cancer palliative patients.

- **Community Pharmacy domiciliary visits** – Pharmacist led medication reviews for housebound patients in their home. Aims to support housebound patients to manage their medicines at home and focuses on patients without a package of care.

Although initially intended to be progressed through community pharmacy practices, the 'outreach' nature of the services described above meant that this was impractical for contractors at this stage whilst the costs and benefits of the schemes (to be weighed against the disadvantages of pharmacy staff leaving their commercial premises) have yet to be evaluated.

Discussions with Community Pharmacy contractors continue to explore the most effective means of engaging their integration with cluster-wide working, providing services compatible with those provided by General Practitioners, eg the Choose Well campaign and flu vaccination – particularly where this can be provided 'off site', eg at a care home, relieving pressure on GPs.

New Models for Primary Care. - **Federated working** – A social enterprise of 6 GP practices to support pooling of funds and services. The GP practise have formed a Federation/Social enterprise Business, a new organisational form, which will provide a platform for the individual independent contractors to legally join together and pool/ hold funds, employ staff and deliver services on behalf of each other for the population served. This model requires a step change in how practices work together and has the potential to be an effective vehicle to redesign pathways between primary and secondary care, using the pooled skills and resources of its members. As a limited company this concept will challenge the current ways in which the Health Board commissions and contracts for services.

The federation will accelerate maturity of cluster and focus individual practices on what services can be planned and delivered sustainably at a network level rather than practice basis (*see box below for further information*).

Other cluster networks are now pursuing exploration of the benefits of closer collaborative working. Three further cluster networks are proactively exploring this through protected learning workshop sessions during this year.

For all of the above it is vital that local cluster network teams are equipped with the improvement skills and capacity needed, and this is a priority for the Health Board as it rolls out its improvement approach.

In June 2016 a Cluster Development Workshop was held within the Health Board to showcase the pacesetter projects and new service developments. This reinforced the importance of cluster networks as a key vehicle for addressing sustainability and service development, with some excellent examples of new models of care already underway.

Some of the other showcase cluster projects featured in the workshop which is helping to reduce demand on GPs and deliver the shift of services, with resources, to out of hospital setting, focussed around the needs of our public include:

- **Cardiology:** GPWSI triaging all cardiology referrals to cardiac consultants via community based clinics. The scheme has reduced waiting times for patients and can assist in getting a rapid diagnosis and earlier treatment for 3,500 patients, reducing repeat attendances at the GP surgery. From a GP workforce perspective it allows development of portfolio careers in primary care supporting recruitment and retention of GPs in the local area.

- **INR:** establishing a safe high quality atrial fibrillation and anticoagulation service based within the community that can be delivered at a practice or cluster level.

- **Diabetes:** Prompt access within primary care to a choice of structured diabetes education for newly diagnosed patients. Nutrition and dietetic support to provide lifestyle interventions in GP clusters. Provision of a nutrition and dietetic service to the frail elderly living in nursing homes, staff and carer education, support for menu and meal planning.

- **Respiratory:** Up scaling and enhancing the Pulmonary Rehabilitation Service to reduce waiting times. This community based work will identify and proactive management to support patients with COPD and Asthma to better manage their condition. Outcome will slow the progression of the disease, prevent exacerbations and keep people fit and healthy.

- **Dermatology**: Equipment including webcams and digital cameras purchased to expedite feedback from the consultant dermatologist for skin lesions e.g., whether an outpatient appointment is required.

- ABMU is piloting the introduction of a **Primary Care Audiology Service**. A significant proportion of ear and hearing related symptoms can be managed by Audiologists rather than by GPs. Patients will be seen by the most appropriate health care professional and help to reduce the number of GP contacts required. Three clusters have been selected as the pilot sites; Cwmtawe, Afan and Bridgend East. The Primary Care Audiology service will be piloted over a twelve month period to assess the effectiveness of the service. Audiology clinics began in August 2016 and will be extended to other GP practices within the selected cluster networks.

- **The Primary Care Vasectomy Service** is provided by General Practitioners with Special Interests (GPwSI) and demonstrates a successful pathway re-design from a hospital delivered model to one that is based in and delivered by primary care. The new pathway commenced in November 2014 and is delivered by two providers from GP premises in Swansea and Bridgend for ABM registered patients via referrals into a single access point (WCCG). Patients are referred and accepted into either service location and it is expected that the total patient pathway does not exceed 15 weeks in total from the initial receipt of referral. Patients are able to access an efficient service that has shorter waiting times and provided in convenient modern community premises which has helped to improve patient experiences. The service has released capacity both in outpatient and day theatre as a result of the safe, effective transfer and has developed positive working relationships between primary and secondary care colleagues.

- **Oral health services**: a significant programme of work is being progressed under the auspices of the Health Board's Local Oral Health Plan to make best use of

community-based skills and services and support vulnerable people, eg our Health Visitors are now working with Designed to Smile colleagues to ensure greater focus on the oral health of 0-3 year olds; waiting times for Restorative dental services are being tackled through engagement of an Dentist with Enhanced Skills in endodontics (eg providing root canal therapy) that does not require intervention by a Consultant. 2017/18 will see high priority being given to reviewing and standardising the domicillary care provided, most notably to care homes, following the completion of the current pilot through which a dental health educator (WHC(15)1 funded) is training care home workers in oral health assessment and hygiene techniques.

