Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 2 – Senedd
Meeting date: Wednesday, 3 May 2017
Meeting time: 10.15

For further information contact:
Sian Thomas
Committee Clerk
0300 200 6291
SeneddHealth@assembly.wales

Informal pre-meeting (09.45 – 10.15)

1 Introductions, apologies, substitutions and declarations of interest

2 Inquiry into primary care – evidence session 1 – Public Health Wales and Local Health Boards

(10.15 – 11.15) (Pages 1 – 55)

Rosemary Fletcher, Programme Director, Primary and Community Care Development and Innovation Hwb, Public Health Wales
Alan Lawrie, Deputy Chief Executive and Director of Primary & Community Care, Powys Teaching Health Board
John Palmer, Director of Primary, Community & Mental Health, Cwm Taf University Health Board

Break (11.15 – 11.25)

3 Inquiry into primary care – evidence session 2 – BMA Cymru Wales and Royal College of General Practitioners

(11.25 – 12.10) (Pages 56 – 64)

Dr Isolde Shore-Nye, Royal College of General Practitioners
Dr Jane Fenton-May, Royal College of General Practitioners
Dr Charlotte Jones, BMA Cymru Wales
Dr Ian Harris, BMA Cymru Wales

4 Paper(s) to note

Letter from the Welsh Language Commissioner regarding the Public Health (Wales) Bill

(Pages 65 – 67)

Letter from the Chair of the Constitutional and Legislative Affairs Committee to the Minister for Social Services and Public Health regarding the Public Health (Wales) Bill

(Pages 68 – 70)

Letter from the Minister for Social Services and Public Health to the Chair of the Constitutional and Legislative Affairs Committee regarding the Public Health (Wales) Bill

(Pages 71 – 72)

Letter from the Cabinet Secretary for Health, Well-being and Sport regarding NHS activity statistics

(Page 73)

Letter from the Minister for Social Services and Public Health to all Assembly Members regarding nutritional standards in hospitals and schools

(Pages 74 – 75)

5 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

6 Inquiry into primary care – consideration of evidence

(12.10 – 12.15)

7 Scrutiny of the Welsh Government draft budget 2017-18 – preparation for in-year financial scrutiny

(12.15 – 12.25) (Pages 76 – 82)

8 Consideration of the Welsh Government's guidance on 'Supporting learners with healthcare needs'

Agenda Item 2

Document is Restricted

PC 20
Ymchwiliad i ofal sylfaenol
Inquiry into primary care
Ymateb gan: Iechyd Cyhoeddus Cymru
Response from: Public Health Wales

1. About the Primary Care Hub within Public Health Wales

1.1 Role and ways of working

The Primary & Community Care Development & Innovation Hub (Primary Care Hub) coordinates support for health boards and clusters, at a national level, in the delivery of the national plan for primary and community care in Wales; facilitates coordinated delivery on a range of primary care projects; and provides support to other projects within the overall work programme for Directors of Primary, Community and Mental Health Services (DPCMH). Colleagues within other Public Health Wales (PHW) national teams work in partnership with Primary Care Hub staff to deliver these projects. Local public health teams (LPHTs) also work closely with the Primary Care Hub, playing a key role in supporting primary care clusters directly within health board areas, and in contributing local knowledge and skills to the national work programme.

1.2 Work programme

The work programme for the Primary Care Hub is agreed and overseen by a Programme Board and currently focuses on four themes: cluster development; access to information and health intelligence; quality improvement and safety; and innovations in healthcare.

1.3 Pacesetter Programme

The Pacesetter Programme has provided funding from Welsh Government to health boards/ clusters to explore new ways of working in relation to Ministerial priorities for primary care of service sustainability, improved patient access and moving care into the community. PHW was commissioned to support this programme and to facilitate its evaluation. A separate response has been prepared by DPCMH, in liaison with PHW, that focuses on the contribution of the programme to an emerging model of primary and community care with the potential to drive transformational change across the NHS in Wales; that document should be read in conjunction with this response.

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

2.1 Cluster development and wider professional involvement

Primary care clusters (also known as neighbourhood care or cluster networks) were intended to involve the wider primary care professions, but we are aware of variation ranging from inclusive arrangements to clusters that have a general medical practice focus. We highlight the need for wider professional involvement (reflected in consistent use of inclusive cluster-related terms) at greater pace.

2.2 Innovation and demand management

Evaluation of the Pacesetter Programme has and will examine the contribution that clinical triage systems can make to management of primary care workload; the bespoke professional services and/ or resources that can moderate the use of acute services by persons with complex care needs; and systems-level integration of out-of-hours services to ensure continuity of care.

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

3.1 Cluster development and role description informed by needs

Development and description of new roles will need to be in line with identified cluster needs, supported by the availability and funding of tailored training for existing staff who are changing roles and for staff newly recruited to primary care. Clusters will need expert support to identify their staffing needs and the resources available to meet them.

3.2 Quality/ safety and assessment of MDT impact

The contribution of multi-disciplinary team (MDT) approaches to service delivery would be broadly reflected in outcome-related measures (such as number of injuries resulting from falls in the home); process-related measures (such as rates of referral to secondary care); and measures related to patient experience (such as survey-derived levels of satisfaction). In the context of other transformation-related changes, accurate assessment of the specific MDT contribution will be challenging. Pragmatic evaluation approaches exist (such as contribution analysis) and there is an existing evidence base on effective MDT working in the scientific literature. How successful MDT pilots are supported to transform into sustainable business-as-usual services requires attention.

