Meeting Date	**27th September 2018**	**Agenda Item**	**4i.**
Report Title	Primary Care Annual Report		
Report Author	Sam Page, Lindsay Davies, Sharon Miller, Heads of Primary Care Hilary Dover, Director Primary and Community Services		
Report Sponsor	Chris White, Chief Operating Officer		
Presented by	Hilary Dover, Director Primary and Community Services		
Freedom of Information	Open		
Purpose of the Report	The report presents the National Primary Care Annual Report and the ABMU Health Board Primary Care Annual report for 2017/18.		
Key Issues	The purpose of the Primary Care Annual report is to describe the context within which directly managed and contracted services have been operating and developed during 2017/18. The report is aligned to the National Annual Report for Primary Care, published September 2018, and seeks to provide a summary of the key issues and achievements for 2017/18. This is within the context of the Health Board Primary and Community Strategy approved in May 2017. In line with the National Annual Report the ABMU Health Board Annual report is structured around the five priority areas/themes of the Primary Care Plan which, 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 National Primary Care Annual Report is presented to ABMU Health Board for information. The ABMU health Board Primary Care Annual Report is presented to the ABMU Health Board for approval		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	√			√
Recommendations	The Board is asked to: • **NOTE** and **APPROVE** the Primary Care Annual Report for 2017/18			

PRIMARY CARE ANNUAL REPORT 2017/18

1. INTRODUCTION

The purpose of the National Primary Care Annual report (**Appendix 1)** and the ABMU Primary Care Annual Report (**Appendix 2)** is to describe the context within which directly managed and contracted services have been operating and developed across all-Wales (national) and ABMU Health Board (local) during 2017/18.

The ABMU Health Board Primary Care Annual report is aligned to the National report and seeks to provide a summary of the key issues and achievements for 2017/18. This is within the context of the Health Board Primary and Community Strategy approved by the Board in May 2017**.**

In line with the National Primary Care Annual report this local report is structured around the five priority areas/themes of the Primary Care Plan that 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.

2. BACKGROUND

Over 90% of patient contacts take place in General Medical Practices of which there are 68 in ABMU. During 2017/18 the number of General Medical Practices in the ABMU area reduced from 73 to 68 (having reduced from 77 in the previous 3 years). This has been as a result of:

- Four sets of practice mergers
- One practice closure and dispersal of the patient list to neighbouring practices

The Health Board also contracts with 125 Community Pharmacies, 95 Dental practitioners (including 7 Orthodontic and two oral surgery specialists). The Health Board also engages with 52 Optometry practices who provide enhanced eye care services.

The Primary and Community Services Unit has responsibility for the management of these contracts and for a wide range of directly managed community services, which are detailed in the report. The Health Board also has responsibility for directly providing General Medical Services to the registered patients of Cymmer Health Centre (circa 2500 patients) and from 1st April 2017 Cwmavon (circa 3300 patients) as a merged practice.

Services are mainly delivered within 11 Cluster Networks which cover a defined geographical area. These Cluster Networks have continued to strengthen and develop during 2017/18 as well as being the organisational platform for delivery of a range of services and are now further developing as innovative agents to drive service delivery and change.

The ABMU Health Board Primary Care Annual Report demonstrates how the Cluster Networks have progressed with a number of priority projects achieving a range of outcomes highlights the innovations which have taken place in the pacesetter

schemes which have been run within the health board. The report also demonstrates the good work which continues in the contracted and directly managed community services and the impact that a number of pathways are having in helping to support people to remain in their own home where appropriate through utilisation of appropriate care and technology.

Key achievements include:

Planning Care Locally:

- Successful planning and implementation of **Cluster programmes** and priority areas to improve services for patients in the community enabled the full utilisation of the funds allocated by Welsh Government (£1.742 million recurrently) together with slippage from the year 2016/2017. This has seen increasing use of the cluster platform to innovate with new service approaches and ways of working, and across agencies, for example Children and Young Peoples Mental Health, Weight Watchers and/or National Exercise Referral Service [NERS] programme for newly diagnosed diabetic and pre-diabetic patients. There continues to be joint cluster approaches to schemes to benefit from economies of scale. For example, pre-diabetic pathway programme for patients in undertaking lifestyle changes to benefit their health and wellbeing in four Clusters.
- Four of the 95 **general dental contractors** in the Abertawe Bro Morgannwg University Health Board area volunteered and met the locally developed criteria to test out a Wales-revised version of the 2005 General Dental contract which aims to reduce the disincentives to providing holistic, preventive care that are inherent in the original.
- ABMU Health Boards investment plan for **community pharmacies** focused on supporting the sustainability of the health and social care services, with a particular aim of minimising unnecessary unscheduled care pressures on General Medical Practice and hospital services. Working closely with colleagues in Community Pharmacy Wales, NWIS, Public Health Wales and GP Cluster leads the following was commissioned:
    - the Common Ailments Service in all 125-community pharmacies;
    - more pharmacies (102 from 46) delivering the Emergency Medication Service [EMS] to ensure that patients can, at no charge, access their repeat medication every evening, weekend and Bank Holiday from a local pharmacy rather be routed through the 111/GP Out-of-Hours (GPOOH) service
    - more pharmacists (100 from 84) to deliver the Help Me Quit smoking cessation service, treating 7% more people
    - 95 (10% more) community pharmacies provided the flu vaccination service to 8000 people, an increase of 34% on the previous year, which contributed approximately 6% of the overall flu vaccination achievement with GPs and cluster based initiatives supported by Public Health Wales.

- **Low Vision Service Wales** accredited optometrists in ABMU undertook 1368 consultations a 5% drop from the previous year but still more than the Welsh average for the same population which reduced almost 10% in 2017/18 from the previous year.
- **Eye Health Examination Wales** activity in the ABMU practices continues to be the highest level in Wales. Almost 23,000 patients received EHEW services in 2017/18, reflecting an increase of 45% in the two years to 31 March 2018: 32.4% in 2016/17; a further 10% more in 2017/18.
- The **Designed to Smile Team** have continued their excellent work in the community, working closely with dentists, the Speech and Language Department and school nursing team to prevent dental decay in pre-school and primary school settings.
- **Paediatric dental pathway;** the clinically-led Referral Management Centre for paediatric referrals was established within the Community Dental Service on a phased basis from June 2017 onwards

Improving Access and Quality:

The ABMU Health Board Primary and Community Strategy proposed the delivery of primary care services at scale, designing and delivering more services closer to home with the aim to deliver excellent health services and improve the quality of patient care. The strategic quality objectives of ABMU provide the cornerstone for the quality objectives within our strategy.

Key achievements include:

- **Patient Engagement** through cluster events and regular Patient Groups, feeding into Cluster Plans and aiding in delivery and achieving the cluster plan aims and engagement via a programme of questionnaires.
- **Falls Scrutiny panels** were developed to review falls by inpatients within Community Hospitals and has shown great improvements in reducing harmful falls.
- **Infection Control** is a high safety priority for the Health Board both in Primary and Community Settings with a pilot in progress to reduce urinary Tract infections for those living in Care Homes, and outcomes of this work being reviewed in January 2019.
- Development of a **Governance Assurance Framework** for General Medical Services which defines what governance means for GMS contractors and establishes a vision of how we ensure this is a priority, at all levels to improve standards and protect patients from unacceptable standards of care.
- The development of the **ABMU Primary Care Dashboard** in 2017/18 provides the Health Board with access to local measures to support measuring and reviewing quality in Contractors where data is available to the Health Board at Cluster level or above.

- **Improving access to services** remains a key priority for the Health Board. Traditional models are no longer sustainable and locally services are changing to ensure they can provide quality services and meet demand. During the last three years there has been a significant move towards expanding the primary care team in all contractor professions, in and 'out of hours' where appropriate. This has helped to provide improved access to services, delivering care closer to home whilst assisting sustainability and workforce issues.
- More people continued to be able to access an **NHS Dentist** over the previous two years in ABMU (62.6%) than in any other Health Board.
- Transfer of management responsibility for the **Restorative Dentistry** service to the Primary and Community Services Delivery Unit (from Morriston Hospital Unit) and the development of more ambitious plans to remodel the service.
- 'Exemplar' work, to map **Optometry practice** capacity (premises, staffing and skills) to support service planning and eye care pathway development.
- Expansion of **Audiology clinics** expanded to locations in four clusters, including the Neath Hub. 5000 cases have now been seen by Primary Care Audiologists.
- A wholesale service delivery review of **Speech and Language Therapy** to improve waiting times. Members of the team have been asked to present their work on therapy outcome measures at national and regional conferences.
- Since investment into the **Pulmonary Rehabilitation** service in 2016 to upscale and enhance the support for our chronic respiratory disease patients in ABMU HB the service has gone from strength to strength, including 2017 NHS Wales Award Finalists.
- Launch of **Telephone First Model Framework** which is being used to champion and refer to when General Medical practices are reviewing their existing access arrangements or are looking at ways to manage demand effectively whilst maintaining and improving access for patients.
- The **GPOOH Service** responded to the challenges of providing a service with a decreasing number of available GPs by re-shaping some of its service provision and has continued to provide a significant and important role in the wider unscheduled care system working with partners across the Health Board area.
- The **Mobilisation Project – Connecting staff to each other, to information and to patients and the public** has enabled the Health Board to mobilise 2,500 community based mobile staff with iPads and clinically governed mobile solutions. Approximately 1,100 of these staff are based in Primary and Community Services. Health Visitors involved with the release of the ABMU-developed Caseload app the have reported a significantly reduced requirement to return to base, resulting in additional patient contacts being possible.

- The drive to introduce new technology at the **Primary Care Hub Neath** has led to exciting new projects being undertaken with improved functionality and reporting as well as a focus on transitioning to a paperless service.
- Successfully established a safe high quality **atrial fibrillation and anticoagulation service** based in the community delivered at practice level.

Equitable Access:

- Bridgend North Cluster commenced delivery of the **Cardiovascular Disease [CVD] Health Check Project** on 1st August 2017; this pilot project is facilitated by ABMU and delivered in partnership with the eight GP practices in the Bridgend North Cluster.
- The Primary Care Unit received **Improvement Grant funding** for five GP practices in Swansea.
- Welsh Government has provisionally allocated £16.2m **Pipeline Funding** to develop new **health and wellbeing centres** in Bridgend and Swansea and refurbish two existing health board owned clinics in Murton and Penclawwd. Development continues at pace on all four schemes.

Skilled Workforce

The Primary Care and Community Services Unit employs almost 1500 staff, most of them managing or providing clinical services. Currently across the 11 GP clusters there are a mixture of cluster pharmacists, social prescribing link workers, cluster community nurses, paramedics, phlebotomists, physiotherapists, mental health workers, occupational therapist, exercise referral specialist, audiologists and primary care Early Years workers. This has been complemented by an increased provision of third sector services through the Heath Board grant scheme and through the use of cluster funds. Community services are delivered jointly with local authorities providing seamless care across Bridgend, Neath Port Talbot and Swansea.

Strong Leaderships

ABMU Health Board continues with an 11 Cluster leadership group providing a more frequent and structured opportunity for interface as peers, with senior managers, corporate and other units in the Health Board and to articulate Cluster development requirements with a greater voice.

3. GOVERNANCE AND RISK ISSUES

The Annual Report provides a summary to the Board of key areas of work taken forward in 2017/18 and demonstrates the effectiveness and breadth of the service delivery.

4. FINANCIAL IMPLICATIONS

There are no financial implications that flow from approving this annual report.

5. RECOMMENDATION

The Board is asked to:

- **NOTE** and **APPROVE** the Primary Care Annual Report for 2017/18

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Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
	✓	✓	✓	✓	✓		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	✓	✓	✓	✓	✓	✓	✓

Quality, Safety and Patient Experience

The Annual Report provides a summary to the Board of key areas of work taken forward in 2017/18 and demonstrates the effectiveness and breadth of the service delivery.

Financial Implications

There are no financial implications

Legal Implications (including equality and diversity assessment)

There are no legal implications contained within this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.

Staffing Implications

There are no staffing implications however, this report describes the workforce within the primary care and community services unit responsible for the management and provision of clinical services.

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

There are no direct implications on the Well-being of Future Generations (Wales) Act. However, the specific updates in this report will be subject to full impact against the act where necessary.

Report History	No previous report for 2017/18
Appendices	1. All-Wales Primary Care Annual Report 2017/18 2. ABMU Primary Care Annual Report 2017/18

Annual Report 2017 – 2018

Executive Summary

'Our plan for a primary care service for Wales up to March 2018'

Directors of Primary and Community Care

(Formerly the Directors of Primary Community and Mental Health)

2018

BACKGROUND

In July 2014 an executive leadership conference was held to consider how NHS Wales could realise the strategic ambition for primary and community care to '*move centre stage'.*

The top priorities identified at the event were:

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

To address the first priority i.e. 'The need for a clearer strategy and vision at all levels', '*Our Plan for a Primary Care service for Wales up to March 2018'* (NHS Wales/Welsh Government (WG) was published in February 2015 to provide vision and direction. (Hereafter referred to as the Primary Care Plan).

A further workshop led by Directors of Primary Community and Mental Health (DPCMH) was held 10 July 2015 and whilst it was acknowledged that some improvements had been made, many of the priorities required greater focus.

The 2015 workshop concentrated on the importance of utilising the current opportunities to raise the profile of primary care. It was concluded that it would be important to present a clear message, articulating risks and consistently presenting evidence of impact of primary care developments on IMTPs.

It was agreed that primary care needed to have equal importance alongside Unscheduled Care and Planned Care programmes, aligning design principles and common purposes, and not viewed as 'separate'. There needed to be a clearer understanding of the impact that primary care activities can have on USC and on planning for whole system change.

It was concluded that a transformational mind shift would be necessary as currently primary care, prevention and public health featured less on strategic priorities. DPCMH set about establishing a programme of implementation of the Primary Care Plan.

A further outcome of the 2015 workshop was the intention to establish a dedicated resource in Public Health Wales to help take the national agenda forward. The Primary Care Innovation and Development (PCDI) Hub was set up in November 2015 initially '*as a virtual and real centre for debate and activity around developing the effectiveness of Primary Care Clusters'(*Set up proposal paper 6th November 2015*).* The PCDI later developed into the Primary and Community Care Development and Innovation Hub (PCCDI) as an integrated resource in June 2016, directed by a Programme Management Board*.*

Since then DPCMH have produced Mid-term and Annual Reports covering the 3-year period focusing on a high-level summary of progress with examples of practice developments at local level.

The 2017/18 Annual Report in addition to summarising activities of the past year also summarises the achievements of national and local actions over the period 2015/18.

INTRODUCTION

The 2017/18 DPCC Annual Report is structured around the original 5 key themes, i.e.

- Planning Care Locally
- Improving Access and Quality
- Equitable access
- A skilled workforce, and
- Strong leadership

This Executive Summary highlights the key messages and acknowledges the ongoing challenges, outlining the priorities for 2018/19 which have been based on the recommendations from '*A Healthier Wales: our Plan for Health and Social Care'* Welsh Government June 2018. Final reflections revisit the priorities from 2014.

KEY MESSAGES 2017/18

1. Progress with Pacesetters

The Pacesetter Programme was a comprehensive range of initiatives funded by WG to stimulate innovation and promote the redesign of Primary Care services with pace.

The first cycle of Pacesetter projects began in April 2015 included a focus on at least one of the following; improved access to services, moving care closer to home and increased sustainability of primary care services. A total of 24 projects were implemented, led by Primary Care Teams across Wales and supported by the Primary Care Community Development and Innovation Hub (Public Health Wales).
Each Pacesetter project was evaluated individually and the outcomes were used to inform decisions on the subsequent scaling up of service developments and to provide the basis for further studies into new ways of working. Learning from the first cycle of Pacesetters led to the development of a new model of primary and community care and influenced the development of a whole system, transformational framework for primary care in NHS Wales. A summary of pacesetter projects 2015 - 2018 is included in the main report.

To ensure that future Pacesetter projects encompassed all elements of the new model of primary care that had emerged, criteria was set to approve new pacesetter projects commencing 2018. In addition, innovations not part of the Pacesetter programme have been collated and shared. All details have been made available via Primary Care One. A further 15 Pacesetter/pathfinder projects commenced April 2018.

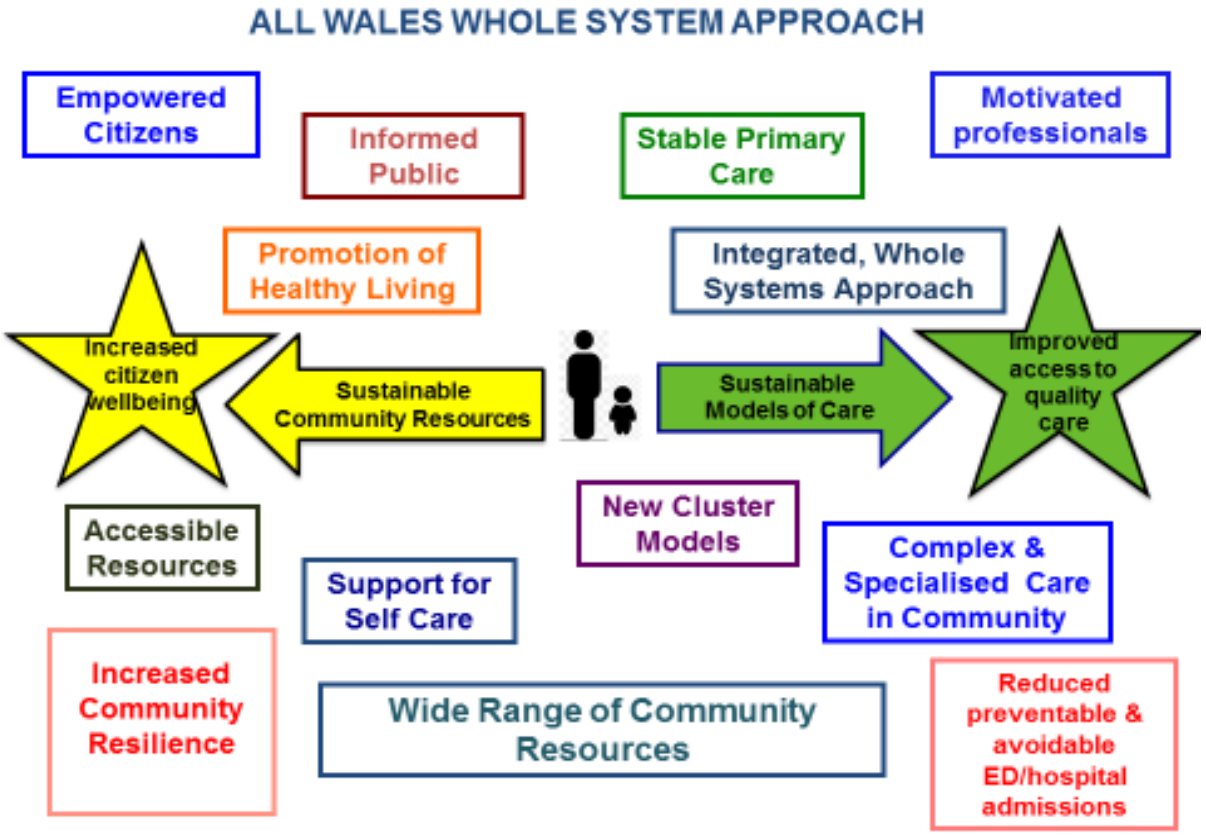
2. The development of new Model of Primary and Community Care

The new model of primary and community care is based on achieving sustainable community resources to increase citizen wellbeing alongside sustainable models of care to improve access to quality care. This requires the public to be well informed and primary and community services to be stable and able to provide complex and specialised care in the community.

The anticipated outcomes of such an approach based on national and international research, alongside the evidence emerging from the Pacesetter Programme, indicates the potential benefits of the transformational model for primary and community care would be:

- Improved citizens' health and wellbeing
- Greater community resilience
- Better practitioner morale, motivation and wellbeing
- Increased recruitment and retention of primary care and community staff
- Sustainable models of care

Many of the actions from 2017/18 were taken forward by the Transforming Primary Care Group who have planned and monitored activities, which make up the components of the model shown overleaf.



Clinical Triage and Multidisciplinary Team working were prioritised for development during 2017/18.

Clinical triage systems at the front door of primary care are designed to direct people to the most appropriate professional/clinical service, moving away from the current system in which the GP filters the majority of patient contacts. Telephone advice is appropriate for a significant proportion of people's requests and, if given by a suitably experienced professional, can safely and effectively reduce the number of face-to-face consultations. A telephone first model, incorporating call handling (or care navigation) and clinical triage, has the potential to direct or signpost people beyond the multi- professionals around the GP.

The telephone first / triage model is also about ensuring access to the right care from the right service in a timely way. However, there are varying definitions and approaches to clinical triage. During 2017/18 it was agreed to survey all practices to ascertain their interpretation and use of different models. The consultation phase ended May 2018 and results will be used to inform the possible identification of a framework of principles.

3. The need to rebalance resources from secondary to primary care

To support the development of a whole system approach to planning will require a rebalance of resources. During 2017/18, the National Primary Care Board (NPCB) commissioned Assistant Directors of Finance to develop a framework to support resource and financial rebalancing from acute hospital care into community and primary care settings, working with the DPCC.

The key objectives of transferring services is to improve the sustainability, quality outcomes and costs of delivering care. Establishing new and improved

community based services, which add value to patients allows for a re- allocation of resources in the most efficient and effective way for population health gain.

The final Framework was approved May 2018 and was issued as a Welsh Health circular (Number 025) in July 2018.

4. Development of Primary Care Clusters – A Good Practice Guide

As Primary Care clusters have developed across Wales, teams have been exploring the options for organisational models to suit their local needs. Whilst it is accepted that cluster development is evolving and will differ both within and between Health Boards, the DPCC highlighted the importance of securing agreement on the core principles and standards for cluster organisation and governance arrangements.

Earlier work on cluster governance carried out in 2015/16 was reviewed and followed by two engagement workshops, held to develop a draft Governance framework. The framework was circulated for an engagement exercise during April 2018 and sections have been reviewed by subject experts. It is intended that a summary Guide to Good practice will be published later in the year with links to more detailed resources and the full framework.
The development of the Governance Framework also addresses the recommendations made in the '*Health, Social Care and Sport Committee Inquiry Report into Primary Care Clusters'* (October 2017).

5. Development of the Primary Care Workforce

Since the publication of *'A Planned Primary Care Workforce for Wales (July 2015 - March 2018)'* and the associated Action Plan, a Primary Care Workforce and OD group have continued to deliver on the recommendations.

The Workforce Plan recommended the need to plan and build a workforce with the right numbers and mix of skills to meet the majority of people's planned and unplanned needs at the right time, by the right person, closer to home in flexible ways and flexible facilities.

The resulting action plan was divided into the following areas:

- Putting in place the foundations for a more robust approach to workforce planning, including,
  - Workforce data and analytics
  - Service redesign
  - Integration

- Supporting the continuing development of primary care clusters and the sharing of best practice, including,
  - Understanding and developing clusters – leadership and skills development
  - Sharing good practice

- Investing in the development of the wider primary care workforce by,
  - Investing in the wider primary care workforce
  - Education and Training

- Stabilising key sections of the current workforce, focus on,
  - Nursing
  - General Practitioners

A summary of achievements has been produced and is referred to in the main report.

Whilst a lot of emphasis has been on the challenges of recruitment especially to GP posts, the importance of engaging all health care professions and wider members of the primary and community care multi-disciplinary team (MDT) in the development and implementation of the transforming primary care model has been recognised. A discussion paper was presented to the Primary and Community Care Reference Group (PCCRG) in January 2018 outlining the context. Subsequently, a questionnaire was developed to outline the new

transformation model framework and to seek evidence regarding impact of individual profession's roles as part of the MDT helping to inform the workforce development element of the programme. The questionnaire also sought comment on access to primary health care and community services.

The main purpose of the questionnaire was to engage with all professions providing input to the wider multidisciplinary teams and consider access to appropriate clinicians and practitioners. This included professionals from within general practice and within the wider range of community based teams across health and social care.

The questionnaire was a chance to demonstrate the impact that can be made and highlight some of the challenges and barriers to progress where these exist. Analysis will be undertaken as part of the FWP for 2018.

6. Focus on Access

The primary care plan focussed on making sure access was simple and clear promoting diagnosis, investigation, treatment and continuity of care as close to home as possible. This has required an emphasis on information, advice and assistance and the provision of services normally provided in secondary care to be available in communities, accessing the wider primary care professional workforce. During 2018, the PCCRG undertook initial work on behalf of WG to start a conversation with professionals and service user groups on the characteristics of what '*good access*' looks like. The workshop aimed to explore what improvements are being tried and where there are gaps requiring further action. The plan would be to articulate the case for change and consider how access can be measured to demonstrate improvements over time.

Plans are now ongoing to develop a national narrative and action plan for delivery of the commitments in *Prosperity for All: The National Strategy* and to improve communications and engagement with the public and professionals regarding changes in primary care. Further workshop events will need to be planned during 2018 to engage the public as well as their representative groups.

7. External Critical appraisal of Primary Care in Wales completed May 2018

As part of the Pacesetter evaluation process, the Health Service Management Centre of the University of Birmingham was commissioned to undertake a critical appraisal of the Pacesetter Programme. The critical appraisal process started in June 2017 and was conducted in four stages, and completed in April 2018. The overall aim of the research was to strengthen the learning for future primary care transformation programmes in Wales through investigating the experiences of Pacesetter teams, exploring the views of stakeholders and comparing outcomes with current research evidence and international best practice.

The conclusions of the report include key messages and implications for future Pacesetter Programmes and the transformation of primary care and community in general. Overall, the review concluded that the Pacesetter Programme was a valuable experience, enabling the testing of innovations and shared learning between Health Boards. Drawing on the experiences of the Pacesetters to develop the Transformational Framework for Primary Care, it has provided a means to translate local lessons into a national vision.

The key findings of the critical appraisal are summarised in the main report. A workshop will be held in October 2018 to share the learning and agree next steps.

8. Extension of Primary Care Measures

The focus of the Primary Care Measures in 2017/18 has been the implementation of a second phase of measures and the creation of a new dashboard on the

Primary Care Information Portal. The Phase 2A measures have focused more on population health. The new dashboard allows easier reporting and enables the user to toggle between views and drill down to Health Board level and Cluster level data.

Phase 2A measures included GP Practice indicators e.g. the percentage of over 65s registered as having dementia/ memory impairment with their GP Practice, and the number of emergency admissions for ambulatory care sensitive conditions; PHW Indicators e.g. Circulatory disease mortality rate per 100,000 of the population for those under 75 years and Seasonal Influenza at risk groups; and Dental Indicators e.g. Children aged 0-17 years who accessed dental services at least once a year and Antibiotic Prescribing.

Health Boards will continue to report on all the measures and will be presented to the Welsh Government Joint Executive Team Meetings. There will be a period of evaluation of the Phase 2A measures before work begins on the next phase.

9. Identification of Key Indicators

In addition to the routine collection of quality and delivery measures, DPCC have worked together to identify 5 - 6 high level indicators to provide a gauge of the pressures/ temperature of primary care services. The first stage of this work has utilised indicators that are readily available and in the first instance relate to general medical service provision. This work will be built on over time drawing on complementary work that is ongoing and include the wider primary care team.
Indicators have been proposed around 3 categories;

- Existing model/contractor status e.g. number and percentage of practices rated red, amber and green on the sustainability framework
- Patient experience e.g. number of practices that are reporting a closed list status, and
- Transforming primary care status e.g. number of community pharmacies participating in the common ailments scheme.

Indicators have been consulted upon and are subject to approval by CEOs and WG.

ONGOING CHALLENGES

1. Bringing about whole system change
2. Cross sector working and integration
3. Sustainability
4. Recruitment of professionals
5. 24/7 services and OOH
6. National patient and public engagement
7. Providing evidence of impact

PRIORITIES 2018/19

At the time of writing, the DPCC were working on a Primary Care response to '*A Healthier Wales'* building on the work over the past 3 years and shifting the focus to a 'wellness system', incorporating areas to promote whole system working across boundaries ensuring that public engagement is central to change. The resulting strategic programme for primary and community care will enable pace and scale of transformation.

The Transforming Primary Care Model included elements that support the intended way forward however; there has been limited focus on issues of prevention and wellbeing with the exception of social prescribing. Going forward, the social model of care needs further development. This requires an understanding of the opportunities that exist across the health, social care and third sector workforce to really understand what matters to people and make every contact count.

Whilst considering the development of the social model of care, the actions from a health perspective will continue. The Critical Appraisal undertaken by the University of Birmingham highlights the need for Health Boards to develop the required local infrastructure to enable transformation within primary and

community, suggesting that the core business of Health Boards will need to shift the balance towards a seamless service embracing the contribution of primary and community care resources.
To take the plan forward a number of key workstreams are currently being proposed e.g.

- Learning from transformation
- Prevention and well being
- 24/7 model
- Digital technology
- Workforce and organisational development, and
- Communication, engagement and co-production

CONCLUSIONS

To complete the Annual Report, DPCC included a brief account of the top 3 achievements which sum up changes over the past 3 years that have had the greatest impact on services. As follows;

Abertawe Bro Morgannwg

- Implementation a new model of primary care
- Developing and promoting new models of working
- Integrated model of health and social care – optimal model for dental/eye care

Aneurin Bevan

- Sustainability of primary care
- Care home support
- Integrated working

Betsi Cadwallader

- Dwyfor temporary resident service
- Developing information governance protocols and policies for clusters
- Enhancing the development and learning for the primary care nursing workforce in north Wales

Cardiff and Vale

- Care Hone Integrated Support Team (CHIST)
- Social prescribing
- Addressing sustainability through the provision of MSK and mental health support in primary care

Cwm Taf

- Baby teeth do matter
- Intergenerational work with young people
- Rapid diagnostic clinic for cancer

Hywel Dda

- Development of community pharmacy services
- Cambrian Primary Care, a GP federation delivering care home enhanced service
- Telephone consulting/doctor first

Powys

- Physician's Associates
- Nurse triage
- Provision of eye care in the community

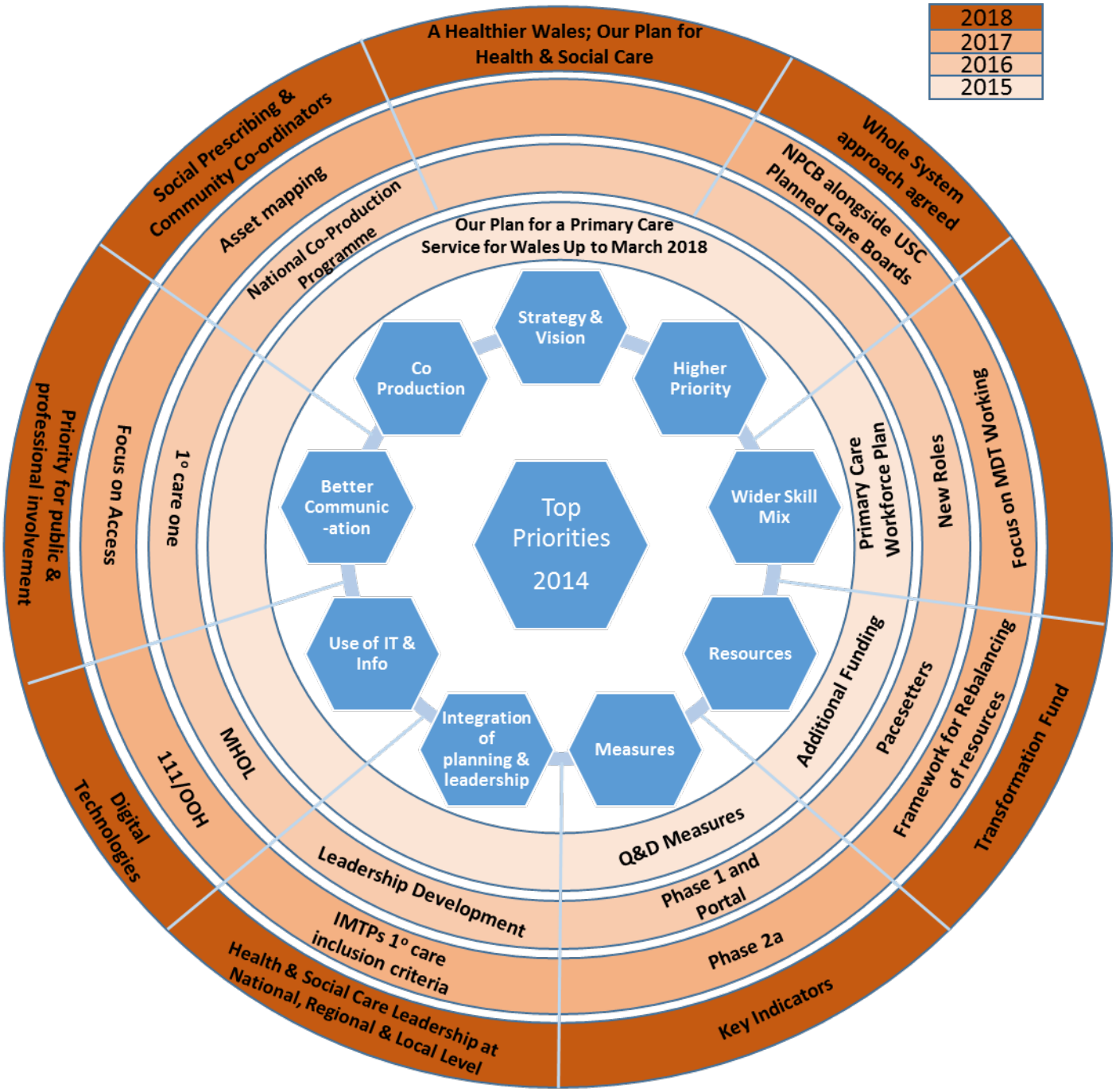
REFLECTIONS

REFLECTIONS ON PROGRESS SINCE THE 2014 WORKSHOP

The diagram below shows the significant progress that has been made since the 2014 workshop. Working outwards from the centre the top priorities (shown as hexagons), align to the actions and achievements each year to address the priority. The outer circle for 2018 shows some of the intentions and priorities moving forward.

Whilst the 2015/18 plan has been concluded, it is obvious that the agenda for the future is substantial and expanding, demonstrating the impact that the work has had over the past 3 years which has achieved *'moving Primary and Community Care Centre Stage'* as originally intended.

Priorities and Achievements



All-Wales

Annual Report

2017 – 2018

'Our plan for a primary care service for Wales up to March 2018'

Directors of Primary and Community Care

(Formally the Directors of Primary Community and Mental Health)

2018

Contents

BACKGROUND

'Our Plan for a Primary Care Service for Wales up to March 2018' was published by Welsh Government in February 2015, *(hereafter referred to as the Primary Care Plan).* The plan detailed key actions to be taken forward at a National level alongside 26 key actions to be taken forward at the local level.

NHS CEOs agreed that implementation arrangements would be taken forward under the leadership of the DPCMH and monitored at the Director's monthly meetings.

The period between April to October 2015 formed the set up phase to determine how each element would be progressed. A Midterm Report published in November 2015 summarised the activity and the processes used to formulate the implementation arrangements for 2016/17.

The first Annual report from the programme 2015/16 provided a high level summary of progress against each of the national actions with examples of developments at local level. It did not include an account of progress made across the whole of the portfolio managed by DPCMH at local level; nor the many activities associated with the development of mental health and community services. Mental health services were prioritised for action during 2016/17 and early scoping of national actions took place from February 2016.

A further Annual Report was published in July 2017 providing a summary of progress and reporting the early outcomes from innovations and pacesetter projects indicating the emergence of a model for whole system care. All Wales Chief Executives also requested the development of terms of reference for Executive peer groups alongside evidence of the contribution to a National Policy and Improvement Programme which incorporated the implementation of the *Social Services and Well Being (Wales) Act (2014)*, and the *Wellbeing of Future Generations Act (2015).*

The 2016/17 Report presented a summary of activities wider than the original recommendations within the Primary Care Plan.

INTRODUCTION

This Report focusses predominantly on activities progressed and delivered during 2017/18 whilst including a summary table of achievements and outcomes covering the period 2015 – 2018.

It attempts to capture all aspects of the agenda that DPCMH (changed to DPCC April 2018) have worked on, on an all Wales basis.

In 2017, DPCMH agreed to prioritise three main areas of work to structure the forward work plan (FWP) e.g.:

- Emerging model and sustainability;
- Contract negotiations, initially GMS;
- Mental Health.

Existing Boards and groups set up previously to take elements of the agenda forward were maintained and actions assigned appropriately. An additional emerging model group was initially set up in June 2017, later evolving into the Transforming Primary Care Group. Final reports on the deliverables from the forward work plans are available via PCOne Website:

http://www.primarycareone.wales.nhs.uk/home

Structures established to facilitate negotiations of the GMS contract are detailed in section 2.2. The Contract Oversight Group initially focussed on contract changes for 2017/18 and will continue to oversee 2018/19 and 2019/20 negotiations.

This report is structured around the five priority areas/themes of the Primary Care Plan:

- Planning care locally;
- Improving access and quality;
- Equitable access;
- A skilled workforce;
- Strong leadership.

Each chapter includes the activities that have contributed to the achievement of the overall aim, with additional sections focussed on areas of work not directly referenced in the above themes.

The scope of work has also been influenced by a number of publications and additional areas of work during the period 2015 – 2018, which have added to the direction and breadth of the changes in primary care, as follows:

- The Social Services and well-being (Wales) Act 2014;
- The Well-being of future generations (Wales) Act 2015;
- Prudent health – Securing health and Wellbeing for future generations 2016;
- Taking Wales forward 2016 – 2021 WG;
- Prosperity for all – the national strategy. The WG wellbeing objectives 2017 (Sept 2017);
- Ministerial task force workforce - Train - work – live in Wales campaign 2017;
- GP services in Wales the perspective of older people (Older People's Commissioner for Wales Feb 2017);
- Health, Social Care and Sport committee inquiry into primary care clusters 2017;
- Parliamentary Review of Health and Social Care in Wales:
    - Interim report July 2017;
    - Final report – A revolution from within January 2018.
- Services fit for the future – quality and governance in health and care in Wales (June 2017).
- Plus, MH publications (not listed).

PART 1 KEY THEMES

1.1 Theme 1: Planning Care Locally

The Primary Care Plan reinforced the importance of bringing together those who assess and plan the needs of the community and those who coordinate access and deliver care, as well as the recipients. Health Boards were required to prioritise the rapid development of primary care clusters each with a leadership team to agree action plans and key milestones to contribute to LHB integrated medium term plans. Plans needed to explain how health boards intended to improve capacity and capability of their primary care services.