- **Optometry**: following the appointment of a Health board optometry advisor, the Health Board will be ensuring that planned care ophthalmology leads review key patient pathways, eg cataracts, with a view to ensuring that the maximum use is made of the skills and experience available in primary care to minimise any unnecessary hospital outpatient assessment or follow up appointments.

These examples of service redesign hold the key to the development of a more sustainable model of care if they are implemented on a comprehensive basis. The Health Board also held a follow up workshop on 22 September to explore how to build on this progress and transfer lessons learned from community cardiology to other chronic condition areas such as diabetes and respiratory medicine. The aim of the workshop was to set out the potential scope of a cluster based service in these areas, and to assess the benefits of this for patients, professionals and the secondary care system. This work is now helping to inform service redesign plans within our IMTP and the associated workforce and financial frameworks, and will feed into the emerging HB Primary and Community Services 5 year strategy.

Other initiatives we are progressing to reduce the workload on GPs include:

- the ability for practices to cross refer patients for sexual health services to neighbouring practices in their cluster, for minor operations service in Bridgend

- Network based Domiciliary CCM Nursing service to treatment housebound patients, including the introduction of diabetes passports in a residential care home

- Upskilling our Practice Nurses, Healthcare Support Workers and Receptionists to work within a prudent framework ‘at the top of their licence’ to move appropriate work away from the GP to the right professional within the practice.

- Patient education - recognition of the significant cultural shift for professionals and patients alike in moving to increased levels of cluster working and the new models of care associated with them, for example, patient expectations of seeing a GP rather than another member of the multi-disciplinary team.

- Promoting choose well campaign and the role of community pharmacy and optometrist to divert appropriate patients from general practice – again prudent framework.

- Changing models of working within the practice, for example, telephone first triage models, and MDT skill mix within in practice – diverse workforce ANPs, Paramedics, Pharmacists, Counselors, GP or divert to other PC professional / hub service eg pharmacist, MH Counselor, physiotherapists as in the Neath Hub pacesetter

NEATH PRIMARY CARE HUB PACESETTER

As is the case across Wales, GP Practices in the Neath Cluster have experienced increasing workloads. The traditional method of every patient seeing a GP in every case is proving unsustainable. It is apparent that better, more effective methods of managing patient demand need to be implemented. In short the current Primary Care Model is unsustainable.

An exciting new service has been developed by Neath Cluster Network to support GP Practices in their efforts to respond to increasing patient demand whilst achieving quality of access for the patient.

The Neath Primary Care Hub provides a range of services including physiotherapy and a mental health support worker from a central point in neath as well as a prescribing pharmacist working in practices throughout the cluster.

All cluster GP Practices have adopted a telephone triage approach based on the positive experiences of some practices in the cluster. To facilitate this hub of services has been established which GPs are able to refer directly into from the point of triage.

In order to achieve this, the cluster has commissioned V360 shared appointment and clinical system to enable GPs to book patients directly into the hub and allow practitioners access to the patients clinical record.

The aim of the pacesetter is to save GP capacity, freeing up essential time to allow GPs to deal with more complex cases thus 'doing today's work today' reporting improved job satisfaction and giving patients a far better patient experience by allowing them access to the most appropriate professional at the right time.

Deadlines:

Evidence shows as much as 30% of presentations to GPs are MSK related. These cases can be diverted to the Hub and other services

In the first 8 weeks operation of the Hub over 200 patients were seen by Hub physiotherapists and 45 patients were seen by the Mental Health Support Worker

In the last 10 months the Hub Pharmacist has saved cluster GPs time supporting over 6,000 patients. 1,000 of these contacts was face to face

Patient feedback has been positive

GPs have reported positive support from the Hub

FEDERATED WORKING ACROSS BRIDGEND: EAST CLUSTER NETWORK PROJECT

Six GP surgeries in Bridgend have joined together to offer a range of new community services for their patients including a bespoke new website aimed at cluster network patients.

Pen-Y-Bont Health (PYB) is the first federation of GPs in Wales and includes all six practices in the Bridgend East Cluster: Ashfield, Newcastle, Oak Tree, New Surgery Pencoed, Pencoed Medical Centre and Riversdale (five of which are training practices varying from a single handed practice to an eight partner practice serving a population of 70,484). As a federated cluster of GP surgeries, the Bridgend East Network has developed Wales' first not-for-profit social enterprise consortium with an NHS Pacesetter status. This allows PYB to bid for public sector contracts to provide local healthcare solutions for local need. Crucially this overcomes restrictions which usually limit contracts to individual surgeries. One GP from each of the six practices was nominated by their partners as 'directors' to attend board meetings, discuss, negotiate and report outcomes of planning meetings to establish the federation.

The federated model allows resources to flow in a sustainable way improving access to services and improved pathways for patients. Engaging with the Third Sector and other agencies should allow for a more diverse way of tracking some of the communities' health concerns. As part of the project the Federated pacesetter will publish resources including a learning log and a toolkit to assist clusters in the future if they wish to follow the federated route.

One of the initial joint projects was the website development www.pybhealth.com which not only contains local information but a wealth of information on common illnesses, dos and don'ts, childhood complaints and health and wellbeing topics (including stopping smoking and diet and exercise). The website will also empower patients to be better informed about health issues before they see their GP. PYB patients can use the website as an aid to help make informed choices.