3.3 Innovation and the MDT contribution

Evaluation of the Pacesetter Programme has and will examine the contribution that MDTs can make to management of primary care workload.

4. The current and future workforce challenges.

4.1 Cluster development and workforce issues

Feedback from clusters, local public health teams and others attests to the pressures that many GPs face to maintain levels of service. Feedback also indicates that this imperative can conflict with engagement in the full extent of primary care cluster ambitions. Some Primary Care Hub staff have had input into primary care workforce strategy. Their involvement indicates that challenges include assurance of attractive career pathways (such as new cluster consultant nurse roles); retention of knowledge and experience; barriers around recruitment process; provision of peer support to those in new roles (such as mentorship); appropriate training; and development of cultures based on inclusivity and mutual respect between all cluster roles.

4.2 Cluster development and evolving professional roles

Well-supported public awareness campaigns will be needed to ensure a prudent public understand that supplementing (not substituting) GPs with wider multidisciplinary roles frees GPs to focus on what only they can bring to primary care; new roles are not intended to replace GPs.

4.3 Innovation and planning in support of sustainable transformation

Evaluation of the Pacesetter Programme has and will examine the central role of workforce planning across primary and community care in facilitating transformation and in ensuring the medium- to long-term sustainability of primary care services. Experience suggests that addressing sustainability must precede implementation of new workforce models and new work they support.

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

5.1 Cluster development and systems working

General practices operate within a primary care context, and primary care within a whole system context (including secondary care and communities). It follows that funding streams to explore new ways of working should reflect this inter-dependence. Although clusters continue to evolve towards wider primary care involvement, in some cases decisions on spending these monies do not reflect this. We encourage equitable access to funding opportunities based on assessment of population needs.

5.2 Quality/safety and primary care service improvement

Our 1000 Lives Improvement team is leading development of a primary care safety and quality programme supported by the Primary Care Hub. This will incorporate several projects that make use of technology to identify and manage risk, with the aim of improving outcomes for patients. The development of clusters provides an opportunity to take a fresh look at strengthening leadership around quality improvement across primary care networks.

6. Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.

6.1 Cluster development and social prescribing

Social prescribing is gaining increasing attention as a means for primary care to engage with primary prevention (health promotion and other activities to reduce the chance of becoming ill), better utilise non-medical community assets and influence social determinants of health locally. To support primary care in this, we are coordinating a map of the evidence, gathering social prescribing activity and organising events to share and promote this learning across Wales to inform decisions on current and future projects.

6.2 Information/ intelligence and population health

The Primary Care Hub is working with others to improve access to relevant and timely health intelligence. We encourage clusters to take a broad view of data describing population needs and to integrate intelligence arising from professions other than general practice. As well as reflecting population needs, cluster plans should be informed by evidence on effective interventions, and we intend to strengthen our support for this. Local public health teams play a vital role in helping clusters interpret population health status, prioritise action and select best value interventions—but tailoring this for 64 clusters challenges capacity.

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

7.1 Cluster development and maturity status

We anticipate that individual health boards will comment on the current maturity of their clusters and nominate best practice examples in their responses.

7.2 Innovation and cluster configuration

Evaluation of the Pacesetter Programme has and will examine approaches to internal configuration of clusters that drive transformation.

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

8.1 Cluster development and support for leadership and skills

We have supported or brokered several initiatives to develop leadership and other skills. These are the Confident Leaders Programme (for cluster leads); coaching and action learning (initially in North Wales and also aimed at cluster leads); and a series of workshops aimed at anyone working in or with clusters (initially on health needs assessment, project management and co-production). A follow-on programme is in development and will be informed by evaluation of events to date.

8.2 Innovation and the role of primary care support units

Evaluation of the Pacesetter Programme has and will examine the organisation and function of primary care support units (PCSUs), particularly their role in relation to the short-term sustainability of primary care services.

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

9.1 Cluster development and academic evaluation of the cluster model

PHW has commissioned an academic partner to survey the functions and maturity of clusters in Wales; review measurement tools designed for comparing primary care maturity and quality; tailor an existing tool for within Wales comparisons; and measure the ‘strength’ of primary care clusters in relation to maturity.

9.2 Information/ intelligence and support for collaborative working

The Primary Care One website promotes collaborative working in Wales and aims to support cluster development at a national level. It aspires to be a central source of information relevant to clusters and promotes mutual support to share learning, cluster-led projects and achievements.

9.3 Quality/ safety and measures of primary care effectiveness

The Primary Care Hub supports the development and implementation of Primary Care Measures being led by the DPCMH. These measures are intended to reflect quality improvements in the primary care contribution to better health outcomes (or proxies thereof).

9.4 Innovation and support for outcomes assessment

New ways of working necessitate some form of outcomes assessment to identify change that has merit and potential for adoption elsewhere through the sharing of learning. We are exploring how we can strengthen our support to clusters through coordinating access to research and evaluation expertise within and without the organisation.