In support of cluster development, a national set of governance requirements have been developed and a national programme of organisational development overseen by Public Health Wales.

From 2015 DPCC have been required to deliver a national approach to supporting innovation in primary care, including structured support mechanisms, systematic evaluation of new ideas and good practice, and prioritising funding for innovative ways of delivering care and improving access

<u>Achievements 2017/18</u>

1.1.1 Cluster Development and Support

The Primary and Community Care Development and Innovation Hub (PCCDI), continued to support cluster networking and development by providing access to a range of leadership and skills education, responding to needs identified by clusters. A third cohort of the '*Confident Primary Care Leaders Programme'* for cluster leads and aspiring cluster leads remains ongoing and the Hub continues to work with Academi Wales to offer the '*Cluster Lead Development Programme*', currently in its second cohort with a third being organised. The Primary Care One Wales (PCOne) website promotes collaborative cluster working and supports cluster development nationally, providing sources of information specific to clusters and cluster leads across Wales as well as the wider primary and community care audience.

Cluster teams continue to recruit to new multi-professional roles and, with the support of their health boards, are proactively developing new services and pathways both within primary care and across the interface with the acute sector. Investment at local level has been used to meet local needs.

1.1.2 Pacesetters and Innovation

The Pacesetter Programme was a comprehensive range of initiatives funded by WG to stimulate innovation and promote the redesign of Primary Care services with pace.

The first cycle of Pacesetter projects began in April 2015 included a focus on at least one of the following; improved access to services, moving care closer to home and increased sustainability of primary care services. A total of 24 projects were implemented, led by Primary Care Teams across Wales and supported by the Primary Care Hub (Public Health Wales).

Each Pacesetter project was evaluated individually and the outcomes were used to inform decisions on the subsequent scaling up of service developments and to provide the basis for further studies into new ways of working. Learning from the first cycle of Pacesetters influenced the development of a whole system, transformational framework for primary care in NHS Wales outlined in Part 2.

A summary of pacesetter projects 2015 - 2018 is at Appendix 1.

1.1.3 Critical Appraisal and Evaluation

As part of the Pacesetter evaluation process, the Health Service Management Centre of the University of Birmingham was commissioned to undertake a critical appraisal of the Pacesetter Programme. The critical appraisal process started in June 2017 and was conducted in four stages, with final completion in April 2018. The overall aim of the research was to strengthen the learning for future primary care transformation programmes in Wales through investigating the experiences of Pacesetter teams, exploring the views of stakeholders and comparing outcomes with current research evidence and international best practice.

The final report and executive summary of the critical appraisal can be found at:

http://www.primarycareone.wales.nhs.uk/home

The conclusions of the report include key messages and implications for future Pacesetter Programmes and the transformation of primary care and community in general. Overall the Pacesetter Programme has proved a valuable experience, enabling the testing of innovations and shared learning between Health Boards. Drawing on the experiences of the Pacesetters to develop the Transformational Framework for Primary Care has provided a means to translate local lessons into a national vision.

The key findings of the critical appraisal are summarised below:

- Transformation of primary care requires a co-ordinated programme of activities that is sensitive to the local and national context. Implementing new models involves clinicians, managers and leaders developing new paradigms for their roles and relationships.
- Team based working is a helpful vehicle for introducing a new dynamic between professions, but requires a willingness for doctors to collaborate with others as equals. Clusters are important forums to connect with local clinicians, but vary in their readiness to support innovations.
- The internal culture within a primary care service is a major influence on its willingness, readiness and ability to engage with a transformation programme. It can be more challenging for those struggling to cope with demands and with no previous opportunities to transform. The pressures experienced by most NHS services can restrict the opportunity and energy to implement transformation and new projects can deplete core professionals from existing services.
- The impacts and learning from the programme would have been greater with more clarity on expected outcomes, a robust evaluation framework, service users and communities being involved in project designs and stakeholders engaged in the oversight of the programme.
- The policy environment can encourage or dissuade primary care services from engaging with reform. A financial incentive system that supports more collaborative and preventative approaches is vital. Collaboration between Health Boards does take place, but there appears to be some tensions that can prevent transparency and sharing of good practice.

1.1.4 Alternative Provider Models of Medical Practice

In 2015 the Welsh Government awarded 'Pathfinder' project funding to support the development of a social enterprise consortium model which was piloted by six General Practices working within Bridgend County Borough.

Part of the project delivery included developing an All Wales Toolkit that could be made available to other GP practices across Wales that may be interested in exploring the option of developing a similar social enterprise venture.
The toolkit draws on the experience of existing federations and other primary care organisations and shares practical advice, research evidence, case studies and resources.

Part of the toolkit includes the definitions of alternative provider models of medical services (APMS), including social enterprise.

The all Wales Social Enterprise Health and Wellbeing Toolkit for General Medical Practitioners was published in 2018. The Welsh Government definition is:

"A social enterprise is a business with social objectives. Their left-over profits are reinvested for that purpose in the business or the community, instead of raising profit for shareholders and owners. A social enterprise tackles a wide range of social and environmental issues. They compete in the marketplace like other businesses, using their business skills to achieve social aims. Like other businesses, social enterprises aim to sustain their business and make profits. The difference is what they do with the profits."

As a social enterprise is not a legal entity but a business approach, there is a range of legal structures/formats that can be adopted by this type of social business such as:

- Charity;
- Mutual venture;
- Employee owned;
- Co-operative;
- Trust.

Choosing the right legal format and structure will depend on a number of things including the proposed business model the new organisation plans to adopt. The Toolkit also describes types of Consortium and Federated models.

A Consortium can be defined as:

- An association or combination of businesses, financial institutions, or investors, for the purpose of engaging in a joint venture; or
- A cooperative arrangement among groups or institutions.

Similarly, a Federation is formed by a number of nations, states, societies, unions etc., each retaining control of its own internal affairs. The words consortium, alliance or federation are often used interchangeably.

There is a range of Consortium/Federated models e.g.:

- Informal arrangement;
- Lead model;
- Special Purpose Vehicle (SPV);
- Limited Liability Partnership (LLP).

The Consortium model chosen in Bridgend was a SPV i.e. a new legal body established to manage the contract.

In the future some partnership arrangements could include developing alliances with third sector organisations, public health bodies and pharmaceutical companies.

In support of developing alternative provider models, HBs in Wales have commissioned Capsticks to prepare a draft of a model APMS contract model. The draft contract model will be based upon the following legislation:

- The NHS (Wales) Act 2006 ("NHS Act");
- The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 ("GMS Regs");
- The Alternative Provider Medical Services (Wales) Directions 2008 ("APMS Directions").

The draft APMS contract model will consist of a standard front end contract (based on the above legislation) with schedules/annexes for population/tailoring at a local level.

Certain provisions of the draft contract will be left open for local determination in order to provide as much flexibility as possible.

1.1.5 IMTP Guidance

Following the agreement to align the Health Board planning cycle with Primary Care, to enable cluster level plans to directly influence and shape IMTPs, DPCC worked with Directors of Planning to agree criteria for HBs to include in their IMTPs, thereby providing evidence of progress in primary care development. IMTPs now include evidence of the following:

- Primary Care Needs Assessments (PCNA) in each cluster area;
- Measures of primary care sustainability;
- Robust PC/community workforce planning based on PCNAs;
- Maturity of Clusters;
- Cluster governance frameworks established in each area;
- IM&T developments to support cluster development and functioning;
- New services established that evidence integration of LA / 3rd Sector services and social prescribing;
- Public engagement and involvement,
- Shifts of staff / other resources to support specialist outreach services and complex care in the community;
- An overview of the MDT workforce to show increases in capacity and capability across all clusters;
- Local OOH service status, with standards;
- The status of primary care estates;
- Support for innovation and quality improvement within primary care, aligned to agreed priorities.

1.1.6 Community Pharmacy

Across Wales Primary Care teams has worked closely with NWIS to rollout the Choose Pharmacy IT platform and Common Ailments Service (CAS). The following are examples from HDUHB and ABMUHB:

Emergency Medication Supply – enables participating pharmacies to supply repeat medication to patients without the need for a prescription if they are unable to obtain via their GP before their next dose is due. The service continues to be rolled out to pharmacies in HDUHB with the number increasing during 2017/18 from 39 to 65. The service continues to have a positive impact in reducing attendances at A&E and diverting individuals from contacting the Out of Hours service, where the reason for contact is related to medication only.

In ABMUHB in 2017/18 saw considerable focus on reviewing and improving contract management maximising the contribution of Community Pharmacies to the unscheduled care system, with 82% of pharmacies (from 15%) now providing 'out of hours' emergency medications and Sunday opening doubled (15 pharmacies across ABMUHB) and late evening (10.30pm) opening available in at least one pharmacy per county.

Common Ailments Service – enables participating pharmacies to provide advice and in most cases treatment at no charge, for 26 common conditions. The national roll-out of the service commenced in February 2017. At the end of 2017/18, 69 pharmacies in Hywel Dda University Health Board had been linked to the new Choose Pharmacy IT platform that allows delivery of the Common Ailments Service. This particular service has the potential to grow and support GMS sustainability. The aim is to have all pharmacies linked to the Choose Pharmacy IT platform and providing the Common Ailments Service by December 2018.

Triage & Treat – enables patients to obtain assessment and where appropriate, treatment for low level

injuries. During 2017/18, 103 patients accessed the service of which 55 indicated they would have attended A&E if the pharmacy service hadn't been available. Although there are only a small number of pharmacies taking part in the service, a new phase of training will be scheduled in 2018 with the aim of the service being more widely available.

Emergency Hormonal Contraception – enables the provision of the "morning after pill" to women aged 13 upwards, subject to a consultation with an accredited pharmacist and there being no medical exclusion criteria. Within Hywel Dda University Health Board, this service has provided around 4,000 consultations each year.

Additionally, Community Pharmacies are ideally placed due to numbers and locations to offer self-care advice and condition monitoring services. A number of such enhanced service are offered in Hywel Dda University Health Board:

Influenza Vaccination - Community pharmacies have been commissioned across all Health Boards to different degrees to offer NHS influenza vaccinations, for a number of years. The service has grown each year with more patients choosing to have their vaccinations provided at a community pharmacy, for convenience. There is no limit imposed on numbers of pharmacies that can offer the service. As with the unscheduled care services, access for relevant patient groups in all areas is the aim. During 2017/18 the number of vaccinations carried out within community pharmacy was 5,155 which represented a 32% increase in activity compared to the previous year.

Smoking Cessation Services - over the last 2 years there has been a focus within Hywel Dda University Health Board on increasing the number of pharmacies that offer a Level 3 Smoking Cessation service. This provides a one-stop service for smokers that want to quit. Community pharmacies are one of the key partners, together with Stop Smoking Wales and Hospital Cessation Services that work under the national Help me Quit branding.

During 2017-18 the number of pharmacies delivering this service increased from 33 to 43 and during this time, the service was accessed by 561 smokers in 2017/18 with 253 (45%) having a successful quit. The target quit rate for all smoking services is 40%. Hywel Dda University Health Board were the first Health Board to work collaboratively with our local Public Health team to engage a Smoking Cessation Champion to support and advice existing pharmacy providers, encourage uptake of the service in others and to promote the service to medical practices.

In ABMUHB, the Primary Care team has also worked closely with Community Pharmacies to reduce the smoking prevalence across ABMUHB to meet the health boards tier 1 target of a 5% reduction in prevalence by 2010 to 16%. To support this agenda, the commissioning of the service has been reviewed to ensure that high prevalence areas have sufficient access to the Community pharmacy smoking cessation service and has commissioned 117% more pharmacies (95 in total) to achieve this. The smoking cessation service is one of fifteen enhanced services that Community Pharmacies within ABMUHB deliver.

INR monitoring - The Health Board has worked with a community pharmacist who is a non-medical prescriber to set up an INR monitoring service for suitable patients in the local community. Historically, patients in the area had to access monitoring via the hospital phlebotomy department some 10 miles away. The pharmacy offers a one-stop service for point of care testing, dosing and prescribing (if necessary) as well as lifestyle advice on maintaining INR levels within range.

1.1.7 Low Vision Service Wales (LVSW)

The DPCC have continued to oversee the expansion of the LVSW established in 2004 as a community based service largely replacing the previous hospital based service.

Patients normally wait less than 2 weeks for an appointment compared to 18 months prior to the service provision. Studies have shown that the LVSW provides comparable clinical outcomes as hospital based low vision services with the added advantages of decreased waiting times and increased accessibility.

To date, accredited optometrists have carried out over 40,000 assessments and over 100,000 low vision aids have been prescribed on loan to patients.

The LVSW accepts referrals from ophthalmology, education, social services or patients themselves. There is no charge to the patient for the service and all aids are loaned free of charge.

1.1.8 Eye Health Examination Wales (EHEW)

DPCC are responsible for overseeing the EHEW Programme Board which is an extended eye care service free at the point of access for patients and enables patients to access eye care services closer to their home. Patients are able to access the EHEW service in their local optometry practice if they have an eye problem they feel needs urgent attention, rather than attending a GP practice, A & E department or an eye department in a hospital. The service also has provision to monitor patients discharged from hospitals following uncomplicated cataract extraction. The service is effective in reducing the number of patients being referred on to the hospital eye care service and has a very high patient satisfaction rate.

The numbers of patients being seen has steadily risen each year since 2016 and likely represents a shift of patients no longer attending their GP for acute eye care problems and patients understanding that they can attend an eye care service in optometry community practices. Referrals from pharmacies and other healthcare providers have also seen an increase in the service.

	2016/17	2017/18
	Activity	Activity
ABMUHB	12,400	13,577
HDUHB	8,220	9,600
PTHB	3,484	3,128
BCUHB	12,526	12,991
ABUHB	15,762	17,870
C&VUHB	15,925	17,869
CTUHB	9,020	10,610
Total	**77,337**	**85,645**

1.1.9 Social Prescribing

During 2017 a Social Prescribing Project Team was set up to oversee and advise on social prescribing in Wales. *A Next Steps* recommendations paper was endorsed by the National Primary Care Board in December 2017 with a plan in place for delivery of the key actions. The final report was published June 2018.

The *Next Steps* plan details actions to progress social prescribing in Wales including dedicated pages on PC One with the website acting as a repository of resources linked to sustainable community assets. There are also initiatives within PHW such as *Making Choices Together* (1,000 Lives) and Community Development (Health Improvement) that will continue to support the agenda. A Social Prescribing Network has been set up to address the gaps in evidence. The network was launched May 2018.

Example – the Torfaen Experience

Torfaen's model of Social Prescribing was developed in response to a need to better connect primary care with a range of services that exist across the community and public sector to tackle the underlying causes of ill health and promote self-help. Whilst Primary Care already utilise many of the services available in Torfaen, the catalogue of services is ever-growing and

changing, and the substantial time required in researching and connecting with these services is often not practicable

There are six participating surgeries in North Torfaen and seven in South Torfaen.

The Social Prescribers are based within each participating practice half a day a week and receive referrals from anyone based within primary care or from the patient themselves. The referral criteria is open, basically, anyone experiencing a social issue impacting on their physical and/or mental health.

Of 487 referrals, 352 (72%) individuals either attended a consultation or received a telephone intervention and 38 (8%) referrals were resolved by providing information directly to the referrer. Over 80% of those referred were, therefore, engaged in the service. (Bromley by Bow have comparable DNA rates with 24% of referred patients)

To date, 41% of onward referrals are to organisations that support with financial and housing issues and 17% are to mental wellbeing services. However, 9% of referrals were made to Torfaen Floating Support which provides support for housing related needs, including mental health.

The following outcomes have been achieved

- *The development of a referral mechanism from primary care into community services*
- *GP practices provided with a range of promotional materials on local services*
- *Development of an evaluation tool to collect evidence on the value of the service*
- *Identification of priority needs through analysis of referrals*

Case Study

H was referred to the Social Prescriber by a concerned relative. There had been some issues with the payment of his Employment Support Allowance (ESA), he was not opening his mail or leaving his home and needed to see the GP but would not make an appointment. On initial visit
the Social Prescriber and Communities First Financial Inclusion Officer were concerned, amongst other things, for his mental wellbeing.

The presenting needs of lack of food, re-instatement of benefits and accessing the GP were supported and focus shifted to the underlying needs and how H could resolve them. Within days H had gone from someone who would not answer the door, the phone or open his mail to someone who was re-arranging his own appointments, organising transport and arranging for a family member to undertake some domestic tasks. By providing the support to remove the immediate stresses, the Social Prescriber had enabled the capacity within H to support himself. This had a positive impact on his self-esteem which promotes his ability to cope. He has now been allocated a Support Worker from Gwalia to continue his journey to wellness.

1.2 Theme 2: Improving Access and Quality

The primary care plan focussed on making sure access was simple and clear promoting diagnosis, investigation, treatment and continuity of care as close to home as possible. This has required an emphasis on information, advice and assistance and the provision of services normally provided in secondary care to be available in communities, accessing the wider primary care professional workforce.

One of the aims was also to place greater emphasis on results of what we do and the impact on people's lives. To demonstrate continuous improvement a suite of quality and delivery measures which had been agreed late 2014, were to be further developed with the assurance of reporting mechanisms and discussion at Board level.

Achievements 2017/18

1.2.1 Primary Care Measures

The focus of the Primary Care Measures in 2017/18 has been the implementation of a second phase of measures and the creation of a new dashboard on the Primary Care Information Portal. The Phase 2A measures have focused more on population health. The new dashboard allows easier reporting and enables the user to toggle between views and drill down to Health Board level and Cluster level data.

Phase 2A measures included GP practice indicators e.g. the percentage of over 65s registered as having dementia/ memory impairment with their GP Practice, and the number of emergency admissions for ambulatory care sensitive conditions; PHW Indicators e.g. Circulatory disease mortality rate per 100,000 of the population for those under 75 years and Seasonal Influenza at risk groups; and Dental Indicators e.g. Children aged 0-17 years who accessed dental services at least once a year and Antibiotic Prescribing.

Health Boards will continue to report on all the measures and included within the Welsh Government Joint Executive Team Meetings. There will be a period of evaluation of the Phase 2A measures before work begins on the next phase.

1.2.2 Key Indicators

Following a request from the Cabinet Secretary, DPCC have worked together to identify 5 - 6 high level indicators to provide a gauge of the pressures/ temperature of primary care services. The first stage of this work has utilised indicators that are readily available and in the first instance relate to general medical service provision. This work will be built on over time drawing on complementary work that is ongoing and include the wider primary care team.

Indicators have been proposed around 3 categories:

- Existing model/contractor status e.g. number and percentage of practices rated red, amber and green on the sustainability framework;
- Patient experience e.g. Number of practices that are reporting a closed list status;
- Transforming primary care status e.g. Number of community pharmacies participating in the common ailments scheme.

Indicators have been consulted upon and are subject to approval by WG.

1.2.3 Access

The Primary and Community Care Reference Group (PCCRG) have undertaken initial work on behalf of WG to start a conversation with professionals and service user groups on the characteristics of what 'good' access looks like. The workshop aimed to explore what improvements are being tried and where there are gaps requiring further action. The plan would be to articulate the case for change and consider how access can be measured to demonstrate improvements over time.

The key messages and feedback from the workshop have been provided in a separate paper which can be found at:

http://www.primarycareone.wales.nhs.uk/home

General messages included:

- Good access means different things to different people;
- There is a need to ensure there is equity of access – wherever people live;
- People generally think of access to GPs but needs to be wider than this – not just access to health;
- Mixed views on whether there should be a central access point or 'many

front doors'. The important thing is wherever people access the system, it should enable access to the care and support they require (need to remove the 'funnel effect');
- Poverty is an issue/barrier in terms of costs of ringing for appointments, travelling for care and support etc.

Plans are ongoing to develop a national narrative and action plan for delivery of the commitments in *Prosperity for All*: *A National Strategy* and to improve communications and engagement with the public and professionals regarding changes in primary care. Further workshop events will need to be planned during 2018 to engage the public as well as their representative groups.

1.2.4 Clinical Triage

Safe and effective call-handling and clinical triage systems at the front door of primary care are designed to direct people to the most appropriate professional / service, moving away from the current system in which the GP filters the majority of patient contacts. Telephone advice is appropriate for a significant proportion of people's requests and, if given by a suitably experienced professional, can safely and effectively reduce the number of face-to-face consultations. A telephone first model, incorporating call handling (or care navigation) and clinical triage, has the potential to direct or signpost people beyond the multi- professionals around the GP.

The telephone first / triage model is also about ensuring access to the right care from the right service in a timely way. However, there are varying definitions and approaches to clinical triage. During 2017/18 it was agreed to survey all practices to ascertain their interpretation and use of different models. The consultation phase will complete end May 2018 and results will be used to inform the possible identification of a framework of principles.

Example - Call Handling and Nurse Triage Project Powys Teaching Health Board

This Project aimed to develop a sustainable model of patient streaming and nurse assessment and treatment, deployed at GP Practice level, in order to:

- *Improve access for patients*
- *Improve effectiveness through ensuring appropriate care interventions*
- *Improve efficiency through reducing inappropriate assessment and/or intervention*
- *Improve Practice sustainability through shared resource and costs*

The aim is to change the flow through primary care by providing appropriate alternatives to GP assessment and intervention.

Outcomes to date

<u>Effectiveness</u>
- *Nurse Triage (for urgent GP appointment requests only): 17,000 encounters. 61% redirected to services other than GP (17.4% received advice only).*
- *Total Triage (for all GP appointment requests): 5,000 encounters. 43% redirected to services other than GP.*

<u>Access</u>
- *Routine GP appointment time wait reduced from 14 days to 3 days*

<u>Efficiency</u>
- *All GP appointment slots increased from 10 minutes to 15 minutes*
- *Reduced DNA rates*
- *Improved staff morale (GPs and Nurses)*
- *Improved continuity of care*

Lessons learned

- *Reduces avoidable demand and improves access*
- *Can be applied to urgent and routine requests*

- *Can be delivered by one Practice for other Practices*
- *Need to train more Advanced Nurse Practitioners to avoid "robbing Peter to pay Paul), and training them takes time*
- *Upskilled Triage Nurses become more marketable*
- *GPs need to build trust in the Triage Nurses for the team to work effectively*
- *Empowers nurses and improves continuity of care for patients*
- *Practices, and individual GPs need to be ready to embrace it before implementation*

1.2.5 111/DOS

The 111 Programme Board has continued to lead the introduction and timetable for roll out of 111 following the Ministerial announcement earlier this year. Plans to date include Pembrokeshire and Ceredigion by September 2018, Powys in October 2018 and Aneurin Bevan in March /April 2019. Work is ongoing with Betsi Cadwaladr to develop a Clinical Hub to support out-of-hours services before Winter 2018/19.

There are also a number of key initiatives that 111 are progressing jointly with HBs and WAST which includes the development of a comprehensive Directory of Services (DoS). The expectation is that it will be in place across NHS Wales when each Health Board rolls out to 111 and LHBs are actively engaged in reviewing, updating and expanding their DoS entries and putting robust maintenance processes in place to ensure that the NHS Wales DoS remains up to date and reliable. This now includes an on-line symptom checker for common conditions and information on self-care. It is hoped to integrate Local Authority database (DEWIS) with the NHS system so that healthcare professionals and the public are directed to the right services to meet their needs and include options provided by the Local Authorities or third sector.

Concurrent work is progressing on the procurement of a new All Wales IT solution for 111 which will eventually replace the separate systems currently in place for NHS Direct Wales (CAS) and GP OOHs (Adastra). A procurement exercise will continue throughout 2018 /19. In the interim, there is a local IT infrastructure within out-of-hours so that all services are now on the latest version of Adastra and this can enable options for closer working between Health Boards on a regional basis and where appropriate, the provision of remote /home working for increasing triage capacity during periods of peak demand.

LHB's are continuing their pathway development work with particular focus on key clinical scenarios to build a consistent level of provision and standard of response throughout Wales, albeit delivered in accordance with local arrangements. Significant and ongoing progress has been made to support 111 go live and there are wider ongoing efforts made in preparation for roll out whilst supporting the wider transformation of urgent care 24 /7.

1.2.6 My Health on Line (MHOL)

Following the original development and implementation of MHoL, additional enhancements and modules have been developed as part of Phase 2 which will support further uptake and utilisation by practices and patients, e.g. a Mobile App, Update of Demographic Details, Online registration and Allergies and Medications information. Additional development is taking place, to develop and make available online access to the Detailed Coded Medical Record and to also enable patients to state language preference.

1.2.7 WCCIS

The Welsh Community Information System (WCCIS) Programme has been set up to deliver the informatics requirements key to the transformation of community services in Wales. A single ICT system for Social Care and

Community Health including, Social Workers, Community Nursing, Mental Health and Therapies has been procured. Under the overarching Master Services Agreement, individual organisations can enter into contracts with the chosen supplier – CareWorks UK. This is an eight-year contract from March 2015, with a possible extension for up to 4 years.
WCCIS will support delivery of integrated, co-ordinated care arrangements to citizens in the community through provision of technology and information for community staff.

- To support community based services to deliver more effective and efficient services to citizens in their own homes;
- To support emerging service models and service redesign through provision of supporting infrastructure, applications and Information Governance models.

When fully implemented across Wales it will overcome the obstacles posed when organisations use different IT systems by securely storing important information covering a range of activities such as community nursing, health and social care visits, mental health, learning disabilities, substance misuse, complex care needs or social care therapy.

There are currently 12 organisations live with WCCIS. They are: Bridgend County Borough Council, Ceredigion County Council, Powys County Council, Powys Teaching Health Board, Blaenau-Gwent County Borough Council, Torfaen County Borough Council, Merthyr Tydfil County Borough Council, Gwynedd Council, Isle of Anglesey Council, Vale of Glamorgan Council, Caerphilly County Borough Council and Newport City Council.

Frontline staff will be able to access and record information 'on the go' using mobile devices such as tablets and smart phones. They will be able to access the best available and most up to date information, so they know who was the last person to see the patient, what happened and what treatment or service plans are in place.

1.2.8 GMS IT

The previous Framework Contract under which GP systems and services were procured expired in 2016. A procurement was recently completed to establish a new Framework. In January 2018, the outcome of the procurement process was announced. The decision has resulted in one of the existing suppliers (EMIS Health Ltd) ceasing to be a provider under the new Framework. This meant that all EMIS Practices need to migrate to a new system, provided by one of the successful suppliers, Vision Health (InPractice Systems Ltd.) or Microtest Ltd.

While Vision Health is an incumbent supplier, they along with Microtest are developing new systems in time for the first migration. Workshops are ongoing to support transfer.

1.2.9 Capacity and Demand Modelling

Initial work commenced in conjunction with the Delivery Unit and was based on a similar approach undertaken in USC. This focused on mapping access routes into primary care as a basis for data assessment and analysis. Using Pacesetter monies, ABUHB commissioned Opersee Ltd to develop a demand/capacity tool which could be used in one GP practice to understand their demand, enable workforce planning and improve coding of the presented condition. The latter should aid a Practice in determining how best to use the multi-disciplinary team to appropriately meet demand. The results of this work were presented to the Transforming Primary Care Group in May 2018. Work is continuing to extend the model to a cluster level to assess transferability and potential benefits.

1.2.10 Rebalance of resources from secondary to primary care

During 2017 the NPCB commissioned Assistant Directors of Finance to develop a framework to support resource and financial rebalancing from acute hospital care into community and primary care settings, working with the DPCC.

The key objectives of transferring services is to improve the sustainability, quality, outcomes and costs of delivering care. Establishing new and improved community based services which add value to patients allows for a re- allocation of resources in the most efficient and effective way for population health gain. Whilst the initial focus is shifting along the health pathway from secondary care to community or primary care provision, the principles of the framework can be used in whole system redesign with key partners such as Local Authority and the Third Sector.

The final Framework was approved June 2018, as a Welsh Health Circular, and can be found at:

http://www.primarycareone.wales.nhs.uk/home

Case study - an element of improving access and quality

Example – Ambulatory Care Sensitive (ACS) Conditions Pathways Cardiff and Vale University Health Board*. A pacesetter project in Cardiff and Vale* University Health Board *developed a set of evidenced based pathways to support patients more safely and closer to home, thus reducing avoidable hospital admissions for ACS*

conditions. The team developed eight ASC pathways, e.g.:

- *Atrial fibrillation;*
- *Heart failure;*
- *Chronic Obstructive Pulmonary Disease;*
- *Diabetes;*
- *Advanced care planning;*
- *Falls related to polypharmacy;*
- *Dehydration and gastroenteritis in under 5s;*
- *Flu/Pneumovax (at risk groups).*

Subsequently pathways reduced to 6.

To take part practices have to sign up to all pathways incentivised and monitored for governance and reporting.

To date 90% of practices are signed up. The scheme will attempt to measure both impact on the USC system including

hospital and OOOH services as well as impact on primary care.

1.3 Theme 3: Equitable Access

Health Boards have been required to identify local solutions maximising primary care services to meet local need, tackling the inverse care law and reducing inequalities in health outcome. Improving access also required a focus on the Welsh language and access for people with sensory loss, learning disabilities, or other cultural needs or minority groups.

Achievements 2017/18

1.3.1 Inverse Care Law Programme

DPCC have received updates on work taken forward as part of the Inverse Care Law programme. This is an all Wales programme based on initial work led by ABUHB and CTUHB. In ABUHB – *Living Well, Living Longer Health Check 2014-2018* was the introduction of a population scale CVD risk assessment, peripatetically delivered in 7 deprived cluster areas involving 48 GP practices as well as microsites. Tests include point of care testing for cholesterol and where appropriate Hba1c, biometrics including height, weight and BMI, lifestyle and behaviour questions, CO monitoring and Cancer screening awareness. Diabetes and CVD ten-year risk scores are calculated and all results are explained and onward referrals made as required. The learning from this approach is now

being shared with all HBs following business case submissions to access an ICL Investment fund.

The model is now being introduced in cluster areas in Abertawe Bro Morgannwg University Health Board, Hywel Dda University Health Board and Cardiff & Vale University Health Board, and in the Montgomeryshire GP Practice, in Powys Teaching Health Board.

The Cwm Taf model tested a practice based approach to Cardiovascular Risk Assessment in 7 practices located across the Health Board. The approach involved the practice identifying patients aged 40-74 years, not already on a "CVD Register" to be invited for a CVD risk assessment performed by trained Health Care Support Workers (HCSW). The pilot Practices served populations with high levels of deprivation and range from single handed to large multi partner practices.

DPCC are involved at local level on taking this work forward as part of enabling more equitable access to services.

1.3.2 Transgender Project

The aim of this project was to gather information from trans people and primary care staff to identify the facilitators and barriers to providing good primary care for trans people. The Centre of Equality and Human Rights (CEHR) worked with two clusters in Wales to implement changes and improve service delivery.

Work is ongoing to develop a final report and recommendations based on information gathered from GP surgery staff and trans people.

The project has also delivered the following;

- Awareness raising training - developed with Unique Transgender and delivered in Cardiff and Vale University Health Board and Powys Teaching Health Board. Following evaluation, a further session will be held in North Wales;
- An e-Learning resource – developed in partnership with the Gender Identity Research and Evaluation Society (GIRES) available bilingually to all NHS staff (including primary care) from April 2018;
- Revisions to the publication '*It's Just Good Care: a guide for health staff caring for people who are trans'*. Edition 2 will be published in April 2018 and supports the awareness raising training commissioned from Unique.

1.3.3 British Sign Language (BSL) - Online service project

During 2017 Cwm Taf University Health Board introduced a pilot online BSL interpretation system to assess its effectiveness, impact and need. It aimed to consider whether online interpretation is an effective alternative to 'face to face', to establish which areas it could work in and to develop a model with scope to be developed for use across other Health Boards in Wales.

A tablet based IT solution was developed and stands designed which could be positioned near a patient for use from a standing or lying down position.

Results showed that participants thought that the online BSL service would be suitable for basic appointments and would like to see the service available in A&E, GP surgeries and on the wards. However, for in-depth appointments or those of a personal nature, the participants felt that traditional face-to-face interpreters would be required.

1.3.4 Welsh Language

In November 2016, the Welsh Language Commissioner attended the DPCMH Meeting to discuss the implementation of *More than Just Words*[1] and ways of

[1] '*More than Just Words*...' is the Welsh Government strategy to improve Welsh Language services in the health and social services sectors.

promoting the use of the Welsh Language in Primary Care. Following discussion, it was agreed to collate current developments/initiatives and to explore pragmatic improvements in Welsh Language provision that could be taken forward on an all Wales basis.

Examples of initiatives that health boards have established together with evidence of effectiveness where available, was shared in March 2017 and incorporated into a tool kit to share good practice.

Work has continued around the support which can be provided to primary care providers to help raise awareness and delivery of Welsh language services.

Following publication of "*Cymraeg 2050*" in July 2017 implementation is being supported by a network of officers to work and provide advice and practical support to individual businesses across Wales and develop projects that include training, events and sharing of best practice. An element of the officer's time focuses on working with primary care clusters/GP practices. During initial meetings the toolkit has been discussed with a view to roll out.

WG are liaising with all HB Welsh language officers to commence initial work in two clusters. i.e. Amman / Gwendraeth (Hywel Dda University Health Board) & Monmouthshire North (Aneurin Bevan University Health Board).

The link below shares offers an example of best practice from Meddygfa Teifi, Llandysul in Hywel Dda University Health Board.

Meddygfa Teifi, Llandysul - https://youtu.be/acyXTGkOL0k

Example - How to improve your surgery's Welsh language service

http://www.wales.nhs.uk/sites3/documents/415/Taflen%20-%20Mwy%20na%20geiriau%20-%20Meddygfeydd.pdf

In the Welsh Language in Health, Social Care and Social Services Awards 2015, Teifi Surgery, Llandysul, won an award for strengthening their surgery's Welsh language services. The surgery took simple and effective steps to provide a bilingual service to patients. Although relatively simple, the steps taken can have a substantial impact on patients' experiences of your services.

Good practice can be replicated by doing the following:

- *When registering new patients, ensure that the registration form asks for the individual's preferred language;*
- *Ask your current patients for their preferred language the next time they visit the surgery;*
- *Make a note of your patients' language choices in their personal records; If a patient notes Welsh as their preferred language, ensure that they are given appointments with Welsh-speaking staff where possible, and remember to greet them in Welsh;*
- *Ensure that staff who speak or are learning Welsh wear a badge or lanyard showing that they speak Welsh;*
- *Ensure that any phone messages, your website, and any posters or forms in the surgery for the public's use are bilingual.*

1.3.5 Primary Care Estates - Last Man Standing

The NHS Wales Shared Services Partnership **(**NWSSP**),** Specialist Estates Services (SES) was commissioned by DPCC to conclude the development of draft documentation, on the property options to support Health Boards with increasing requests from GPs to take on their leasehold obligations.

SES has progressed the work on the assumption that GPs will continue to be responsible for securing their own premises. Health Board powers to enter

into contracts are set out in WHC (2015) 031, which also sets out the process it must follow to record and submit transactions to WG. It confirms that Health Boards have delegated powers to enter into contracts up to £1m.

A final report was provided to DPCC early 2018 which has been referred to Directors of Finance prior to approval from CEOs.

1.3.6 Integrated Health and Care Centres

In December 2017 the Cabinet Secretary announced plans to deliver 19 new integrated health and care centres across Wales by 2021. Funding of up to £68 million has been identified subject to the agreement of successful business cases from the HBs.

Facilities are intended to improve access to a range of health and social care services closer to people's homes. HBs are working with a range of delivery partners, including local authorities, housing associations and the third sector, to bring together a range of public services into community hubs.

1.4 Theme 4: A Skilled Workforce

The Primary Care Plan recommended the need to plan and build a workforce with the right numbers and mix of skills to meet the majority of people's planned and unplanned needs at the right time, by the right person, closer to home in flexible ways and flexible facilities.

The importance of engaging health care professions and wider members of the primary and community care multi-disciplinary team (MDT) in the development and implementation of the transforming primary care model was recognised. A discussion paper was presented to the PCCRG in January 2018 outlining the context which has led to a proposed approach to engage with professional groups and wider team members. A questionnaire was developed to outline the new transformation model framework and to seek evidence regarding impact of their profession's role as part of the MDT helping to inform the workforce development element of the programme. The questionnaire also sought comment on access to primary health care and community services.

The main purpose of the questionnaire was to engage with all professions providing input to the wider multidisciplinary teams and consider direct access to appropriate clinicians and practitioners. This included professionals from within general practice and within the wider range of community based teams across health and social care.

The questionnaire is a chance to demonstrate the impact that can be made and highlight some of the challenges and barriers to progress where these exist. Analysis will be presented to the PCCRG and the TPC group later in the year. Next steps will be informed by the DPCC.

Achievements 2017/18

A Planned Primary Care Workforce for Wales (July 2015 - March 2018) and the associated Action Plan was reviewed and refreshed for 2017/18.

The action plan was divided into the following areas for action:

- Putting in Place the Foundations for a more robust approach to Workforce Planning, including,
  - Workforce data and analytics
  - Service Redesign
  - Integration

- Supporting the Continuing Development of Primary Care Clusters and the Sharing of Best Practice, including
  - Understanding and Development Clusters
  - Sharing Good Practice

- Investing in the Development of the Wider Primary Care Workforce by,

- Investing in the wider primary care workforce
- Education and Training

- Stabilising Key Sections of the Current Workforce, focus on
  - Nursing
  - General Practitioners

Deliverables and a summary of achievements was produced by the Primary Care Workforce and OD group and can be found at:

http://www.primarycareone.wales.nhs.uk/home

Some examples of MDT working are provided below.

Example - Occupational Therapists in South Pembrokeshire Cluster-HDUHB

Two Band 7 Occupational Therapists funded by South Pembrokeshire Cluster (five Practices) and who are, employed by Health Board are using the Anticipatory Care Planning approach. This approach helps to identify patients who are regular users to the service; increasingly frail, and isolated, providing Occupational Therapy intervention to proactively resolve health and social issues at an early stage, minimizing crisis situations that result in inappropriate presentation/admission to residential or hospital care. Focus is on enabling people to maximise their own potential, promoting self-management,

preventing ill health and dependency, thus releasing professional capacity. Thereby reducing demand on general practitioners by addressing and resolving underlying functional issues that are the root cause of

multiple and regular contacts with the practices.