The federation has also set up a joint mental health, counselling service for PYB patients over the age of 18. Before this, patients were usually signposted to local charities for support but now the federation is able to offer direct counselling services. A service is also planned for patients with diabetes who are prescribed injectable agents.

Item 2

The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

As outlined above, there are 11 cluster networks in ABMU HB, each with a central management team in place to support and develop cluster working.

The national investment into clusters and the pathfinder/pace setter and Primary Care IMTP and Workforce Funding from Welsh Government has been essential in supporting plans to diversify the workforce and develop more sustainable models of care within our cluster networks.

The Health Board is redesigning the workforce, working with primary care and third sector providers to ensure that we have the right level of staff with the appropriate skills to deliver services in the most appropriate setting. Our cluster workforce is being developed to support prudent healthcare principles, service developments and overcome recruitment difficulties for certain staff groups.

Examples of workforce redesign and the redistribution of work and roles can already be seen across the 11 clusters. There have been opportunities to change the skill mix across the whole care spectrum both to address the core GMS work as well as addressing some of the demand factors, such as complexity, increasing number of frail older people, and the need to address the widening health inequalities gap. Investment in the wider primary care workforce has included:

- **Clinical Pharmacists**; contributing to clinical work relating to medicines in GP practices, supporting safe and effective medicines use.
- **Acute Clinical Outreach utilising GP's** working closely with elderly care physicians to provide real alternatives to hospital admission.
- **Chronic Conditions Nurse** for housebound patients in order to provide a person-centred, holistic approach to the management and education of patients with chronic morbidities.
- **Counsellors**; increasing access to mental health and emotional wellbeing services.
- **Physiotherapists;** acting as first point of contact for musculoskeletal conditions
- **Advanced Audiologists;** a 12 month plot operating across 3 clusters to diversify the primary care team and receive direct triage referrals from practice for appropriate patients to release the burden from GPs
- **Physicians Associates;** two practices across the ABM area have received year two students on clinical placement as part of a Physician Associate role undertaken in Worcester University. Swansea University has launched its own Physician Associate Course which commenced in September 2016 and practices across Swansea and Neath Port Talbot will be hosting these students during their clinical placement year.
- **Third Sector Primary Care Occupational Therapists;** to support fast track interventions in the community.
- **Early Years Specialist worker** in Penderi cluster in Swansea to address social problems linked to parenting
- **Mental Health Link Workers and Community Dementia Support Workers;** embedded within our integrated community teams and working out in practices to extend the pathway of care for dementia support within primary care

- **11 Care Navigators** employed within the Community Network Operational Teams / integrated network teams for Anticipatory Care
- **Extended Practice Nurse and Health Care Support Worker** roles via training programmes, for example, ARTP Spirometry, ECG, phlebotomy.
- Extended roles of GPs – with Special Interests (GPwSIs) 5 **Cardiology GPwSIs** employed to develop community cardiology clinics
- **Integrated Gower Team;** local authority and health board care staff provide a more efficient domiciliary service for residents of the Gower.
- **Developing the skills of our Cluster Clinical Leadership** team with 8 of the 11 cluster GP leads / 2 Area Clinical Directors on the Welsh Government funded Confident Leaders Programme
- Increased use of **Telephone Triage** and Consultation (21% of practices), ensuring patients access the right healthcare professional for their needs.
- Development of **district nurse led wound care clinics.**
- **Community pharmacists;** considerable investment and expansion of the Level 3 Stop Smoking Service across community pharmacies; development of 'Homely Remedies' policy for nursing/residential homes, emergency supply service allowing pharmacists to supply medication in the absence of a prescription in an emergency situation.
- ABMU is Wales' pathfinder site for the new **111 service**; access to health professionals including advanced paramedics and pharmacists for urgent telephone advice and clinical assessment; commissioning this service involved remodelling that provided hitherto by NHS Direct and incorporating the GP Out of Hours Call Centre service previously provided by an external provider [Primecare]. Early indications – eg over the busy Christmas period which saw a 20% rise in calls for Out of Hours services – would appear to indicate that the new model coped very well, with no additional pressure placed on Emergency Departments and GPs. A particularly helpful element of the 111 service, available at peak times only so far, is the presence of a multi-disciplinary 'Clinical Support hub', including a GP, Nurse practitioner and pharmacists – the latter proving very useful in dealing with requests for prescriptions out of hours.
- access to **oral health care** NHS professionals in ABMU is amongst the best in Wales but remains patchy, and is being improved through several initiatives:

    - Remodelled urgent care access services in and out of hours which increased significantly the capacity of the service to meet urgent care demand
    - Two dental practices utilising a new Wales Prototype contract that is not activity-driven but facilitates a holistic approach to oral health care, with increased use of hygienists and therapists focussing on oral hygiene, with intrusive dental treatments minimised in line with need
    - Introduction of a new dentist with capacity to take on 100s of new patients in the socially deprived upper Afan Valley, spearheading a campaign to ensure the specialist Community Dental Service has greater capacity to focus on providing oral health care for vulnerable people by transferring their healthy child patients to the new general dental service.

- Extending the utilisation and skills of **optometrists and non-medical eye care professionals** in line with the key principles of prudent healthcare. The Health Board has supplemented the Welsh Government funding made available to provide independent prescribing training for optometrists to manage glaucoma cases and more acute eye care in the community, and the Higher Certificate in Glaucoma

providing skills in detecting change in clinical status and decision-making in patients with stable ocular hypertension or glaucoma.