PC 21

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: Cyfarwyddwyr Iechyd Sylfaenol, Iechyd Cymunedol a Iechyd Meddwl

Response from: Directors of Primary, Community & Mental Health

The Directors of Primary Community and Mental Health (DPCMH) come together on an All Wales basis every month to work collectively on matters that affect each Health Board within the spheres of primary, community and mental health services. This collaborative work considers both tactical and business as usual matters as well as the delivery of the ambitions set out in the Primary Care Plan for Wales. A report on that activity for 2015/16 demonstrates the breadth and depth of the work undertaken as well as the work programme, as agreed with Welsh Government, for the current year. A similar report will be forthcoming for the work undertaken during 2016/17 and the proposed work plan for the coming year. In addition we have outlined to Health Board Chief Executives the work that we intend to pursue in 2017/18 set against a number of key drivers on strategic change for NHS Wales. As such, the DPCMH feel well placed to provide a detailed response to the questions set by the Inquiry, as well as demonstrating the significant work that has been undertaken, and will continue to be undertaken, on Primary Care services across Wales and providing that leadership both to national programmes and at Health Board level

Several of the questions are better responded to on a national basis through the DPCMH, than they would be at a local Health Board level. Responding to the Inquiry in this way we would hope to provide full answers to the work that has been undertaken in the domains outlined. Individual Health Boards will undoubtedly wish to respond to specific elements and in particular elements of question 3 (workforce), question 4 (use of cluster funds) and question 6 (the maturity of local clusters). Public Health Wales (PHW) will have submitted a related but individual response.

This specific response is set in the context of the Pacesetter Programme, funded by Welsh Government to promote innovation across primary care and delivered through health boards and primary care clusters in Wales. This funding (£4m) was part of the 2015/16 recurrent investment made by Welsh Government in Primary Care services. The development of this programme has been a key part of the work of the DPCMH and the Primary and Community Care Development and Innovation Hub (the Primary Care Hub) which was established in 2016 by PHW, with an accountability to the DPCMH.

PHW via the Hub was commissioned to support the Pacesetter Programme and facilitate evaluation of the 24 projects that focus on the Ministerial priorities of service sustainability, improved patient access and moving care into the community. The outcomes of individual projects inform an emerging model for primary care with the potential to drive transformational change across the NHS in Wales.

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

A range of cluster models is emerging across Wales to suit different geographic, professional and patient populations. Allowing different models to evolve, whilst ensuring standardised outcomes and governance frameworks, appears to be effective. The benefits of more formal cluster models, e.g. federations, include stronger practitioner commitment to transformative change and new ways of working.

1.1 Multi-disciplinary Cluster Team (MDT)
There are significant opportunities to manage primary care demand through an MDT approach, matching cluster workforce expertise with the needs and demands of the local population. Cluster teams are well placed to provide holistic care because they understand the clinical history, social situations, personal backgrounds and families of their patients. A wide range of professional skill-sets, with each team member spending most of their time on activities that add greatest value, ensures that patients receive appropriate care without unnecessary delays. Pacesetter projects indicate that cluster MDTs cope better with the practice workload and report higher morale and motivation.

1.2 Clinical Triage
A clinical triage system directs patients to the most appropriate professional within the cluster team at the point of contact, greatly reducing the day-to-day workload of GPs and improving access to the right care. High quality clinical triage promotes patient safety through facilitating early assessment; less 'noise' in the system assists speedier identification of sick people and opportunities for early intervention. National standards and guidance would promote safe and effective systems for clinical triage.

1.3 Integration with Specialist Care
Specialist staff, such as Care of the Elderly consultants and specialist nurses, working alongside cluster teams can make a significant impact by supporting community-based care and providing educational opportunities for primary care professionals.

1.4 Primary Care Out-of-Hours (OOH) Services
Newly redesigned OOH services offer multi-professional assessment and seamless patient care across the in-hours / out-of-hours interface. This is particularly important for complex patients, the elderly and those receiving palliative care, to ensure an understanding of individual needs and continuity of care.

1.5 Infrastructure for Clusters
A strong governance framework, with clear accountabilities and indemnity, is an essential foundation for new cluster models. Pacesetter teams report the importance of robust, user-friendly primary care information management technology (IMT) systems to support redesign, communication, joint-working, bench-marking and automated data capture on a cluster basis. Human resource processes and financial systems must be aligned to change with pace. Increasingly, the design of estates needs to support MDTs working on a cluster basis.

1.6 Access to Mental Health Services
It is clear that rapid access to appropriate and locally driven mental health provision is becoming a strong theme in emergent cluster plans around Wales. The second year of cluster plans across Wales shows evidence of clusters commissioning MIND and other providers for in-practice mental health clinics. The Valleys Steps model in Cwm Taf and other tier 0 Cognitive Behavioural Therapy (CBT) models are also in their early phases and showing strong evidence of working well with primary care to avoid escalations.

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

The Pacesetter projects researched extended roles for paramedics, nurse practitioners, pharmacists, physiotherapists, technicians, occupational therapists, mental health counsellors and Local Authority professionals within a cluster setting. Evaluation of these

new roles and services includes their impact on patient satisfaction, reduction in face-to-face GP consultations and avoidance of hospital admissions. There is evidence from other research of the benefits of cluster roles for physician associates, healthcare support workers, dietician, optometrist, speech and language therapists, behaviour change consultants and dental hygienists. Outlined below are the findings from the research. Further information is available on an emerging model that could be in place across Wales to deliver transformational change from recruitment through to reduced reliance on secondary care services.

2.1 Team working

Ownership of new cluster roles by the existing primary care team is essential to success. Teams that use assessment of local health needs and patient demand to recruit professionals with the appropriate skills realise the greatest benefits.