Example - General Practice Support Officers (GPSO) - Cwm Taf University Health Board

Merthyr Cluster has introduced GPSOs as part of the frontline resource within GP Practices. Six GPSOs (full time) were employed during 2017 and are based across 9 GP practices. Appointments and working times are during normal practice hours. Referrals are made by any member of practice staff or patients have the flexibility to self-refer. Length and frequency of appointments will vary

The project is currently funded until March 2019

The main role of GPSOs is to influence cultural and behavioural change for service users within a Primary Care setting and advise/assess service users and address social issues, offering support in correlation with the social services and wellbeing Act. They aim to promote independence and
enable service users to take responsibility for their own health and wellbeing

GPSOs have made over 3000 patient contacts to date and are collaboratively working with Third Sector organisations, Public Health and Community Coordinators. They aim to support the reduction of attendance within general practice for non-medical intervention

1.4.1 Community Paramedics

DPCC prioritised the development and roll out of models of community paramedics as part of cluster MDTs. The following models have been piloted during 2017/18:

- Primary Care Support Team Model (Hywel Dda University Health Board): Involves role development for five Advanced Paramedics (APs), who are part of a GP led MDT, providing additional support to medical practices;
- Primary Care Practice Model (Cwm Taf University Health Board): Involves role development for four APs undertaking home visits on behalf of the St John Aberdare Medical Practice. This scheme is directly linked to the North Cwm Taf MDT and virtual ward (VW) model.

In addition to the MDT models, there has also been agreement to test new ways of community working between Clusters and WAST's clinical response model:

- Community-based partnership model (Cardiff & Vale University Health Board): A pathway linking a rapid response vehicle (RRV) directly to the three local Primary Care Practices within the Western Vale Primary Care Cluster. This model is directly dependent upon clinical supervision from GPs, who utilise the Paramedic to undertake appropriate home visits;
- Community-based partnership model (Abertawe Bro Morgannwg University Health Board): The same model as in Cardiff and Vale University Health Board, where WAST is supporting the eight practices of the Afan Valley Cluster.

The Cwm Taf University Health Board MDT scheme, and Cardiff and Vale University Health Board pathway (or system of working) have been subject to evaluation by the Bevan Academy. The evaluation report will be published in June 2018.

1.4.2 Primary Care Non-Medical Clinical Staff in Post

GP practice staff data relies on an annual census for England and Wales, including head count and full time equivalents (FTEs) for nurses (split into Advanced, Extended and Specialist, and Practice Nurse). Information is also collected regarding 'direct patient care' and 'other staff groups'. However, there is no further breakdown of information to enable head count and FTE of these 'other' roles.

To address this gap, an additional data collection was requested to provide detail regarding other roles including audiologists; paramedics; pharmacists; dietitians; mental health counsellors; OTs; optometrists; physician associates; physiotherapists; podiatrists; psychologists; speech & language therapists, and social prescribers or equivalent.

Pending the implementation of a Primary Care Web Tool for Wales, this *Non-Medical Clinical Staff in Post* data provides an interim attempt to gather details of the mixed professional teams that are emerging. Whilst the quality of the data maybe variable this information offers a baseline for future comparison.

1.4.3 Physiotherapy

There has been significant development in physiotherapy services supporting the transformation of primary care in Wales, particularly in relation to the management of musculoskeletal (MSK) conditions.

Provision across Wales remains variable to meet local needs. Two HBs are 'scaling up' services across the area as well as implementing first contact physiotherapists Advanced physiotherapy practitioners can independently prescribe medicines, use injection therapy and have non-medical rights to diagnostics. One HB has introduced a telephone triage service covering the whole area to improve access for patients. Other HBs are continuing to develop services including models such as 'walk-in' clinics for self-referral and patient education (shared decision making) models.

Example

Betsi Cadwaladr UHB is implementing first contact physiotherapists across the UHB and now has a service delivering to over 60 GP practices. The advanced physiotherapy practitioners can independently prescribe medicines, use injection therapy and have non-medical rights to diagnostics. Cwm Taf UHB has introduced a telephone triage service

covering the whole UHB area which has improved access for patients. All other Health Boards are trialling or continuing to

develop services including models such as 'walk-in' clinics for self-referral and patient

education (shared decision making) models.

The Chartered Society of Physiotherapy has supported the transformational developments with resources including:

-General Practice Physiotherapy posts - A guide for implementation and evaluation

-Think Physiotherapy for Primary Care - Policy Briefing Wales 2017

-Cost Calculator - Physiotherapists as first point of contact

-Model job description for FCP posts

1.4.4 Physician's Associates (PA)

PAs were introduced as new roles to Wales with the first training courses commenced in September 2016. The first cohort will qualify this year. PA's normally have a science related degree prior to undertaking the 2-year course and are trained in the medical model. They are currently an unregulated workforce although discussions are ongoing with statutory regulators.

A Physician's Associate framework has also been developed by NWSSP to ensure consistency of application and to support successful implementation of the Physician Associate role in both primary and secondary care and within a cross section of clinical specialties.

A PA Implementation group will be supporting management of internships to commence on one LHB and also sharing best practice. A number of LHBs are currently recruiting from the first cohort due to qualify. An evaluation will be taken before further expansion.

1.4.5 Community Pharmacists

The expertise of pharmacists and the wider pharmacy team has been recognised as an essential element of a multidisciplinary approach to patient care. There are key areas where the impact of pharmacy is evident. There has been a focus on prevention in Community Pharmacies with public health advice and expert advice on use of medicines including over the counter medicines, common ailments schemes (CAS) provision of influenza vaccination (and meningitis in some areas), stop smoking support and obesity clinics. All of which help in reducing need for patients to access other primary care services.

Pharmacists have also been situated in frailty clinics and one-stop elderly care clinics as well as GP Practices, reducing the need for patients to attend GP appointments and hospital A&E as problems are picked up much sooner and addressed. Specialist pharmacy teams assess the ability of patients to manage medicines in their own homes supporting independent living for longer. They are also supporting patients in care homes through more focused work and driving more clinically faced services from the community.

1.5 Theme 5: Strong Leaderships

For the past three years there has been a commitment to strengthen and develop leadership at all levels to deliver the plan.

1.5.1 National Level leadership

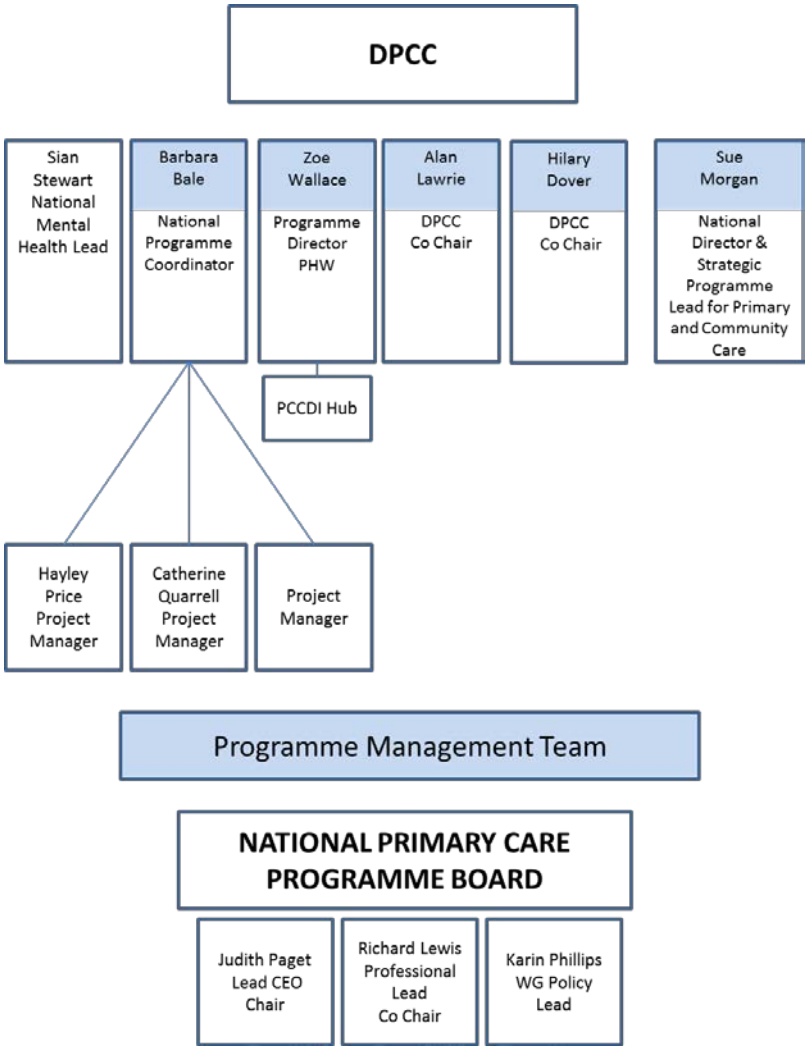
Since 2015, DPCC have led the national primary care programme reporting to the lead CEO. At the end of 2015 a National Professional Lead for Primary Care was appointed to work with DPCC and WG Policy leads to form the Senior Leadership Team. From 2016, the programmme team overseeing the totality of the work was expanded to include the Programme Director for the PCCDI Hub, a National Co-ordinator for the programme, the National lead for GMS and strategic development and the National lead for Mental health.

During 2017/18 roles and posts changed, whilst retaining an overall Senior leadership group. See below. Project support has also been variable currently supporting 2 wte project managers.

National Director & Strategic Programme Lead for Primary Care

A post of National Director and Strategic Programme Lead for Primary Care in Wales was established in March 2018 replacing previous temporary arrangements. This post reflects the ongoing commitment to a national approach to Primary Care in Wales.

DIAGRAM OF PROGRAMME TEAM FROM APRIL 2018



Changes 2017/18

National Primary Care Board

The National Primary Care Board (NPCB) was set up in March 2017 to provide a strong collaborative mechanism to enable solutions to barriers which impact across Wales on the pace and scale of the delivery of the national primary care plan.

The NPCB reports to the NHS Wales Executive Board and is a partnership to:

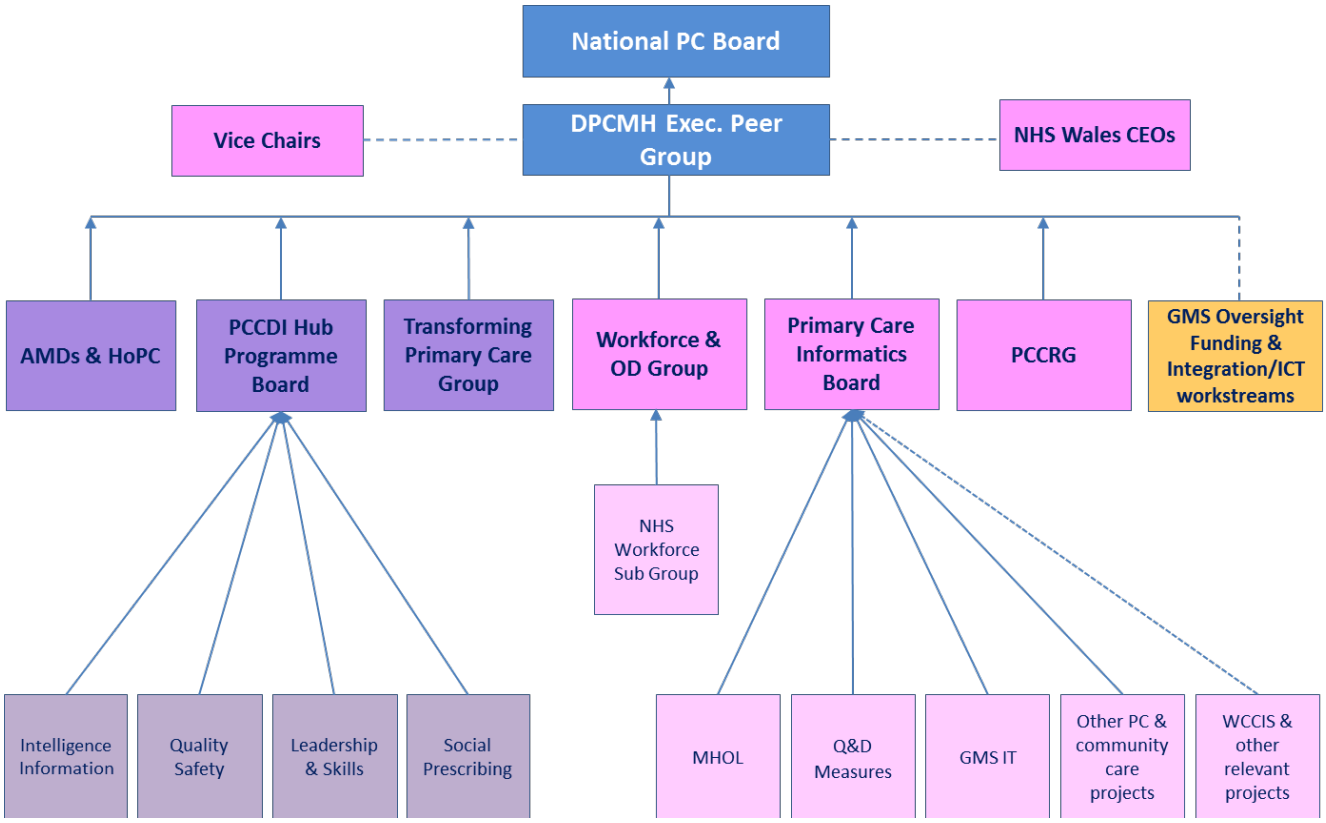
- Increase the focus and traction of primary care as part of an integrated sustainable health and care system
- Prioritise and oversee the Primary Care Directors' Programme of Work, key priorities will include unscheduled care, cluster development, integrated pathways, integrated workforce and contracting
- Triangulate with other relevant National Programmes of Work and activity such as the Unscheduled Care and Planned Care Boards.

- Increase the focus on integration – horizontal and vertical – in the health and care systems

In September 2017, the National Board held a workshop, focussing on key priorities, opportunities, risks and mitigation for the new national plan and the new model for primary and community care in Wales. The output from the workshop was reported to the December meeting of the Board together with a revised illustration of the new model, which is explicit on all components to ensure clarity that it is proposing a fully integrated system.

Following a governance review in 2017/18, the only formal group directly reporting and accountable to the NPCB is the DPCC.

SEE DIAGRAM BELOW - GOVERNANCE STRUCTURE FROM APRIL 2018



Primary and Community Care Reference Group (PCCRG)

The purpose of the Primary and Community Care Reference Group (PCCRG) is to support the work of the DPCC national work and the delivery of the Primary Care Plan by:

- Providing advice on professional and care standards and the work of the Primary Care Programme in Wales
- Considering the implications of emerging policy and practice and advising on the appropriate professional response in Primary and Community care
- Developing appropriate linkages to the national programmes for planned and unscheduled care
- Helping to join up work across professional and representative groupings.

In 2018, the PCCRG supported the engagement with the MDT team by

developing a questionnaire and leading an access workshop. Results and next steps will be shared during 2018.

1.5.2 Local Level Leadership

Cluster Governance Good Practice Guide

As Primary Care clusters have developed across Wales, teams have been exploring the options for organisational models to suit their local needs. Whilst it is accepted that cluster development is evolving and will differ both within and between Health Boards, the DPCC highlighted the importance of securing agreement on the core principles and standards for cluster organisation and governance arrangements. Earlier work on cluster governance carried out in 2015/16 was reviewed work followed by two engagement workshops, held to develop a draft Governance framework. The framework was circulated for an engagement exercise during April and sections have been reviewed by subject experts. It is intended that a summary Guide to Good practice will be published later this year with links to more detailed resources and the full framework.

This work was carried out concurrently with a request from the Cabinet Secretary in response to the Health, Social Care and Sport Committee Inquiry into Primary Care Clusters October 2017. The development of the Governance Framework aims to address the recommendations made in the Report.

Confident Primary Care Leaders Programme

The Primary Care Commissioning Community Interest Company (PCC) was commissioned to run 3 cohorts of a Confident Primary Care Leaders programme over the past 3 years. The programme is open to cluster leads and aspiring cluster leads, representing all health boards. The programme comprises seven sessions and has been well evaluated. Future requirements will be informed by a continuing needs assessment.

Primary Care Cluster Leads Development Programme

This programme was organised by Academi Wales, and held in north Wales during 2017. A second cohort is ongoing. The programme provides a combination of action learning sets and coaching.

Cluster Leads Network

A cluster leads network has been formed to provide a forum for continued networking following the conclusion of the Confident Primary Care Leaders programme. The network is facilitated and supported by the Hub and 1000 Lives Improvement and is open to all cluster leads in Wales. The network has been instrumental in developing the Cluster Governance framework, the Primary Care One Wales website and the triage questionnaire. The format for the network will be reviewed during 2018.

PART 2 ACHIEVEMENT OF THE FORWARD WORK PLAN 2017/19

The DPCC forward work plan (FWP) for 2017/18 was based on an assessment of the recommendations arising from the Pacesetter and Cluster Development Reports 2016/17, alongside the original national commitments within the Primary Care Plan and the ongoing requirement of priority areas identified in 2016.

This section provides an overview of achievements of the priority areas, e.g.

i. Implementation of the emerging model and sustainability;
ii. Contracts negotiations (initially GMS);
iii. Mental health.

Priorities have been taken forward and detailed plans exist for the deliverables

and timescales for projects overseen by the Transforming Primary Care Group, the Primary Care Workforce and OD group, the Primary Care ICT and Informatics Board and the Primary and Community Care Development and Innovation Hub (PCCDI) Programme Board.

Details of achievements are available at:

http://www.primarycareone.wales.nhs.uk/home

2.1 Priority 1 - Implementation of Emerging Model and Sustainability

Implementation of the emerging model and sustainability included 3 overarching aims which were then broken down into achievable actions and deliverables, as follows:

2.1.1 Acceleration of delivery of pacesetters and cluster development

As detailed in paragraph 1.1.2, Pacesetter and pathfinder projects have been ongoing since 2015 and support provided to ensure progress and evaluation. Most projects have continued for the 3 years with a small number commencing 2017. To ensure that future pacesetter projects encompassed all elements of the new model of primary care which had emerged, criteria was set to approve new pacesetter projects commencing 2018. In addition, innovations, not part of the pacesetter programme have been collated and shared. All details will be made available at:

http://www.primarycareone.wales.nhs.uk/home

From the results of activity, it was agreed that two elements would be prioritised for focus and development across Wales, i.e. Clinical triage and Multi-disciplinary team working including the role of community paramedics. (See paragraphs 1.2.4 and 1.4.1)

Another element of acceleration of care in the community and cluster development included the prioritisation of anticipatory frameworks of care and advanced care planning for a number of key areas. Each LHB has shared their ongoing activities that have been summarised and shared in a separate document available on request. Initiatives include expansion of frailty models and the use of virtual wards.

Pacesetter projects commencing 2018 are listed at Appendix 2

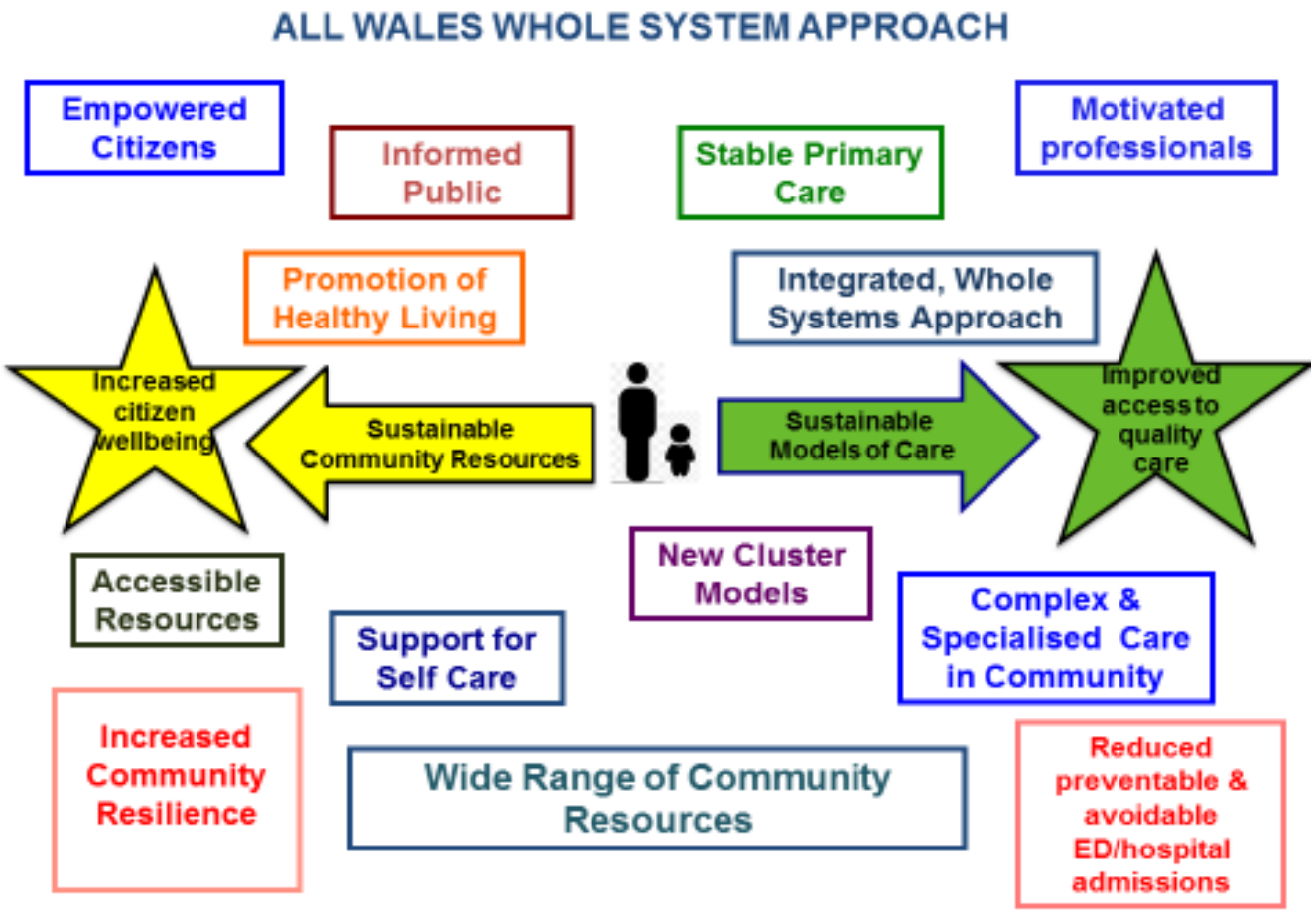
2.1.2 Ensuring sustainability

Focussed work was necessary at practice level as well as at cluster level to ensure sustainability. These activities included projects to capture capacity and demand and examining current, and the potential for future support across regions and sharing of common approaches to manage practice related change e.g. List closures. The number of sustainability framework submissions has also been monitored at an all Wales level. Any increase may indicate fewer practices at risk, possibly due to greater support or a greater willingness to request support at an earlier stage. Hence, detailed understanding at local level is perhaps more relevant.

2.1.3 Measuring progress

Development of quality and delivery measures for primary care and the creation of a primary care portal to report to Boards has been ongoing for the past 3 years. See paragraph 1.2.5.

A transformational programme of change to primary care and community services which arose from the pacesetters has enabled a whole system approach to redesign, driven by national quality standards but with flexibility to respond to local community needs (see diagram below).



The transformation model is based on achieving sustainable community resources to increase citizen wellbeing alongside sustainable models of care to improve access to quality care. This requires the public to be well informed and primary and community services to be stable and able to provide complex and specialised care in the community.

The anticipated outcomes of such an approach based on National and international research, alongside the evidence emerging from the Pacesetter Programme, indicates the potential benefits of the transformational model for primary and community care would be:

- Improved citizens' health and wellbeing;
- Greater community resilience;
- Better practitioner morale, motivation and wellbeing;
- Increased recruitment and retention of primary care and community staff;
- Sustainable models of care.

Many of the actions from priority one were taken forward by the Transforming Primary Care Group who have planned and monitored activities which make up the components of the Transformational Model for Primary and Community Care. A separate FWP detailing the achievements can be found at:

http://www.primarycareone.wales.nhs.uk/home

2.2 Priority 2 – Contract Negotiations (initially GMS)

Primary care contracts are subject to review to ensure they enable the provision of services to meet people's needs. All

changes to the contracts are subject to formal negotiation processes.

The GMS contract and ongoing work in relation to enhanced services were identified as the key priority for 2017/18.

Priority 2 specified 3 areas for action:

2.2.1 Ensuring that changes to contracts meet the future requirements of the primary care service

Priority was initially given to developing and agreeing governance and decision-making mechanisms to take forward negotiations on the GMS contract. For this reason, a GMS Contract Oversight Group was established. The Director of Primary Care and Innovation, Welsh Government chairs the group and membership includes representatives from GPC Wales, Welsh Government and NHS Wales. In addition to developing governance and decision making mechanisms actions included agreeing a high level action plan (augmented by the WG/NHS/GPC Wales Chatham House event) and monitoring and reporting on negotiations to DPCC, CEOs and the NPCB.

As well as the Contract Oversight Group (COG), six work streams were initially established to provide advice to the group and to help inform the formal negotiation process between Welsh Government and GPC Wales/BMA. These were later reduced to four and include:

- Cluster Development (chaired by GPC Wales);
- Workforce (chaired by Welsh Government);
- Demonstrating Quality (chaired jointly by Welsh Government and RCGP Wales);
- Funding (chaired by NHS Wales).

Each work stream includes representatives from GPC Wales, Welsh Government and NHS Wales. There is also a primary care (either DPCC or head of primary care) representative on each of the work streams and there is an AMD representative on each work stream.

Following discussion at an early GMS COG meeting, a number of issues were identified for each work stream to consider and provide advice on whether they should be included for consideration as part of contract negotiation and if so, whether it should feature in the process for the 2018/19 contract or for future years. A high level timeline was also developed to ensure the work was undertaken to enable negotiations to take place in a timely manner.

Each of the work streams have subsequently reviewed and provided advice back to the GMS COG and this has informed the negotiation process for the 2018/19 GMS Contract. The negotiation process is still currently ongoing. The issues for consideration for subsequent years will be considered later in the year.

Health Board representatives have been asked to ensure there is sufficient and timely engagement with other Health Board colleagues to ensure they represent the collective, agreed position. The lead Chief Executive for Primary Care ensures Chief Executives are kept appropriately informed and involved. There is also a standing item at each DPCC meeting, as well as at the joint meetings of heads of primary care and AMDs and there is engagement with the All Wales HB Finance Directors Primary and, Community Care Sub Group. It has been agreed that the general communication briefs will also be shared with the National Primary Care Board.

Arrangements are expected to continue for discussions in relation to the GMS Contract for 2019/20 and beyond.

It is also expected that similar arrangements will be put in place to ensure effective oversight and delivery of contract reform for other primary care contracts.

2.2.2 Support for the national level dental contract

Presentations were made to the DPCC to ensure activity was prioritised at local level. Progress is ongoing.

2.2.3 Ensuring best value for money for the Pharmacy contract.

This work has been led by the Heads of Pharmacy at local level. National support for activity will likely form part of the FWP for 2018/19

2.3 Priority 3 Mental Health

In relation to Priority 3, DPCC were assured that the elements of the mental health agenda have been taken forward in year supported by local MH senior managers. National coordination of activity was however challenging during 2017/18 due to the absence of a National Director for MH and the low number of DPCC who hold the executive portfolio lead for MH. Therefore, this report does not attempt to summarise the deliverables achieved in year. End of year reporting will be via the most appropriate national MH forum/board. Areas of work that all DPCC have participated in and have overseen include:

- All Wales collation and reporting of MH breaches;
- Development of MH measures;
- Implementation of the MH and LD Commissioning Framework;
- Places of Safety review;
- Development of the Dementia strategy;
- All reporting requirements are updated by WG Policy and professional leads every 3 months.

PART 3 DRAFT FORWARD WORK PLAN 2018

The overarching priority areas for 2018/19 are;

1. Supporting strategic primary care development, which will include:
   - a focus on 24/7 care and OOH;
   - communications and engagement;
   - incorporation of interconnected themes such as access and integration with other sectors and working with USC, Planned Care and mental health agendas.
2. Enabling activities, which will include:
   - GMS contract negotiations;
   - Workforce and OD development; Supporting infrastructures including IM&T with an emphasis on digital technologies.

To lead the FWP, DPCC have separated ongoing and future activity areas into strategic primary care development and business as usual.

AREAS OF ACTIVITY TO FORM PART OF FWP 2018/19

STRATEGIC PRIMARY CARE DEVLOPMENT	BUSINESS AS USUAL
Core areas of DPCC FWP	**Activities led by DPCC reported by exception**
OOH/111 Communications and engagement Clinical triage and MDT working Compassionate Communities including social prescribing Complex care/out of hospital care Capacity and demand planning Critical appraisal and evaluation Digital technologies [GMS Contract Negotiations] [Impact of Pharmacy Contract on PC Transformation]	Cluster governance Pacesetter and pathfinder support PMCAT Sustainability – PCSU Quality and Delivery Measures Key Indicators GMS IT MHOL Workforce Planning Leadership and skills Single performers list Welsh Language
Interconnected themes	**Activities led by others. DPCC '*ask*' to be clarified**
Access Integration with other sectors USC Planned Care Mental health	Estates Finance Quality and safety Health intelligence EHEW/LVS CEHR projects on equalities WCCIS

Strategic primary care activities have been designed to incorporate the request from the Chief Executives Management Team National Policy and Improvement Programme to focus on Digital developments and joint working and agreement of deliverables with the USC and Planned Care National Programmes, and other executive teams.

The draft FWP was finalised following publication of the '*A Healthier Wales'* and the incorporation of additional actions for 2018.

A final draft of the FWP as at July 2018 is at Appendix 3

PART 4 NEXT STEPS

The DPCC's Third Annual Report brings to an end the reporting period covered by *'Our Plan for a primary care service for Wales up to March 2018*.

Significant progress has been made over the past 3 years resulting in primary and community care becoming acknowledged as central to whole system care.

The publication '*A Healthier Wales: our Plan for Health and Social Care'* (Welsh Government) June 2018 sets out a long term future vision of a 'whole system approach to health and social care which is focussed on health and wellbeing, and on preventing illness.

The Report states that:

"To achieve this future vision, we will develop 'new models of seamless local health and social care, which will scale up from local to national level. These models will build on a foundation of local innovation including through Clusters of primary and community care providers"

The DPCC forward work plan therefore prioritises agreeing a national understanding for the pace and approach to cluster development overtime and the intended implementation arrangements at local level. The DPCC will finalise the FWP in August 2018 to enable deliverables to be agreed and monitored.

Delivering on the actions and recommendations from '*A Healthier Wales*' is a long term approach requiring integrated planning across primary, secondary and community care and other sectors. The DPCC will work in partnership with other NHS Executive groups at national level and with Regional Partnership Boards at Local level. A new approach to planning and delivery will form the next stage of this work.

PART 5 TOP 3 ACHIEVEMENTS 2015-2018 PER HEALTH BOARD

ABERTAWE BRO MORGANNWG UHB

IMPLEMENTING A NEW MODEL OF PRIMARY CARE

During the last three years there has been a significant move towards expanding the primary care team. This has helped to provide improved access to services, delivering care closer to home whilst assisting sustainability and workforce issues.

Currently across the 11 clusters in ABMUHB there are a mixture of cluster pharmacists, social prescribing link workers, cluster community nurses, paramedics, phlebotomists, physiotherapists, mental health workers, occupational therapist, exercise referral specialists, audiologists and primary care Early Years workers. This has been complemented by an increased provision of third sector services through the HB grant scheme and through the use of cluster funds.

DEVELOPING AND PROMOTING NEW MODELS OF WORKING

- Telephone First Model Framework which is being used to champion and refer to when practices are reviewing their existing access arrangements or are looking at ways to manage demand effectively whilst maintaining and improving access for patients. The framework set out 7 steps and has identified reference standards for each area which are intended to direct and define a specific, consistent approach to telephone consultation and provide assurances to service users of the model of access.
- The Pen y Bont Health Federation, established as a result of pacesetter funding to develop a social enterprise consortium with 5 General Practices in Bridgend, has worked with other clusters and cluster leads across Wales to share their learning, experience and journey on their path to federation status. The federation has facilitated the success of the development of an All Wales Toolkit which is available to other GP practices across Wales that are exploring the option of developing a social enterprise. The toolkit draws on the experience of the federation and provides practical advice, evidence, case studies and sign-posts to Welsh support organisations and grant makers.
- A merger framework has been introduced and invested in to facilitate the creation of larger more sustainable primary care practices that both stabilise sustainability issues and provide an excellent platform for providing extended services
- The HB has developed an innovation patient communication plan with 11 pro-active media campaigns to date and more planned. These 'articles' have attracted significant interest through social media platforms and are helping primary care professionals discuss with their patients the most appropriate way to meet patient needs.

INTEGRATED HEALTH AND SOCIAL CARE SERVICES – OPTIMUM MODEL FOR DENTAL/EYE CARE

ABMUHB continued to support a new dental contract model – the Prototype – in two of its practices, which provided a helpful foundation for the dental contract reform programme introduced from September 2017. From 2011 onwards, issues of access, quality and prevention had been addressed in two of ABMU's practices by removing the standard Unit of Dental Activity (UDA) target from the whole of the contract; instead paying the practices on a Capitation and Quality Payment which focused on patient numbers and promoting prevention.

Responsibility for encouraging uptake and monitoring use of the Wales-wide Eye Care Examination (ECEW) and Low Vision Services across Wales was transferred to Health Boards in 2016. The period since has been a significant (30%) increase in utilisation of the ECEW in ABMUHB and a major gap in Low Vision Service provision resolved.

ANEURIN BEVAN UHB

SUSTAINABILITY OF PRIMARY CARE

The Health Board have managed a range of difficult circumstances while maintaining and improving services despite the challenges whilst progressing the new model of care.

A detailed Sustainability Report was prepared with several recommendations, resulting in the establishment of a Sustainability Board chaired by the Chief Operating Officer with a detailed programme of work.

The Primary Care Operational Support Team has been key in exploring new ways of working in Primary Care, including developing and implementing the Transformation Model of Primary Care and supporting practices with Access Quality Improvement schemes.

As a result, 2 out of the 4 managed practices have fully embraced the transformational model with a wide range of extended roles in post including paramedic, practice based pharmacist, ANP, OT with Physicians Associate and Physiotherapist soon to join the teams.

One of our managed practices is now delivered services from the new Brynmawr Well Being Centre, which incorporates Brynmawr Medical Practice and various community services including Community Dentistry, Podiatry and Sexual Reproductive Health.

We have also completed 3 major improvement grants, including internal reconfiguration of premises to improve patient experience and increase both clinical and administrative areas. Meanwhile, we have also continued with the funded roll out of Store & Scan to store patient records centrally and release additional space within premises to increase clinical/admin areas.

A workforce planning formula has been developed to support workforce modelling and used within sustainability workshops, delivered to each NCN, to assist with planning for the future. Furthermore, a financial calculator has been developed to help with consideration of financial support to practices.

In addition to Welsh Government funding, the Health Board has supported optometry training and secured the delivery of Optometry Services within HMP Usk & Prescoed.

The Health Board are fully engaged with the Dental Contract Reform Programme with 3 practices currently participating. We also continue to monitor and invest in access to dental services and received additional funding from Welsh Government in both 2016/17 and 2017/18. Since 2015 a total of 908,893 patients received a course of NHS dental treatment.

We have also successfully commissioned the delivery of a dental domiciliary service for the residents of Blaenau Gwent, Caerphilly, Newport and Torfaen.

CARE HOME SUPPORT

We have successfully worked with our Care Home colleagues in the assessment and prevention of falls, the development of Advanced Care Plans and managing the deteriorating resident.

A falls pilot using the iStumble tool was commenced in March 2017, with 26 care home sector employees received falls awareness training. After 3 months of the pilot, the tool was being used 100% of the time by these care homes to assess fallers. Pilot data was positive and has been shared with Senior Managers at WAST who are delighted with the increased use of the tool and the reduced number of 999 calls.

Sepsis training sessions continue to be delivered to nursing and residential homes, these training sessions are always very well evaluated and nurses tell us that the knowledge gained will influence and possibly change their practice. Over 270 care home staff have received Sepsis training since January 2017. The training includes raising awareness of sepsis, identification of the deteriorating patient, use of NEWS and SBAR.

A collaborative approach to ACP across ABUHB has been embraced with the Primary Care professional development team working closely with the ACP facilitators for secondary care to ensure equity and consistency of training and support regarding ACP. The drive on training ACP in nursing and residential homes remains a priority for the team and it is now estimated that 71% of nursing home residents and 39% of residential home residents have an ACP in place.

ABUHB currently has 56/78 practices accredited and commissioned to provide the Care Homes DES. The aim of the DES is to enhance the care provided for residents in care homes through a proactive, holistic coordinated model of care. This includes a programme of assessment and regular reviews of the mental and physical health of the residents within the nursing home and includes, where appropriate, end of life care planning. The aim of the DES also in relates to the facilitation and encouragement of closer multi-disciplinary working between community professionals, e.g., community nurses, community pharmacists, dieticians, mental health professionals and social services.

INTEGRATED WORKING

In June 2017, the Gwent Adult Strategic Partnership Board was convened, co-chaired by the Director of Social Services for Torfaen Local Authority and Divisional Director for Primary Care & Community Services. The partnership has developed six overarching strategic priorities for 2018 – 2020:

1. Address the needs of our ageing population by providing preventative support and early intervention
2. Develop an integrated ‘place-based’ approach to supporting people by reconfiguring existing services to strengthen community resources
3. Co-develop a sustainable health and social care workforce
4. Identify and adopt a means of managing risk in the community
5. Ensure that full advantage is taken of assistive technology where feasible
6. Optimise the use of temporary funding streams to test models that support delivery of strategic priorities

The key work streams for 2018 will be an extensive review of all existing schemes funded via the Integrated Care Fund (ICF) to assess how well they meet these strategic priorities and the development of a revised approach to the domiciliary care market; aiming to commission on a regional basis with terms and conditions in line with ethical commissioning charter and to sustain this sector in the longer term. Included in this work will be the

development of health and social care wellbeing roles and the provision of an academy approach to not only train and develop staff but to educate and inform patients, volunteers and carers.

The process by which GASP will achieve its strategic objectives is via five Integrated Service Partnership Boards, which have been tasked with agreeing integrated action plans to achieve these broad aims, and the local NCN partnerships across Gwent.

BETSI CADWALADR UHB

DWYFOR TEMPORARY RESIDENT SERVICE

The Dwyfor Cluster Area of North West Wales attracts significant numbers of holidaymakers during the key school holidays. The additional demand of the holidaymakers was putting pressure on the 5 GP practices that were already struggling to recruit GPs to work for them. Utilising cluster funds a Temporary Resident Service has now been running for two years. The Out of Hours service provides a call handler and GP and or ANP to see patients from a central location, initially the Bryn beryl Community Hospital but in this year from the Nefyn GP practice.