- Work is now ongoing – through the 111 Directory of Service and through clusters - to ensure that all professions are aware of diagnosis and treatment that patients can receive directly from the 87% of community optometrists who are accredited Eye Care Examination Wales [ECEW] practitioners, and of the support that can be provided to improve the life experience and well being through the 23 practices that currently provide a Low Vision Support service. Both these services have, as a consequence of additional publicity and the drive to incorporate ECEW practitioners into the Cataract and low level Glaucoma pathways, experienced a significant increase in their utilisation.

- There is a strong desire within clusters for a multidisciplinary workforce model and future collaboration between practices, there is also recognition that many GP premises are not sustainable into the future. The 11 cluster plans outline opportunities and priorities for making better use of wider clinical roles such as pharmacists, physiotherapists and counsellors. In addition, commitment is given to exploring new clinical roles such as physician associates and roles such as lifestyle coaches Audiologists and OTs. The voluntary sector and other primary care contractors also play an integral role. Priorities include:

- Extending the range of professionals and maximising the skill mix within the clusters including pharmacists, pharmacy technicians, practice based physiotherapists, advanced practice audiologists.
- Support opportunities to mentor and train physician associates and provide training placements for nurses.
- Increased nursing workforce and skill mix to manage chronic conditions, minor illnesses.
- Continue to improve access to mental health and wellbeing services.
- Roles to support prevention, independence and wellbeing i.e. CVD Health Check Programme, Occupational Therapists.
- Providing development opportunities for the unregistered workforce.

- The Health Board, working with Swansea University and the ARCH programme (A Regional Collaboration for Health) is also exploring the opportunity to establish a Primary Care Academy with Swansea University to accelerate training, reinforce local recruitment and longer term GP retention across the Health Board.
- The Health Board has also commissioned Swansea University (College of Human and Health Sciences) to explore the scope and nature of the existing advanced practice workforce within community and primary care across the ABM footprint and to provide recommendations regarding future workforce needs in order to inform workforce planning. This piece of work is due to be completed in spring 2017 and will help to inform cluster and IMTP plans from 2017/2018 and beyond.

- In terms of how the contribution of each of these cluster professionals and new workforce roles can be measures, this is still under development within ABMU HB. We have produced a report for our Board on the new Primary Care Measures portal (September 2016 public Board) and are currently in the process of converting some of these Measures into a PCS Unit Dashboard for daily/weekly/monthly reporting.

Annex 1:

http://www.wales.nhs.uk/sitesplus/documents/863/2%20%28iv%29%20Primary%20Care%20Measures%20for%20Wales%20Performance%20Report.pdf

- Many of the specific posts have impact and evaluation frameworks attached to their funding stream and work is progressing to collect this data to evidence their contribution.

Item 3

The current and future workforce challenges

ABMU Health Board in common with many parts of the UK is experiencing sustainability issues in both primary and community services. Sustainability concerns have been reported by a number of general practices across ABMU, driven by issues such as a lack of ability to recruit or retain General Practitioners; workload pressures and demands due to an ageing population and a reported transfer of work into primary and community Services; expected population growth within ABMU of approximately 30,000 over the next ten years. The changing demographics of the GP workforce and poor condition of some of the primary care estate has also affected the ability of practices to provide sustainable services.

Delivering primary care to meet the needs of the population

Sustainable primary care services rely on stable and sustainable general practice and therefore there has been the need for short-term work to help stabilise practices to deliver on high workload and workforce pressures. This has included:

- Opportunities for career development through portfolio careers for GPs in ABMU to support future recruitment and retention.
- Development of more innovative recruitment campaigns including social media, recruitment videos and website http://www.wales.nhs.uk/sitesplus/863/page/87351
- Contribution of primary care nursing considered at cluster level, providing opportunities to develop new skills.
- Cluster specific solutions;
    - GP fellowship scheme to encourage recently-qualified GPs to practice in areas that has been difficult to recruit

Annex 2

- Federated GP model
- Neath Primary Care Hub
- Cluster Salaried GPs

  http://www.wales.nhs.uk/sitesplus/documents/863/Salaried%20Gp%20Advert.docx%202016.pdf
- Utilisation of cluster network monies to substantially improve access to a wider multi disciplinary team as described in the previous section.
- Establishment of a Practice Support Team and alternative portfolios for GPs

Annex 3

- GP Occupational health service rolled out across ABMU.

- Joint work with the Wales Deanery to improve recruitment and retention of dentists within South Wales through the Postgraduate Dental Training Unit [PGDTU], established at Port Talbot Resource Centre in 2010. In September 2014 the training programme was changed to include greater variety in the training placements, ranging through primary, community, secondary and tertiary care aiming to broaden skills, and encourage local workforce retention. September 2016 saw a further change with a tightening in UK-wide requirements that Satisfactory Completion of Training be demonstrated with students exposed to the full range of dentistry that could be expected in practice. As a consequence the service profile of the PGDTU has been remodelled to include its operation as a 'normal' general dental practice, and to become part of the rota of dentists providing urgent dental care in-hours.