2.2 Extended roles

- The cluster pharmacist can work in a specialist clinical area or a more generic role, addressing a range of medication issues. Experienced pharmacists identify high-risk patients from a medication perspective and support patients to manage their own health, offering alternatives to medication through advice and social prescribing.
- Greater understanding by the cluster team of the in-house occupational therapist role assists in identifying people who would benefit from these services, with potential to link directly with Social Services and Third Sector services.
- Extended scope physiotherapists are leading successful musculoskeletal (MSK) services within cluster teams, leading to reductions in GP consultations for MSK conditions.
- Advanced Nurse Practitioners assist with more complex patients and can undertake clinical triage within clusters. Practices indicate the importance of aligning new nursing roles with existing services to ensure good planning and coordination.
- Mental health counsellors manage a range of mental health problems in patients who return frequently and offer brief intervention techniques when appropriate.
- The GP with Special Interest (GPwSI) brings specific clinical expertise and is well placed to be a ‘cluster champion’ in a specialist area, offering support and clinical advice to colleagues and forging closer links with acute clinical teams. GPwSI posts are proving successful in attracting GPs into an area.
- Advanced Practice Paramedics are trained in a wide range of clinical assessment and decision-making skills, treating patients close to home and reducing unnecessary hospital visits.
- Practice-based Social Worker roles have proved successful, not only in subsuming the many social problems and issues which GPs have to deal with every day but also in “tracking” practice patients who are admitted to hospital and facilitating timely discharge. The role has also been effective working in partnership with the practice pharmacist and visiting house bound patients.

2.3 Collaborative arrangements

- Integration with local authority and voluntary sector staff on a cluster basis can reduce Accident & Emergency attendance and hospital stays. Regular MDT meetings support individuals to live independently at home, steering many away from residential or nursing home care.
- Joint rotas, shared learning opportunities and co-location of cluster staff with other agencies, e.g. Welsh Ambulance Services Trust and Local Authority improves integration.

3. The current and future workforce challenges

The fragility of many practices across Wales has a range of causes including increased volume and complexity of workload, and difficulties in recruitment. The rapidly shrinking GP workforce is one of the most challenging aspects of primary care, with increased workforce pressures, unstable practices and risks to the quality of patient care. There is an urgent need to increase capacity in the system, with new workforce roles and alternative models that do not simply move existing resources around the healthcare system.

3.1 Primary Care Sustainability
Detailed statistics on practice sustainability assist in the assessment of resilience and risk. The Pacesetter Programme indicates the value of standardised measures for sustainability and the use of dashboards to inform a national view of primary care resilience and workforce planning.

3.2 Health Board Support Teams
Methodologies to increase the resilience of practices and facilitate recruitment are under evaluation. A collaborative approach across adjacent health boards helps to maximise resources and attract new professionals. Flexible career schemes offer interesting GP jobs whilst providing locum cover for practices across a cluster or health board area.

3.3 Multidisciplinary Approach
The enhanced cluster team offers flexibility and responsiveness to changing conditions and demand, promoting sustainability, resilience and improved economies of scale.

3.4 Ministerial Taskforce on Workforce
The Minister's taskforce has brought a welcome focus to workforce activities with a strong initial focus on GP recruitment and retention in the form of a national recruitment campaign supported by local Health Board activities (this focus is now moving out across the primary care professions). It is also seeking to accelerate the development of primary care workforce projections. The development of more forensic workforce planning in primary care will support better Integrated Medium Term Planning (IMTP) representation of the recruitment challenge and necessary activities to address it.

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

Whilst this response largely refers to Pacesetter activities, the DPCMH would observe that in broad terms the direct funding of clusters has been a success. Year one of the funding was generally focused on set up arrangements for various activities and some one-off spends for equipment; year two has seen the development of service related activities with Service Level Agreements (SLAs) for social worker support or mental health clinic provision.
Activities commissioned at local level have ranged across several areas:

- Direct access physiotherapy
- Care & Repair
- Minor ailments scheme
- Welsh language
- Pharmacy appointments
- Diabetic feet service
- Lifestyle coordinators
- MDT/Cluster planning

- Information and Communication Technology (IMT) – Web GP / Vision 360
- Cardiovascular risk
- Wound management
- Social worker appointments

Future years should see some positive alignment between Health Board, Pacesetters and Cluster plan service priorities.

5. Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities

The MDT approach to cluster working, with a workforce based on population health needs, offers opportunities to focus on prevention and early intervention. In planning for future services, it will be essential to factor in services that support self-care, social prescribing and the promotion of health and wellbeing outside the traditional medical model.

The research conducted on the Predictive Risk Stratification Model (PRISM) should be further considered for its potential to support anticipatory care models; and the work already conducted through the Inverse Care Law Health checks (between Aneurin Bevan and Cwm Taf University Health Boards), which is now rolling out nationally, should be interrogated for its impact on outcomes following earlier intervention. In the future, list analysis and segmentation of the list to better manage risk in the population should be considered.

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

The mature cluster provides holistic care for the community, moving from a collection of GP-based services into fully functioning organisations that draw in the full range of agencies to support co-ordinated care for the entire population. Referrals are made only when necessary and people return to care of the primary care team as soon as possible.