The service is greatly valued by the local practices and has a high satisfaction rating from the patients accessing the service.

DEVELOPING INFORMATION GOVERNANCE PROTOCOLS AND POLICIES FOR CLUSTERS

A Cluster Lead from South Wrexham worked closely with Information Governance colleagues in Betsi Cadwaladr University Health Board (BCUHB) and NWIS to develop a new set of documentation to support practices to meet the IG requirements relating to the sharing of patient data where necessary for cluster working. This work had national significance in that the tools developed are now available to all practices and clusters in Wales.

ENHANCING THE DEVELOPMENT AND LEARNING FOR THE PRIMARY CARE NURSING WORKFORCE IN NORTH WALES

Pre-registration student nurse placements have previously been very limited within primary care. The initiation of regular student nurse placements has been developed, with regular placements now provided by 15 GP practices across North Wales. Working in collaboration with Bangor University, general practices and BCUHB, both adult and child branch students are now gaining vital learning opportunities in primary care; with over 30 student nurses placements achieved over the last year. Feedback from practice managers, nurse mentors and all students has been extremely positive and further placements have been welcomed.

A new 12-month practice nurse learning programme has been developed and so far has provided 13 registered nurses, new to primary care roles, the opportunity for placements in general practice. Through a blended approach of in–house learning, education packages and mentor supervision and support, all nurses have found this a valuable experience, gaining a vast array of knowledge, clinical skills and confidence. So far, all nurses have gained permanent positions within primary and community care on completion of the programme, supporting the sustainability of the services. A poster presentation reflecting the programme was presented at the Chief Nursing Officer conference in May 2017.

Eight new training posts for nurse practitioner roles have been developed across the Central Area, supported by an ANP mentor, medical staff and in conjunction with attendance on Bangor University advanced clinical practice modules. This structured programme, within a positive learning environment, encourages a standardised but flexible

approach to safe practice. Guided by placement handbooks, governance frameworks and dedicated supportive systems and education, this programme is helping to promote safe, skilled, competent and quality driven nurse practitioners in primary care.

Rotational nursing posts between primary care and community nurses have been established which offer greater learning opportunities and integration of existing nursing staff. This has greatly increased their professional nursing scope, communication across teams and consequently enhanced working relationships, providing a stepping stone to the development of Community Resource Teams.

The development and local commissioning of 2 new HCSW primary care qualifications, has enhanced the development and skills of this workforce locally. The Agored Level 3 Diploma and Level 4 HCSW Certificate in Higher Education are now provided in a range of locations across North Wales, supporting further HCSW progression, safe delegation and aiding the retention of staff; 35 HCSWs have already attended these courses, with more attending this ongoing programme.

CARDIFF & VALE UHB

CARE HOME INTEGRATED SUPPORT TEAM (CHIST)

This is joint work between the Cardiff Community Resource Team and WAST to work with and support care homes to reduce unnecessary admissions to hospital. This includes a range of multi-disciplinary education and support:

- Advance care planning (getting staff to start the conversation about escalation of care out of hours. Trying to find out what the clients want and do not want to happen when their health deteriorates).
- Falls prevention and management training provided by physiotherapists and EAST incorporating the 'I Stumble' tool.
- Dietician/SALT ongoing education programme.
- Regular meetings with care home managers to discuss and reflect upon 999 calls and admissions from the home.
  Prompt access to nursing assessment.

SOCIAL PRESCRIBING

Approximately 20% of GP attendances are for social/wellbeing related issues. The cluster has been looking at service models that promote the philosophy of self-care, access to information and advice as an alternative to using health services. Evidence has shown improved outcomes in terms of health and wellbeing through linking with community assets, with reduced social isolation and adoption of healthier lifestyles. The pilot work involved two schemes. One focused on community gardening to improve physical activity, fruit and veg intake and social isolation. The other scheme was a time credit community currency for patients with psychosocial issues.

ADDRESSING SUSTAINABILITY THROUGH PROVISION OF MSK AND MENTAL HEALTH SUPPORT IN PRIMARY CARE

Musculoskeletal conditions account for around 20-30% of the overall General Practice caseload and around a third of consultations related to mental health. To help address sustainability issues and free up GP time, two models have been piloted:

- First Contact Practitioner (FCP) Physiotherapists

  This provides access to physiotherapists for people with acute or chronic MSK. This provides significant benefits for patient experience and general practice sustainability. Other benefits of embedding physiotherapy within primary care include reduced MSK

referrals into secondary care and the resulting reduction in demand for orthopaedics, pain services, rheumatology and other community based Muscular Skeletal Assessment and Treatment Services. Expert intervention reduces prescription costs, radiology referrals and the costs associated with the issuing of Med 3 certificates (sick notes).

- Mental Health

  This involved mental health practitioners working as part of an extended GP service. The practitioners receive direct referrals from the GP screening service as well as from GPs and see individuals on a follow up basis. There has also been funding for third sector support who provide a tiered range of psycho-social and well-being support. Initial evaluations included a demonstrable reduction in Community Mental Health Team (CMHT) referrals, PMHSS referrals and Primary Care Counselling referrals with positive feedback reported from all stakeholders.

CWM TAF University HB

BABY TEETH DO MATTER

Over the last 10 years, there has been a significant improvement in children's oral health across Wales except in Cwm Taf University Health Board (CTUHB). Over the same period, the number of CTUHB children attending a dental practice reduced. Therefore, the Health Board has made it a priority to improve children's oral health specifically targeting children under 5 years of age. A pilot 'Baby Teeth DO Matter' started in Merthyr Tydfil in April 2017 where dentists/dental therapists from 3 dental practices are working with GP practices by attending their baby clinics. Parents are given oral health advice and encouraged to make a dental appointment for their baby & themselves, if they have not recently attended.

The Health Board has funded this pilot within existing GDS Contracts by reducing the contracted Units of Dental Activity by 5%. The Health Board also introduced an awareness campaign throughout CTUHB giving the key oral health messages via posters, social media & radio advertising.

During 2017/18 the number of children (0-17 years) accessing general dental services increased by over 1,500 children with the highest % increase in children aged 0-2 years. Increases in patient numbers were seen in all localities but in Merthyr Tydfil where the dentists attended GP baby clinics, the % increase was twice that seen in the other localities.

INTERGENERATIONAL WORK WITH YOUNG PEOPLE

The primary care and localities team have worked with our training and development colleagues and lead for volunteering within the UHB to challenge the belief that we can only work with young people over the age of 17 yrs. Our view was that this is too late in their subject choices and we wanted to open their eyes to the variety of opportunities that the NHS can offer. We worked with local schools to develop the following programmes:

Health Care Taster Programme year 10 – Inform young people age 14/15yrs before career / 'A' level choices are made, about all the opportunities the NHS offers

The programme takes the form of an organised 5 day fully supervised tour of a range of health environments offering exposure to a variety of health roles for pupils from year 10. Two out of the Five days are dedicated to community and primary care services with inputs and activities from clinician across community and primary care from GP's / Dentists / Optometrists / Pharmacy / District Nursing / Community Hospital staff etc.

Young Peoples Volunteering – Provide young people a real experience at ward level while offering a positive experience for patients

A pilot scheme has been implemented and evaluated in Ysbyty Cwm Rhondda hospital with a small group of year 11 students (age 15/16) visiting 1 hour a week to chat, read, or generally befriend patients on our dementia friendly ward. The evaluation from volunteers, staff, patients and relatives is very positive with changes measured in the Volunteer's skills and beliefs about the environment and noticeable changes in patient's general wellbeing.

Clinical Placement for BTEC Health & Social Care – support and provide career opportunities through clinical placements as part of the curriculum

A pilot programme has been established with a local school's Health & Social Care students where they will undertake a proportion of their required work experience on work placements built into the curriculum within Cwm Taf UHB.

RAPID DIAGNOSTIC CLINIC FOR CANCER

It was a growing concern that too many people present late or wait too long in the system as a result of vague symptoms that could be cancer. The Health Board has implemented a Rapid Diagnostic Clinic for Cancer which aims to detect more cancers in people who present with vague symptoms and significantly cut diagnostic waiting times. It is basically a 'once stop shop' where the patient can have an assessment, diagnostic tests, review by experts and a diagnosis all on the same day and within a very short period of time, in some cases within hours of referral. This clinic is based on the Danish model and was implemented following a visit to see how the Danish Health Service is speeding up cancer diagnosis.

HYWEL DDA UHB

DEVELOPMENT OF COMMUNITY PHARMACY SERVICES

The role and impact that community pharmacy services can have on supporting local populations is increasingly being recognised within Hywel Dda University Health Board (HDUHB), particularly because of the growing sustainability pressures within General Practice. With 99 pharmacies located across the three counties of Carmarthenshire, Ceredigion and Pembrokeshire most of the Health Board's residents reside within a reasonable distance of a pharmacy.

Over the last 12 to 18 months the range and extent of enhanced services commissioned from community pharmacies across HDUHB has increased in line with the national direction for service change and development (*Taking Wales Forward).*

It is with this clear agenda that enhanced services delivered by community pharmacies within HDUHB are being developed and accessibility for patients is increased. The overall aim is to promote pharmacies as a first point of contact for low level ailments and injuries.

There are a number of enhanced services offered by pharmacies that support elements of unscheduled care and offer an alternative to patients from accessing GP appointments or even attending A&E. See section 1.1.6.

Looking forward to 2018-19 there are many strands of work that will be followed in relation to further developing the range and scope of community pharmacy services.

- The current range of services will be extended to more pharmacies, with support and emphasis on those elements that offer unscheduled care e.g. Emergency supply of medication, Common Ailments Service, Triage and Treat;
- Identification of a small cohort of pharmacists for Independent Prescribing and development of services that would enable this skill to

be utilised in a way that would support general practice;
- Working with hospital respiratory consultants, establish a pharmacy chest x-ray referral service in Llanelli for patients that display symptoms that could be indicative of lung cancer, as part of a research project;
- Progress a project on identifying and establishing a number of Pharmacy Walk-in Centres within HDUHB, thereby further enhancing the role of pharmacies as a first point of contact.

CAMBRIAN FEDERATION DELIVERING CARE HOME ENHANCED SERVICE

Background

The Cambrian Federation is aligned to the North Ceredigion Cluster and comprises of seven GP practices.

With the implementation of the new Care Homes DES in 2017 the federation have taken over the delivery of the enhanced service. One of the practices has taken a lead on the administration of the service.

Why it has made a difference

In working in this way the Federation has demonstrated that it is possible to commission enhanced services at a greater scale than with a single or "partnered" practices. Having one practice administering the process has enabled a streamlined approach.

TELEPHONE CONSULTING/DOCTOR FIRST

HDUHB have commissioned GP HUB Wales to provide a remote telephone consultation to three of its managed practices in Kidwelly, Pontyates and Goodwick. As part of a transitional support / sustainability support package.

Each practice has a total of 30 patient contacts per day available to book, which generally takes about 3 hours for GP Hub Wales to complete. This is largely comparable to a whole time GP working within a practice with a booked appointment system in place.

The GPs working for the Hub have full secure access to the practices' electronic systems, patients' notes, hospital letters etc., exactly as if they were working in the practice. The Hub GPs are able to book directly with the practices own GPs and advanced practitioners for urgent appointments on the same day. Otherwise, an on-screen message is passed to the reception staff informing them that a patient needs to be seen by a GP/Nurse Practitioner/Other HCP.

GP HUB Wales provides a list of activities and duties which is felt to be the most efficient use of their telephone consulting.

Prescriptions are managed by the remote Hub GPs creating the clinically appropriate prescription and saving them to the system. The reception team is responsible for printing the prescriptions in the local surgery and the GP in that surgery is responsible for the timely signing of those prescriptions.

Referral letters can be typed up by the remote Hub GP in the consultation notes and the reception staff can then send them on following their own internal referral protocols.

Why it has made a difference

Prior to the commissioning of the GP Hub service the patient access in the Managed Practices was significantly constrained by the number of onsite clinicians. Whilst the decreasing GP medical workforce in the Managed Practices remains a significant problem, the GP Hub service as part of a wider multi-disciplinary team has played a significant part in maintaining appropriate levels of access.

POWYS TEACHING LHB

PHYSICIAN ASSOCIATES

Background

Since 2015, Powys Teaching Health Board (PTHB) has been involved in developing the role of the Physician Associate (PA) in Mid Wales to support practices with sustainability.

The Health Board continues to work with three universities to support PA students as they study and prepare for their new careers. This involves the students undertaking primary care placements in the county and preparing them for work in Mid Wales after they qualify.

Why it has made a difference

The PA is a rapidly growing healthcare role in the UK, working alongside doctors in GP surgeries. PA support doctors in the diagnosis and management of patients. They are trained to perform a number of roles including: taking medical histories, performing examinations, analysing test results, and diagnosing illnesses under the direct supervision of a doctor.

In Powys, where it is proving difficult to recruit GPs, the PA role is providing valuable assistance to medical practices keeping pace with the needs of their patients.

There are currently five qualified PA working for medical practices in Powys, with a further two due to start before the end of 2018 and one acting as the mentor across Powys.

PROVISION OF EYE CARE IN THE COMMUNITY

Background

PTHB work closely with primary care optometrists, to develop a range of services for patients:

- Post-operative cataract eye examinations are undertaken in Powys by primary care optometrists (under the provisions of Eye Health Examination Wales);
- Primary care optometrist trained as a Low Vision Practitioner are available in 12 locations offering a free 1-hour long appointment within two weeks;
- Optometrist provide services under the provision of Eye Health Examination Wales (EHEW) in 17 locations avoiding the need for a direct referral to a hospital ophthalmologist.

Why it has made a difference

In August 2017 the HB approved a plan to train primary care optometrists to provide a greater range of care in the community for patients with active glaucoma, with 5 optometrists currently undertaking the required training ahead of introducing the service.

PTHB has for over 3 years worked in partnership with RNIB Cymru to support the employment of an Eye Care Liaison Officer. The ECLO has links to all parts of Powys and regularly attends the busier ophthalmology clinics.

Consultant-led outreach ophthalmology clinics are delivered from six locations in Powys, including Llandrindod Wells and Brecon hospitals where, in addition to out-patient clinics, a range of non-DGH eye care services are available, including day case surgery. In addition, Brecon has a very successful Wet AMD service. Although consultant-led, the service is heavily supported by primary care optometrists, including some which have been trained to provide injections to the eye as part of the treatment provided.

The above ensures that services can be delivered as close as possible to where patients live.

NURSE TRIAGE

Background

PTHB in common with many parts of the UK are experiencing sustainability issues due to a number of challenges that are affecting General Practice; demand is outgrowing capacity, ageing population, increased number of sustainability applications, workforce and workload pressures.

With this in mind there has been a transformation with the way medical practices have started to implement a flexible workforce model by introducing alternative Health Care Professionals to deliver a range of services for patients that don't require a GP consultation.

Why it has made a difference

In 2015, 4 practices in South Powys under the umbrella of 'Red Kite Community Interest Company' introduced a nurse triage model to 45,583 patients, providing practice nurse-led telephone triage for patients requesting urgent and on the day appointments, including signposting to the most appropriate service.

The impact and the effects of the model demonstrated that the triage system was managing and/or redirecting at least 53% of the 'on the day' patient demand away from the GP. Following the successful Nurse Triage service, Total Nurse Triage was piloted at one practice for all patient requests for a GP appointment. Prior to Nurse triage the wait for a GP appointment was in excess of 14 days. This was reduced by 25% with many appointments available the next day or within a few days and routine appointment times for all GP's increased from 10 to 15 minutes.

The new model has ensured that a GPs time is spent on those patients who clinically needed to see a Doctor, which has improved continuity of care.

OUR PLAN FOR A PRIMARY CARE SERVICE FOR WALES UP TO MARCH 2018 (WELSH GOVERNMENT FEBRUARY 2015)

NATIONAL ACTIONS

Action	Status at April 2018
From 2015-16, Health Board Directors of Primary, Community and Mental Health will deliver a co-ordinated national approach to supporting innovation in primary care, including structured support mechanisms, systematic evaluation of new ideas and good practice, and prioritised funding for innovative ways of delivering care and improving access.	**Achieved**
Innovation Since 2015 DPCC have agreed collectively to support individual projects as a national programme of pathfinders and pacesetters. Learning events have been held to share learning and support has been coordinated. Most projects were agreed for 3 years although based on ongoing evaluation a small number of projects commenced 2017. Final reports and tool kits are currently being collected and will be made available on Primary Care One for all pacesetters completed over the 3 years. In 2018, criteria were agreed to select new pacesetter projects which commenced April 2018. The outcomes of the pacesetters and pathfinders contributed to the emerging model of primary care now being taken forward. In addition, over 100 innovations in care delivery have commenced across Wales utilising local monies and integrated care funds. Evaluation In addition to evaluation of individual projects, an external Critical Appraisal was commissioned from the University of Birmingham. The final report is for publication May 2018. Improving access Whilst many of the pacesetter projects have contributed to improving access, focussed access workshops have been held and are planned to promote a shared understanding of a wider definition for the public and health professionals.	
In 2015-16, health board directors of primary, community and mental health will commission a training programme to support co-production in primary care for health professionals	**Achieved in part engagement Ongoing**
A number of national events have been held to focus on a shared understanding of co-	

production and asset mapping. In addition, a Primary and Community Care reference group has been set up to engage professionals in all stages of primary care development. A questionnaire was circulated March 2018 to ascertain all profession's understanding of the emerging model of primary care plus a request to share profession specific initiatives to improve access. Analysis will be used to inform the need for further engagement and inclusion. In addition, earlier actions related to the Choosing Wisely Initiative have been developed into the Making Choices Together (MCT) Programme. Patient decision making tools and shared decision making training have built on pilot work in primary care. This work is ongoing.	
Developing a strategic approach on securing new methods of financing service developments and facilities, including accessing funding from wider sources and ownership models.	**Achieved in part**
Priorities changed over the 3 years to focus on accessing funding at a more local level engaging with local authorities. From a national perspective priority has been given to developing a framework to support resource and financial shifts from acute hospital care into community and primary care settings. It can also be used to cost primary care support services by community teams. Detailed work has also been undertaken in relation to GP practice estate with small grants accessed and national approaches to the storage of records coordinated. Management of leases has also been addressed.	
Further development of a national set of core quality and delivery requirements and measures for primary care by December 2015 for all health boards to report on to their boards and Welsh Government from April 2016.	**Achieved**
This work was staged to enable a small set of quality and delivery measures to initially be collated via a primary care portal. At the same time further measures were being developed engaging a wider audience. Following the launch of the portal, reporting arrangements to Boards was taken forward on an all Wales basis and data recording improved based on use. In 2018 Phase 2 of the measures were launched adding to the original set. Embedding the collection and reporting remains a priority. Work for 2018 has prioritised the need to agree 5-6 key performance indicators that can be used to assess the risks in primary care. Wider work is ongoing for broader indicators of improvements which will continue in year.	
A series of regular follow-up chief executive's conferences to review progress, beginning in January 2015;	**Achieved**
National conferences have been scheduled throughout the 3 years with latter events involving face to face time for Executive groups to discuss progress directly with the Cabinet Secretary.	
Development of a national approach to the development of primary care clusters, such as a set of core governance requirements on the accountability of primary care clusters by March 2015 and an organisational development programme from 2015-16.	**Achieved ongoing**
A Cluster Network Development Programme has been in place since 2014/15 with all practices able to receive 200 QOF points for participating in the cluster programme. From October 2015 LHBs have supported Primary Care Clusters to draw in all local partners to deliver local solutions and strategies, including the establishment of patient participation mechanisms. Papers were circulated in 2016 to share expectations of ongoing maturity and offer shared understanding of governance approaches. During 2017/18 work has focussed more on engaging clusters to jointly develop a framework for cluster governance. This framework	

and accompanying tool kits is currently being consulted upon and results will form the publication of a Good Practice Guide.	
A development programme for professionals on co-production and patient and public communication during 2015-16.	**Achieved in part**
As above, professional engagement has been led at national level whilst public engagement has predominantly been led at local level. Central funding was made available in 2017 to support local communication teams to publicise a shared understanding of the changes in primary care. Communications and engagement with the public has been prioritised for 2018.	
Introduction and phased roll out of the 24/7 free to call 111 number for urgent health need from October 2015-17	**Achieved**
The 111 service was successfully implemented across ABMU Health Board as a Pathfinder for Wales in October 2016 followed by Carmarthenshire in May 2017. The pathfinder was implemented to test practicalities of establishing the combined services of NHS Direct and the GP OOH service. An external evaluation examined data from the first 6 months of the service providing positive evidence about roll out and impact.	
A nationally led evaluation of local approaches to assessing those people at risk of unplanned care, such as people with long term health conditions by March 2016.	**Achieved and ongoing**
It was agreed that this action could be achieved by drawing on the learning from the Inverse Care Law Programme (ICL) which had commenced in ABUHB and CTUHB, as well as earlier work on the use of PRISM. Whilst the ICL and PRISM models are different in nature both provide an approach to predictive testing. Implementation to date has focussed on a local approach based on the needs of the local populations. The PRISMATIC study aimed to describe the processes of introducing a predictive risk stratification model (PRISM) and to estimate its effects on delivery of care, patient satisfaction, quality of life and resources used. The PRISM tool was originally introduced in 32 practices across Carmarthen, North Wales and Cardiff. The tool is supported by NWIS and continues to be used in some areas. The ICL project in ABUHB - *Living Well, Living Longer Health Check 2014-2018* is a population scale CVD risk assessment, peripatetically delivered in 7 deprived cluster areas involving 48 GP practices as well as microsites. The ICL approach in CTUHB Board undertook a pilot to test a practice based approach to Cardiovascular Risk Assessment in 7 practices located across the Health Board. Approaches to ICL are now being rolled out across Wales.	
Leadership and oversight of a rolling programme of peer review from 2016-17.	**Not led by DPCC**
Work has been ongoing to explore a methodology for cluster / practice clinical audit / review / quality improvement and making connection to ICHOM. The work links to GMS contract negotiations. In addition, a National Peer Group have produced a NHS Wales Peer Review Framework that may offer the opportunity to link existing work with clusters and local practices around quality improvement. This may link with future GMS contract discussions.	
Welsh Government Actions – DPCC contribution	
By March 2015, the Welsh Government will refresh its current health and Care Strategy to support better use of information for the public and care professionals and more effective	

use of integrated ICT systems.
During 2016 DPCC agreed to establish a Primary Care ICT and Information Board to capture and monitor all the ICT activities ongoing in primary care and to support prioritisation of projects for NWIS. Separate projects may also have individual arrangements to assess progress which are reported to DPCC via the Primary Care ICT Board.
Welsh Government, working with NWIS, will further develop My Health Online to include access to people's health records; clinical information from hospital appointments; discharge advice and information.
Increase in functionality has related to the making of appointments, repeat prescriptions, dashboard reporting, re branding, on line MHOL registration, Mobile/Smart phone access, Demographics details update, sending of messages, access to medical records, alerts, language requirements and proxy/Carer access. Each element has been piloted over the 3 years and usage increased. Work continues on roll out and promotion.
By March 2015, the Welsh Government will publish a primary care workforce development plan in support of local action to deliver the overall plan for a primary care service for Wales up to March 2018.
The Primary Care Workforce and OD Plan was published August 2015. DPCC set up a Workforce and OD group to take the actions forward and monitor implementation. A NHS specific group also came together to share good practice and identify common challenges. Many of the actions were incorporated into the Transforming Primary Care Forward work plan in 2017**.** Regular reports have been submitted to show progress in all actions.

Key Actions - Period 2015 - 2018

Key to RAG Rating	
✓	Achieved
O	Almost on plan
X	Not achieved

Key Actions	**AB**	**ABMU**	**BC**	**CT**	**CV**	**HD**	**P**	**Commentary/Actions**
HBs will support GP practices to collaborate at cluster level to develop and deliver an action plan with specific goals and actions for developing and improving GP services and local solutions to help deliver sustainable and improved local health and wellbeing, reduced health inequalities and improved service quality and performance	✓	✓	✓	✓	✓	✓	✓	
Develop and deliver a 3 year plan, informed by the cluster level plan for GP services with specific goals and actions for developing and improving primary care services to deliver improved local health and wellbeing, reduced health inequalities and improved service quality and performance	✓	✓	O	O	O	✓	O	**CT** – detailed demand and capacity work being undertaken across clusters. Will be used to assess the use of skills for clinical and wider workforce staff groups. **CV** – OD programme in place for rapid ongoing development of clusters.
HBs will support their primary care clusters to draw in all local partners, such as the third sector and local government to deliver local solutions and strategies to improve health and wellbeing of the local community, help prevent avoidable ill health and provide ongoing care for people living with long term conditions or who are frail and elderly.	✓	✓	✓	✓	✓	✓	✓	
HBs will support primary care clusters to establish patient participation mechanisms and to demonstrate how they are actively seeking and responding to people's experience of all aspects of primary care to drive and report on continuous improvement in the quality of care for their communities.	O	O	O	✓	O	O	✓	**AB** - patient engagement street events. **ABMU** – 5 cluster networks have received specific support to establish patient/carer forums as part of the Health City

								community voice programme. **CV** – some focused groups and PPI activities e.g. health fairs taking place. **HDUHB** – a PPG network has been established and offers of support have been made to all clusters. One cluster is scoping this work at present.
HBs will support their primary care cluster, to introduce a rolling programme of peer review for primary care, based on a set of nationally agreed core principles with HB directors of primary, community and mental health help develop to drive and report on continuous improvement in the quality of care.	X	✓	X	✓	O	✓	X	**AB** – no framework for core principles in place across Wales. **CV** – primary care portal and measures used to compare against clusters and improve quality. Prescribing visits taking place.
HBs, through their annual refresh of their 3 year IMTP, informed by cluster lever plans will set specific goals and actions at cluster level	O	✓	O	✓	O	✓	O	**CV** – cluster plans are focussed on addressing local need. Specific ICL national project in S&E Cardiff locality has ceased, although ICL work in the locality more generally continues.

Local Health Board Actions								
	AB	**ABMU**	**BC**	**CT**	**CV**	**HD**	**P**	**Commentary/Actions**
HBs will work with primary care to identify people at increased risk of poor health or exacerbations of existing conditions and manage that risk through an agreed individual care plan.	✓	✓	O	O	O	✓	O	**CT** – examples of risk identification can be evidenced: The CT Health check programme & virtual ward pilot in Cynon Valley. **CV** – some good examples of this being taken forward e.g. COPD, Diabetes.
HBs will, explicitly reflect their primary care cluster's 3 year plans in the annual refresh of HB level 3 year IMTP.	✓	✓	✓	✓	✓	✓	✓	
HBs should consider and develop joint contracting arrangements with multiple service providers, include LAs, the 3rd and independent sectors (NPCN 2014 pp11)	✓	✓	✓	O	✓	✓	✓	**CT** – SLAs in place with a number of 3rd sector and jointly funded posts.

HBs will work with LAs, 3rd sector and others to begin to phase in a national online and telephone service called 111 to provide access to a wide range of reliable health and wellbeing info, advice and assistance.	✓	✓	O	O	O	✓	O	**CT** – work has commenced in respect of 111 preparedness. **CV –** engaged and involved in the 111 roll out, although not due to directly affect CV until 2020.
HBs, LAs, 3rd and independent sectors will begin using a shared IT system to collect and share info to support primary care.	O	O	O	X	O	O	O	**AB** – WCCIS pilot in one LA. One Borough not yet signed up to WCCIS but deployment order signed by the HB. **ABMU** – work has progressed through the Western Bay Programme Board to develop common and shared IT and data collection systems across the Western Bay footprint. **CT** – this action rests with NWIS. Some progress on implementation but the health aspect of the WCCIS is behind schedule. **CV** – engaged in WCCIS roll out. The Vale LA have adopted the product. **HDUHB** – engaged in the WCCIS roll out, this is in place in Ceredigion but not yet in place in Pembrokeshire and Carmarthenshire.
HBs will encourage use of *Add to your life and my health online* by their local populations (NPCN 2014 pp13)	✓	✓	O	✓	O	O	O	**CV** – the primary care team continue to promote MHOL. **HDUHB** – MHOL continues to be promoted and this is in place for prescriptions more so that appointments. Many practices citing that this is at odds with their models for telephone consulting and triage.
HBs will, through their annual refresh of their 3 year IMTP, informed by cluster level plans, demonstrate how they will provide increased capacity and a growing range of primary care close to home.	✓	O	O	✓	✓	✓	✓	**ABMU** – priority has been given through the HB financial plan to invest in the new enhanced service for INR and Care Homes.
HBs will agree with WAST how paramedics can help to deliver care at home and in the community (NPCN 2014 pp 14)	✓	O	O	✓	✓	O	O	**ABMU** – formal collaborative work with WAST including piloting paramedic resource allocation continues but has faltered recently as pressure across the Unscheduled Care

								System has required WAST to focus to paramedic resource on HALO and other initiatives. **HDUHB** – we have been working with WAST on the development and implementation of these roles since 2015. This has slowed due to other commissioned priorities. Ongoing discussion reflecting a strong HB position.
HBs will optimise the EHEW service to provide the majority of care closer to home (NPCN 2014 pp14)	✓	✓	✓	✓	O	✓	✓	**CV** – the eye care agenda is being taken forward via the Optometric Advisor working with secondary care.
HBs will also continue working with all services and practices in primary care including community pharmacists, dentists and optometrists on opening times (NPCN 2014 pp 15)	✓	✓	O	✓	O	✓	✓	**CV** – access work continues to be a priority across all independent contractors.
HBs need to plan, educate and train a more flexible local healthcare workforce and develop the potential role of AHPs, which requires priority being given to their education and training (NPCN 2014 pp 15)	✓	O	✓	✓	✓	✓	✓	
HBs will work with their partners and service providers to develop more ways for people to access medication, treatment and information, advice and assistance in using and managing their medication in the best way (NPCN 2014 pp 20)	✓	✓	✓	✓	✓	✓	✓	
From April 2015 HBs will use the agreed national set of primary care quality and delivery requirements and measures, developed by HB directors of primary, community and mental health by Dec 2014, developed further by Dec 2015 to drive and report on continuous improvement in the quality of care (NPCN 2014 pp 15)	✓	✓	O	O	✓	✓	✓	**CT** – detailed work is taking place between the primary care team and Assistant Director for information in respect of the primary care measures.

ABMU Health Board
Primary Care Annual Report 2017/18

Contents

Foreword

Emma Woollett
Vice-Chair, ABMU Health Board

This is my first year as Vice Chair for ABMU Health Board, and it is my pleasure to present the 2017/18 Annual Report for Primary Care, which demonstrates the commitment and passion of colleagues across the service. Despite these challenging times within the NHS of increasing and unprecedented pressures, this report shows the progress that has been made in delivering high quality primary care services to our local population over the last year.

*Our **Primary & Community Services Strategy 2017-2022** sets the vision and direction for our services for the next five years. This report highlights how we are working towards achieving our priorities, to scale up and integrate primary care and community services, to improve outcomes, achieve efficiencies and provide responsive care that meets the needs of our population. We can only achieve this by working with our partners and stakeholders to maintain and improve the quality of our services whilst ensuring financial and service sustainability. In this report we are able to successfully showcase our highly skilled workforce and what can be achieved effectively as multi-disciplinary teams to develop a modern primary care service that is first class. With excellent relationships between our different services and with our partners, we are able to develop and provide care closer to home and continue to work closely with patients, members of the public and professionals.*

*In 2018/19 we are faced with new challenges which I am confident we will rise to. The national publication of **A Healthier Wales; Our plan for Health and Social Care** sets the ambition of designing and delivering health and social care services together, around the needs and preferences of individuals, with a much greater emphasis on keeping people healthy and well. The announcement from the Cabinet Secretary for Health and Social Services, advising that from 1st April 2019, the responsibility for providing healthcare services for people in the Bridgend County Borough Council area will move from ABMU Health Board to Cwm Taf University Health Board means that during this year we will be going through a transition period. We will need to plan and consider the opportunities this will give us to build on the high quality services we provide to our patients on an eight cluster footprint across two local authority areas.*

I wish to express our thanks and appreciation to all staff and stakeholders for their continued commitment as we look forward to this exciting year ahead.

Our Values and Purpose

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

Our Values are important. They define what we do and how we should do it. This report sets out how we have endeavoured to follow them as we have set about delivering our health objectives in 2017/18.

Our Purpose is ***"To improve the health of our community and to deliver effective and efficient healthcare in which our patients and users feel cared for, safe and confident."***

Background

The National Primary Care Annual Report produced for 2015/16 was the first report to respond to *'Our Plan for a Primary Care Service for Wales up to March 2018' [The Plan]* published by Welsh Government in February 2015. The Annual report provided a high level summary of progress against each of the national actions with examples of developments at local level.

Subsequent annual reports have been developed to present a summary of activities wider than the original recommendations within the Primary Care Plan. Locally our Primary Care Annual Report is intended to respond to the 2017/18 national Primary Care Annual report and provide local context against key priorities.

Introduction

The purpose of the Primary Care and Community Services Annual Report for 2017/18 is to describe the context within which directly managed and contracted services (the four independent primary care contractor professions), and Out of Hours service have been operating and developed in line with the national and local priorities.

The report is aligned to the national Primary Care Annual Report and seeks to provide a summary of the key issues and achievements for 2017/18. This will be within the context of the Health Board **Primary and Community Strategy** approved in May 2017**.** The strategy sets out the Health Board's vision for a vibrant and sustainable future for primary and community services and was developed through a series of listening events, and workshops.

In line with the national plan this report is structured around the five priority areas/themes of the Primary Care Plan which, 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. These key areas include:

- Planning care locally
- Improving access and quality
- Equitable access

• A skilled workforce
• Strong leadership.

The scope of work has also been influenced by a number of publications and additional areas of work which have added to the direction and breadth of the changes in primary care, as follows:

- The **Together for Health** strategy for health care in Wales, which places primary and community services at the heart of health care delivery and emphasises the importance of prevention, early diagnosis and high quality services, with patient feedback as a key driver for continuous service improvement.
- '**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) and Primary and Community Services strategy. During 2016/17 the Chief Dental Officer issued a series of communications which conveyed the need for a greater focus on developing and implementing options to reform the primary care dental contract and progress the work to revise dental pathways, supported by increased connectivity and e-referrals. The intention – confirmed in early 2017/18 - to shift the focus of the 'Designed to Smile' oral health education programme towards younger, pre-school children and integrated work with dentists and other health professionals was also flagged.
- The health and wellbeing of children has been promoted through the **Healthy Child Wales Programme** [HCWP] - the universal health programme for all families with 0 – 7 year old children which was launched in October 2016. It requires implementation of a consistent range of evidence based preventative and early intervention measures, and provides 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.
- The **Well-being of Future Generations (Wales) Act 2015** which sets long-term goals for a prosperous, resilient, healthier, more equal Wales with cohesive communities, a vibrant culture and thriving Welsh language.
- The **Social Services and Well-being (Wales) Act 2014** which places a duty on statutory bodies to work together with the public to promote wellbeing, give people a greater voice in and control over their care, promote independence, responsibility and the coordination of services around people, motivate self-care, and provide care as close to home as possible.
- The **Public Health Bill** which aims to create those social conditions that are conducive to good health and where avoidable harms can be prevented.
- Prudent health – Securing health and Wellbeing for future generations 2016;
- GP services in Wales the perspective of older people (Older People's Commissioner for Wales February 2017).
- Health, Social Care and Sport Committee inquiry into primary care clusters 2017.
- Parliamentary Review of Health and Social Care in Wales.

Abertawe Bro Morgannwg University Health Board [ABMU]

ABMU covers a population of approximately 500,000, making up around 17% of the total population in Wales. The population is already increasing, projected to increase by approximately 42,000 people (8.1%) between 2013 and 2036, particularly in the older age bands and is already representing a significant increase in the demand for health and social care services. As in the rest of Wales, there has been a significant increase in the number of elderly people requiring care. Most of the overall increase, and that in the overall, young persons and black and ethnic minorities are in Swansea (0.5% increase in population).

The Primary and Community Services Unit

The Primary and Community Services Unit [PCS] was created in August 2015 as one of the six delivery units of the Health Board tasked with the development and delivery of safe and effective services out of hospitals. The Primary and Community Services Unit has responsibility for the wide range of directly managed community services listed in Table 1 below as well as contractual arrangements with 345 independent primary care providers, approximately 1800 nursing home beds, a range of third sector organisations and responsibility for a revenue budget of circa £236m. Community nursing services are configured within clusters and are co-terminous with Social Services counterparts. There is a strong ethos of partnership working across the three geographical areas

Table 1: Services managed or contracted by the Primary and Community Services Unit in 2017/18

<table>
<tr><th>Primary Care</th><th>Community Care</th><th>Therapies and Health Sciences</th></tr>
<tr><td rowspan="3">- Cluster Networks
- Community Pharmacies
- General Medical Services
- General Medical Out of Hours service
- General Dental Services, in and out of hours
- Optometrists
- Postgraduate Dental Training Unit</td><td rowspan="3">- Community cardiology
- Community dentistry, including oral health education
- Pulmonary Rehabilitation
- Community hospitals
- Continuing Health Care
- District nursing
- Community Resource Teams
- Health visiting
- Public health nursing – safeguarding, school nursing</td><td>- Audiology
- Chronic Pain
- MSK (MCAS)
- Podiatry
- Orthotics
- Speech and Language</td></tr>
<tr><td>Intermediate/hospital services</td></tr>
<tr><td>- Restorative dentistry</td></tr>
</table>

Over 90% of patient contacts take place in General Medical practices which are responsible for providing General Medical Services [GMS] from 0800 to 1830, Monday to Friday with urgent cover outside these hours (72% of the year) provided by ABMU's Out of Hours service.

During 2017/18 the number of General Medical Practices in the ABMU area reduced from 73 to 68 (having reduced from 77 in the previous 3 years). This has been as a result of:

- Four sets of practice mergers
- One practice closure and dispersal of the patient list to neighbouring practices

The Health Board also contracts with 125 Community Pharmacies, 95 Dental practitioners (including 7 Orthodontic and two oral surgery specialists) and engages with 52 Optometry practices who provide enhanced eye care services.