GP Out of Hours Service (GP OOH)

ABMU HB is beginning to sketch out a 2-3 year plan for development of GP OOH Services, the first part of that plan being to re-brand it as Urgent Primary Care Service, which includes expanding the multi-disciplinary make-up of the service. This will entail creating a team which will be GP-led but will include Pharmacists, Practice Nurse Practitioners and Health Care Support Workers, in line with developments in General Practice in-hours. We will also intensify our links with WAST to develop and incorporate the role of the Paramedic Practitioner and make further use of rapid response vehicles. The principle aim of re-constituting the service and the posts within it is to ensure its sustainability by widening the scope of professionals that can respond to demand and reducing dependence upon the GP as the only source of response, which is important given the current GP shortage in ABMU and Wales. The vision is to create a GP led service with GPs continuing to be the principle source of triage but with the potential for the GP from the point of triage to transfer much of the face-to-face treatment and care (currently standing at 50% of activity) to other more cost effective professionals. This sits well with the principle of prudent healthcare with professionals working to the top of their licence and cost effective use of human resources.

8 of the 73 GP practices across ABMU currently have live vacancies for salaried GPs / partners on the Health Board website and the Health Board is also advertising salaried GP posts for the Fellowship Scheme (up to 9 WTE GPs) and the Practice Support Team (up to 3 WTE GPs).

In 2015/16 and addition 70.7 WTE staff were recruited into the Health Board to support cluster working across the various Welsh Government Primary Care Funding streams and an additional 64.6 WTE are in the process of being recruited in 2016/17.

Further Priorities being progressed in 2016/2017

- Continue to support and encourage collaborative working at cluster network level
- Enable effective workforce planning and support the development of cluster plans ensuring they address workforce needs.
- Share good practice and experience of new primary care models and extended primary care professionals i.e. physiotherapists, paramedics, pharmacists.
- Continue to support investment in the wider primary care workforce.
- Explore opportunities to reduce/streamline back office management functions through the provision of expert support and advice, provided through Shared Service Partnership.
- Manage public expectations and understanding of advanced, specialist and new roles, promoting alternative models of care through patient engagement.
- Provide further opportunities to develop specialist services, through the development of new patient pathways and GPwSI.
- Address GP sustainability through direct clinical support (mulit-professional practice support team), and roll out new models of primary care at pace i.e. practice mergers, GP federations.

- Continue to strengthen the multidisciplinary team working by evaluating the roles of extended primary care professionals.
- Continue to make best use of skills and support further investment in training and development.
- Roll out the anticipatory care model across all 11 clusters.

Item 4

The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients

To date clusters in ABMU have received £1,742,000 through their direct allocation from WG.

The cluster networks are utilising the funds made available to them to invest in a widening of the multi disciplinary team as described in Section 2 with each cluster network agreeing priorities for expansion of the team that would be of most benefit to the population and stakeholders within the network based on current needs. Some of the new workforce diversification posts recruited to work across the clusters include:

- the appointment of Physiotherapists, Occupational Therapists (based in the third Sector to support Healthy Homes and prevention), Mental Health Counselling services, chronic conditions nurses, paramedics and salaried GPs

Annex 4

Annex 5

- A significant amount of cluster network monies have been invested into the appointment of cluster pharmacists and a Prescribing Technician. Areas that the cluster pharmacists have supported include :

  - Nursing home medication reviews
  - Diazepam reductions (particularly in elderly as increased risk of falls)
  - NSAID reductions in elderly
  - Care home /assisted living polypharmacy reviews
  - Polypharmacy reviews for older patients
  - Flu vaccinations for housebound patients in conjunction with medical reviews.

  Early results show that the Cluster pharmacists have taken workload away from GP's they have carried out nursing home reviews, medication reviews and other relevant clinical tasks that may have been highlighted from their medicines management annual reviews, that otherwise GP's would need to do.

  The feedback from cluster clinical leads has been very positive and work is in progress to make the appointments permanent.

- Of particular note is a project being undertaken by the Penderi network in conjunction with the City and County of Swansea and the Health Board to employ an early years worker who will focus on ensuring that children in one of the most deprived parts of the Health Board have a good start in life and are ready for school in line with the aims of World Health Organisation Healthy City programme.

- Another innovative cluster funding workforce development is the introduction of a lifestyle coach in the North network, a partnership with HALO leisure service, the lifestyle coach will take direct referrals from the CVD Risk Assessment pilot project in the North cluster and will support obese and overweight citizens to make the appropriate lifestyle changes to reduce their risk of cardiovascular disease through an individually tailored 12 week accredited foodwise (nutrition) and NERS (exercise) programme.

This investment has supported a range of innovative projects including for example:

- Targeted pre-diabetes screening and lifestyle intervention advice across four cluster networks to raise awareness of and reduce the risks of developing diabetes in at risk adults

- Continued partnership with the third sector – such as the Healthy Partnership Project, extension of Citizens Advice Bureau scheme

- Focus on self care and co production through leaflets and radio campaigns

- Five patient carer forums established for cluster networks in Swansea under Big Lottery Community Voice Programme

- Introduction of SNAP 11 software across 6 practices in one cluster network to support the collection of patient feedback on service provision

- Four bowel screening pilot sites to increase early detection of bowel cancer

- Various health promotion initiatives including, alcohol screening pre diabetic work, community weight management, promotion of the Healthy City Directory

- The introduction of CRP point of care testing to reduce inappropriate antibiotic prescribing for lower respiratory tract infections

- Development of local Mental Health Services through increased counselling and CBT provision, mental health drop in clinics and mental health guide

- Establishment of a network based MSK service to reduce referral to secondary care

- Increased consistency across practices in networks re use of MHOL, texting services, reception staff training and patient experience, particularly in those practices introducing call management/clinical triage systems