Pacesetter projects demonstrate:

- Integrated care can only be achieved through significant investment in IMT systems to ensure secure communications between professionals and agencies.
- Building flexibility and patient choice into new service delivery models helps to secure the trust and co-operation of patients and professionals in whole system redesign.
- A review of clinical pathways for ambulatory care sensitive conditions and other common conditions helps to inform planners where professionals should be located to deliver effective patient-centred care outside the hospital setting.

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

In overall terms the DPCMH have prioritised cluster development very strongly. Early work on models for understanding cluster maturity and matching supporting resources has given way to a deliberate programme of cluster support activities being delivered through the Primary Care Hub. There are now several programmes providing leadership development in support of cluster working being accessed regularly by cluster leads across Wales.

Locally, significant efforts have been made by Health Boards to support Clusters in their development and cluster plans are being prioritised in this round of IMTPs.

The Pacesetter programme highlights the importance of clinical and managerial leadership in successful innovation and service redesign within clusters.

7.1 Clinical Leadership
Clinical leaders are essential to educate, advise, support and lead innovation. Cluster Champions promote new services and cascade key skills amongst the Primary Care team. Educational sessions to demonstrate improved clinical outcomes help to engage and assure professionals.

7.2 Innovation Networks
Workshops facilitated by PHW have provided project leads with opportunities to share ideas, experiences and outcomes and enabled colleagues to envisage large-scale development for the future of primary care in Wales.

7.3 Business Development Managers
Pacesetters have proved the value of experienced practice managers in driving cluster innovation. There is potential for economies of scale in back-office functions of clusters through developing practice manager teams, led by experienced Business Development Managers on a cluster basis.

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

Pacesetter project evaluations are based on success in finding solutions to the three ministerial priorities for primary care. Individual projects have been delivered and evaluated by each health board, with co-ordination and support provided through a partnership approach between the Primary Care Hub, 1000 Lives Improvement Service (PHW) and Health Board DPCMH. There has been assessment and dissemination of the shared learning from the programme and national learning events held. The Pacesetter Programme is tendering for a partner to evaluate activities undertaken thus far and further activities to follow.

Documentation referred to in this response and available on request:
- DPCMH Annual Report 2015/16
- DPCMH work plan
- Role of PHW Primary & Community Care Development & Innovation Hub
- Pacesetter Programme – an emerging model for primary and community care in NHS Wales

Produced for and on behalf of the All Wales DPCMH.

PC 24

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: Conffederasiwn GIG Cymru

Response from: Welsh NHS Confederation

The Welsh NHS Confederation response to the Health, Social Care and Sport Committee inquiry into primary care.

Contact: Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation.
[redacted] Tel: [redacted]

Date: 29 January 2017

Introduction

1. We welcome the opportunity to contribute to the Health, Social Care and Sport Committee inquiry into primary care. Primary care is vitally important to our national health service and we must recognise the range of professionals who are part of the primary care service. Primary and community care encompasses a range of services including, but not exclusively, GPs, general practice nurses, pharmacy, dentistry, specialty clinics, optometry, community and district nurses, midwives, health visitors, mental health teams, health promotion teams, physiotherapists, occupational therapists, dietitians, speech and language therapists, podiatrists, phlebotomists, paramedics, public health teams, rehabilitation teams, social workers, other local authority staff and all those people working and volunteering in voluntary organisations which help meet the health and well-being needs of people in our communities. This inquiry is timely to highlight the significant work that is being done and the developments in primary care sector across Wales.

2. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. The Welsh NHS Confederation and our members would be more than happy to provide further information to Members of the Committee.

Overview

3. As changes in demographics and our lifestyles have resulted in a dramatic rise in demand on the health and care services, it has become increasingly clear that a transformation in the way treatment is delivered is required if the NHS is to meet the needs of a future population.

4. We know the demand for primary care services continues to increase, with about 19 million patient contacts a year. Primary care continues to represent the significant majority of NHS patient contact and primary care acts as a gateway to a range of other services, especially referring patients to acute services. The development of primary and community services is a fundamental part of the Health Boards' clinical service strategy, "Changing for the Better", and the National Primary Care Plan for Wales has created a welcome catalyst to accelerate the changes needed to create a more sustainable health and social care system across Health Boards.

5. As highlighted, primary care encompasses a range of professions and GPs themselves increasingly recognise that they need and want to be part of that wider primary care team. That will mean the role of primary care changing, where they will be providing services for the more complex patients and co-ordinating the wider primary care team. Over the years there has been greater integrated

and multi-professional services across communities in Wales, and they have been created around the 64 Clusters.

6. The multi-professional service that primary care encompasses is clearly highlighted in the "Our Community: Ten actions to support primary care in Wales"[i] document that the Welsh NHS Confederation's Policy Forum has developed. The document, submitted as part of our evidence and endorsed by over 30 health and social care organisations in Wales, highlights what is required to ensure a sustainable primary and community care sector. This includes encouraging the development of a long-term vision for primary and community care services, with social services and cross-sector organisations working in partnership to deliver integrated, person-centred care closer to home and the investment required to achieve this.

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

7. A range of Cluster models are emerging across Wales to suit different geographic, professional and patient populations, ranging from GP led Clusters to multi-disciplinary teams. Allowing different models to evolve, whilst ensuring standardised outcomes and governance frameworks, appears to be effective in reducing demand on primary care services. The Clusters, and the more formal Cluster models e.g. federations, have led to stronger practitioner commitment to transformative change and new ways of working across Wales.