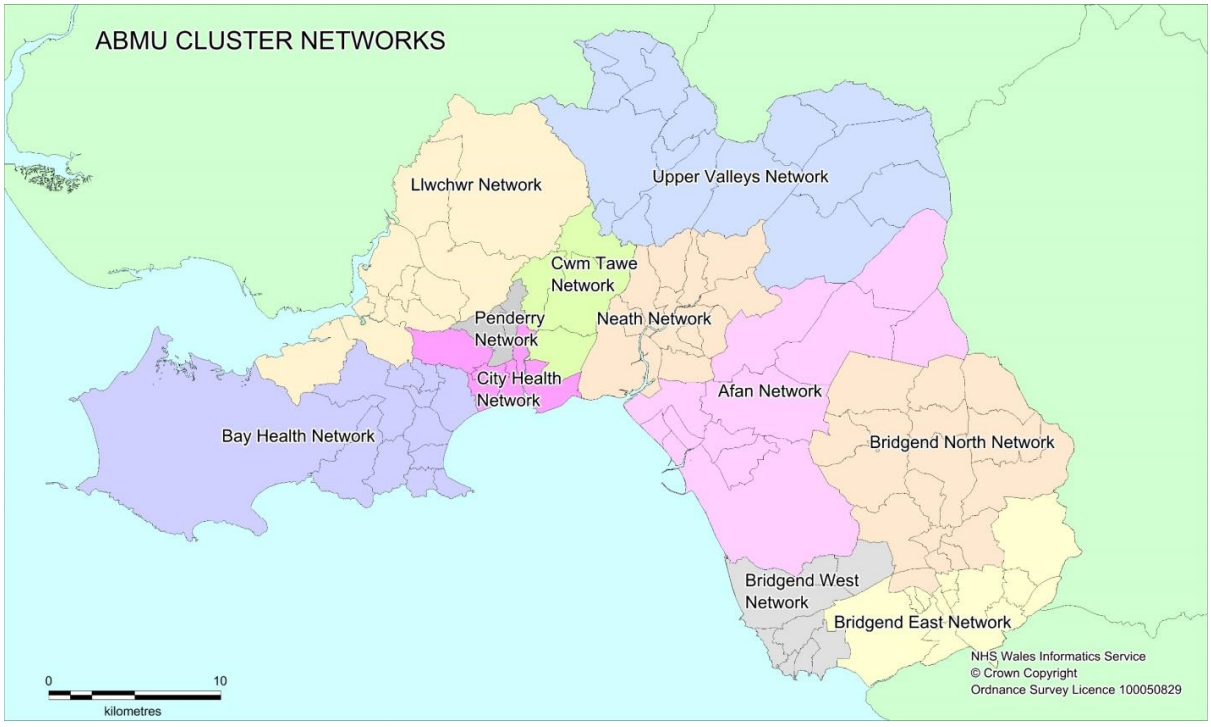
The Health Board remains responsible for directly providing general medical services to the registered patients of Cymmer Health Centre (circa 2500 patients). From 1st April 2017 the Health Board was also responsible for providing managed General Medical Services in Cwmavon for 3300 patients. To enable the Health Board to deliver high quality directly managed primary care services and to maintain the best possible service to patients, the two practices merged to become one Practice team delivering services from the two Health Board premises at Cwmavon and Cymmer.

PART 1. KEY THEMES

1.1 Theme 1: Planning Care Locally

ABMU Health Board Primary and Community Strategy reinforced the benefits of building integrated health and social care services around the patient on a population basis. The strategy prioritises patients receiving services in the community from individuals who are part of teams that are organised at cluster network level. 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 sustainably.

The location of the 11 cluster networks is illustrated in the map below. Their populations vary from approximately 30,000 (registered patients) in Upper Valleys to over 75,000 in Bay Health. The clusters now provide the structure for organising and delivering many community health and social care services, and continue to build on the strong links forged with the Third Sector and Local Authorities.



Each Cluster has an identified clinical lead who provides oversight and leadership for the Cluster multi-agency entity as well as the programmes of work within it. This includes the expanding multi-disciplinary teams delivering a wide range of services for clusters, from keeping people well to responding to more acute needs.

Achievements 2017/18

1.1.1 Cluster Development and Support

The Primary and Community Services Unit has continued to strengthen and develop the 11 Clusters during 2017/18, supporting Cluster Leads and promoting Clusters as the organisational platform not only for the delivery of services but as innovative agents to drive service delivery and change.

This has included considering and responding to the findings of the Inquiry into Primary Care Clusters by the Health, Social Care and Sport Committee, published in October 2017. Key areas of achievement include:

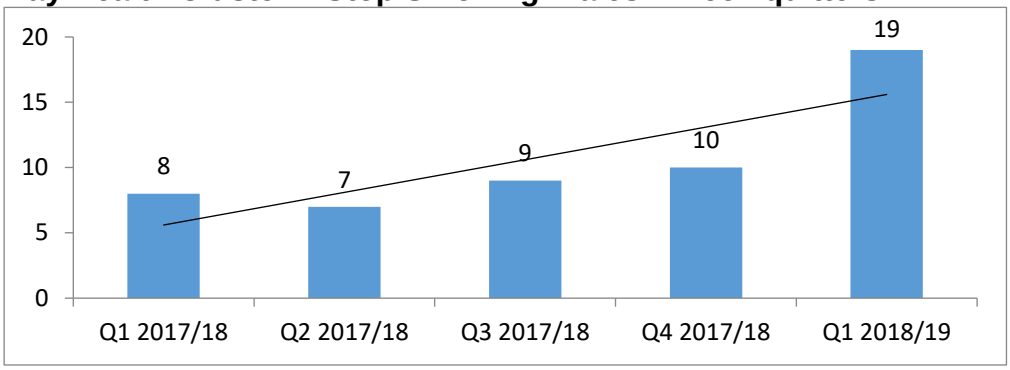
- Successful planning and implementation of Cluster programmes and priority areas to improve services for patients in the community which enabled the full utilisation of the funds allocated by Welsh Government (£1.742 million recurrently) together with slippage from the year 2016/2017.
- Health Board establishment of Voluntary Ex Ante Transparency (VEAT) notices, a form of notice which was first introduced in December 2009 to allow users to issue awards to companies who they believe are the only company selling something that they need to procure, on behalf of Clusters. This has enabled rapid commissioning of appropriate Third Sector services to meet identified priority areas and needs within a robust procurement framework.
- More sophisticated and robust approach to performance management, service improvement, and evaluation of cluster-based programmes.
- Facilitating the clusters ability to consider and improve both access to and the sustainability of services in primary care.
- Increasingly utilised the cluster platform to innovate with new services, test different approaches to service delivery and ways of working across partner agencies.
- Joint cluster approaches to schemes to benefit from economies of scale.

Throughout this report we are able to demonstrate and provide a wide range of examples of some these achievements.

Prevention of ill Health

- **Smoking Cessation Support**; undertaking training and increasing the use of C02 Monitors; collaborating with Action for Smoking and Health; recording C02 levels of patients who are registered smokers and encourage patient to quit smoking though the Help Me Quit and Level 3 community pharmacy smoking cessation services. Findings have indicated a positive effect on the quality of referrals to Smoking Cessation services

- **Bay Health Cluster – Stop Smoking Wales 4 week quitters**



- **Weight Watchers and National Exercise Referral Service [NERS]** programmes available for newly diagnosed diabetic and pre-diabetic patients.

- **Pre-diabetic pathway** programme for patients, offering advise on lifestyle changes to benefit their health and wellbeing in four Clusters. The number of people in Wales with diabetes is increasing with an average rise of about 3% every year since 2010. In Afan Cluster network of ABMU population of 50,500 prevalence of diabetes is 7.4%. Concerned about the diabetes 'ticking time bomb' and relying on evidence that early identification and management of patients at risk of developing diabetes could help to reverse the growing trend, the Afan Cluster GP practices developed a project aimed at
    - Identifying pre- diabetic patients and those at risk.
    - Providing an annual detailed lifestyle/health check

  Initials results from 1st 1215 patients April 2017 are encouraging :

    - Mean HBA1C 2015 pre intervention 41.9
    - Mean HBA1C 2016 post intervention 39.3
    - % group currently Pre diabetic 2015 54.5%
    - % group currently Pre diabetic 2017 37.5%
    - % Drop in Pre Diabetics 2017 v 2015 32.0%

  The project has been rolled out to 4 other clusters within ABMU Health Board covering a registered population of 175,000 patients. So far over 17,000 patients with pre diabetes or at risk of pre diabetes are now being screened.

1.1.2 Pacesetters and Innovation

Since the first cycle of Pacesetter projects in 2015, intended to support a range of initiatives, funded by Welsh Government, to drive forward innovation and service change at pace, ABMU Health Board has been committed to leading nine projects to test and expand on primary care innovation. Ongoing commitment for these schemes require financial commitment from the Health Board to continue or mainstream.

	Pacesetter	Allocation £	Yearend highlights
1	**AGPU - Acute Clinical Outreach** The Acute Clinical Outreach pathfinder model has been closely aligned with the developing Acute Clinical Response in Swansea. The ACO will comprise of a multi-disciplinary outreach team of GPs, Consultant Geriatrician, and Advanced Nurse Practitioners, which in turn will be supported by a wider team of acute nurses.	0.080	The enhancement of the Unit has led to realisation of the following key objectives: 1. Constantly delivering high quality care in a safe environment 2. Enhanced patient experience by providing local care tailored to individual needs of the patient 3. Developing partnership arrangements to promote and deliver a comprehensive range of value for money. Included in national Critical Appraisal via University of Birmingham
2	**Primary Care Hub (Neath)** To change the model of access to primary care to enable GP Practices to sustain services in response to rising demand and give practices early access to key musculo skeletal, mental health and third sector services as part of a primary care hub.	0.100	• An increase in patients dealt with through advice by phone • An increase in available GP consultations • A decrease in overall face to face GP consultations • Leading to an increase in GP consultation time • A more consistent pattern of DNA rates • A reduction in DNA rates for face to face consultations Included in National Critical Appraisal via University of Birmingham. Continued Pacesetter funding until March 2018.
3	**East Network Federated Working** To form a legally recognised body (Social Enterprise Business) representing in excess of 60,000 patients, engaging with the Health Board to provide better health services	0.075	The funding has released GP partners from Practice to work together to undertake the visioning and establish the legal Business model, to become company Directors and has provided the confidence for GP partners to think innovatively beyond practice

	Pacesetter	Allocation £	Yearend highlights
	to patients through local delivery.		boundary and confidence to share resources, develop new workforce roles and service models. These GP partners from the 6 practices in the Federated Business will become advocates and mentors to accelerate the roll out of federated working across the rest of the cluster networks in Wales. A Social Enterprise Toolkit has been developed and shared nationally. Included in National Critical Appraisal via University of Birmingham
4	**Tackling high rates of Antibiotic prescribing** Reducing rates and improving the quality of antibiotic prescribing in primary care clusters through targeted antimicrobial stewardship; aiming to minimise the potential risks for increasing antibiotic resistance and *C.difficile* infection.	0.024	Since the Campaign commenced, the Health Board had reduced antibacterial prescribing at a faster rate than the Welsh average. However, since the summer, the gap began to narrow and for the December 17 quarter, the gap was less than the 2% target. Data analysis has indicated that a number of practices have been unable to reduce antibacterial prescribing as anticipated. As a result there will be: • Targeted support to high volume prescribing practices. • Targeted support for practices that have been unable to reduce antibacterial prescribing by more than 5% in the last year. Philosophy of approach mainstreamed into core work programme. Included in National Critical Appraisal via University of Birmingham.
5	**Pacesetter- Renal** To develop alert systems in primary care to reduce the harm caused by acute kidney	0.007	A new Chronic Kidney Disease [CKD] alert initiative was launched in ABMU in November 2017 building on the learning from this

	Pacesetter	Allocation £	Yearend highlights
	injury (AKI) through early recognition of at risk patients. Also to review patients with AKI and chronic kidney disease (CKD) by a specialist renal pharmacist aiming to improve patient outcomes.		national pacesetter. The National CKD audit is also providing information to practices on their CKD management which will support improved patient quality of care. Philosophy of approach mainstreamed into core work programme. Included in National Critical Appraisal via University of Birmingham
6	**Domiciliary Medicines Management** The Health Board's Medicines Management team provided support to patients with known problems managing medicines in their own home without a package of care, so reducing risk of harm, admissions and improving patient outcomes. Improve collaboration and joint working within a cluster area	0.014	Advice and practical support to help individuals manage medicines in their own homes to reduce risk from adverse drug events, Reduce unscheduled care and improve outcomes from the treatment of chronic diseases. Philosophy of approach mainstreamed into core work programme. • 73% of patients able to manage medicines following visit and initial intervention • 70% reduction in likely/possible unplanned care following initial Intervention • 41% referred on for further discussion/support (often not medicines related) Philosophy of approach mainstreamed into core work programme. Included in National Critical Appraisal via University of Birmingham
7	**Repeat Prescription Ordering Hub** The prescription ordering service provides an additional method for patients to order their repeat prescriptions. Patients telephone a single number and order their	0.200	The first General Medical practice was brought on line on October 23rd, with subsequent practices in the East Cluster each week. • 12,229 repeat prescriptions processed - this reflects 18.3% of total repeat orders

	Pacesetter	Allocation £	Yearend highlights
	prescription with a trained, non-clinical, call handler. The call handler consistently delivers a structured intervention with patient consent which checks which items were required during a 5 minute (approximate) telephone call, before generating the prescription. This will allow time to establish exactly what the patient requires. Once complete the prescription will be generated in the ordering hub and printed for signing within each GP practice.		taken by GP surgeries prior to the Ordering Hub • 3089 reauthorisations passed back to Cluster Pharmacist/GP (this represent 25.26% of repeats processed) • 802 queries from patients passed back to GP practice • 295 medicines management queries dealt with by hub that would have usually been directed/dealt with by GP surgery • 1549 repeat items rationalised/reduced after hub processing of patient order • 14 repeat items removed from repeat as no longer required • 74 items reduced in quantity on repeat to match actual patient usage /need. Mainstreamed into core work programme further evaluation to be undertaken to consider further rollout across Clusters.
8	**New Model Federation / Collaboration Development and Roll Out**	0.075	Other clusters across ABMU HB area being supported through the pacesetter programme to look at alternative models of integrated, collaborative working and establishment of legal entities in line with the learning from the East pacesetter and the national direction in the Emerging Model and the recommendations in the Health and Social Care Committee review of Cluster working 2017
9	**Advanced Primary Care Hub Development and Roll Out**	0.080	Other clusters across ABMU HB area being supported through the pacesetter programme to look collaboratively at MDT cluster based working and establish hubs in line with the learning from the Primary Care Hub (Neath)

	Pacesetter	Allocation £	Yearend highlights
			pacesetter and the national direction in the Emerging model and the recommendations in the Health and Social Care Committee review of Cluster working 2017. Continued Pacesetter funding until March 2018.

Dental Contract Reform

In 2017 four of the 95 general dental contractors in the Abertawe Bro Morgannwg University Health Board [ABMU] area volunteered and met the locally developed criteria to test out a Wales-revised version of the 2005 General Dental contract which aims to reduce the disincentives to providing holistic, preventive care that are inherent in the original. They have joined the Health Board's existing two 'Prototype' practices which had already demonstrated that eliminating the Unit Dental Activity target-driven approach resulted in greater access and more holistic care. They are now providing a helpful foundation and in-built control test for the dental contract reform programme introduced from September 2017. The six practices (four Contract Reform and the two Prototypes) have, since September 2017, formed a ABMU Contract Reform group, supported by the Health Board, Public Health Wales and the Chief Dental Officer to share learning, and views on the proposed programme, its benefits, potential pitfalls and how it can be taken forward. ABMU is also represented on the Chief Dental Officer's [CDO's] national contract reform group through the Dental Director and Primary Care Manager who has driven and supported much of this work locally.

The national dental contract reform programme launched by the Chief Dental Officer in June 2017 built upon the Prototypes as well as experience introduced from elsewhere in the UK. They were joined by four other practices in ABMU (14 across Wales) to test a 'blended' contract methodology which comprises a compromise between the GDS contract and the prototype described above. Phase 1 of the contract reform programme, from September 2017 to March 2018, reduced – rather than eliminated - the UDA target by 10%. This eased the time and financial pressures on practices to enable them to complete and submit clinical profiles on all patients assessed and treated. The results of the practices' Assessments of Clinical Oral Risks and Needs [ACORN] will, along with a survey of 18-25 year olds, increase awareness of population oral health changes and challenges in adults, influencing service design and provision.

The six, very different, practices who comprise the Phase 1 Contract Reform group hold a total contract value of approximately £2.2 million to deliver 86,833 UDAs or equivalent. The UDA rates per practice varied significantly for contracts ranging from 5,800 to 34,500 UDAs. Between them, they can provide a true test of what can be delivered with contract restrictions lifted to varying degrees, improving access to dental services that, without a challenging UDA target to deliver, can focus on providing more, preventive, services to patients in primary care.

1.1.3 Critical Appraisal and Evaluation

On a national level we actively participated in the critical appraisal of the Pacesetter Programme, undertaken by Health Service Management Centre of the University of Birmingham. The appraisal looked at the delivery of these projects in each Health Board and the overall contribution of the Pacesetter Programme to large-scale primary care transformation. The aim was to provide learning for future primary care transformation programmes in Wales through comparing the experiences of the Pacesetter programme with research evidence and international best practice. An all-Wales learning event, co-ordinated by Public Health Wales' Primary Care Hub and Birmingham University, will be held during 2018 to share this learning with senior Health Board teams and other key stakeholders in Local Government, Third Sector and with representatives from Community Health Councils, and will provide a platform for further discussion.

Locally, there has been an increase in proactive review and evaluation. This has included:

- A review of baseline data for National and Local Pathways and planned programmes of work to make improvements. Particular areas of achievement have been in relation to Children and Young People's Mental Health, Measles, Mumps and Rubella [MMR], Chronic Obstructive Pulmonary Disease [COPD] and Cancer. Just one example of good practice lies within one Cluster which is now developing a Mental Health action plan for its cluster and has aligned a proportion of Cluster spending with this area of work, and has worked closely with the GP Lead for MacMillan Cancer Framework to audit cases of cancer.
- Commissioning of a formal evaluation for Social Prescribing Link Worker in Cwmtawe *(See 1.1.1 Social Prescribing)*
- Close working with 1,000 Lives Service Improvement Team to deliver evaluation and quality improvement for Primary Care Children's and Families Team Early Years' Worker *(See 1.1.1 Social Prescribing)*

1.1.4 Alternative Provider Models of Medical Practice

The Pen y Bont Health Federation, established as a result of pacesetter funding *(See 1.1.2 Pacesetters and Innovation)* to develop a social enterprise consortium with six General Practices in Bridgend, has worked with other clusters and cluster leads across Wales to share their learning, experience and journey on their path to federation status. The federation has facilitated the success of the development of an All Wales Toolkit, which is available to other GP practices across Wales that are exploring the option of developing a social enterprise. The toolkit draws on the experience of the federation and provides practical advice, evidence, cases studies and sign-posts to Welsh support organisations and grant providers.

1.1.5 Integrated Medium Term Plan [IMTP] Guidance

The NHS Finances (Wales) Act 2014 requires the Health Board to develop an integrated three-year plan each year, which balances financially on a rolling annual basis. However, the Health Board agreed to develop an Annual Plan for 2017/18 as our care system was unsustainable due to demographic changes and health

inequalities in the population we serve; a model of care which is overly weighted towards inpatient services and an imbalance in demand and capacity, leading to significant performance, workforce and financial challenges. Welsh Government were also clear that to provide the foundations of an IMTP, the Health Board will need to update its Clinical Strategy and develop an Organisational Strategy to provide a clear strategic direction for the Health Board.

1.1.6 Community Pharmacy

Many of the 125 Community Pharmacies within Abertawe Bro Morgannwg University Health Board area are open at hours when other health care professionals are unavailable and play an important and growing role in ensuring that people who feel the need for health care support can access professional help close to home, minimizing the need for a GP appointment.

A new Community Pharmacy Contractual Framework [CPCF] was introduced in April 2017 with Health Boards using a newly 'top-sliced' element of pharmacy funds to commission additional or new enhanced services. The stated aim of the new contract was to "*Make better use of pharmacists to improve access to services by providing the first port of call for the consultation and treatment of common minor ailments".*

ABMU's investment plan for community pharmacies focused on supporting the sustainability of the health and social care services, with a particular aim of minimising unnecessary unscheduled care pressures on General Medical Practice and hospital services. 2017/18 also saw the primary care management team work closely with individual pharmacies and Community Pharmacy Wales to help deliver key public health targets around smoking cessation and flu immunisation, as well as develop further the substance misuse services. Highlights are summarised below, working closely with colleagues in Community Pharmacy Wales, NWIS, Public Health Wales, and GP Cluster leads in 2017/18 ABMU commissioned the following:

- the **Common Ailments Service** in all 125-community pharmacies; 102 were delivering the service by 31 March 2018
- additional **pharmacies** to open during evenings and extended hours: 16 pharmacies were open on a Sunday by year-end, a 128% increase from 2016/17
- more pharmacies (102 from 46) delivering the **Emergency Medication Service** [EMS] to ensure that patients can, at no charge, access their repeat medication every evening, weekend and Bank Holiday from a local pharmacy rather be routed through the 111/GP Out of Hours service
- more pharmacists (100 from 84) to deliver the **Help Me Quit smoking cessation** service, treating 7% more people
- 95 (10% more) community pharmacies provided the **flu vaccination service** to 8000 people, an increase of 34% on the previous year, which contributed approximately 6% of the overall flu vaccination achievement with GPs and cluster based initiatives supported by Public Health Wales.

The **Common Ailment Service [CAS]** is a free NHS service that patients can access for advice and treatment of 26 conditions. The service involves the patient registering

with the pharmacy and undergoing a private consultation with the pharmacist. Advice is provided on how to manage their condition and treatment where necessary.

Implementation of the CAS commenced in October 2017, rolled out on a cluster by cluster basis by the NHS Wales Informatics Service [NWIS], supported by the Health Board to an average of 7 pharmacies a week. At the end of 2017/18, it had been commissioned across 9 of the 11 clusters and was already being well used, particularly in those clusters where there were close links with the General Practitioners. By 31st March, there had been 446 consultations, 188 of which had taken place that month. Of the 26 common ailments covered by the CAS, the most treated by far (167 consultations) was conjunctivitis, with significant numbers of patients also treated for acne, head lice and oral thrush.

As indicated in the summary above, the requirement to make the maximum impact to reduce **flu** outbreaks saw increased collaboration between GP practices and Pharmacies with significant results. Additionally, due to increased pressure on GP practices that left some unable to vaccinate residents in a number of Care Homes, ABMU developed and implemented NHS Wales' first "Off-site" flu service, through which community pharmacies could provide vaccinations within care homes when other health professionals are unable to do so. Seven care homes participated. The primary care team presented at the national influenza awards to share the work and support other health boards to adopt the service.

A new **Medicines Management Support for Care Homes** enhanced service was developed. This replaced the previous (Advice to Care Homes) service which only provided for a twice yearly visit by community pharmacists or technicians. Analysis of the data from these visits indicated that more frequent medicines management support was required, with a greater emphasis placed on identifying and addressing issues to prevent reoccurrence. The new model provides a more prudent, patient outcome focused approach where medicines management issues are identified.

By 31 March 2018 **smoking** across ABMU had reduced to 19%, and had done so faster than elsewhere in Wales. However, the annual expected reduction of 5% more quitters per year to ensure achievement of the national target of 16% by 2020 was not met. Monthly activity data shows that in 2017/18 community pharmacies treated 2221 smokers, a 7% increase in the number of patients who have accessed the service. Health Board staff continue to work closely with Community Pharmacy Wales to engage with pharmacies to drive this service to achieve the further increase that will be necessary to ensure the 2020 target is met.

1.1.7 Eye Care in the community: Eye Care Examination Wales Services

The **Low Vision Service Wales** [LVSW] is a Primary Care rehabilitation service for both adults and children with a vision impairment living in Wales. This enhanced NHS service is free of charge to patients, and provides for both adults and children with a vision impairment.

Over two thirds of patients seen within the LVSW are over 80 years old. 24 (42%) of ABMU's optometry practices are now accredited to provide the service, following the retirement of a very active Port Talbot based provider in early 2017.

The service assesses people with poor vision and provides them with appropriate aids to help their daily living, reducing risks associated with:

- Medicine mismanagement
- Loss of independence and confidence
- Increase in social isolation and depression
- An inability to cook/clean/shop
- Increased risk of falls, burns and/or malnutrition
- Problems with education/employment/travel

The aids provided are categorised as follows:

- Hand held and stand magnifiers
- Spectacle mounted aids including the Peli lens
- Distance aids
- Electronic aid (the Visum Ecare in 2017/18)
- Lighting
- Accessories

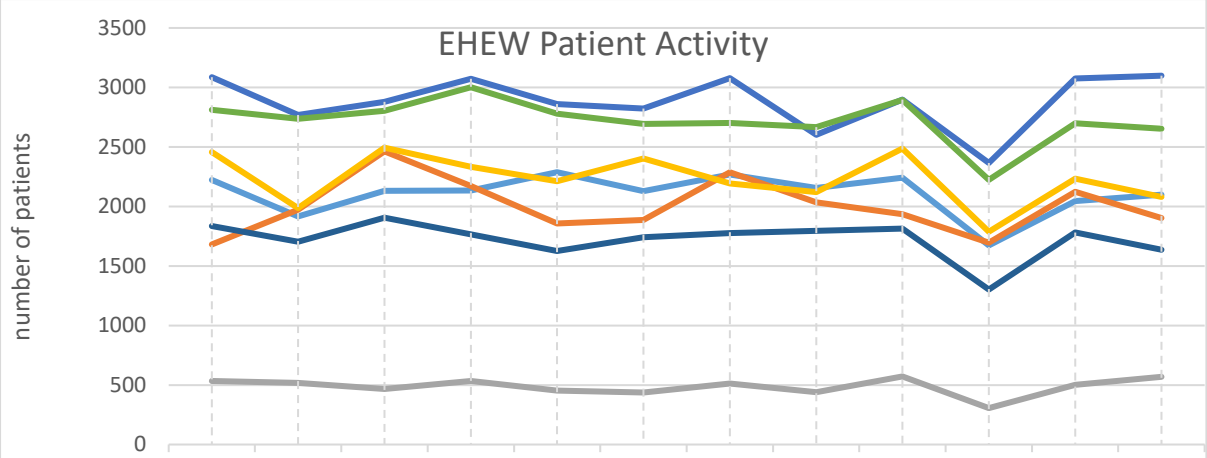
Across Wales, the ratio of aids provided per consultation averages 2.46 (from 2.27 in 2012/13), 56% of which are in the hand-held category. LVS-accredited optometrists in ABMU undertook 1368 consultations in 2017/8 a 5% drop from the previous year but still more than the Welsh average for the same population which reduced almost 10% in 2017/18 from the previous year.

Performance in ABMU was, at year end, expected to rise following the distribution in Quarter 4 of LVS publicity leaflets to other primary care practitioners, health and social care practitioners and public libraries.

The **Eye Health Examination Wales [EHEW**] service supports patients through provision of the following three types of service:

- investigation of acute eye care or annual check for patients at risk of developing eye disease (classified as Band 1 for which the optometrist is paid £60.60)
- further inform referrals to the hospital eye service, e.g. pre-cataract assessment (Band 2 - £40.40)
- review of patient following a Band 1 or for post-operative cataract monitoring (Band 3 - £20.20)

The geographical coverage and percentage of EHEW practices in ABMU remains, at 88%, considerably lower than across Wales as a whole (94%) and will remain so unless and until more of the large supermarket-based Optometry practices support the scheme. However, as can be seen in the chart below, EHEW activity in the ABMU practices continues to be the highest level in Wales. The chart below shows that almost 23,000 patients received EHEW services in between April 2017 and March 2018. This is an increase of 45% in the last two years (32.4% in 2016/17 and a further 10% more in 2017/18).



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
ABM	2223	1916	2131	2135	2288	2129	2268	2156	2242	1673	2045	2100
HDDA	1681	1974	2463	2171	1856	1887	2287	2035	1936	1695	2123	1902
POWYS	533	517	468	535	454	436	512	440	572	306	501	570
BETSI	2457	1986	2494	2334	2213	2403	2193	2122	2487	1788	2234	2081
ABUHB	3087	2769	2878	3073	2860	2824	3079	2603	2897	2366	3077	3099
C&V	2813	2736	2805	3002	2780	2694	2703	2666	2895	2224	2698	2653
CWM TAF	1836	1704	1906	1766	1627	1741	1776	1796	1815	1302	1781	1637

The increased activity has come at a cost that has exceeded the monies transferred from Welsh Government to Health Boards by 19.7% in 2016/17, 12.3% in 2017/18. In ABMU, the cost of the service rose by 10.3% in 2017/18 to £1.26 million, £117.7k above the available budget with a resultant cost pressure within the primary care budget.

The volume and associated cost of Band 1 treatments account for most of the substantial increase in activity in 2016/17 and 2017/18, indicating an increase in signposting from GPs and, perhaps, the new 111 service in ABMU. However, the most significant rise (175% in the two years to 31 March 2018) has been in Band 3 treatments. This reflects the significant increase in the number and proportion of post-operative cataract monitoring now being undertaken in the community, an anticipated consequence of the review of the national and local cataract and pathway that commenced in 2016/17.

1.1.8 Social Prescribing

Social 'prescribing' (or social referral as a term that is being more frequently used) is gaining a strong profile, from the local level through delivery of a wide range of wellbeing services. The demands on primary care mean that the current medical model is not sustainable. The need to look at a patient's wellbeing means that primary care needs to go further than just diagnosing and treating people. Social referral has been identified as a mechanism to support professionals when considering an individual's social environment to achieving health and wellbeing.

Professionals have access to a several online signposting tools including 111 Directory of Service, DEWIS and Infoengine - http://en.infoengine.cymru/ which is an

online directory of services covering Powys, Ceredigion, Pembrokeshire, Carmarthenshire, Pembrokeshire, Swansea, Bridgend, Neath Port-Talbot and Wrexham. The aim is to highlight the brilliant and varied services that are available in the community and provide all of the relevant information about each service. Each organisation and group is responsible for their entry on infoengine. Swansea cluster practices refer informally to community groups or Third Sector organisations by using the Swansea Healthy City Directory. The Directory consists of comprehensive lists of groups, clubs, and organisations who can offer support, teaching and encouragement to help people feel healthy and well.

Clusters in ABMU recognise the added value of the Third Sector and the need, through a prudent healthcare approach, to support patients for social and non-medical issues which could impact upon their health and wellbeing in the longer term. As such Clusters have commissioned through dedicated funding schemes, Third Sector and other partner agencies, to deliver on this agenda. Some of this work has been mainstreamed to be delivered via other funders or the community themselves. This includes:

- The Cwmtawe Cluster has employed a social prescribing link worker which is having initial excellent feedback from patients and practices.
- The Penderi Cluster have appointed an early year's worker to tackle the issue highlighted from the Healthy City Best Start presentation to the cluster where national and local research was presented into reducing health inequality and narrowing the gap in readiness for school. This showed the best way to give children the best possible outcome in later life is to invest in their early years. The importance has been reinforced in a new Public Health Wales report into the effects of adverse experiences in childhood (ACEs). It found that a poor start in life affected children's health well into adulthood. Children with four or more ACEs as they grow up are more likely to get lung or heart disease later in life. They are also more likely to be a victim and/or perpetrator of violence. GPs often witnessed this cycle repeating into the next generation.
- The Neath cluster employ a Community Mental Health and Wellbeing Worker who works on a one to one basis with patients to signpost them to appropriate organisation to offer them help and support.

Commissioning of Third Sector Services to the value of £274,000 to meet locally identified priorities including:

- Children and Young People's Counselling
- Social Isolation and Maintaining Independence
- Low level mental health issues in adult

Links with cluster piloted programmes, onward funded by the Health Board for Carers' Helpdesks and Citizens' Advice Bureau services across a number of clusters

Healthy Homes Scheme Caseworkers work with patients in the North Cluster to provide a holistic housing focused service which offers practical solutions for the home environment, provision of aids and adaptions, as well as practical advice and support to help them live more comfortably, safely and independently at home.

The West Cluster refer patients to the Care and Repair Healthy Homes project. The Healthy Homes Project provides a vehicle for embedding a third sector housing related service into a primary care setting and provides practical solutions in order to achieve change to the home environment and carrying out preventative measures to avoid accidental injury and falls that can lead to hospital admission.

In one cluster a total of 292 referrals were received for the year 2017/2018. 305 Caseworker home visits were completed. In addition, 237 Occupational Therapist assessments were carried out, to arrange larger scale adaptations and specialist equipment. The average age of patients was 80 years old, and 36% had fallen within the last 12 months. During the year, in excess of £500,000 of benefits and grants were accessed for individuals using the service from works ranging from grab rails to walk in bathrooms.

Within the East Cluster patients that are experiencing isolation and loneliness are referred to a range of services including befriending, lunch clubs, community cafes and coffee mornings.

1.1.9 Oral Health and Dental Services

Action to tackle poor dental health and improve access has two main thrusts: preventing the incidence of decay through oral health education, and increasing the availability of accessible dental services. The Primary and Community Services Unit is responsible for oral health education as well as dental service provision across ABMU Health Board.

Oral Health; In the absence of fluoride in local water, *Delivering Better Oral Health*[1] suggests that all children should have fluoride varnish applied within each course of treatment. Public Health Wales reported, earlier in 2018, that the proportion of 12 year olds with decayed or missing teeth had reduced significantly over the past five years to 29.6% from 45.1% across Wales. The achievement in the ABMU area has been even more significant, reducing from 47% to 28.9% over the same period and reaffirmed the picture revealed in the previous year's survey of young children that showed that dental disease levels continued to improve across all social groups with most deprived areas seeing the largest reduction in decay.

It is considered that the continued increase in the activity of the **Designed to Smile team**, (an NHS Dental programme funded by the Welsh Government helping children to have healthier teeth) working in schools and nurseries in the Health Board's most deprived areas has made a major contribution to this.

[1] *Delivering Better Oral Health – an evidence-based toolkit for Prevention, 4th Edition June 2014, Public Health England, distributed UK-wide*

In 2017/18 there were a number of achievements by the Designed to Smile [D2S] Team:

- The adoption of the 2016 Public Health Wales-led *Lift the Lip* pilot campaign between Designed to Smile and Health Visitors across ABM. The excellent joint working with the Designed to Smile team to make every contact count, now includes closer working with dentists, the Speech and Language Department and school nursing team to prevent dental decay in pre-school and primary school settings, with specific training.

- The publication of *WHC (17)23 Refocussing of the Designed to Smile Child Oral Health Programme* cemented the need to focus on the youngest children and ceased the fissure sealant element of the programme. The Designed to Smile team continued to provide fluoride varnishing in the 300+ schools and nurseries in which it educates and treats children but was required by the same Welsh Health Circular to cease the education programme for the year 7 age group as it was considered that there was no evidence base to warrant its continuation.

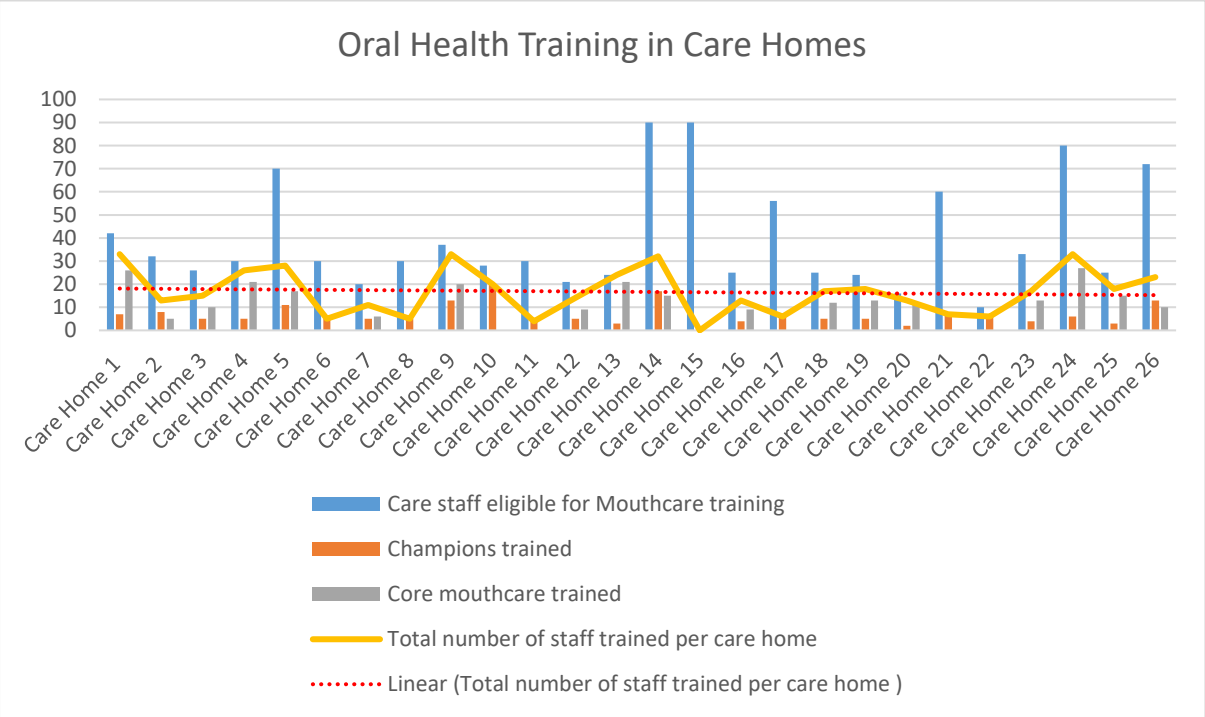
- The number of nursery and school settings in which the Designed to Smile team delivers continues to rise and change, with an additional 18 settings identified by the Welsh Oral Health Information Unit in 2017. The challenge for the D2S team is securing 100% engagement, e.g. four of the new cohort actively sought D2S input, three did not engage and five 'actively' refused. Although this position improved subsequently it was not without considerable effort and engagement directly with the schools, through the Healthy Schools teams and others and this will continue to require engagement at senior partnership level to achieve 100% engagement in target areas.

- WHC(17)23 also required the local D2S team to engage directly with the 14 Teaching Dental Practices within the ABMU area to ensure Dental Foundation Trainees and senior colleagues are briefed on latest oral health education advice and training and provided, where appropriate, with the means to provide more fluoride varnish treatments within General Dental Practice. The impact of the change in emphasis in the programme will emerge within the next few years. It is hoped that there will be a significant increase in the percentage of children who receive the twice-yearly fluoride varnish applications recommended in Delivering Improved Oral Health. Although more than a third of five year olds in ABMU were reported in 2016/17 to have decay affected teeth, only 6.6% (compared with Wales wide figure of 8.9%) received this, albeit that it was recognised subsequently, in 2018, that ABMU's dentists appeared to have under-recorded this particular activity.