- Maturing of cross border relationships

- Training and information on issues such as Falls Prevention information, Dementia, prescribing call handling and customer care

- Extending opportunities to improve access – use of Primary Care Foundation to review demand management and access, increased use of telephone triage,

- Development of a new women's refuge service

- Improving the delivery of end of life care

- Cluster networks have a strong track record of working collaboratively with the third sector as a result cluster network funds are also being utilised to enhance access to third sector organisations for patients to third sector organisations. Over £65,000 has been invested in a grant scheme in partnership with the Swansea Council for Voluntary Service to provide patients of the relevant cluster network with direct access to a arrange of services including children and young people counselling , services to combat social isolation, support for asylum seekers and mental health provision, services for carers. counselling services for young people,

- An innovative scheme looking at providing enhanced access to evidence based social prescribing services is also under development in the Cwmtawe network.

- Cluster funding has also been used to purchase standardised equipment across practices within clusters including:
    - CRP machines which support effective antibiotic prescribing.
    - Bariatric Weighing Scales to improve accessibility of service closer to home.
    - Dermatoscopes and associated training to support effective identification and management of skin lesions and conditions
    - Alivecor monitors which measure cardiac patterns and support effective identification of Atrial fibrillation

- to fund the instillation of patient information screens in reception areas to support cluster level public health campaigns; to fund Pocket medic within a cluster - an application to support chronic conditions management; to purchase vision 360 software to enable mobile working to improve patient safely for home consultations and reduce GP workforce pressures; to fund the instillation of Skype for business across 9 practices in a cluster to support Skype meetings and training to reduce travel times and time out of practice for GPs and practice staff

Workforce Development Funding (2015/16)

In August 2015 the Health Board received an allocation of £627,000 to invest in a range of new schemes to support the development of the primary and community care workforce. The funds were allocated on a recurring basis for three years, based on fulfilment of specific delivery agreements. The investment was committed using a balance of recurring and non-recurring schemes around the following broad areas:

- Training and development of core general practice professionals.
- Medicines Management roles and support.
- Easing clinical pressure within the community; Primary Care Mental Health Liaison Worker, Care Home Interface Nurses; Professional Development Nurse for District Nursing.

For 2016/2017 further commitment has been given to support;

- ABMU is piloting the introduction of a **Primary Care Audiology Service**. A significant proportion of ear and hearing related symptoms can be managed by Audiologists rather than by GPs. Patients will be seen by the most appropriate health care professional and help to reduce the number of GP contacts required. Three clusters have been selected as the pilot sites; Cwmtawe, Afan and Bridgend East. The Primary Care Audiology service will be piloted over a twelve month period to assess the effectiveness of the service. Audiology clinics began in August 2016 and will be extended to other GP practices within the selected cluster networks.

- Community dietetic programme to support the management of frail and older people in care homes and Type 2 Diabetes Education in the community.
- Non recurring use of monies to continue support for training, development and robust workforce planning – to be decided on an annual basis
- Establishment of a multi-professional practice support team that can be utilised to provide direct tangible support to practices facing sustainability issues

Item 5

The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice

Cluster Networks in ABMU Health Board

As outlined above there are eleven cluster networks within the ABMU Health Board area and the populations vary from about 30,000 to over 75,000.

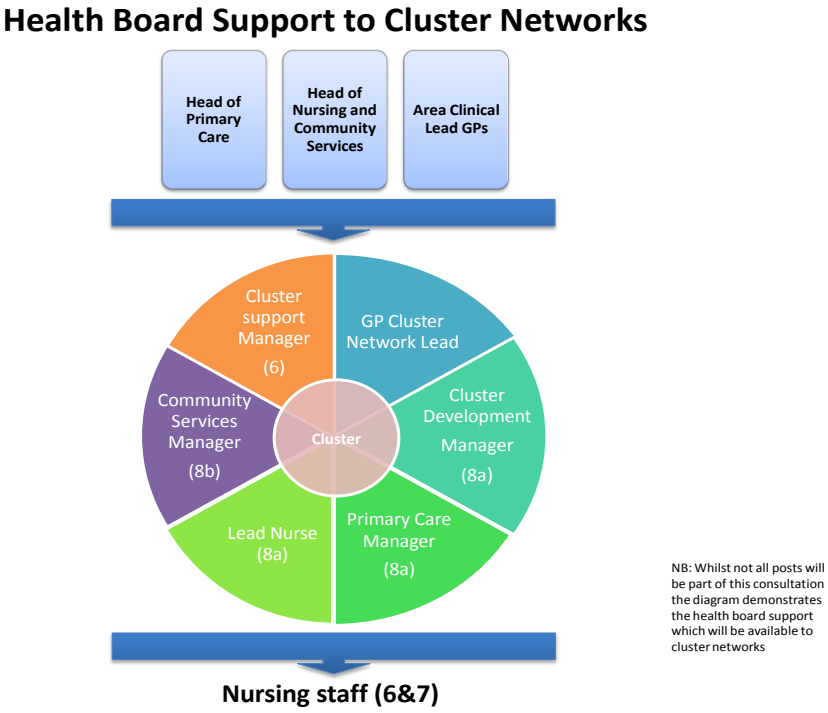
There is clear leadership within the networks from GPs in particular; and, the networks have been developed on a multi professional and multi agency basis. They now form the basis for organising and delivering many community health and social care services, and have developed strong key links with the third sector.