8. While a there are a number of developments and initiatives, demand on primary care continues to be high. Clusters have a key role to play in re-shaping the response to demand through identifying training needs and opportunities at a very local level and identifying local gaps in the service. Most gaps in the health service ultimately lead to problems "falling through" to primary care and the first response usually comes from the GP practice or community team. Clusters should have the local knowledge and "intelligence" to identify these problems and find local solutions. As Clusters develop they need further opportunities to have the levers to effect change e.g. financial, management responsibility and power and, probably most importantly, the profile and ability to influence other areas of the service.

9. The following projects and initiatives have been introduced recently across Health Boards to reduce demand on GPs:

Pacesetter projects

10. The Pacesetter Programme, funded by Welsh Government, promotes innovation across primary care and delivered through Health Boards and primary care Clusters in Wales. The Pacesetter projects have provided an important step forward in supporting innovation in primary care across Wales, and provided an opportunity to learn lessons across Health Board boundaries and work at scales within Clusters. The aim of this pacesetter is to avoid people from going into hospital unnecessarily and avoiding care home placements.

11. The Pacesetter Programme is still developing however initial results have been extremely positive, with good feedback on relationship building across the interface and up-skilling of GPs and the acute nursing team and the saving of bed days through providing care in the community as opposed to a hospital admission. The outcomes of individual projects inform an emerging model for primary care with the potential to drive transformational change across the NHS in Wales.

Multi-disciplinary Cluster Teams

12. There are significant opportunities to manage primary care demand through a Multi-disciplinary Team (MDT) approach, matching Cluster workforce expertise with the needs and demands of the local population.

13. Cluster teams are well placed to provide holistic care because they understand the motivations, clinical history, social situations, personal backgrounds and families of their patients. A wide range of professional skillsets, with each team member spending most of their time on activities that add greatest value, ensures that patients receive appropriate care without unnecessary delays. Pacesetter projects indicate that Cluster MDTs cope better with the practice workload and report higher morale and motivation within the workforce. Through developing and promoting new roles within primary care (pharmacy, paramedics, social workers etc.) it will help reduce demand. Clusters need to consider how best to educate both professionals and the public of the importance of these roles so that the first point of call is not necessarily the GP.

Clinical Triage

14. In some Clusters, a clinical triage system directs patients to the most appropriate professional within the Cluster team at the point of contact, greatly reducing the day-to-day workload of GPs and improving access to the right care. High quality clinical triage promotes patient safety through facilitating early assessment and assisting speedier identification of sick people and opportunities for early intervention. The further introduction of national standards and guidance for the NHS would promote safe and effective systems for clinical triage.

Primary Care Out-of-Hours (OOH) Services

15. Newly redesigned OOH services offer multi-professional assessment and seamless patient care across the in-hours / out-of-hours interface in some Clusters. This is particularly important for complex patients, the elderly and those receiving palliative care, to ensure an understanding of individual needs and continuity of care.

Infrastructure for Clusters

16. A strong governance framework, with clear accountabilities and indemnity, is an essential foundation for new Cluster models. Pacesetter teams report the importance of robust, user-friendly primary care IMT systems to support redesign, communication, joint-working, bench-marking and automated data capture on a Cluster basis. HR processes and financial systems must be aligned to change with pace. Increasingly, the design of estates needs to support MDTs working on a Cluster basis.

Access to Mental Health Services

17. Providing timely and person-centred mental health services is becoming a strong theme in emergent Cluster plans around Wales. The second year of Cluster plans show evidence of Clusters commissioning MIND, and other providers, for in practice mental health clinics.

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

18. There is a strong desire from our members for Clusters to have multi-disciplinary workforce model and future collaboration between practices depending on local need and geography because one size does not fit all. Examples of workforce redesign and the redistribution of work and roles can have are already being seen across the Clusters. There have been opportunities to change the skill mix across the whole care spectrum both to address the core General Medical Services work as well as addressing some of the demand factors, such as complexity, increasing number of frail older people, and the need to address the widening health inequalities gap.

19. The national investment into Clusters and the pathfinder/pace setter and Primary Care Integrated Medium Term Plan (IMTP) and Workforce Funding from Welsh Government has been essential in supporting plans to diversify the workforce and develop more sustainable models of care within Cluster networks.

Team working

20. Across Wales Health Boards are redesigning the workforce, working with primary care, social care and third sector providers, to ensure that they have the right level of staff with the appropriate skills to deliver services in the most appropriate setting. The Cluster workforce is being developed to support prudent healthcare principles, service developments and overcome recruitment difficulties for certain staff groups. Ownership of new Cluster roles by the existing primary care team is essential to success. Teams that use assessment of local health needs and patient demand to recruit professionals with the appropriate skills realise the greatest benefits.

Extended roles

21. The Pacesetter projects extended roles for paramedics, nurse practitioners, pharmacists, physiotherapists, technicians, occupational therapists, mental health counsellors and Local Authority professionals within a Cluster setting. Evaluation of these new roles and services includes their impact on patient satisfaction, reduction in face-to-face GP consultations and avoidance of hospital admissions. There is evidence from other research of the benefits of Cluster roles for physician's associates, healthcare support workers, dietitians, optometrist, speech and language therapists, behaviour change consultants and dental hygienists.