- The evidence indicates that Designed to Smile, although still in its infancy, is beginning to deliver on its intended outcomes. 2017/18 also saw work continue under the auspices of the 1000 Lives-led oral health in care homes programme[2]

[2] Established following the publication of WHC(2015)001 Improving Oral Health in Care Homes

There has been specific work to strengthen the links from Designed to Smile and Health Visiting teams to **general dental practices** to enable them to secure immediate access for children who need dental care. In the past, there had been a direct route for these professionals to signpost parents to the Community Dental Service [CDS]. However, particularly since the publication of WHC(2016)005 *the Role of the CDS and Services for Vulnerable People* emphasised the pressing need to ensure the CDS focused on patients with special care dentistry needs rather than healthy children, that route has not been appropriate. 2017/18 saw the commencement of considerable joint work between primary and community dental service leads to ensure access to General Dentistry is readily available for these children in deprived areas with a new general dental contract commissioned in Cymmer to take on patients, many of whom were formerly treated by the CDS at schools bases, in the Afan Valley.
In 2017/18, the oral health checklist and training package which had been tested and rolled out to 15 homes in the 2016/17 pilot was modified to reflect experience and extended to a target of 37 Homes, comprising 57% of homes for the elderly across ABMU. At 31 March 2018 26 (40% of care homes) were participating fully participating and staff training had increased as indicated in the chart below.



At year end 76% of target staff (780 out of a possible 1026 staff) had been trained by the single-handed **Community Dental Service [CDS]** Oral Health Educator or care home staff she trained: 174 staff as mouth care champions and 434 in core mouth care by CDS, plus 172 staff trained in mouth care by their in-house champions. To date outcome measures which would support a qualitative evaluation of this national programme's effectiveness have not yet been developed but are anticipated as the programme becomes more established across Wales.

Staff training increased but continues to be a challenge, especially with an increase in care home participation. To support this an induction pack, requested by care homes, prepared, tested, refined and re-tested before being distributed. It has been

acknowledged that deployment of additional dental clinical professional resources will be required to reach all staff in all care homes. The most effective means of achieving this objective will be considered as part of the overall integrated (Community and General Dental Services) domiciliary oral health care package whose development is a priority for the Health Board from 2018.

Paediatric dental pathway; With concern that a high level (1.6%) of children in ABMU received their dental care whilst under a General Anaesthetic, the Health Board decided to introduce a Referral Management Centre to review the referrals formerly sent directly from General Dental contractors to the Health Board's commissioned provider of paediatric dentistry under a General Anaesthetic. The clinically-led Referral Management Centre for paediatric referrals was established within the Community Dental Service on a phased basis from June 2017 onwards. A significant proportion of children were referred back to their General Dentist or re-routed to CDS' new paediatric assessment and treatment service. This had the effect of reducing by 60% the number of children receiving treatment under a General Anaesthetic with the primary care provider.

The reduction was partially offset by an increase in the number of urgent referrals for treatment under a GA which continued to be sent straight to the primary care provider. The full impact of the pathway (reducing the number of GAs) will only be demonstrated when an urgent pathway is developed to manage urgent referrals into the service in 2018.

1.2 Theme 2: Improving Access and Quality

The ABMU Health Board Primary and Community Strategy proposes the delivery of primary care services at scale, designing and delivering more services closer to home with the aim to deliver excellent health services and improve the quality of patient care. The strategic quality objectives of ABMU Health Board provide the cornerstone for the quality objectives within our strategy.

1.2.1 Quality

Quality Objective	**Achievements 2017/18**
Quality Objective One - To plan and deliver our service with the people living in the communities we serve, so that they are person-centred, caring and responsive to need.	The use of SNAP 11 Friends and Family patient feedback within the managed practice and dental training unit and GP practices within the East Cluster The Upper Valleys Cluster is currently involved in a survey with MacMillan which will enable us to capture the experiences of cancer patients using the GP pathway; the information they have been given, and ongoing support.

A number of our clusters have undertaken Patient Engagement Events.

The Neath Cluster held a 'You Talk, We Listen' event during 2017/18 which was organised collaboratively with third sector colleagues to provide patients with an informative open session. It was an opportunity to hear patient views and experiences relating to existing services and seek suggestions for new developments. Help was enlisted from various local partners, including Citizens Advice Bureau, Macmillan, Community Health Council and Community Connectors to promote the concept of seamless patient health and wellbeing processes. Patients were given the opportunity to complete feedback forms and following the engagement sessions action plans have been developed and are in the process of being implemented.

Regular patient groups, sharing their thoughts and experiences to support development of cluster priorities and services.

Extensive communications programme of healthcare services, providing alternatives to the GP practice as the default first point of contact for patients, accessing Welsh Government allocated funds of £25,000 to ABMU Health Board

	 ABM HEALTH Primary Care Hub New hub boosts access to community care Patients are giving a thumbs up to a brand new health hub in Neath that offers **specialist care and advice** closer to their homes. The Primary Care Hub, which has just opened in a new building off Dyfed Road, is aiming to provide people with easy access to health services in their community, as an alternative to seeing their GP. Patients are referred to the hub by their doctor, who assesses their needs to see if they need to see a GP face-to-face or would be better off seeing one of the health care professionals at the hub. They include audiologists Debra Kelshaw and Suzanne Houghton who treat people with hearing problems, tinnitus, or wax build up. Debra said "Patients really like the hub because they can see multiple As well as audiology, the centre also offers physiotherapy and mental health support, and more services are in the pipeline. Rhys Wilkes from Neath was at the hub seeing physiotherapist Alex Tsouroha because of a rugby injury to his knee. "I had an operation so I'm trying to get back to fitness. The service here is great so we'll see how it goes now," he said. Hannah Williams, another specialist physiotherapist at the hub, said "People prefer to be seen near their own homes. Previously they would have had to travel to Neath Port Talbot Hospital. Now I can see patients within a maximum of a week, and This included 11 stories, articles and videos, promoting and sharing access to primary care. Coverage by BBC Wales, Wales Online Radio interviews across a number of projects. Within 2017-18 there was a Facebook 'reach' of 233,000 following the first activity, with significant online traffic maintained thereafter, and over 2,600 patients actively engaging in the posts' discussions.
Quality Objective Two – To deliver excellent, effective and efficient services based on evidence and standards.	A short form has been developed in Datix, an on line incident reporting tool, to encourage GP practices to report incidents relating to the Breach of CMO's Standards of Communication, Referral and Delegation. The pilot has ended and is now live - the unit will be able to share the themes with colleagues in secondary care to support improvements in patient care. This work has been supported by the Local Medical Committee (LMC). The Quality & Safety Manager is working closely with the corporate team to ensure actions from alerts are recorded accurately. This involves Health Board wide teams i.e. Medical Device, Health and Safety and Medicines Management groups. This process needs to be formally agreed before progression to Medical Device Alerts.
Quality Objective Three – To make sure everything we do is as safe as possible.	Improvements were made in the processes used to investigate, close and share lessons learned from all reported incidents through the Primary and Community Services Unit's Quality and Safety Committee, this work has evolved since 2016/17 with all units sharing lessons learned within Service Quality & Safety meetings to share within teams. Falls Scrutiny panels were developed to review falls by inpatients within Community Hospitals and has shown great improvements in reducing harmful falls. Pressure Ulcer Scrutiny Panels have now evolved to locality scrutiny panels who meet at the Unit Pressure Ulcer scrutiny panel bi monthly to discuss and share

learning. A patient non concordance policy has been developed and an audit identified 50% improvement when it was followed by staff as it supports them to identify why the patients do not want to follow advice – this will be shared with the HB wide scrutiny Panel with the aim of supporting colleague in secondary care. The learning outcomes have improved throughout the past 12 months significantly.

Infection Control together with Reduction of Healthcare Associated Infections (HCAI) and

Antimicrobial Resistance (AMR) is a key safety priority for the Health Board in Primary and Community settings. The achievements to date and ongoing projects listed below are aimed to achieve the targets set by Welsh Government to reduce HCAI by 2020/21.

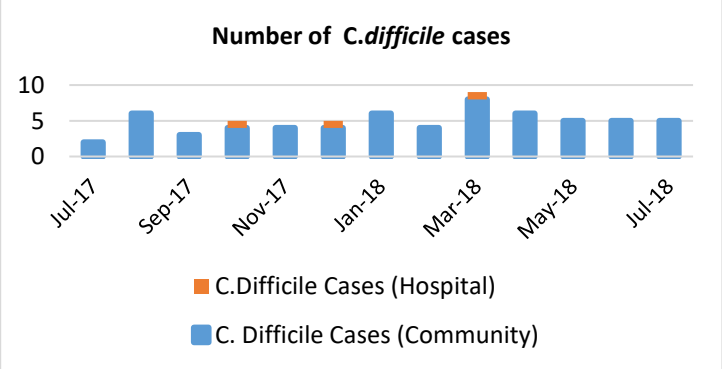
Key achievements and ongoing projects to date include:

- Pilot project within 2 ABMU Clusters to prevent and improve treatment pathways for Urinary Tract infections for those living in Care Homes, and outcomes of this work being reviewed in January 2019.
- Support following ABMU antibiotic guidance using algorithms
- Introduction of new UTI guidelines in primary and community services with the aim to reduce E.coli septicemia prevalence.
- Consider the clinical need for Proton Pump Inhibitor (PPI) if the patient clinical picture indicates antibiotic us to reduce C.Diff prevalence.
- Collaborative work with the Health Board's Infection Control Team is very successful and lessons learned from the SEA analysis following C.Diff cases are well received by GP colleagues.

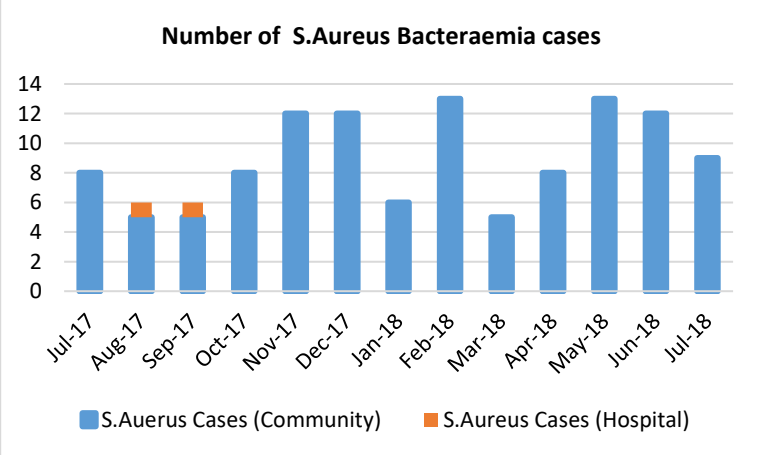
- Antimicrobial stewardship champions agreed within Primary and Community Services Unit.
- Community Hospital have received favorable reports from Infection Control Team
- UTI Friday project to facilitate review and discontinuation of long term prophylaxis treatment for UTIs

Bar charts below give a pictorial representation of progress;

Bar chart 1: the number of C. difficile cases in the Community and Community Hospitals



Bar chart 2: the number of S. Aureus Bacteraemia cases in the Community and Community Hospitals



Bar Chart 3: the number of E. Coli Bacteraemia cases in the Community and Community Hospitals

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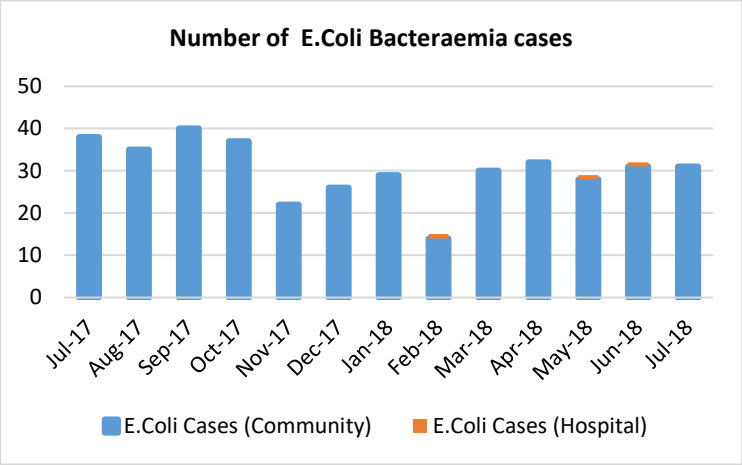
<tr><td></td><td> 
</td></tr>
<tr><td>Quality Objective Four –

To organise the Health Board for Excellence and Continuous Improvement</td><td>Development of a Governance Assurance Framework for GMS which defines what governance means for GMS contractors and establishes a vision of how we ensure this is a priority, at all levels to improve standards and protect patients from unacceptable standards of care. The framework facilitates early engagement between the Health Board and Contractor and ensures governance arrangements are appropriately designed and operating, so that breaches of the GMS Contract, likely to impact on the provision of high quality safe health care are identified and acted upon. During 2017/18 as part of the three year rolling programme the Primary Care Team undertook 3 In-depth practice visits and 21 Standard visits, feedback reports have been considered at Quality and Safety Forums and lessons learnt shared with contractors. Actions taken include:
Key themes are presented to GP Governance Leads and Practice Manager Forums
Development of a clinical directive to support uptake of childhood immunisations and good practice shared
ABMU safeguarding team to share up to date local contacts and resources.
Provided a template complaint letter and poster to support practices with responses in line with Putting Things Right
Provided guidance to practices to complete audits – 7 Steps.
Ensure robust arrangements are in place for practices to receive safety alerts.
Facilitated further discussion of clinical governance within clusters to provide peer support and reflection.</td></tr>
</table>

- Continue to promote the National GP Sustainability Framework.
- Promote the use of online mandatory training opportunities.
- Continue to progress through the Access and Sustainability Forum increased compliance with Access and ways to promote use of My Health On Line.

General Medical, Dental and Community Pharmacy were supported and encouraged to ensure completion of nationally approved self-assessment tools which inform and trigger practice follow up visits where appropriate, e.g. by ABMU's Dental Practice Advisor.

2017/18 saw **Health Inspectorate Wales** [HIW] visit a further 11 of the 105 dental contracts (95 contractors), a total of 51 (49%) since the planned three year programme commenced. Of the eleven practices visited, HIW expressed concern about the following, all of which were either dealt with at the time of the visit or in line with an immediate improvement plan :

- the capacity of 5 practices to deal with a Cardio Pulmonary emergency as <2 staff were either out of date with their training (being new in post) or could not produce certificates
- lack of evidence of emergency drugs and equipment checks being undertaken with sufficient frequency (5 practices)
- need to update policies on adult and child protection (4 practices)
- improvements in record keeping required (9 practices)

The latter is the most commonly identified issue (in HIW, QAS and Performance Management processes) in dentistry, often as a consequence of misunderstanding of the dental regulations – a factor recognised by the Wales Deanery and Health Board; both ensured training sessions were provided for local dentists in 2017/18.

Four GP Practices received HIW inspection, including our own directly managed practice. Overall, HIW reported safe and effective care across all practices visited. Patients reported they were happy with the care they received and they found no immediate assurance issues. Key findings include:

- Positive cluster working was identified in all 4 practices

	• Clear management structures at all 4 practices • Safe medicines management arrangements in of the 4 practices. • No practice had a patient participation group • Issues with staff training records at all 4 practices, some staff had not had annual appraisals. • Improvements to record keeping were identified at all 4 practices • Patients reported difficulties in getting an appointment at 3 of the 4 practices. The Unit Quality and Safety Forum has considered these findings and have put in place an action plan to address during 2018/19.

1.2.2 Primary Care Measures

The Primary Care Measures for Wales Report for Phase 1 was presented to the ABMU Primary and Community Services Board in September 2017. The report identifies mixed performance with ABMU leading performance across Wales on some measures, and in others being below to the national average. The report identifies areas of good practice and actions for improvement.

1.2.3 Key Indicators

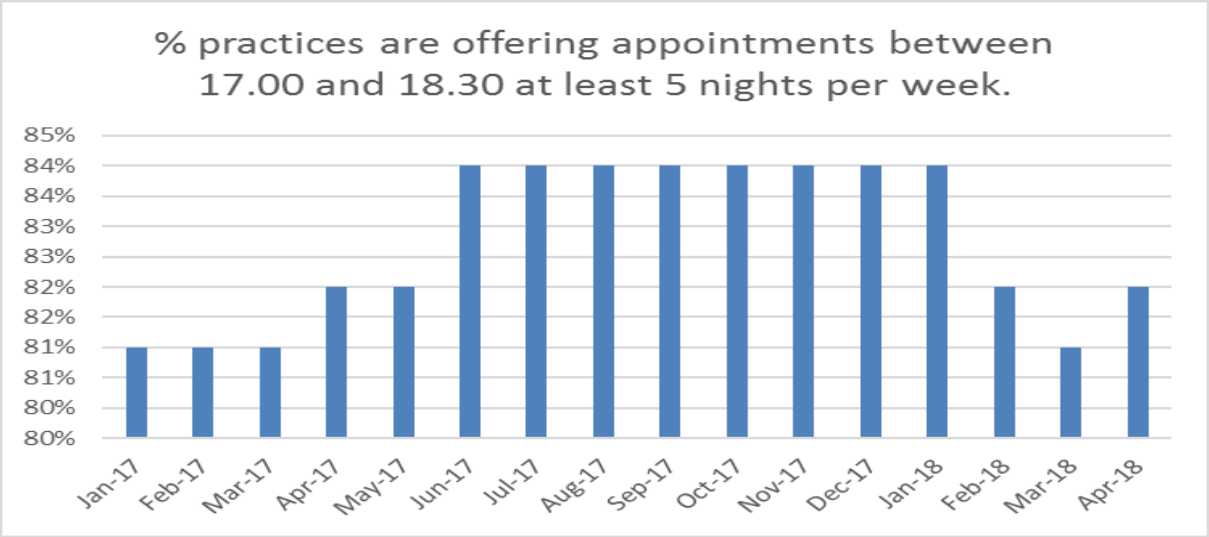
There are other measures available that are not part of the national phase one measures detailed in this report. The development of the ABMU Primary Care Dashboard in 2017/18 provides the Health Board with access to local measures to support measuring and reviewing quality in Contractors where data is available to the Health Board at Cluster level or above.

1.2.4 Access

Improving access to services remains a key priority for the Health Board. Traditional models are no longer sustainable and locally services are changing to ensure they can provide quality services and meet demand. During the last three years there has been a significant move towards expanding the primary care team in all contractor professions, in and 'out of hours' where appropriate. This has helped to provide improved access to services, delivering care closer to home whilst assisting sustainability and workforce issues.

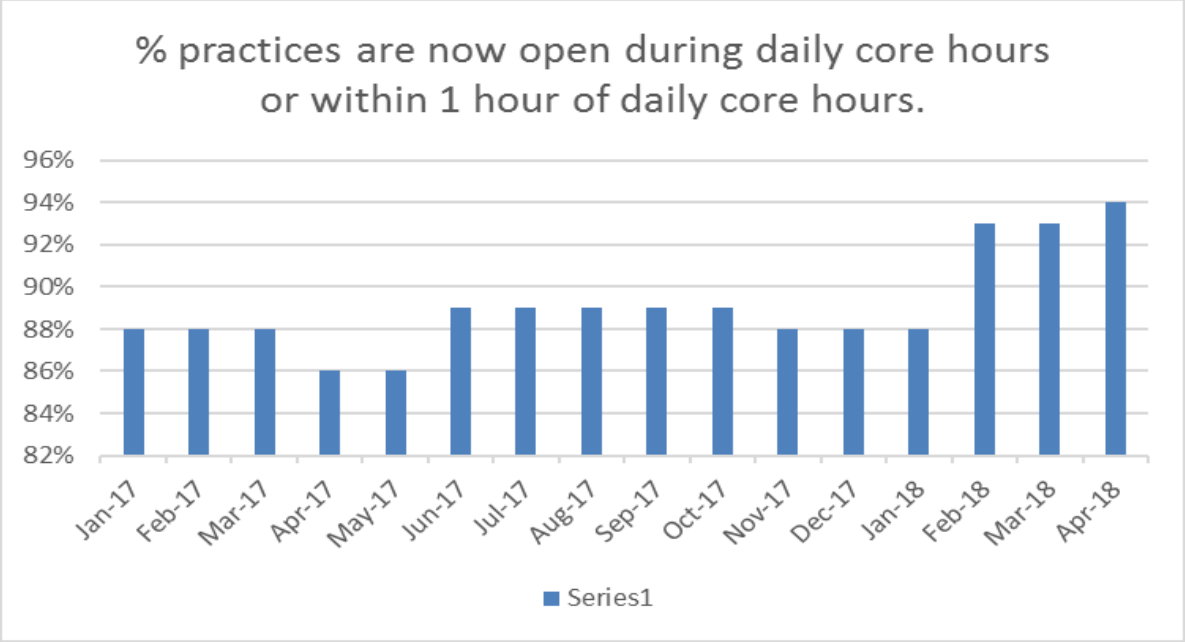
% GP practices offering appointments between 17:00 and 18:30 at least 5 week days

As at April 2018 56/68 (82%) practices are offering appointments between 17.00 and 18.30 at least 5 nights per week. There has been a decrease in the percentage of GP practices offering appointments 5 days a week 17.00 – 18.30, the Health Board are hopeful with the clinical governance visiting programme and open conversations regarding access which are taking place we will see an increase.



% GP practices open during the daily core hours or within 1 hour of daily core hours

64/68 (94%) practices are now open during daily core hours or within 1 hour of daily core hours. There has been significant improvements made over the past 3 months, from 88% to 94% increasing their opening hours during daily core hours to achieve the Welsh Government target.



In common with other parts of the UK/Wales sustainability issues are being experienced in general medical practices within ABMU.

- There continues to be widespread reporting of difficulties in obtaining locum cover or being able to recruit salaried or partner GPs.
- Two single-handed contracts were returned during 2017/18; a list dispersal was completed for one practice and the other being merged with an existing Health Board managed contract.

- One practice served notice to cease dispensing from a branch surgery.
- The Health Board approved the withdrawal of GMS services from a branch surgery.
- The Health Board agreed to one practice list closure to new patients for a period of 12 months
- There were six practice boundary changes agreed during 2017/18 as the practices look to reduce their practice areas to assist in managing demand.

The number of practices overall has reduced from 77 to 68 within recent years. In line with the direction set out in the Primary and Community Services Strategy. This trend is expected to continue and a number of other practices have already approached the Health Board enquiring about possible merger.

The Health Board has been keen to take a pro-active approach to mitigate against sustainability issues. Pro-active support has included:

- A pro-active visiting programme to practices to offer formal/ informal support and encouragement, if appropriate to formally apply for assistance
- The establishment of the **Practice Support Team (PST)** consisting of Clinical Director, salaried GPs, Senior Nurse and Service Development Manager who provide diagnostic and service transformation support to practices. The PST works closely with the Primary Care, Medicines Management, Finance and Workforce colleagues. In 2017/18 the PST have worked with 18 practices.
- The development of the **Telephone First framework** – launched in February 2018 *(See 1.2.5 Clinical Triage).*
- Establishment of an innovative **primary care recruitment and networking event** aimed at attracting new recruits into practices within ABMU Health Board and to discuss opportunities for career progression. Seven GP practices took part in the event with 68 attendees on the evening. Feedback so far has been very positive.
- Building on collaborative working through the clusters the Health Board during 2017/18 supported four sets of practices to merge.
- The Health Board has encouraged closer working and collaboration between GMS practices. A **merger framework** has been introduced and invested in to facilitate the creation of larger more sustainable primary care practices that both stabilise sustainability issues and provide an excellent platform for providing extended services.
- Support for clusters to develop a **GP fellowship scheme** which provides incentives to recruit newly qualified GPs to settle in the area and join General Practice.

- Through 19 **local sustainability assessment panels** attended by both CHC and LMC consideration of 15 applications which have been formally made by practices. Panels have granted a range of additional practical or financial support on a case-by-case basis.

- Support for clusters to utilise funds to **extend the MDT primary care teams.**

- Through the Access and Sustainability forum the development, agreement and review of policies and frameworks that can assist such as the merger framework, the practice support team Service Level Agreement, the Telephone First framework and the practice boundary change process. The forum regularly review the position and has developed vulnerability maps to show geographical location of practices at risk.

Delivery of Cluster based Multi-Professional Teams:

- Cluster pharmacists, most clusters demonstrating the ability of the role to save GP capacity as well as improving quality of care.
- Paramedics, providing rapid access to housebound patients, evaluation demonstrating ability to deliver service to 8 patients/1000, with 774 patients seen in five months within one cluster.
- Cluster Specialist Nurse for chronic conditions.
- Physiotherapist provision demonstrating reductions in demand on centrally provided services.
- A number of independent practices have undertaken to employ their own allied healthcare professionals
- Refinement of model to meet local needs – testing and changing the workforce e.g. phlebotomist, Wound Dressings Nurse and Chronic Disease Conditions Nurse.



- Early Years Workers in partnership with the Local Authority, showcased at Primary Care Conference and Welsh Conference for Innovation. Evaluation showed nearly 700 GP appointments saved in the first year in one Cluster from October 2016 to October 2017 *(See Section 1.1.8 Social Prescribing)*
- Social Prescribing Link Worker - implemented in partnership with Council for Voluntary Service, nearly 86 interactions in the first three months of service (2017) *(See Section 1.1.8 Social Prescribing)*

- Close working with Local Area Co-ordinators *(See Section 1.1.8 Social Prescribing)*
- Occupational Therapists to undertake assessments and support adaptations, avoiding hospital admissions.

Reducing avoidable demand on unscheduled care

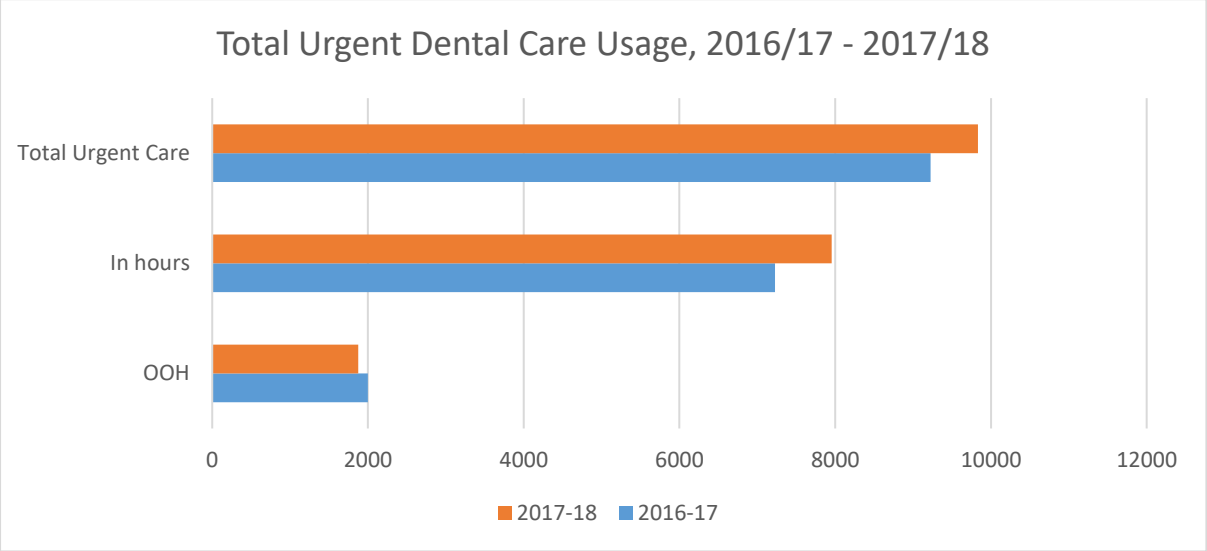
- Practice based delivery of flu vaccinations resulting in the largest percentage point increase for Health Boards, in eligible vaccinated adult population since 2014/15 an increase of 3.2% in 65+, and 2.7% in under 65 at risk groups – Public Health Wales Annual Report 2017/18
- 7 day working across Acute Clinical teams (ACT)
- Pioneering "Bevan exemplar" pilot one ACT working with Welsh Ambulance to prevent unnecessary hospital admissions
- Community services presence on acute hospital sites as part of "Breaking the cycle"
- Established pathways for End of Life patients via District Nursing Services.
- Pathway development in Gorseinon Hospital to support an enabling approach which has led to a reduction in overall length of stay.
- Produced and further distributed the Falls Prevention Guide

- Antimicrobial stewardship - purchased CRP equipment for a number of practices. C-reactive protein (CRP) is a blood test marker for inflammation in the body and can help clinicians determine if antibiotic prescribing is necessary.

Across ABMU Health Board, District Nursing teams in all areas have improved access to their services and introduced Single Points of Contact. Early feedback from service users and stakeholders is positive. This development is in line with recommendations following external reviews and is supporting future service innovation and improvement.

The latest data published by Stats Wales (December 2017), reflected in Public Health Wales' ***Oral Health*** *For All* (published February 2018) indicates that more people continued to be able to access an **NHS Dentist** over the previous two years in ABMU (62.6%) than in any other Health Board. However, as reflected in the continued high level of telephone queries to the Health Board and NHS Direct/111, securing a regular dentist remains challenging across much of the area. The access figure includes those people who have accessed a dentist through the Health Board's urgent care system, in or out of hours as well as individual patients who may have attended the dentist multiple times.

Access to **urgent dental care** is required for those with pain or infection. This needs to be provided both in a timely way and with sufficient quantity for those with need and with appropriate triage of calls. Data from a 2017/18 Public Health Wales review of urgent dental service provision by local health boards highlighted variations in capacity and in timing of capacity through the week. Weekday access is important to avoid storing up problems for the weekend services. The past three years has seen a greater focus on in-hours, in-week access to urgent care and in ABMU 30 appointments per week per 100,000 people are now provided via the GDS (Wales's average 25). The increase in usage from 2016/17 is set out below.



As can be seen, almost 10,000 people accessed the urgent dental care service in or out of hours, 81% in hours, an overall increase of 7% from the previous year. The explanation for this rise does not rest solely with difficulties in accessing general dentistry: many patients are choosing to access urgent dental care which is charged at £14.00 for a one-off treatment rather than pay £43.50 for a full course of treatment, which usually requires several appointments during working hours.

The need to increase overall provision of general dental services was tackled with some success in 2017/18, following the agreement reached within the Health Board and with Welsh Government, to produce a three year (rather than annual) service investment plan for dental services. The plan, informed by activity and contracting trends was necessary to ensure that more of the Welsh Government-allocated ring-fenced monies dedicated to dental services could be spent in-year. This aim had proved challenging in 2016/17 as a consequence of various factors, not least the decision to improve governance by utilising a formal procurement process to award all non-recurrent as well as recurring funding for dental activity. Adopting a thorough procurement process undoubtedly improved governance but was too resource intensive to enable the existing primary care team to complete a tender process for additional dental activity in-year.

As can be seen from the table below ABMU's expenditure per adult and child on dental services was significantly above the all-Wales level. Although this is particularly the case for orthodontic activity, largely a reflection of the location of orthodontists in cities and larger towns, e.g. Cwm Taf has no orthodontic provision. Other factors also impact

on this such as the move to increase low units of dental activity values. Increasingly robust contract performance management is in place to ensure best contract value.

EXPENDITURE on DENTAL SERVICES, CHILDREN AND ADULTS*	**Abertawe Bro Morgannwg**	**Wales**
GDS Spend/child (non –orthodontic)[1,5]	£38.50	£34.69
Orthodontic GDS spend/ child[1,5]	£26.15	£19.46
GDS spend/adult[1,5]	£45.43	£42.15
*extracted from Oral Health for All, Public Health Wales, February 2018 [1] Public Health Wales Observatory , [5]NHS Business Services Authority,		

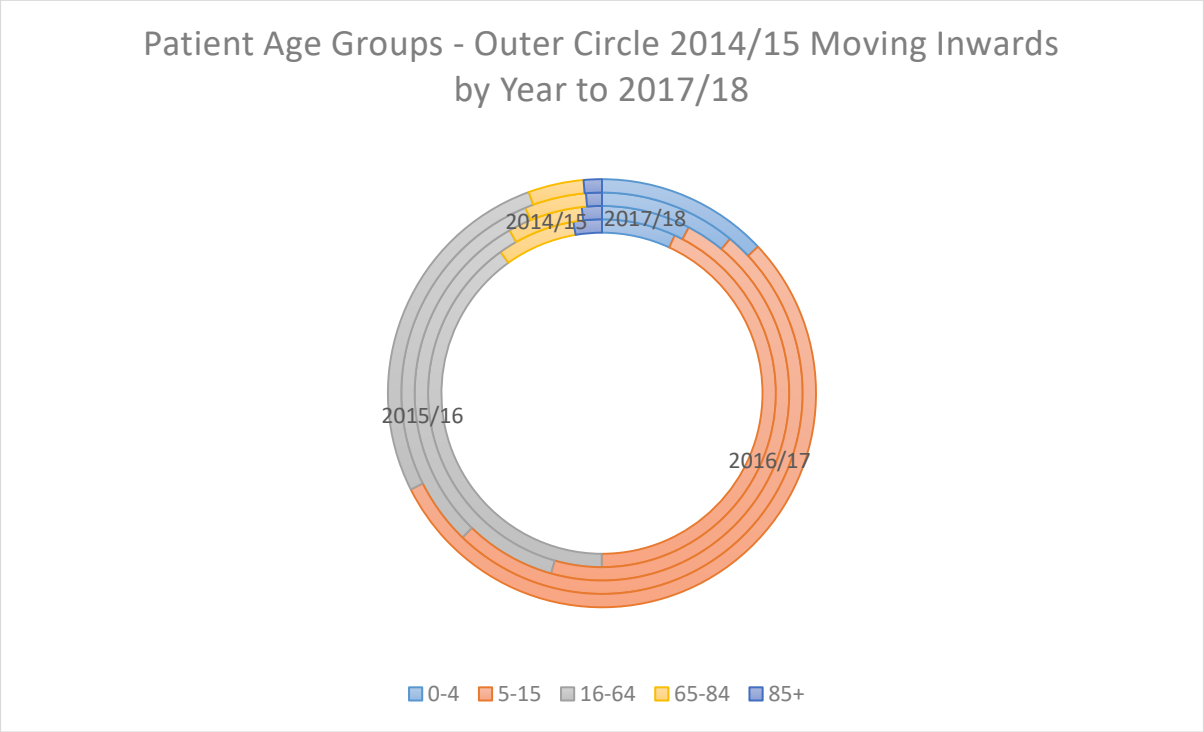
In November 2017, an additional 15,302 **Units of Dental Activity [UDAs]** (£367,248) were awarded to General Dental Practices in areas of high need across the Health Board area, the impact of which should be seen progressively in access and expenditure figures throughout 2018-19.

The same procurement process also saw a **new dental contract** for 12,500 UDAs (£300,000) awarded to a new dental provider in the Port Talbot area which will provide a significant increase in access to NHS dental care within the local area during the 2018/19. Based on contractors' stated norms for expected activity per dentist the total number of UDAs awarded can be estimated to comprise the equivalent of adding almost four full time dentists to ABMU.

As indicated above, the 62.6% of people reported as having accessed general dental services in 2017 includes people who will have used the dental service several times. The challenge of ensuring that dentists determine recall intervals using NICE guidance on clinical need, rather than six month call-backs, was revealed in contract information which indicates that the number of unique patients actually reduced by 3% in 2017 compared to 2016. However, there were pockets, for example, the prototype and reform contract practices *(See 1.1.2 Pacesetters and Innovation*), where it was evident that more new patients were taken on.

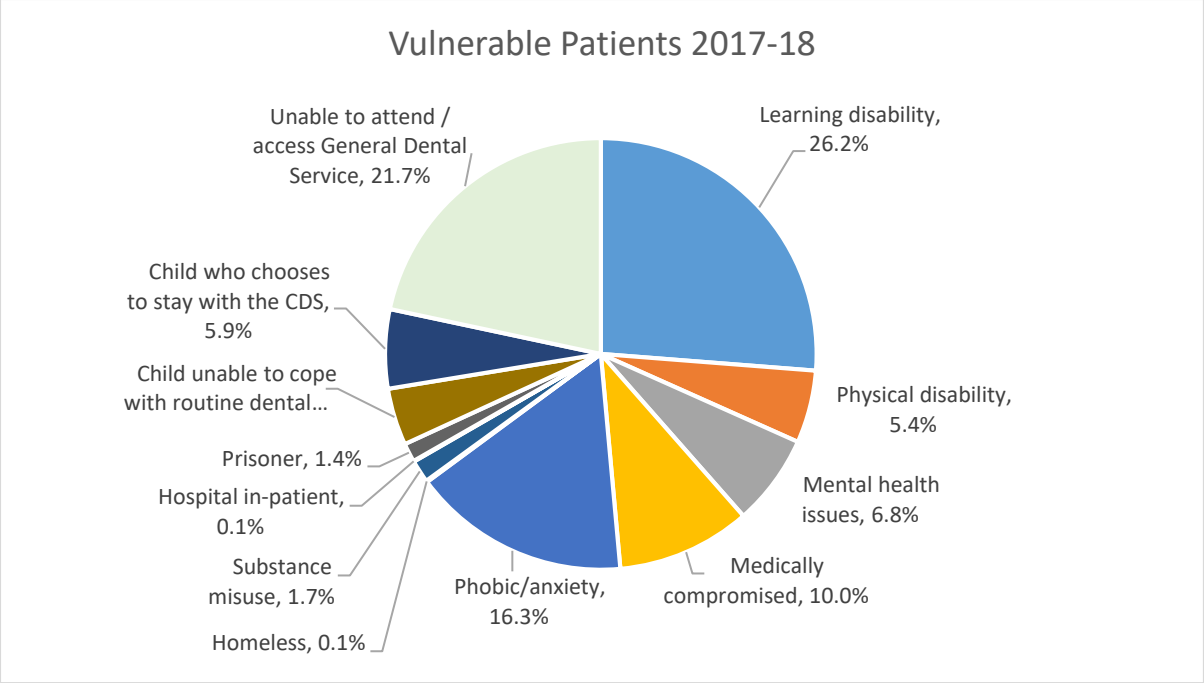
At year-end it emerged that 75% of practices over-achieved or achieved activity within their contract tolerance level (95-100%) in 2017-18 compared with 82% in 2016/17. The explanation offered by those contractors who failed to reach their annual activity target was the struggle to retain or recruit dentists to vacant posts. The Health Board noted the emerging recruitment issues and took active steps to tackle this towards the end of 2017/18.