The 11 cluster networks meet on a bi/monthly basis with membership being drawn from GP practices, social services, community nursing, third sector, medicines management, Health Board dietetics, public health and some input from community first/ leisure services and, in Swansea, Local Authority Planning Departments. We are in the process of working to bring in the other primary care contractors more actively into the cluster meetings: community pharmacy, community optometry and general dental services. We are also working with secondary care clinicians, in particular elderly care physicians so that they become attached to cluster networks, and are developing new ways of working with A&E services.

ABMU Health Board is committed to the accelerated development of cluster networks and this will feature in emerging Primary and Community Services Strategy.

As part of this commitment the Health Board is currently changing its organisational arrangements to support the accelerated development of clusters. The strengthened

arrangements are set out below



The Health Board has appointed two area clinical leads and two cluster development managers which will be responsible as part of a broader team to develop the cluster network into more automous vehicles who will play an even more increased role in shaping health and social care community services, targeting services to improve health and well being and reducing health inequalities and to facilitate the delivery of services closer to home. This will require an acclerated programme of cluster network development which will be agreed as part of the developing Primary and Community Services Strategy.

We have also recently reviewed the job role of our 11 (GP) cluster leads, standardising their role across the clusters, a copy of the extant JD is embedded below, this is due to be reviewed and revised again by 31/3/17.

Annex 6

Each Cluster has finalised its third cluster network plan, informed by cluster health needs profiles. Annual reports and risk registers have been published on progress in year two and will shortly be completed for the third year. Progress on moving forward with cluster network priorities has been good and this has included

- Diversification of the workforce (detailed elsewhere)
- Supporting public health priorities, self care and choose well programmes
- Piloting new models of collaborative working
- Investing in modern technology and equipment to support improved patient care
- Peer review and support for improved patient pathways

- Considerably strengthening relationships with the third sector and access to an increased range of services, including the Healthy Partnership project which saw over 25 practices hosting a range of different voluntary sector services within general medical practices.

Main cluster development needs

- Leadership and support to develop
- Financial and governance accountabilities – as role expands further increased business and financial support.
- Time to identify and implement new models of working
- Pace of response from ABM for service change / development

Barriers to progress, governance issues – all being tackled:

- Pressures on core primary care services: recruitment, staff retention; solutions and suggestions being developed with primary care leads
- Ability to recruit to posts – availability of pharmacy technicians, medicines management professionals, advanced nurse practitioners, to recruit into networks with the investment that has been released – shared with WG Workforce leads and will be identified in revised ARCH prospectus as an area where collaboration with Swansea University and other education providers can assist
- Investment in challenging financial climate
- Capacity/ time constraints linked to pressures
- Cross border issues for patients straddling network boundaries

Item 6

Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision Setting the Direction

Local Leadership

The Health Board recognises that good quality leadership and management of our staff/contractors is critical to improving our retention rates. We are therefore providing a wide range of development programmes to support and develop leaders and managers at all levels, both inside and outside of the Health Board, to improve their skills and improve staff experience.

As indicated above ABMU HB has a robust clinical and non-clinical management structure in place to support cluster development.

The Unit Medical Director, working with the two Area Clinical Directors covering the 5 and 6 cluster geographies respectively, meet with the 11 cluster leads on a monthly basis in order to facilitate the sharing of good practice and leadership development.

Additionally within each of our 5 / 6 cluster areas we have a multi-disciplinary management team overseeing the work of the individual primary care development managers and cluster development managers who work at the cluster level.

We are also in the process of aligning our other HB support functions: Business Support and Finance and HR functions down to cluster level and are working to up skill all of our cluster support staff and our cluster leads so in a variety of topics including project management and workforce planning, service improvement and monitoring and evaluation.

ABMU Health Board has clearly signalled it is committed to the strategic shift of services to primary and community services and identified the continuing development of cluster networks as being a key part of that strategy. The Health Board is embarking on the development of a Primary and Community Services strategy that takes account of the development of integrated community services and cluster networks to date and sets out a vision for the future. To develop the strategy views will be sought from a range of key stakeholders and it is intended it will be agreed by the Health Board in the spring of 2017.

The cluster networks have a protected learning time programme that allows practices within a cluster network to regularly meet and consider service pathways and related issues. Topics that have featured in the programme recently include equality, diversity and human rights, cardiology service updates, gastroenterology, dermatology, child protection, national exercise referral programme, diabetes, respiratory, diagnosis of lung cancer domestic abuse and support services.

The Health Board supports this by providing cover for the practices that take part on the protected learning time programme.

In addition to the protected learning time scheme some cluster networks have now decided to meet on a more frequent basis than the GMS contract stipulates in order to progress their action plan priorities on an acclerated basis.

National Leadership

Confident Primary Care Leaders Programme

Following the Cluster Lead Survey conducted in 2015, the Confident Primary Care Leaders Course has been commissioned by Public Health Wales, It is aimed at cluster leads and aspiring cluster leads across NHS Wales. It is a bespoke programme consisting of nine half-day sessions which will be delivered by Primary Care Commissioning Community Interest Company (PCC), a not-for-profit organisation which runs confident leader sessions on a regular basis and with first-hand experience of working with primary care.

Sessions are led by qualified coaches and expert facilitators and include: Population Health and Maximising Patient Experience; Business Planning and Finance; Building a Culture; Influencing, Negotiating and Chairing Skills; Understanding Leadership Styles.