22. As the Policy Forum "Our Community": Ten actions to support primary care in Wales" briefing highlights, there are a range of professionals working within primary care who play a significant role in supporting patients within the primary and community care setting. Specific roles include:
    - Clinical pharmacists; contributing to clinical work relating to medicines in GP practices, supporting safe and effective medicines use. The Cluster pharmacist can work in a specialist clinical area or a more generic role, addressing a range of medication issues. Experienced pharmacists identify high-risk patients from a medication perspective and support patients to manage their own health, offering alternatives to medication through advice and social prescribing.
    - Greater understanding by the Cluster team of the in-house occupational therapist role assists in identifying people who would benefit from these services, with potential to link directly with social services and third sector services.
    - Extended scope physiotherapists are leading successful MSK services within Cluster teams. This is leading to the reduction in GP consultations for musculoskeletal conditions.
    - Advanced nurse practitioners assist with more complex patients and can undertake clinical triage within Clusters. Practices indicate the importance of aligning new nursing roles with existing services to ensure good planning and co-ordination.
    - Counsellors are ensuring an increase in access to mental health and emotional well-being services. Mental health counsellors manage a range of mental health problems in patients who return frequently and offer brief intervention techniques when appropriate.
    - The GP with Special Interest (GPwSI) brings specific clinical expertise and is well placed to be a 'Cluster champion' in a specialist area, offering support and clinical advice to colleagues and forging closer links with acute clinical teams. GPwSI posts are proving successful in attracting GPs into an area.
    - Advanced practice paramedics are trained in a wide range of clinical assessment and decision-making skills, treating patients close to home and reducing unnecessary hospital visits.

- Integration with local authority and voluntary sector staff on a Cluster basis can reduce A&E attendance and hospital stays. Regular MDT meetings support individuals to live independently at home, steering many away from residential or nursing home care.
- Chronic conditions nurses for housebound patients in order to provide a person-centred, holistic approach to the management and education of patients with chronic morbidities.
- Joint rotas, shared learning opportunities and co-location of Cluster staff with other agencies, e.g. Welsh Ambulance Service Trust and Local Authority, improves integration.

23. While there are significant developments engaging with a wide range of health and social care professionals within the Cluster model, it can be challenging for Health Boards. There is a need for a change in culture to break down the old silo way of thinking. In addition, every professional group is extremely busy with demanding case-loads, long waiting lists and lots to do. Professional's interest depends upon finding solutions to their problems so only a minority of people will actively engage in strategic planning and visions of future models of care. We would recommend that each Cluster needs to identify problems from discussion with the professionals, develop solutions through small management teams composed of senior staff who have the authority to make changes and then work with local professionals.

The current and future workforce challenges

24. The enhanced Cluster team offers flexibility and responsiveness to changing conditions and demand, promoting sustainability, resilience and improved economies of scale. However the fragility of many practices across Wales has a range of causes, including increased volume/ complexity of workload, and difficulties in recruitment. The rapidly shrinking GP workforce is one of the most challenging aspects of primary care, with increased workforce pressures, unstable practices and risks to the quality of patient care. There is a need to increase capacity in the system, with new workforce roles and alternative models that do not simply move existing resources around the healthcare system.

25. There are a number of workforce challenges that continue. Many Health Board are experiencing sustainability issues in both primary and community services. While there continues to be challenges around GP recruitment, these challenges are not unique to Wales. The Cabinet Secretary's Taskforce on Workforce has brought a welcome focus to workforce activities with a strong initial focus on GP recruitment and retention in the form of a national recruitment campaign supported by local Health Board activities (this focus is now moving out across the primary care professions). We hope that the national and international campaign launched by the Welsh Government in October 2016, making it clear that Wales is an attractive place for doctors, including GPs, to train, work and live, will have an impact. The changing demographics of the GP workforce and poor condition of some of the primary care estate has also affected the ability of practices to provide sustainable services. The development of more forensic workforce planning in primary care will support better IMTP representation of the recruitment challenge and necessary activities to address it.

26. Sustainable primary care services rely on stable and sustainable general practice and therefore there has been the need for short-term work to help stabilise practices to deliver on high workload and workforce pressures. This has included:
    - Opportunities for career development through portfolio careers for GPs to support future recruitment and retention.
    - Development of more innovative recruitment campaigns, including social media, recruitment videos and website http://www.wales.nhs.uk/sitesplus/863/page/87351

- Contribution of primary care nursing considered at Cluster level, providing opportunities to develop new skills.
- Cluster specific solutions e.g. GP fellowship scheme to encourage recently-qualified GPs to practice in areas that has been difficult to recruit, Cluster Salaried GPs and the establishment of a Practice Support Team and alternative portfolios for GPs.
- Joint work with the Wales Deanery to improve recruitment and retention of dentists within South Wales through the Postgraduate Dental Training Unit [PGDTU]. In September 2014 the training programme was changed to include greater variety in the training placements, ranging through primary, community, secondary and tertiary care aiming to broaden skills, and encourage local workforce retention. September 2016 saw a further change with a tightening in UK-wide requirements that Satisfactory Completion of Training be demonstrated with students exposed to the full range of dentistry that could be expected in practice. As a consequence the service profile of the PGDTU has been remodelled to include its operation as a 'normal' general dental practice, and to become part of the rota of dentists providing urgent dental care in-hours.