2017/18 has seen a considerable focus on ensuring that children and adults have access to the most appropriate dental care provider. Wherever possible, that should mean access to a primary care practitioner, i.e. 'general' dentist, to maximise capacity in ABMU's Community, Orthodontic, and Restorative Dental services for the people who need them. This has been a particular problem in the Community Dental Service which by the end of 2016 still provided only 34% of its treatments to patients who could be categorised as requiring 'special care dentistry'. The data now available for 2017/18 indicates that this position has improved significantly as illustrated in the two charts below.

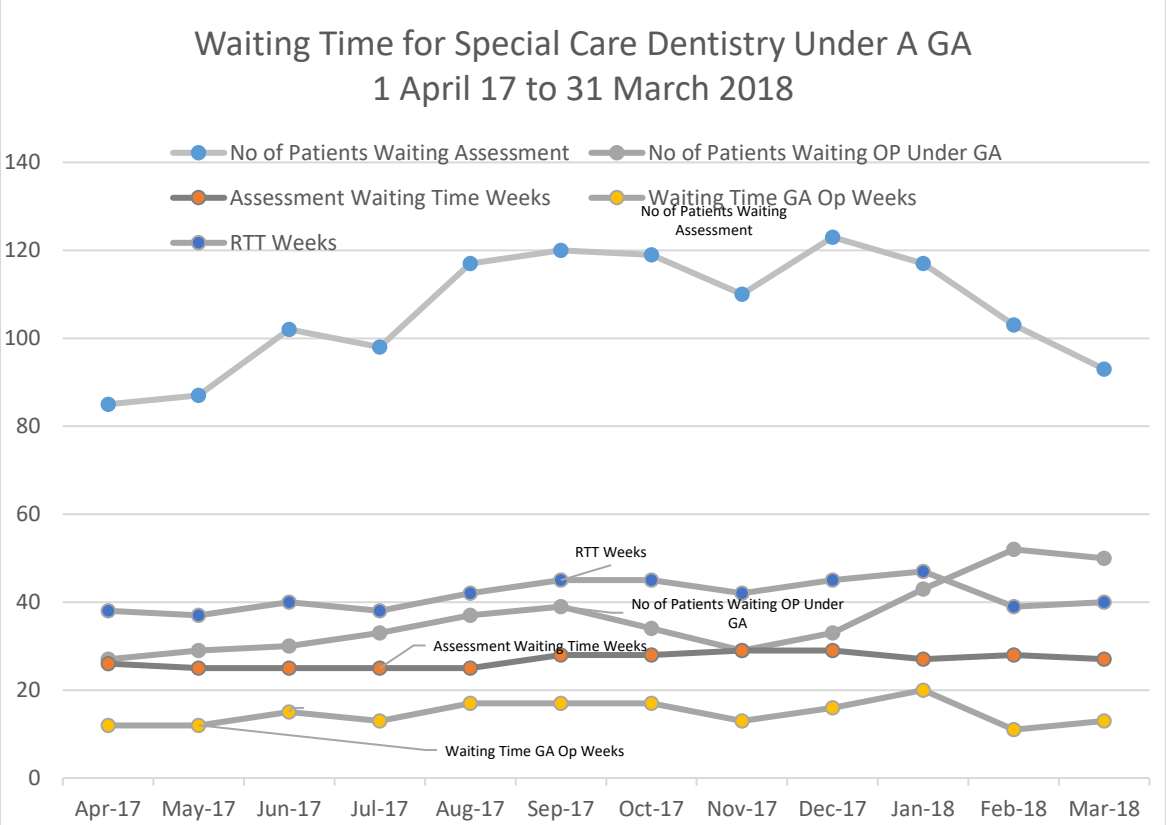


The above chart illustrates the change in the age profile of patients receiving treatments by the CDS over the four years to the end of 2017/18, by which time approximately 50% of treatments were provided to children under 15. Equally significant has been the 100% reduction in the percentage of children who are recorded as having been treated by the CDS because of the child (ie parent) chose to remain with that service. It is unlikely that this figure – currently 6% - will ever be eliminated completely given that much of this reflects treatment of a vulnerable patient's siblings.

As indicated in the chart below, the majority of the vulnerable people that are the focus of CDS have a significant learning or physical disability, a dental phobia or are 'house' bound, the latter including patients in forensic psychiatry, elderly mentally ill, and specialist school facilities within ABMU itself and the community.



A significant number of these patients require treatment under a General Anaesthetic. Since 2014, this care has been delivered on a day case basis at the Princess of Wales' Eye Theatre suite with two lists provided weekly to accommodate pre-assessment and theatre sessions. Prior to the creation of this service, this particular group of patients could wait up to twelve months for treatment. The reputation of the service provided and an increasing awareness of the need to ensure vulnerable people receive care has doubled the numbers referred in recent years. This has resulted in a growing mismatch between capacity and demand, which saw Referral To Assessment/Referral To Treatment performance rise again to above forty weeks and plateau in 2017/18.



The Theatre provision for this group of patients is led formally by a Consultant in Restorative Dentistry, delivered by a joint CDS/Restorative team supported by Anaesthetics and Morriston Hospital Dental Unit Dental Nurses nurses. 2017/18 saw the commencement of work to access an additional theatre list and associated clinical resources to achieve a reduction in RTT for this group of patients.

2017/18 saw the transfer of management responsibility for the Restorative Dentistry service to the Primary and Community Services Delivery Unit (from Morriston Hospital Unit). This coincided with the re-emergence of significant challenges to meet Referral to Assessment targets in Restorative Dentistry as the balance between demand and capacity proved no longer capable of dealing with the growth in referrals from General Dentists that has built steadily over the preceding ten years.

Traditionally, the focus of the specialty's clinical team has been approximately 80% devoted to hospital acute trauma and cancer whilst demand from primary care risen exponentially partly driven by the in-built disincentives of GDS contract to provide time-consuming difficult treatments. The consequent de-skilling in general dentistry has further increased the referral rate. The Health Board has identified and tackled this in the past, developing and delivering a Masters in endodontics and recruiting a Dentist with Enhanced Skills [DES] in that sub-speciality to support the consultant-led service and reduce waiting times. 2017/18 saw the development of more ambitious plans to remodel the Restorative Dental service to create an intermediate care model based on Port Talbot Resource Centre, led by a new Consultant post, supported by additional DES resource, including the General Dental Fellowship that will be piloted from September 2018.

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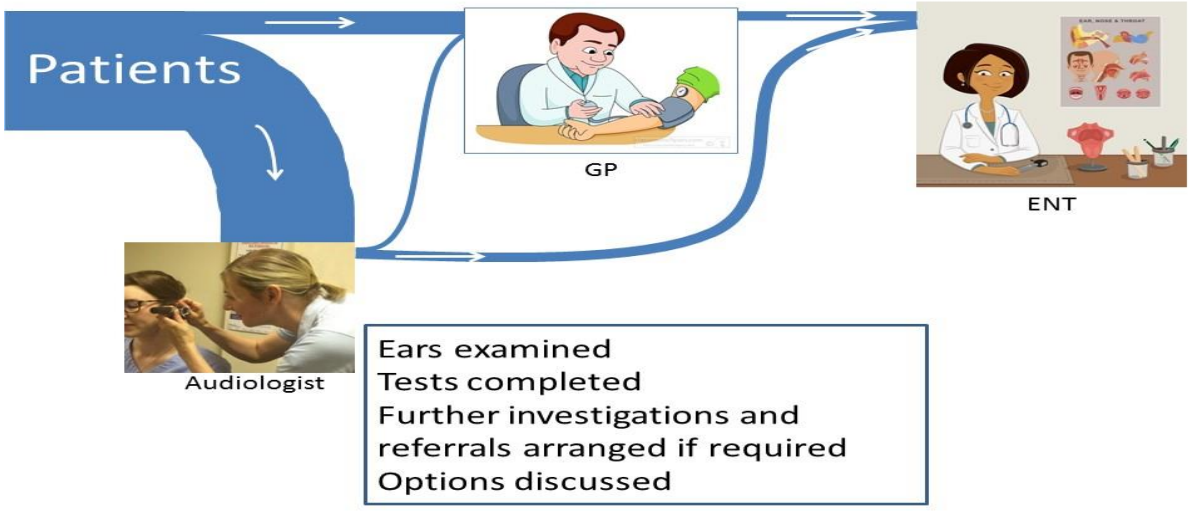
ABMU's delivery of the **National Eye Care Plan** [Eye Care Delivery Plan] has a significant dependence upon the capacity of its 52 **Optometry** practices and their engagement within the local health and social care system as a whole. For this reason, 2017/18 saw the commencement of an exercise, supported by Optometry Wales and recently praised as 'exemplar' work, to map Optometry practice capacity (premises, staffing and skills) to support service planning and eye care pathway development.

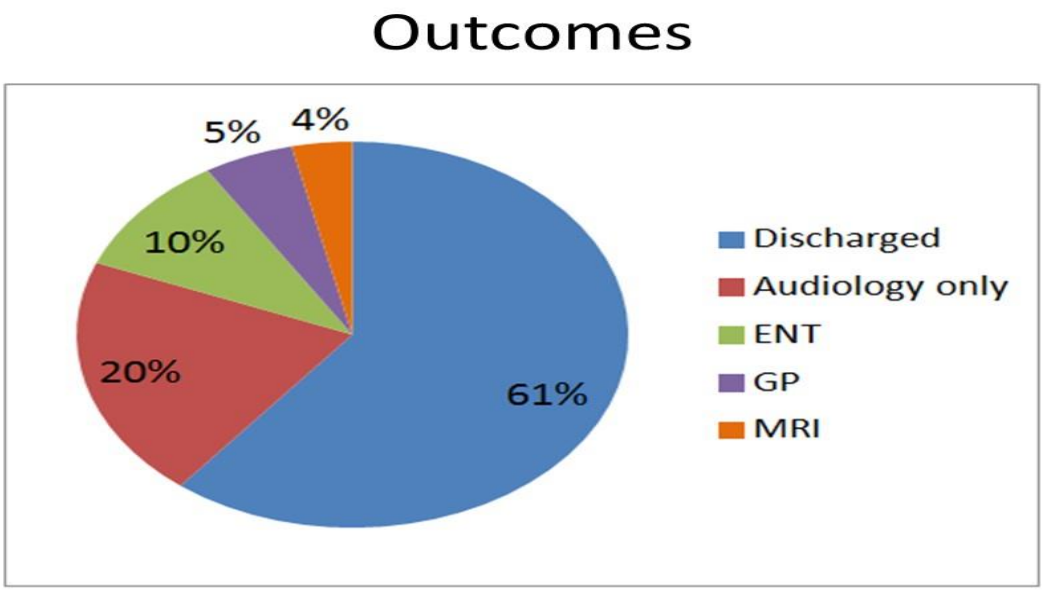
Unlike the other primary care professionals, optometrists are paid on a fee for service basis by Welsh Government, there being no formal primary care optometry contract. However service and financial accountability for the two services that comprise the Eye Care Examination Wales service [ECEW] devolved to Health Boards in 2016/17 to increase local profile, accountability and service development. ECEW comprises two distinct services: the Eye Health Examination Wales and Low Vision Services which are both provided by optometrists accredited as part of the national programme. They play increasingly important roles as part of the cluster-based primary care services as well as facilitating a transfer of key parts of ophthalmology pathways from a secondary care setting to primary care.

The Health Board's Primary Care and Community Services Unit manages a number of **Therapies and Health Science services** which make a significant contribution to providing care closer to home. Summarised below are some of the key achievements in 2017/18.

The first **Primary Care Audiology** clinic opened in August 2016. The clinics have since expanded to locations in four clusters, including the Neath Hub. The service has "value based" principles and completely re-designs the traditional pathway for patients with ear and hearing related symptoms.



A review of the service shows that over 5000 cases have now been seen by Primary Care Audiologists. Only 5% of cases required a further appointment with their GP, 10% were referred to the Ear Nose and Throat [ENT] service and 4% were referred for diagnostic imaging. The remaining cases (81%) were either discharged or managed entirely by Audiology.



Currently only 2.0 wte Audiologists are working in a Primary Care setting. A demand analysis estimated that an average of 1.0 wte audiologist would be required to provide the necessary capacity in each of the eleven clusters.

A recent development in the Primary Care Hub will involve increasing capacity for the cluster by employing an Associate Practitioner to perform non-complex tasks. This is being trialled until April 2019 and could provide a model for a more affordable means of expanding the service across the Health Board

Examples of Feedback

- *We have found the new audiology service here at Port Talbot Resource Centre invaluable, especially as now they offer wax removal. Since we have started advertising the service, patients are being referred directly using the Outlook booking system which is simple to use, without the need to see a GP first, thus freeing up appointments and no long waiting lists for patients. An excellent service all round.* ***Practice Manager***
- *As a practice we would like to give you some feedback to the audiology clinic that has recently been set up in the Resource Centre. We find this is a tremendous help to our patients in many ways. The availability of appointments is easily accessible for them, as they have a choice of date and time. It give them confidence when they attend your clinic as it is in the same building as out GP surgery, patients feel less afraid when something is familiar to them. Some have said they feel apprehensive when they attend the hospital. A great benefit to all* ***Practice Manager***
- *It has been such a positive addition to the service model at the Resource Centre and has been a smooth transition. I'm not aware of a single person who has a negative thing to say about it. If we could begin to start replicating this across other services too it would ease the burden in Primary Care significantly. I think it's also positive that it's been a straight forward, low-*

tech, solution that has used existing IT resources and therefore has had little training burden. I know that the Afan practices that lie outside of the centre wish to become part of the scheme as soon as possible. ***Practice Manager***

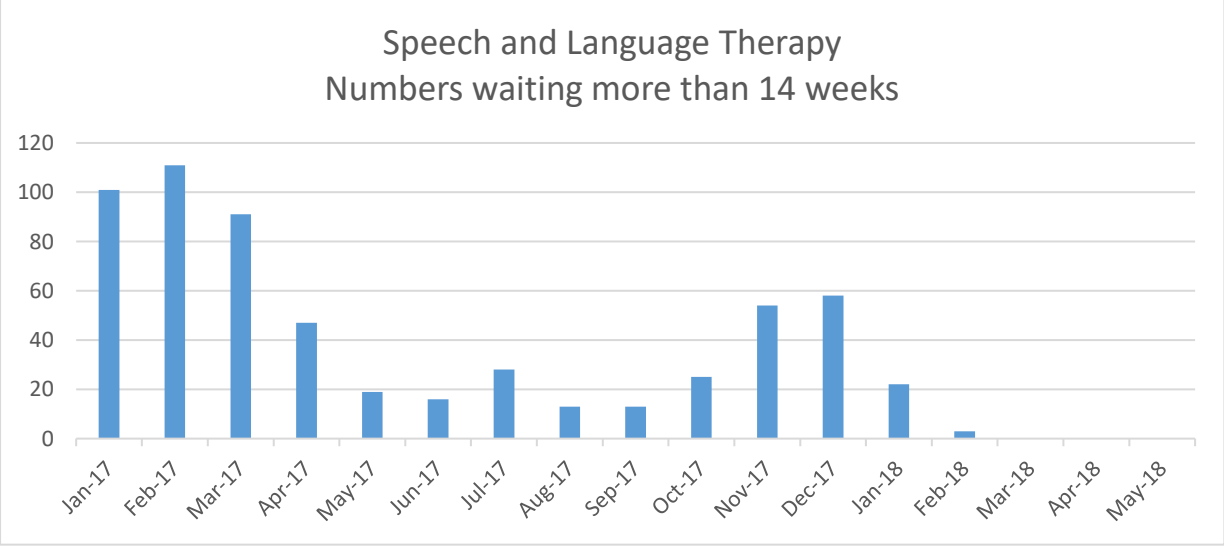
- *There is nothing that could have made the experience better. I had presented at my GP on Monday with this issue and to be able to have an appointment with Natalie today just two days later is a fantastic. She has also made the necessary referrals and I feel that things are moving forward quickly which is reassuring.* ***Patient feedback***

The **hearing loss pathways** plan was approved for implementation in Swansea and Neath/Port Talbot areas from September 2018. The new pathway will involve transferring 1000 ENT (west) referrals each year to Audiology.

Funding was made available in 2016/17 to ensure that **hearing aids** could be routinely provided for both affected ears. This enabled Audiology to achieve full compliance with both the Adult and Paediatric Quality Standard Audits.

Demand on audiology continues to increase due to the transfer of demand from ENT and an ageing population. Reportable waiting times for new hearing aid patients has been maintained within target levels. However there is pressure on non-reported lists such as the paediatric and vestibular pathways. Demand, activity and waiting lists are monitored monthly.

The access waiting time target of 14 weeks has been a long-standing challenge for **Speech and Language Therapy** because of high demand. A wholesale service delivery review has been undertaken to address this with an improvement in waiting times seen this year:



The service has strong partnerships with the local authorities who have commissioned several posts to address the needs of school age children. Funding was also obtained from the Welsh Government ALN Innovation Grant to provide training for all nursery staff in schools in the Swansea and Neath Port Talbot areas to undertake screening and intervention using the WELLCOMM programme. The department also translated the programme into Welsh and delivered training in Welsh for Welsh medium schools.

The department collects therapy outcome measures for every patient who has contact with the department and has been part of a national pilot led by the Royal College of Speech and Language Therapists. Several of our team have been asked to present their work at national and regional conferences this year. One of our Health care support workers was successful in achieving a Patient Choice award.

We now offer an enhanced service to undertake objective assessment of swallowing disorders led by therapists with extended scope of practice in fibreoptic evaluation of swallow (FEES) and videofluoroscopy (VF). A joint paediatric VF clinic with colleagues in Hywel Dda for their patients has also been developed. A member of our paediatric dysfluency team attended a residential course for young people who stammer in Swindon in her own time and as a result secured a free place for one of her patients. The impact of this course was so powerful and far reaching that the department has decided it will host a similar course for young people next year.

A laryngectomy patient was helped back into the swimming pool again 10 years after undergoing extensive surgery which meant she could only breathe through her neck. The Flying Start team in Neath Port Talbot have successfully trialled a “paper-lite” approach, recording their patient notes on the Health Board’s electronic patient information system [PIMS]. This has saved time and reduced the Information Governance risks associated with paper case notes, particularly at the point of transfer to the core SLT service.

Following the independent review of **Chronic Pain Services** in 2017 a recommendation was made to identify a further resource to increase the Clinical Psychologist capacity. Resources have been identified and interviews are due to take place in November 2018. This will increase capacity for the high pressures on pain management programmes and individual psychology support and also provide an opportunity to remodel the service to continue to meet changes in demand on specific aspects of the service. Key achievements include:

Cellma clinical system development (dependent on company support) to support clinicians with electronic communication, GP letters and record keeping. Develop the system to provide additional simple and safe recording, including PROMS and PREMS. It is anticipated this will also provide more detailed medication information and means for audits re prescribing and efficacy.

The Chronic Pain team continue to support Swansea University Medical School by running a full Pain week and providing ongoing input into learning and development of medical students via LOCS.

The service team has had regular input into the upcoming living with persistent pain document by WG, currently for consultation.

Suggestions continue to be made to support pharmacy financial targets and reducing drug expenditure whilst maintaining a high quality and efficient service. The service is open and looking forward to further discussions.

Referral to treatment targets continue to be achieved in all stages.

The Musculo-Skeletal Advice Service [MCAS] has had electronic triage implemented which has resulted in more timely triage and signposting with an increase of available capacity available due to efficiency of model. Joint injection clinics have been developed increasing capacity within service whilst offering a timely and expert service to patients. In addition the appointment of a Joint GP hub and MCAS Physiotherapist has improved links, aided recruitment, learning and has informed potential future hub based models. The PBMA Exercise and Lifestyle Programme (ELP) has commenced.

Since investment into the service in 2016 to upscale and enhance the support for our chronic respiratory disease patients in ABMU HB the service has gone from strength to strength. Key achievements for 2017/18 include.

Pulmonary Rehabilitation

- The service continues to provide Pulmonary Rehabilitation [PR] courses in all clusters across the ABMU HB footprint in community venues.
- Interstitial Lung Disease specific PR courses in Morriston Hospital, Swansea and Bridgend Locality.
- Continue to provide 'pre-hab' to patients with COPD out in the community enabling patients to attend PR who would not have been able to before due to psychological, nutritional and physical reasons.
- Classed as gold standard Multi-Disciplinary Team PR in Wales. Professionals include Physiotherapists, Respiratory nurses, Dietitians, Occupational Therapists, generic technicians, fitness instructors and administrative staff.
- Unique collaboration with National Exercise Referral Scheme. Fitness Instructors work within the PR team to deliver the exercise component in order to provide consistency and continuity. The aim is to improve uptake of the long term adherence to activity post PR course.
- 2017 NHS Wales Award Finalists
- Nationally the clinical lead is the chair of the National Pulmonary rehabilitation work stream promoting PR across Wales and supporting Health Boards to raise standards for our chronic respiratory disease patients.
- Lead sits on NACAP (National Audit for COPD and Pulmonary Rehab) in order to help influence data collection and targets for all PR services across Wales and England.
- Proposed bronchiectasis specific PR for November 2018 in Neath Locality as the centre for all ABMU HB patients with this condition.

Data already showing trend of reduced admissions and reduced bed days for those admitted in patients who have completed PR in ABMU HB. 'Value Based Healthcare'.

- Completion rates as of June 2018 were 71% (national target 70%) compared to 25% prior to investment.

- Waiting times have significantly been reduced to 2-5 months within national guidelines. Variability does depend on delivery of PR in networks and where patients live. National target is for 85% of patients to be enrolled within 90 days to a PR course. Patients within ABMU HB can receive Referral to Treatment within a week if required.
- Within the dietetic Service 64% of patients were assessed as high risk at the beginning of treatment, this was reduced to 29% post intervention.
- Activity objective measurements improved by 79%
- Knowledge objective measurements improved by 75%.

Early Discharge and Admission Avoidance Team Bridgend

Key areas of work in 2017/18:

- Continued to provide Early Discharge and admission avoidance to our chronic obstructive pulmonary disease patients in the Bridgend Locality.
- Admission avoidance scheme in place in North and East network with plans to roll out to whole of Bridgend Locality to provide equity of service.
- Increased referrals to team by 28%
- 94% of all hospital referrals were accepted (self/GP/MDT)
- 40% of referrals accepted from secondary care.
- 96% of referrals seen within 1 working day.

It is claimed that hospital admissions can be avoided by effective interventions in primary or preventative care (Purdy et al 2009). Prevention of hospital readmission is an international priority aimed to slow disease progression and limit costs (Harries et al 2017)

- Princess of Wales Hospital mean length of stay for a COPD exacerbation is 5:42 days, with the COPD team involved this is reduced to 1:93 days. This equates to £420 opportunity cost saving per patient. In 4 months this equates to £12,180 with improved patient flow and safety with appropriate care in the appropriate setting.
- Re-admissions (within 90 days) reduced to 6% from 23% between 2016, and 2017

Admission Avoidance Initiative in Primary Care

This initiative targeted the cluster network with the highest prevalence of recorded COPD diagnosis and featured collaborative working between primary and secondary care.

89% of patients accepted avoided a highly likely admission equating to a cost avoidance of £6,500 in 4 months. In the first year cost avoidance of £23,000.

Quality of Life Scores improved by 64%

Combined potential savings/cost avoidances from primary and secondary care services amounts to £131,331 for 4 months. Estimated £302,760 for next 12 months.

Savings also involve reduced GP home visits/reduced outpatient, appointments/optimisation of medication with reduced wastage.

37% of patients referred to the team require a prescription change by Band 7 Physiotherapist non-medical prescriber.

The COPD team works closely alongside the Pulmonary Rehabilitation Team for access of the Dietitian, Occupational Therapist and Generic Technician enabling further improvements in treatment quality. The collaboration between teams allows for high quality care of our chronic respiratory disease patients.

1.2.5 Clinical Triage

In February 2018 ABMU launched its **Telephone First Model Framework** which is being used to champion and refer to when General Medical practices are reviewing their existing access arrangements or are looking at ways to manage demand effectively whilst maintaining and improving access for patients. The framework sets out 7 steps and has identified reference standards for each area which are intended to direct and define a specific, consistent approach to telephone consultation and provide assurances to service users of the model of access.

The framework is designed with the patient in mind, based on prudent healthcare principles, to ensure they are seen by the right clinician for the appropriate level of care within a safe and acceptable period of time. The patient journey and patient safety is at the core of this model and ensures patient are seen as individuals allowing them to make a shared decision with the clinician, working together as a team and ensuring ongoing learning and development through patient feedback and indicators to benchmark against. 25% of practices are doing some form of telephone first/ telephone triage and the framework looks to support and standardise practice to ensure good access.

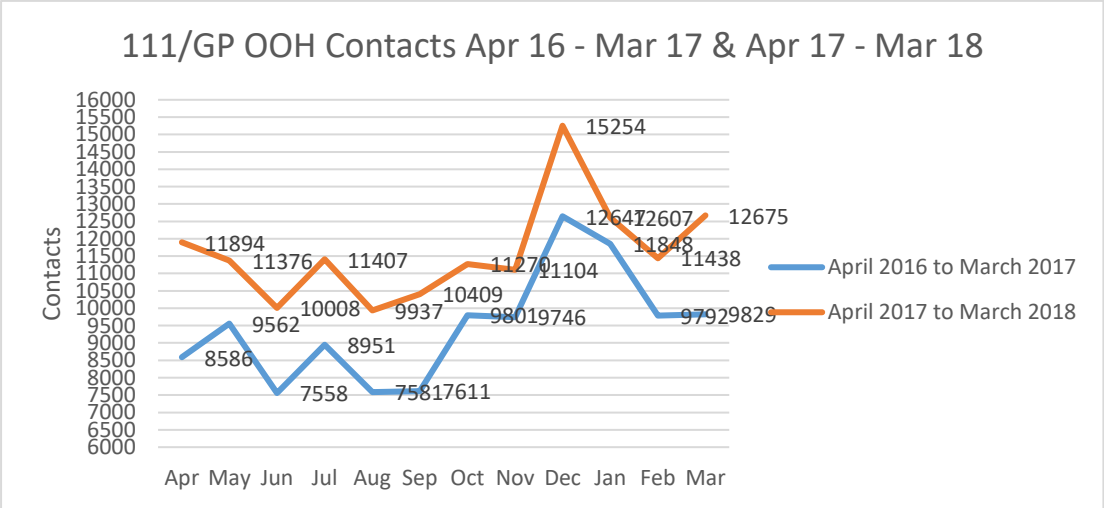
The **Primary Care Hub Pacesetter for the Neath Cluster** has successfully demonstrated that a cluster of practices can address access issues by working together supported the creation of a central multidisciplinary team (the 'Hub') with physiotherapists, wellbeing worker, pharmacist and audiologist. The GPs within the Neath Cluster have adopted Vision360 software, which they use to book patients into appointments with the Hub clinicians whilst speaking to patients during Telephone First conversations.Learning from the Hub is being rolled out to other clusters adapted to local geography and practice access models *(See 1.1.2 Pacesetter and Innovation)*

1.2.6 Urgent Primary Care Services/111/Directory of Service

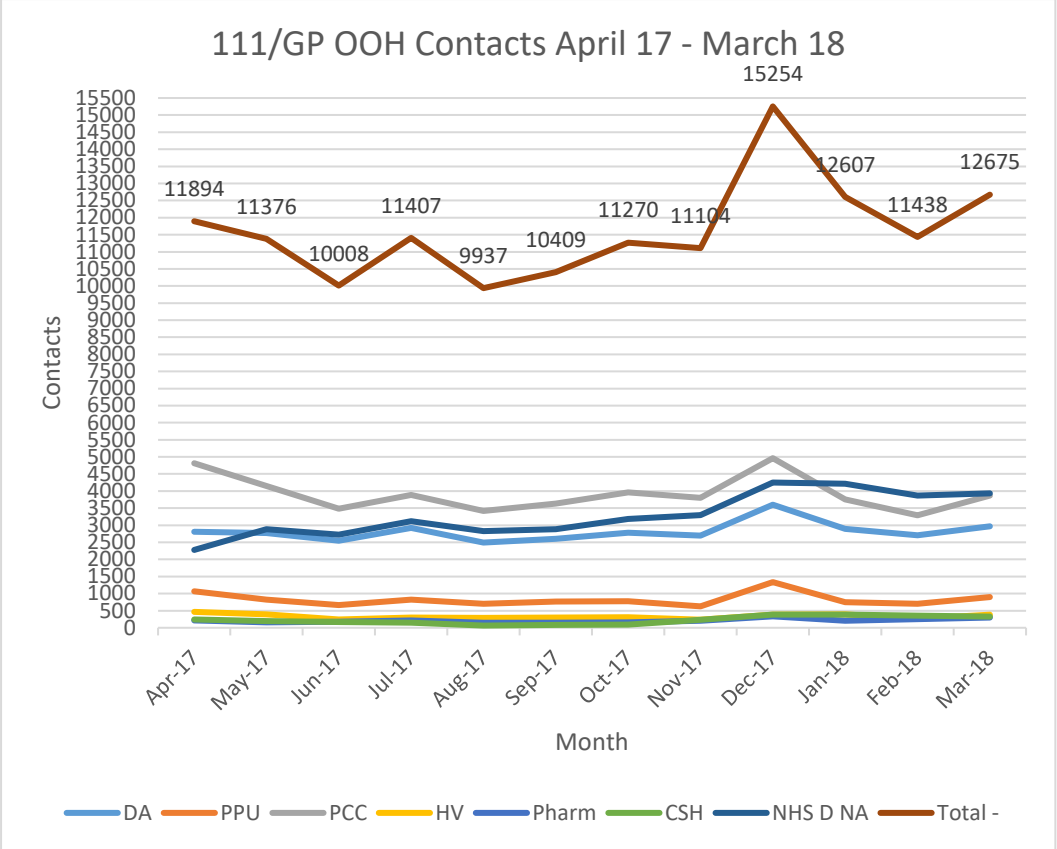
The Health Board commissions or provides access to primary care dental, pharmacy and medical services. The dental and pharmacy provision are discussed at sections above.

The out of hours medical service, usually referred to as the GP Out of Hours Service continued to provide urgent primary care services to the population of ABMU Health Board across 115 hours each week in conjunction with the newly developed 111 service throughout 2017/18. The 111 Service provides a single telephone number for members of the public to access health advice and the GP Out of Hours Service [OoH] following a telephone clinical triage by a nurse.

The increase in patient contacts with the service between 2016/17 and 2017/18, including patient contacts with a nurse in 111 and the OoH Service is illustrated in the chart below. This increase may be due to a number of factors including a rising/ageing demographic, increase in morbidity, especially chronic illness and patient expectation.



Despite the increase in demand, the service continued to cope well with a high level of calls managed over the phone with advice, prescription or appropriate signposting to an alternative service. This is illustrated in the chart below. 63.4% of patients who contacted the service in 2017/18 were dealt with through advice only, i.e. without the need for a face to face appointment or home visit; 33.7% required an appointment at a GPOOH Treatment Centre. Only 2.9% needed a home visit



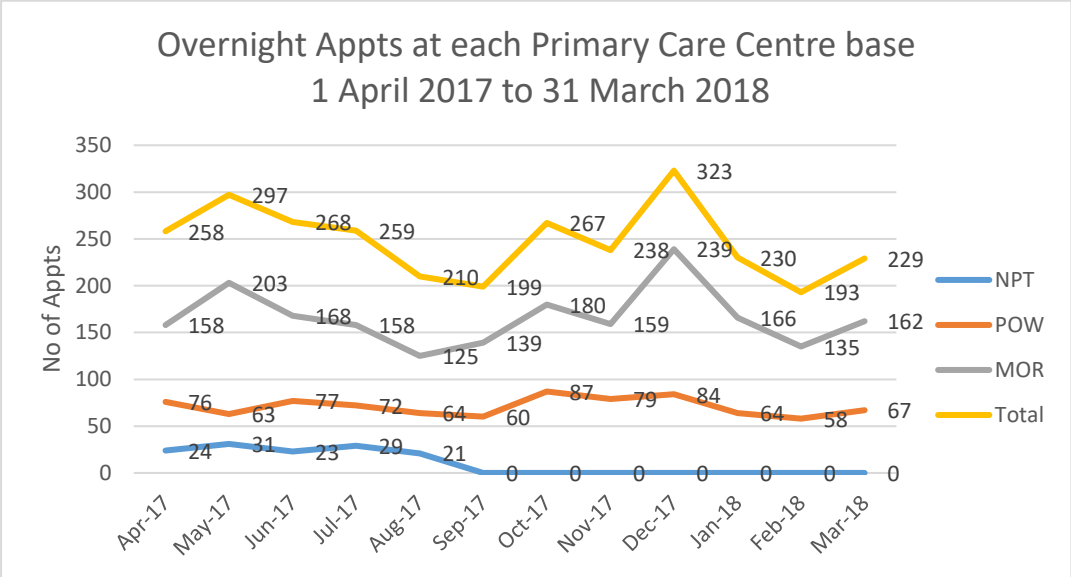
Key:

DA = Doctor Advice	PPU = Prescription pick up
PCC = [attendance at] primary care centre Advice	NHS D NA = NHS Direct Nurse
HV = Home visit	Pharm = pharmacist advice
CSH = Clinical Support Hub (111 based)	

Despite having the second highest call volume in Wales, the ABMU service has delivered an excellent record of timely call back.

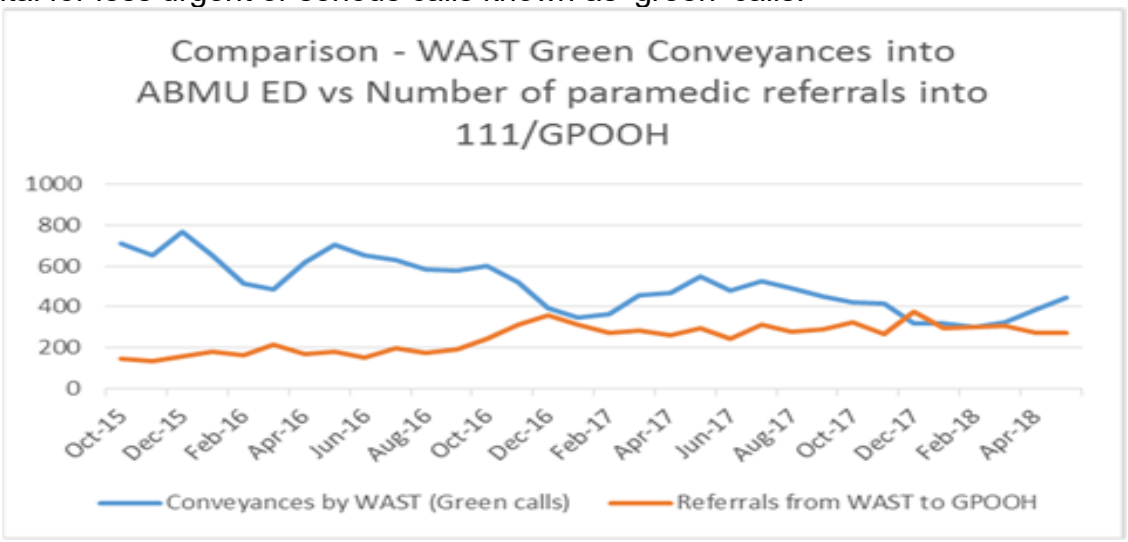
In 2017/18 the GP OoH Service responded to the challenges of providing a service with a decreasing number of available GPs by re-shaping some of its service provision. The provision of an overnight service, between midnight and 8 am, was of particular concern as far fewer GPs were inclined to work the shift. Analysis of activity showed that there was much lower patient demand overnight, with very few face to face appointments needed across the Health Board area. The few appointments needed were in the main provided at GP OoH Treatment Centres at Morriston and Princess of Wales Hospital Treatment Centres. It became clear that the diminishing GP resource needed to be concentrated at these centres particularly as it was becoming increasingly difficult to find GPs to work overnight at the Neath Port Talbot Hospital-based GP OoH treatment centre. Acknowledging the significant sustainability problems faced by the service, the Community Health Council acknowledged that a temporary cessation of overnight provision at Neath Port Talbot Hospital was required in August 2017.

The chart below shows that the temporary cessation of service did not have any detrimental effect upon the capacity of Morriston and Princess of Wales GP OoH Treatment Centres to cope with an increase in face to face appoinment activity. Potential patient inconvenience was accommodated with an offer of transport if required.



NB the December spike evident on the above chart reflects the nomal seasonal increase around Christmas.

The GP OOH Service continued to provide a significant and important role in the wider unscheduled care system working with partners across the Health Board area. Health professionals - Welsh Ambulance Service paramedics, district nurses and nursing homes - were given direct phone access to the GP OoH Treatment Centres to enable them to speak to a GP and get clinical advice on the management of a patient. The chart below shows the increase in the paramedic referrals to GP OoH and the corresponding decrease in conveyances by the Welsh Ambulance Service [WAST] to hospital for less urgent or serious calls known as 'green' calls.



The GP OoH Service developed closer links with the ambulance service when, in November 2017, it tested the feasibility of paramedics – rather than GPs - undertaking any home visits that were required on the overnight shift. Using paramedics to undertake the visits meant that the GP on shift could spend more time in the treatment centre triaging/advising patients over the phone and seeing patients face to face. The pilot proved successful and the GP OoH Service used paramedics, when available, to provide home visiting cover overnight at critical points in the year. The use of paramedics to undertake home visits is subject to a more substantive service development outlined below under *Forward Look 2018/19.*

Working closely with the Professional Lead for 111 Pharmacists, the Clinical Director of GP OoH developed the role of pharmacists on the Clincial Support Hub in 111 to provide advice and, where appropriate, prescriptions for patients, as well as booking face to face appointments with a GP.

1.2.7 My Health on Line

The rapid growth and adoption of a telephone triage and consultation model within ABMU general medical practices meant that MHOL was only adopted enthusiastically within ABMU for prescription bookings, practices preferring to manage allocation of medical and other appointments and other services to patients.

1.2.8 Welsh Community Information System (WCCIS)

The purpose of WCCIS to bring about transformational change to the ways of working between health and social care through an integrated system, with one record for the citizen.

ABMU sits within the Western Bay[3] Governance arrangements for WCCIS. Swansea City Council will be due to sign its deployment order with Care Works (WCCIS supplier) and are due to go live in February 2020. Bridgend County Borough Council is already live with WCCIS from April 2016. Neath Port Talbot Council is in the process of submitting its business case to their management team.