The programme commenced in September 2016, with a second cohort commencing in November, the Programmes run on a monthly basis.

The ABMU HB Primary Care Medical Director, both of the HB Area Clinical Leads and seven of the eleven cluster leads are registered on the Confident Leaders programme.

Further leadership development and training opportunities are being scoped by the Primary & Community Care Development & Innovation Hub, hosted by Public Health Wales and again, ABMU HB management team will take every opportunity to support our employed staff and staff within our independent contractors to engage in learning and development opportunities. The most recent course ABMU HB and affiliated cluster staff attended was the Hwb facilitated one day project management workshop held on 23/1/17.

Item 7

Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken

Monitoring and Evaluation:

Regular monitoring reports are submitted to Welsh Government on a quarterly basis for all of our funded pathfinder/pacesetter projects, the IMTP / workforce delivery agreements and the cluster level funding grants.

In addition, Public Health Wales have been providing support, guidance and oversight of the evaluation of the pathfinders / pacesetters to date. A copy of the interim evaluation is embedded below:

Annex 7

A further external evaluation into the benefits and outcomes of this pacesetter investment across Wales is also due to be commissioned by Welsh Government in the next month or so and will we understand, take 9-12 months to evaluate and produce the final report.

Welsh Government has also commissioned Public Health Wales to scope the potential to develop a maturity framework for clusters which is still being scoped.

Welsh Government are also in the process of developing a specification to tender for an external evaluation of the pathfinder/pacesetter programme across Wales.

Local Community input

To inform cluster network plans each general medical practice produces a practice development plan which sets out how the practice population has been involved in developing their priorities.

In addition the Cluster/ Health Board has benefitted from attracting Big Lottery funding to support the establishment of patient carer forums as detailed below.

Work is also being undertaken to gather patients views on the services put in place or bieng considered by clusters and this is detailed below.

ABMU - Healthy Partnerships Project
The aim of the Healthy Partnerships project was to increase the awareness of and signposting to third sector organisations (that support self-care and independence) from primary care.

From April 2013 – December 2014, the Healthy Partnership Project supported GP Practices and Third Sector Organisations across the Abertawe Bro Morgannwg University Health Board area to develop links by arranging for third sector information stands and bookable appointments within GP Practices. In addition to this training sessions focussing on third sector provision were also arranged for both clinical and non-clinical staff. In total 48 third sector organisations and 32 GP Practices (across ABMU) participated in the Healthy Partnerships Project

The main outcomes of the project were as follows:

- An increase in professional's knowledge of the support that is available from the third sector.
- An increase in the uptake of third sector services, by patients.
- An increase in signposting to third sector services from GP Practices.

The Healthy Partnerships project has demonstrated that, by thinking differently and maximising the resources that are already available, you can make a positive impact on the health and well being of individuals.

- ***For GP Practices*** the project has shown that a targeted approach supports increased signposting to third sector organisations.
- ***For third sector organisations*** the project has also demonstrated that by collaborating with GP Practices there are a number of direct benefits for third sector organisations, which include the opportunity for organisations to promote their services/projects to a targeted community; the opportunity to engage with those that are considered hard to reach and also the opportunity to directly engage with GP Practice staff and to build sustainable relationships.
- ***For patients*** the project has demonstrated that improved partnership working between the third sector and GP practices has a direct benefit for patients. From the number of enquiries reported by third sector organisations (following their information stand) we can deduce that those individuals have in turn accessed information and/or received additional support from third sector organisations as a direct result of the information stand. Anecdotal feedback from GP Practice staff also supports this with practice staff commenting on the benefit of this service for their patients.

ABMU Health City Community Voice – Patient and Carer Participation Groups

Big Lottery funding under the Community Voice Programme was obtained to establish five patient and carer participation groups in the Swansea area linked to the cluster networks. The Project began in July 2013 and will run until June 2017.
The main objectives of the project were to:

- Raise awareness of services, which are available (locally) and how to access them.
- Share views on the services that individuals currently receive/would like to receive.
- Work with service providers (from primary care, social services or the voluntary sector) to develop and deliver improved services and support.
- Contribute to the work of the Healthy City Programme.

Patient and Carer Participation Groups are now in operation within all five cluster network areas. The patient and carer participation groups are included as a key objective under

strategic aim 1 of all five cluster action plans and the participation groups strategically link with cluster networks. The groups support the work of the cluster network in addressing some of the priorities identified, as well as enabling patients and carers to be more involved and able to influence the design and delivery of local health, social care and well being services, ensuring that they are responsive to local need.

Within the final year of the project, the focus will be on implementing the priorities within the cluster network plans and ensuring the sustainability of the groups following the end of funding in June 2017. To date two cluster networks have committed to providing continued funding to allow the patient carer forum to continue.

Gathering patient views of extended cluster services

Work is also ongoing within the Cwmtawe network to undertake a survey of patients that identifies the need for additional services that can improve mental health and well being which will be used to shape the commissioning of services from the third sector. Surveys will be undertaken by the practices supported by the Council for Voluntary Services.

Work is also being undertaken to survey patient satisfaction of the increased access to mental health services by the City cluster and the impact that the services have made on the patient's well being.

SNAP 11

Bridgend East Cluster have invested in SNAP 11 patient satisfaction software and are trailing its use and applicability within general practice and also comparing date across practices at the cluster level.