ABMU is involved in preparatory activities on a local, regional and national level with several work streams to ensure that the functionality of WCCIS is fit for purpose for staff. ABMU has a joint Mobilisation and WCCIS Project Board and Operational Group and when fully implemented this will ensure we are able to overcome the obstacles posed when health professionals use different I.T systems. This is supported by the ABMU Health Board "**Mobilisation Project – Connecting staff to each other, to information and to patients and the public".** This project is enabling the Health Board to mobilise 2,500 community based mobile staff with iPads and clinically governed mobile solutions. Approximately 1,100 of these staff are based in PCCS. 650 devices were deployed to community teams across the health board as part of a familiarisation phase, which completed in July 2017.

The project has now entered its second phase, working with community services to implement new ways of working, making use of a benefits realisation framework. The

[3] Regional partnership for the Health Board and Local Authorities [and other partners?] for Swansea, Neath Port Talbot and Bridgend

project team has completed this work with District Nursing and Health Visiting teams across the Afan, Upper Valleys, and Neath cluster networks; as well as School Nursing and Local Area Coordinator teams. Work is underway to complete roll out to all community services across the Neath Port Talbot locality, including Speech and Language and the Community Reablement service by September 2018. Work is due to start with Swansea-based services in September, and Bridgend in December 2018. Over 1,000 devices have been deployed to community staff.

The use of the digital dictation mobile solution has enabled speech therapists in Neath Port Talbot to create an additional 18 patient contacts per week. Through a caseload management application [app], the Acute Clinical Team [ACT] service within Neath Port Talbot Community Resource Team [CRT] has saved 136 minutes per day per member of staff. This equates to an additional 95 patient contacts per week across the team. Similarly, Health Visiting teams in Bridgend and Neath Port Talbot cluster networks are seeing 25% and 12% more patients per day respectively.

The release of the ABM-developed Caseload app allows clinicians to manage their personal caseload and outcome appointments from their mobile device. A small group of Health Visiting staff are piloting the app. Those involved have reported a significantly reduced requirement to return to base, resulting in additional patient contacts being possible.

Many staff and patients are already familiar with mobile devices and see this as a positive step forward for services. Nominated champions for each service support staff and patients not familiar and confident around mobile devices. These champions meet regularly to share ideas and scope potential benefits, and assist with the team with mobile working workshops held regularly at Morriston and Princess of Wales hospital. Capital funding was approved by Welsh Government and received for the purchase of the devices, with ongoing revenue costs to be met by the Health Board.

The work with Channel 3 Consulting on the identification of baselines, the creation of a benefits register, benefits measures and reporting, implementation plans and post implementation review will be key in the quantification of benefits.

1.2.9 IT in General Medical Services

The drive to introduce new technology at the Primary Care Hub Neath has led to two exciting new projects where improved functionality and reporting as well as a focus on transitioning to a paperless service.

Boasting improved functionality, better reporting mechanisms and integrated software, **Vision Anywhere** has been introduced to the Hub to improve on efficiency levels. By allowing our healthcare professionals to spend less time on administrative tasks, their time is freed to focus on patient care.

Some of the advantages of the new software system include:

- Summary view shows the most important aspects of a patient's record – similar to the Vision Patient Preview
- Documents are available to be viewed having been integrated (vision Only)

- Acute, repeat and issued medication
- Examinations including blood pressure, height, weight and peak flow
- Drug and non-drug allergies
- Test results
- Clearly defined which surgery the patient is attached to
- Better data entry
- Record common observations quickly using predictive data entry
- Repeat Synch of medication
- Instant filing of data to the patient record.
- Record data without opening patient record.
- Care Reminders

Printing costs are a significant expense within healthcare and so the Primary Care Hub has invested in **QR Info Pods** to help address this issue.

The Hubs QR Info Pod uses dynamic Quick Reader bar codes to store multiple websites, documents and information pages in one easily accessible board.

This investment will not only lead to a reduction in printing costs for leaflets, patient information packs and letters, but has also helped patients access necessary information that can be easily stored on mobile devices once scanned.

Likewise, Hub management receive quarterly reports documenting the number of hits each links has received over a period of time, which allows for an analysis of what information/ services patients are seeking. This can lead to bespoke clinics/ services being highlighted and delivered to help address patient needs.

1.2.10 Capacity and Demand Modeling

The Acute Clinical teams Bevan Commission Exemplar was awarded to Neath Port Talbot and Swansea acute teams to attend acutely unwell patients who may benefit from assessment and intervention in the community rather than hospital admission. Welsh Ambulance Service Team clinical desk also assess patients using an enhanced triage tool, the acute team can also view the WAST live incident stack and identify

suitable patients that may be suitable for the team. The Health Board is continuing to support the previous national pacesetter **Acute Clinical Outreach team** in Swansea which has demonstrated valuable benefits whilst a sustainable solution is found.

1.2.11 Rebalance of resources from secondary to primary care

The Health Board continues to progress a programme of service transformation supporting services to move out from hospitals where safe and effective to do so. Previous examples include the primary care vasectomy service, audiology outreach and increased utilisation of community based eye care examination and treatment services.

In 2017/18 the Health Board successfully established a safe high quality atrial fibrillation and anticoagulation service based in the community delivered at practice level. This new service resulted in a significant shift in service provision for circa 6,000 patients across the cluster networks where care was previously delivered in outpatient setting in secondary care.

1.3 Theme 3: Equitable Access

1.3.1 Inverse Care Law Programme

Bridgend North Cluster commenced delivery of the Cardiovascular Disease [CVD] Health Check Project on 1st August 2017; this pilot project is facilitated by ABMU and delivered in partnership with the eight GP practices in the Bridgend North Cluster.

The ABMU HB CVD Health Checks project is part of the National Inverse Care Law Programme, looking at primary prevention of CVD in 40 – 64 year olds who are not currently on a disease register. Health checks are community based and link directly with the individual GP practices and places a strong focus on empowering positive modifiable health behaviours and increased health literacy.

The focus of the National programme is to support Health Boards in Wales to reduce premature mortality and emergency admissions from CVD in Wales' most deprived areas, by improving the identification and management of cardiovascular risk factors. To date Health Checks have been offered to 1253 eligible patients (36% that were offered) from three Practices which has resulted in 359 patients (28%) referred to additional services i.e. health and lifestyle, smoking cessation.

1.3.2 Transgender Project

The Health Board acknowledges the national work ongoing and is awaiting development of a final report and recommendations based on information gathered from GP surgery staff and transgender people.

1.3.3 Equality and Diversity/British Sign Language (BSL)

Many aspects of this agenda were progressed in 2017/18, most notably in the following areas:

- In November 2017 ABMU hosted "*It Makes Sense*", the national sensory loss awareness campaign to promote the accessible healthcare standards amongst health professionals.
- As indicated at *section 1.3.5 Primary Care Estates* below, greater compliance with Equality Act requirements to meet the access requirements has been tackled through the design of new buildings and refurbishments of primary and community care accommodation, including the award of improvement grants for General Medical and Dental services, the latter to install hearing loops and ramps where required. In Health Board premises, 2017/18 also saw toilet and waiting facilities for bariatric and wheelchair dependent patients introduced at Port Talbot Resource Centre.
- The Health Board extended its funded support for primary care patients who required language translation (including British Sign language) to receive services to all primary care contractors, i.e. optometrists and dentists as well as General Medical Practitioners.

1.3.4 Welsh Language

Our 2016 survey of all directly managed and contracted primary and community services was repeated in-year and built upon, e.g. through General Medical practice visiting programme, to establish the extent of compliance with *More than Just Words*[4];. 2017/18 saw a particular focus on establishing service capacity to make patients the 'Active Offer' sought by the Welsh Language commissioner to deliver services through the medium of the Welsh. Although it was confirmed that less than 10% of GP practices were in a position to comply 100% of the time, that performance was exceeded in general dental services, their compliance having been tested and supported through inclusion of compliance in the required criteria prior to expanding their contracts.

Within our directly managed services, it was confirmed that very few Health Board departments are in a position to consistently deliver services in the Welsh Language, - Speech and Language Therapy department and Welsh-government funded Designed Smile programme are notable exceptions. However, community hospital in-patient facilities, therapies and the primary care departments have prioritised the need to be able to do so and can field a Welsh speaker for support during the working week at least.

1.3.5 Primary Care Estates

ABMU is developing a ten year primary and community care estates strategy as part of its overarching Primary and Community Services strategy.

The existing estate has been reviewed in detail during 2017/18. The review has looked at functional suitability, utilisation, building maintenance and condition, compliance with health and safety regulations, healthcare guidance and building regulations including disabled access. This information will be used to inform the updated strategy.

[4] '*More than Just Words*...' is the Welsh Government strategy to improve Welsh Language services in the health and social services sectors.

Local Development Plans have also been examined to establish future population growth and linkages with Local Authorities are being improved in order to maximise opportunities across organisations as part of the 'One Public Estate' agenda.

The Primary and Community Estates Strategy will ensure, upon completion that all ABMU primary care estate premises are fit for purpose and the quality of the environment is suitable for all building users.

The Primary Care Unit received **Improvement Grant funding** for five GP practices in Swansea. Works, scheduled for completion by March 2019 include:

- Replacement of windows to improve insulation and provide increased energy savings to Gower Medical Centre in Scurlage
- Internal refurbishment to upgrade the waiting area, office accommodation and reception to Kingsway Surgery in Swansea.
- Upgrading of treatment room for Mumbles Medical Practice.
- Reconfiguration of records storage to provide additional phlebotomy room in Talybont Surgery.
- Improving disabled access and soundproofing of consulting rooms to Fforestfach Medical Practice

Future works are also planned to provide improved and extended facilities for the Amman Tawe Medical Practice at Ystalyfera clinic and North Cornelly Surgery. The proposal at North Cornelly will extend the existing premises to provide improved GP clinical space. The project (pictured) has been submitted for planning permission with Bridgend County Borough Council.

New primary care facilities opened in 2017/18 included Mountain View Health Centre (pictured above), opened in April 2018; consisting of a combined family centre, pharmacy and GP surgery in Mayhill.

Works also started on the construction of two new Third Party Development schemes in the Vale of Neath and Porthcawl. The Vale of Neath Primary Care Centre will provide new, much needed, primary care and GP accommodation for the residents of Glynneath, Resolven and the surrounding villages. The development (pictured left) is progressing well and is scheduled to be completed in February 2019.

Porthcawl Primary Care Centre (pictured right) is due for completion in early 2019 and will provide new, expanded, GP and primary care accommodation, replacing outdated buildings that are no longer suitable for healthcare use in the 21st Century.

1.3.6 Integrated Health and Wellbeing Centres

Welsh Government has provisionally allocated £16.2m to develop new health and wellbeing centres in Bridgend and Swansea and refurbish two existing health board owned clinics in Murton and Penclawwd. Development continues at pace on all four schemes. Subject to business case approval the works to Murton and Penclawwd will begin in late autumn 2018. Planning for the Bridgend scheme is scheduled to be submitted in September 2018.

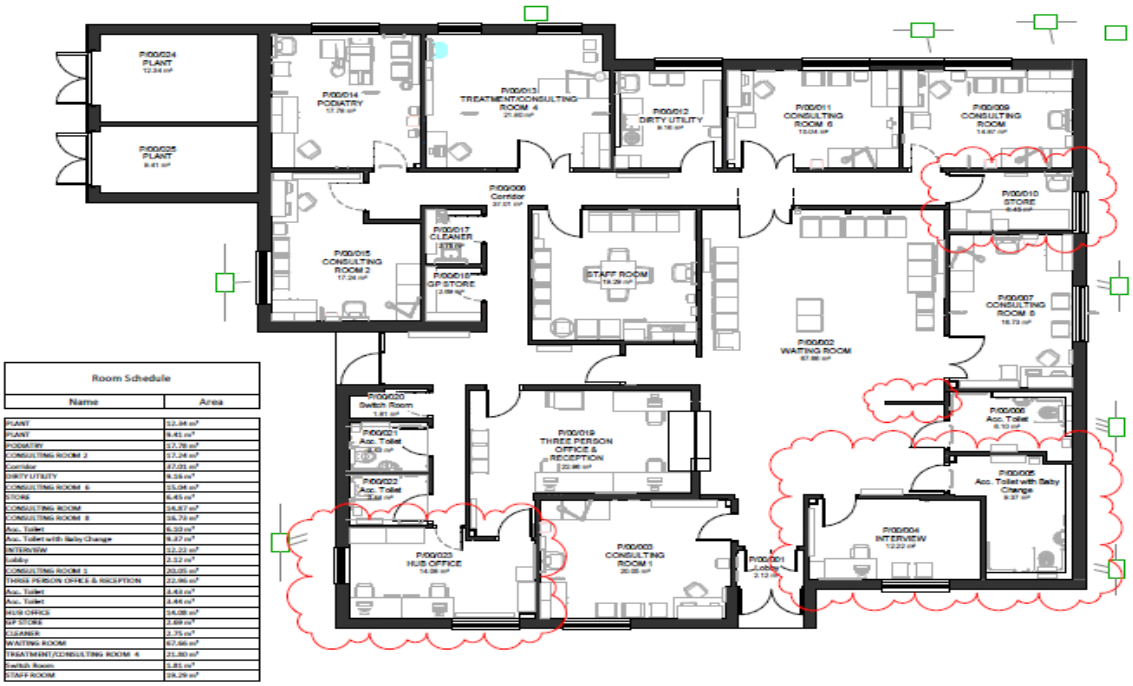
Bridgend Health and Wellness Centre is being developed in Partnership with Linc Cymru and will form part of the 'Sunnyside Wellness Village' in Bridgend, a combined health and social housing community. This will provide closely aligned support to people in managing their physical, mental and social health and wellbeing, early identification and management, ensuring coordinated planned care. An initial artist's impression of the scheme is included below.

Development of the Swansea proposal is also continuing with a schedule of accommodation agreed and appointment of a project manager to lead the scheme in August 2018. The development of a City Wellness Centre within Swansea City Centre will provide a wide range of well-being and primary and community services for the population of Swansea. Proposed services for both the Swansea and Bridgend schemes will include GP services, dental services, children services, pharmacy, third sector services, audiology, speech and language, mental health and sexual health services.

The refurbishment of Murton Health Centre will provide five consulting rooms for future GP and community service use. The existing site is in very poor condition. The building is a branch site for Mumbles Medical Practice. The proposed floor plan is shown below:

The refurbishment of Penclawwd Health Centre will provide seven consulting rooms for the expansion of GP and community services. The building is in very poor condition due to a lack of maintenance investment over the last 30 years. The building is a branch site for Gowerton Medical Practice and a range of primary care services

including wound care and podiatry service are also delivered. The proposed floor plan is shown below.



1.4 Theme 4: A Skilled Workforce

The Primary Care and Community Services Unit employs almost 1500 staff, most of them managing or providing clinical services. Throughout this report it has demonstrated that breadth of the workforce across the 11 GP clusters, including cluster pharmacists, social prescribing link workers, cluster community nurses, paramedics, phlebotomists, physiotherapists, mental health workers, occupational therapist, exercise referral specialist, audiologists and primary care early years workers. This has been complemented by an increased provision of third sector services through the Heath Board grant scheme and through the use of cluster funds.

District Nurses, Health Visitors, School Nurses and Integrated Community Resource Teams work across the 11 cluster networks.

The Chief Nursing Officer for Wales has supported the implementation of a legislative framework which establishes safer staffing levels. The principles for District Nursing have been adopted in ABM and work continues to align services to fully meet the requirement. The principles for Health Visiting are currently being scoped and drafted.

A key requirement for a safe and sustainable nuring workforce is to further explore opportunities for skill mix. The role of the Health Care Support worker is being developed and well as the future role of the Nursery Nurse within Health Visiting.

ABMU Health Board, via a skilled workforce, has developed a Community Wound service. This is achieving better healing outcomes for patients, more efficent use of resources and is considered an interesting area of practice, evidenced by postive recruitment.

Successful investment from Welsh Government has enabled the Primary Care and Community Services Unit to transform its traditional continence service from product supply to a health promotion model delivered via specialist staff.

The CRTs operate within Section 33 pooled budgets ensuring that seamless services are provided to frail older people within the community through the provision of integrated health and social care.

Through a partnership approach there is a mixed economy of employers for these staff including ABMU Health Board, individual practices on behalf of clusters, third sector organisations, Bridgend HALO Leisure, and Swansea Council. Evaluations are taking place of many of these posts however the initial feedback from patients and practices is very positive.

The **Bay Cluster MDT** has a cluster nurse and two pharmacists, and access to Action for Elders and Red Café sessions tackling social isolation and promoting self-care. The cluster pharmacists have carried out over 6,000 patient consultations to date improving medicines management and patient safety. The nurse has seen 157 home visits with only one patient admitted and many admissions avoided.

The **GP Out of Hours service** *(See 1.2.6 Urgent Primary Care Services)* has experienced the same sustainability challenges as the in-hours services for the same reasons. Prior to late 2017/18 the ABMU GP Out of Hours service had a combination of excellent local leadership and the attraction of enhanced pay rates out of hours mitigated successfully against the national and local issues which were depleting the supply of GPs, i.e. less motivation to work unsocial hours, particularly amongst the younger age groups, early retirements, plus the unknown implications of the HMRC guidance that GPs working out of hours should be considered employees. This led to some curtailment in the number of hours each base could remain open and the introduction of alternative professionals, discussed at 1.2 above.

Sustainability of **general dental services** [GDS] in 2017/18 saw some large corporate practices reporting that they were experiencing problems recruiting dentists, with consequent impact on the dental activity they were able to provide. Retention of young dentists began to emerge as a problem in 2017/18, with all 14 dental training practices in ABMU reporting difficulties retaining their Dental Foundation trainees. It is considered that this is a consequence of the disincentives associated with the Unit of Dental Activity Target-driven GDS contract but also the UK-based allocation of training places. There is also a perception that many young dentists no longer aspire to take on the responsibilities of running a practice. ABMU's Post Graduate Training Unit at Port Talbot has trained 35 postgraduate dentists since completion of its first course in 2010, of which 9 are still working in the ABMU area (two within the Community Dental Service).

ABMU was therefore keen to work with the Deanery to introduce, in September 2015, a 'longitudinal' training programme based around ABMU and Cwm Taf's Dental training units with rotations into practices that provided intermediate care (oral surgery) and the Community Dental Service. The hope was that a two-year training period

would provide sufficient time and incentive to encourage trainees to establish roots in the area. However, this proved no more successful than the previous experience and, being as complex to undertake to deliver, the training programme reverted to one year's duration from September 2017.

As ABMU has concerns about retention of skills locally, in March 2018 it developed a three year **General Dental Practitioner Fellowship** that it will pilot from September 2018, linked with the Contract Reform programme. Expressions of interest will be sought from individual practices and Dental Foundation Trainees themselves to receive funding which would support their placement and training as a Dentist with Enhanced Skills who could contribute to both the practice and the overall requirements of oral health services within ABMU. In 2018 the placement is being offered to train in the provision of Endodontic services (assessment and treatment of root canal disease) through the ABMU Restorative Dentistry-provided MSc course in endodontics and working alongside specialists in an intermediary setting. It is hoped that the chosen individual, as well as some of the annual cohort of six MSc-trained dentists, will be able to strengthen the skill-base of primary care dentistry and ensure that less patients need to be treated in hospital, with consequent reductions in waiting times.

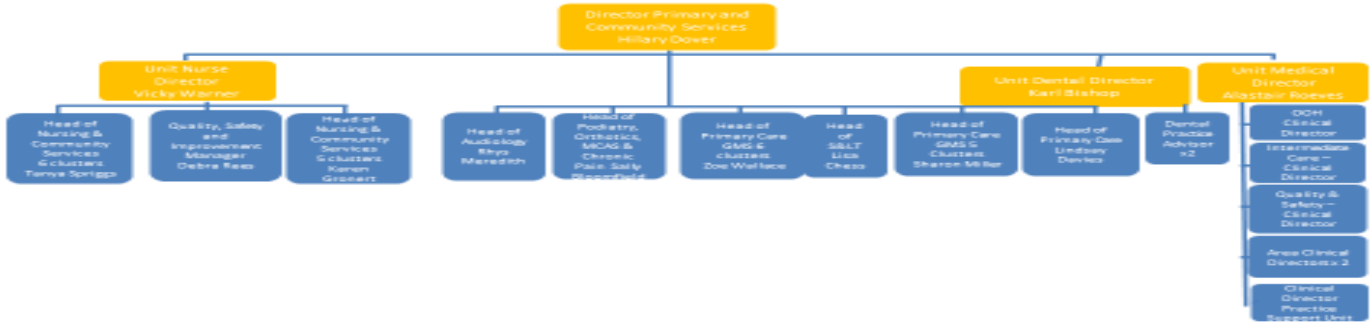
The introduction of Dental Contract Reform *(See section 1.1.2 Pacesetter and Innovation)* and more use of a varied skill mix in dental practices requires the development of national and local workforce plans to ensure there is sufficient supply of these individuals to support dental practices. It is also important that practices also have the physical capacity in which they can work

2017/18 also saw the commencement of a workforce survey of primary care **optometry services** by Optometry Wales which, at year end, looked likely to indicate that there were vacancies in most large practices and that recruitment and retention pattern is similar to that experienced in the other primary care professions, ie growth in proportion of young women in the workplace, but far fewer optometrists inclined to take on partnerships or indeed full-time work, preferring instead to work part-time and/or on a locum basis.

Towards the end of 2017/18 the ABMU primary care team also instigated a service mapping exercise of optometry services to inform future eye care plans by gauging the extent to which there is community capacity as well as appetite to take on any more work that is currently undertaken in secondary care and to build Eye Care Examination Wales services.

1.5 Theme 5: Strong Leaderships

There is a commitment in ABMU to strengthen and develop leadership at all levels. Primary & Community Services Unit Senior clinical and managerial team support to clusters is outlined in the diagram below.



Confident Primary Care Leaders Programme

In 2017/18 the second cohort of five cluster leads and aspiring leaders represented ABMU Health Board at the Confident Primary Care Leaders Programme.

Cluster Leads Network

ABMU continues with an 11 Cluster leadership group providing a more frequent and structured opportunity for interface as peers, with senior managers, corporate and other units in the Health Board and to articulate Cluster development requirements with a greater voice.

Cluster Organisational Development

- Two Clusters have undertaken initial steps to explore potential afforded by forming a formal collaborative entity.
- Some clusters have provided resource for additional capacity for business development and project implementation
- Collaborative working to ensure cover for Protected Learning Time sessions covering pertinent primary care and cluster topics such as delivery of Flu programmes, CPR training, Physiotherapy provision, Palliative Care and C-Difficile among others.
- Expansion of Practice Manager meetings to support Cluster development

PART 2. Work Plan 2017/18

2.1 Achievements against 2017/18 forward work plan

	Objective	Status
Cluster Networks	The management and clinical leadership of PCCS strengthened providing each cluster network with an agreed level of support.	Completed – see section 1.1.1
	Roll-out of a common point of access to Community based services in all three geographical areas based on a test of change model in Swansea	Completed
	A renewed focus on evaluation and learning from good practice both within ABMU, across Wales and beyond.	Completed – see section 1.1.3
	Improved use of technologies across community services, leading to greater efficiencies and access to services.	Completed – see section 1.2.8
	The implementation of the five year strategy for PCCS and cluster networks, as contained within the Primary and Community services Strategy 2017 – 2022.	Completed – see section 1.2
General Medical Services	An audit against the Health Board reasonable standards of access criteria agreed jointly with LMC in 2015.	Completed – see section 1.1.1
	A revision of the standards with an aim to increase the overall access	Review commenced for completion in 2018/19
	Support for the 11 cluster networks to review access and sustainability for patients to primary care services.	Completed – see section 1.1.1
	Rollout of lessons from the 11 cluster networks in relation to the expansion of the primary care multi-disciplinary team and the national pacesetter – the Neath Hub.	Completed – see section 1.2.4
	Implementation of directed enhanced services to provide an enhanced level of general medical services for all care home residents within the health board.	Completed

	Implementation of an enhanced service at practice level for one stop point of care anticoagulation testing and dosing across the Health Board which will reduce the need for venous sampling and bring care closer to home.	Completed – see section 1.2.10
Oral Health and Dental Services	A dental service and financial investment plan will be finalized and implemented, with increased resources devoted to securing access to general dental services in areas of high need and for vulnerable groups	Completed – see section 1.2.4
	An adapted version of the general dental contract will be piloted in up to five practices, the aim being to create a more holistic service focused on prevention and minimal intervention	Completed – see section 1.2.4
	With concern that a high level (1.6%) of children in ABMU received their dental care whilst under a General Anaesthetic a Single Point of Access for paediatric referrals will be introduced in June 2017 with a view to ensuring that clinical care pathways are appropriate.	Completed – see section 1.2.4
Community Pharmacy	The new community pharmacy contract will be introduced on a phased basis from September 2017, with Health Boards using pharmacy funds to commission additional services. ABMU's investment plan will focus on supporting the sustainability of the health and social care services with a focus on development within clusters: • increasing the number of pharmacies open and delivering emergency and palliative care services out of hours • Commissioning the Common Ailments Service • Commissioning more smoking cessation services	Completed – see section 1.1.6
	95 (10% more) community pharmacies will commission the flu service in conjunction with the GP colleagues, BMA Cymru Wales' GP committee (GPC Wales) and Community Pharmacy Wales (CPW) having signed a 'Memorandum of Understanding' to encourage collaborative working, designed	Completed – see section 1.1.6

	to improve the uptake of the NHS Flu vaccination	
Community Optometry	Work with all-Wales Clinical lead to secure more LVS providers and ensuring greater uptake of the services they provide, notably in Port Talbot	Completed – see section 1.1.7
	Work with hospital based colleagues to review eye care pathways and implement consistently across ABMU, maximizing awareness of Eye Care Examination Wales services.	Completed – see section 1.1.7
Out of Hours	PCCS will develop, implement and monitor a comprehensive Unscheduled Care Plan as an integral part of the Health Board's agreed clinical service strategy	Completed – see section 1.2.6
	The Out of Hours model will be reviewed and revised in collaboration with, introducing a wider range of professionals to ensure the service is sustainable	Completed – see section 1.2.6
Audiology	Hearing Loss pathway plans will be prepared with the aim of diverting appropriate patients traditionally channelled to ENT to Audiology.	Completed – see section 1.2.4
	Training will be provided for audiologists to expand their competencies to include non-medical referral for diagnostic imaging and micro-suction ear care.	Completed – see section 1.2.3
	Further expansion of Primary Care Audiology is expected with the ultimate aim of having services available at all clusters	Completed – see section 1.2.4
MCAS	Appointment of a Joint GP and MCAS **Physiotherapist** to improve links	Completed – see section 1.2.4
	Commence Exercise and Lifestyle Programme	Completed – see section 1.2.4
Speech and Language	In 2017/18, the department is a pilot site for the Royal College of Speech and Language Therapists [RCSLT] project recording therapy outcome measures on a national database. Every patient seen by the SLT department will receive an outcome measure pre and post intervention to measure impact.	Completed – see section 1.2.4

Services closer to Home	Establish a safe high quality atrial fibrillation and anticoagulation service based within the community that can be delivered at a practice or cluster level.	Completed – see section 1.2.11
Workforce	The evaluation of the range of initiatives to identify those with the greatest impacts. By focussing on those initiatives, and rolling out across the health board footprint, it is expected that the benefits will become magnified and embedded in normal working practice.	Completed – see section 1.4
	Working with partners across Western Bay to progress the integration agenda in line with the "what matters to me model"	Completed
	Reviewing the roles and potential roles for Advanced Practitioners and aligning to workforce planning	Completed – see section 1.4
Information Technology	Services under the scope of the pilot will begin to change their processes and working practices following receipt of the devices.	Completed – see section 1.2.7
	The Channel 3 Benefits work to be completed in June 2017 will provide a more comprehensive and quantified list of benefits which will enable services to prioritise and plan the changes to their business processes in order to unlock these benefits.	Completed – see section 1.2.7
	Wider rollout in July 2017	Completed – see section 1.2.7
Estates	Larger combined GP and community schemes are on site at Mayhill [completion scheduled for late January 2018] and it is planned that the Porthcawl and Vale of Neath schemes will commence by Autumn 2017.	Completed – see section 1.3.5
	Proposals are in development to create three health and wellbeing hubs	Completed – see section 1.3.6
	Local Authorities' Local Development plans will be reviewed to establish future population growth and linkages with Local Authorities will be improved in order to maximise opportunities across organisations as part of the 'One Public Estate' agenda.	Completed – see section 1.3.5
	The Primary and Community Estates Strategy will ensure, upon completion that all	Ongoing – see section 1.3.5

	ABMU primary care estate premises are fit for purpose and the quality of the environment is suitable for all building users.	

PART 3. Forward Work Plan 2018/19

3.1 Planning Care Locally

3.1.1 Cluster Development and Support	• To ensure clusters are developed in line with *A Healthier Wales; Our Plan for Health and Social Care* and ensure opportunities are progressed through the National Transformation Fund which will support implementation of the plan, particularly new models of seamless health and social care promoted by Regional Partnership Boards. • To continue to produce and agree 11 cluster plans, and to utilise evaluation to assist in dissemination of learning and good practice. • To ensure full spend of cluster allocated resources. • Continued implementation of the five year strategy for Primary and Community Services and cluster networks, as contained within the Strategy 2017 – 2022 • Increase of investment in Third Sector services to meet local priorities • Widening of involvement in clusters by dentistry, community pharmacies, local authority partner areas such as Department of Sport and Health, Poverty Prevention, and Housing and continued focus on liaison with secondary care • Explore the opportunities for Clusters to work with volunteers to support patient engagement, peer support, and promotion of keeping healthy messages. • Consider need to mitigate risks and maximise opportunities arising in line with the ABMU Boundary change as of 1st April 2019.
3.1.2 Pacesetters and Innovation	• Evaluate and review outcomes of **pacesetters** to inform decisions on scaling up of service developments and future new ways of working. • Extend and further develop the **dental contract reform programme**, with at least 10% of ABMU's practices participating. The data emerging from the first phase being likely to indicate that Health Boards and Practices can be confident in reducing further UDA targets in return for specific quality initiatives to secure greater, more appropriate, patient access to

	General Dental Services with improved health outcomes.
3.1.3 Critical Appraisal and Evaluation	• Enhanced delivery of **independent review and evaluation** for Cluster programmes from commissioned providers and Swansea University. • Participate and share national learning from the Birmingham Critical Appraisal review.
3.1.4 Alternative Provider Models of Medical Practice	• Continue to explore options for Clusters to develop **social enterprise ventures.**
3.1.5 IMTP Guidance	• Ensure **cluster level plans** directly influence and shape the Health Board planning cycle.
3.1.6 Community Pharmacy	• Completion of the **Common Ailments Service** [CAS] implementation in all 125 pharmacies and a broadening of the service itself to include more conditions, e.g. Test and treat service in development with NWIS for patients with potential tonsillitis. • Commissioning of pharmacists to undertake **Independent Prescribing [IP]** training in parallel with work to develop enhanced services that IP-qualified community pharmacists can deliver, e.g. Proton Pump Inhibitor [PPI] service that will support patients and general practice by the community pharmacist and pharmacy technician delivering smoking cessation, healthy lifestyle and exercise referral with a view to reduce inappropriate prescribing of PPIs. • Development of a community pharmacy based **blood borne virus screening service** for clients at identified as being at risk of hepatitis C to meet the requirements of the WHC/2017/048 in relation to testing and treating in the community pharmacy setting. • Strengthening of primary care based **Respiratory Services,** through provision of a community pharmacy based inhaler technique service, learning from the good practice already in place in Aneurin Bevan and Powys Health Boards.
3.1.7 Low Vision Service Wales	• Continue to work with all-Wales Clinical lead to secure more Low Vision Service providers and ensuring greater uptake of the services they provide, notably planned commissioning of replacement service in Port Talbot

	• Apply learning from the inclusion of the 'patient depression' element that it is proposed be included in the Low Vision Service from 2018/19, working with stakeholders and partners as appropriate.
3.1.8 Eye Health Examination Wales [EHEW]	• Work with hospital based colleagues to review **eye care pathways** and implement consistently across ABMU, ensuring Health Board budgets for eye care services reflect changes in pathways and service providers • Work with the national leads and local optometry and ophthalmology representatives to gauge **patient and stakeholder satisfaction** with the services provided • Work with national EHEW leads and local primary care and medicines management colleagues to explore the scope to provide an enhanced '**EHEW plus'** service, e.g. on a Hydroxychloroquine screening pathway
3.1.9 Social Prescribing	• Continue to support clusters to expand and improve their approach to **social referral** • Work together with local partners to **build safe and resilient communities,** to help people help themselves.
3.1.10 Oral Health and Dental Services	• Further develop the **Paediatrics dental pathways** to accommodate urgent care requirements as well as changes in service provision required as a consequence of the Chief Dental Officer's planned guidance to remove multi-drug sedation treatment, known as 'deep sedation' from any non-hospital site. This is likely to result in a small reversal of the downward trend in paediatric GA treatments whilst alternative service models are developed. • Reduce referral to assessment and treatment times for patients requiring **Restorative Dentistry** and Special Care Dental treatment under a General Anesthetic.

3.2 Improving Access and Quality

3.2.1 Quality Objectives	• Progress a formal method of capturing family and friend's feedback from GPs taking the lead on an All Wales approach. • Stepping up efforts in directly managed services to ensure patient participation, improve patient experience and patient rights for a coproduced approach to healthcare. • To continue to build on the foundation of good work last year on responding to 72% of concerns within 30 working days.
3.2.2 Primary Care Measures	• Report on the Primary Care Measures for the ABMU position
3.2.3 Key Indicators	• Local and national measures and key indicators to inform governance assurance Programmes.
3.2.4 Access	• Complete the revision of the **GMS access standards** with an aim to increase the overall access. • Continue to support the 11 cluster networks to **review access and sustainability** for patients to primary care services. • Training will be provided for audiologists to expand their competencies to include non-medical referral for diagnostic imaging and **micro-suction ear care.** • Opportunities to expand the coverage of **Primary Care Audiology** will be explored with the ultimate aim of having full services available in all clusters. • Remodelling of **Chronic Pain** service in line with strategic direction/Cluster based model. Clusters for a pilot outreach clinic already being identified and protocols developed. • Continuing to provide the safe and multimodal chronic pain service that the external review has commended. • Remodelling of **MCAS** service in line with strategic direction/ Cluster based moel. • Provision of outcomes from pilot ELP to inform futire provion.
3.2.5 Clinical Triage	• Develop an action plan and self-assessment tool to support the promotion of the telephone first framework.

3.2.6 Urgent Primary Care Services/111/Directory of Service	2018/19 will see the following work taken forward to ensure the establishment of a sustainable GP-led urgent primary care service as an integral part of the wider unscheduled care service in ABMU with regional and national partners. • Develop a more sustainable service by widening the skill mix to include nurses, paramedics, physicians associates and healthcare support workers to decrease the dependency of the service on GPs • Implement the advanced pharmacist role which will enable pharmacists with advanced skills and training to provide face to face appointments for a defined set of patient presentations. • Agree and implement a Service Level Agreement with Welsh Ambulance Service NHS Trust for the provision of a paramedic each overnight shift (8 pm – 8 am) 7 nights a week, 52 weeks of the year to undertake home visits.
3.2.7 My Health on Line	• Continue to promote uptake and utilization by practices and patients as new developments take place.
3.2.8 WCCIS	• Continue roll out and maximise opportunities.
3.2.9 GMS IT	• Ensure practices are supported during the migration to new GMS systems.
3.2.10 Capacity and Demand Modelling	• Consider learning from pacesetters across Wales to further understand demand to enable more robust workforce planning.
3.2.11 Rebalance of resources from secondary to primary care	• Ensure a more robust approach to the development of additional or alternative services by primary and community service through the implementation of an agreed national Financial Framework to support the shift of secondary acute services and enable the ‘churn’ of cluster innovation funds

3.3 Equitable Access

3.3.1 Inverse Care Law Programme	• Continue to roll out the CVD Health Checks across all practices in the North Cluster and commission formal evaluation of provision and outcomes.
3.3.2 Transgender Project	• Take forward recommendations from national work.
3.3.3 Equality & Diversity/BSL	• Deliver various improvements to **access to oral health care for vulnerable groups**, including asylum seekers, prisoners (HMP Swansea) and the housebound, e.g. Complete and implement an integrated (general and community dentistry) oral health and dental pathway for domiciliary care, building on the work developed through the care homes oral health programme • Ensure revised access standards reflects the needs of all patients.
3.3.4 Welsh Language	• Review of DOS in 111 to ensure all departments are clear on how they can ensure they can meet patient expectations to receive services through the Welsh Language or access services if they have a disability.
3.3.5 Primary Care Estates	• Finalise a ten year primary care estates strategy. • Complete improvement grant works
3.3.6 Integrated Health and Care Centres	• Progress primary care capital pipeline schemes

3.4 A Skilled Workforce

3.4.1 Oral Health	• Work will be commissioned in 2018/19 to confirm the retention rate for those trained in ABMU's dental training practices that would help gauge whether this should be considered a cause for concern, it being understood that the retention rate generally is significantly less than at the Training Unit and is reducing • Work with Local Dental Committee to review physical and staff capacity in general dental practices, lest it is a barrier to dentists wishing to adopt contract reform and to ascertain any sustainability challenges. • Undertake, jointly with the Local Dental Committee, a survey of General Dental practice staffing and facilities to help gauge the extent to which practices are in a position to remodel the services they provide. It is known that currently

	not all practices are in a position to embrace the multi-disciplinary approach upon which the holistic model of service sought by the reform programme depends, notably contractors who are single-handed and/or operating in small premises that cannot accommodate additional staff, e.g. hygienists, therapists, dental nurses. • Implement the **General Dental Practitioner Fellowship** pilot to retain qualified dentists locally and test out a new intermediate care model of Restorative Dentistry
3.4.2 Eye Care	• Complete community eye care capacity map to inform discussion with secondary care colleagues on eye care pathway service developments.
3.4.3 Cluster	• Mobilisation of the community workforce on a Cluster footprint (improving the use of technology to support the workforce • Develop and recruit to a PA Internship Programme • Undertake a workforce and needs analysis to roll out the Primary Care Hub.

3.5 Strong Leaderships

3.5.1 Local Level Leadership	• To introduce a programme of organisational development supported by the All Wales Primary Care Governance Framework and resource pack, developed by Public Health Wales/ Directors of Primary and Community Services.
3.5.2 Cluster Leads	• Completion of the Confident Leaders programmes for 5 more Cluster Leads in 2018