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

27. The Funding allocation to GP Clusters is very welcome and some innovative projects are being rolled out as a result. Overall our members believe the direct funding of Clusters (with £6m of central funding) has delivered real progress. Whilst year one of the funding was generally focused on set up arrangements for various activities and some one off spends for equipment, year two has seen the development of service related activities with SLAs for social worker support or mental health clinic provision.

28. While overall the funding allocated has been welcomed, the sums are relatively small and the financial rules and regulations limit Cluster's ability to use them most effectively. The inability to "roll over" money into the next financial year means money has to be spent before end of year, which can lead to short term spending decisions and lower value for money than could be achieved with longer timeframes. If we want to re-design a service, recruit, train and make real change, flexibility and sufficient lead time is required.

Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities

29. The MDT approach to Cluster working, with a workforce based on population health needs, offers opportunities to focus on prevention and early intervention. In planning for future services, it will be essential to factor in services that support self-care, social prescribing and the promotion of health and well-being outside the traditional medical model.

30. The research conducted on the PRISM model should be further considered for its potential to support anticipatory care models; and the work already conducted through the Inverse Care Law Healthchecks (between Aneurin Bevan UHB and Cwm Taf UHB), which is now rolling out nationally should be evaluated for its impact on outcomes following earlier intervention. In the future list analysis and segmentation of the list to better manage risk in the population should be considered.

31. Public engagement is also vital in relation to improving population health outcomes and ensuring people access the right treatment and professional advice when they need it. The Choose Well

campaign is one important addition which gives people more information and helps them make the right decision on which services they choose based on their symptoms.

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

32. Cluster networks do bring about greater liaison/interaction between various professional groups within the network which improves collaborative working. Cluster working and its funding has resulted in the trial of various initiatives to reduce demand on GPs which would not have otherwise been possible. This is a new way of working that would have been inconceivable prior to Cluster working/funding. The mature Cluster provides holistic care for the community, moving from a collection of GP-based services into fully functioning organisations that draw in the full range of agencies to support co-ordinated care for the entire population. Referrals are made only when necessary and people return to care of the primary care team as soon as possible.

33. The Pacesetter projects demonstrate:

- Integrated care can only be achieved through significant investment in IMT systems to ensure secure communications between professionals and agencies.
- Building flexibility and patient choice into new service delivery models helps to secure the trust and co-operation of patients and professionals in whole system redesign.
- A review of clinical pathways for ambulatory care sensitive conditions and other common conditions helps to inform planners where professionals should be located to deliver effective patient-centred care outside the hospital setting.

34. Each Cluster has now finalised its third Cluster network plan, informed by Cluster health needs profiles. Annual reports and risk registers have been published on progress in year two and will shortly be completed for the third year. Progress on moving forward with Cluster network priorities has been good across Wales and this has included:
    - Diversification of the workforce;
    - Supporting public health priorities, self-care and choose well programmes;
    - Piloting new models of collaborative working;
    - Investing in modern technology and equipment to support improved patient care;
    - Peer review and support for improved patient pathways;
    - Considerably strengthening relationships with the third sector and access to an increased range of services.

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

36. Some of the barriers to progress that have been identified, and are being considered, include;
    - Pressures on core primary care services: recruitment, staff retention; solutions and suggestions being developed with primary care leads;
    - Ability to recruit to posts – availability of pharmacy technicians, medicines management professionals, advanced nurse practitioners, to recruit into networks with the investment that has been released;
    - Investment in challenging financial climate;
    - Capacity/ time constraints linked to pressures; and
    - Cross border issues for patients straddling network boundaries.

Local and national leadership supporting the development of the Cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, Setting the Direction [Opens in a new browser window]

37. Health Boards recognises that good quality leadership and management of staff/contractors is critical to improving retention rates. Health Boards are therefore providing a wide range of development programmes to support and develop leaders and managers at all levels, both inside and outside of the Health Boards, to improve their skills and improve staff experience. The Pacesetter programme highlights the importance of clinical and managerial leadership in successful innovation and service redesign within Clusters.

38. In overall terms the Directors of Primary Community have prioritised Cluster development very strongly. Early work on models for understanding Cluster maturity and matching supporting resources has given way to a deliberate programme of Cluster support activities being delivered through the Primary Care Hub in Public Health Wales. There are now several programmes providing leadership development in support of Cluster working being accessed regularly by Cluster leads across Wales.

39. Clinical leaders are essential to educate, advise, support and lead innovation. Cluster Champions promote new services and cascade key skills amongst the primary care team. Educational sessions to demonstrate improved clinical outcomes help to engage and assure professionals.

40. Following the Cluster Lead Survey conducted in 2015, the Confident Primary Care Leaders Course has been commissioned by Public Health Wales, It is aimed at Cluster leads and aspiring Cluster leads across NHS Wales. Sessions are led by qualified coaches and expert facilitators and include: Population Health and Maximising Patient Experience; Business Planning and Finance; Building a Culture; Influencing, Negotiating and Chairing Skills; Understanding Leadership Styles. The programme commenced in September 2016, with a second cohort commencing in November, the Programmes run on a monthly basis.

41. The Cluster networks have a protected learning time programme that allows practices within a Cluster network to regularly meet and consider service pathways and related issues. Topics that have featured in the programme recently include equality, diversity and human rights, cardiology service updates, gastroenterology, dermatology, child protection, national exercise referral programme, diabetes, respiratory, diagnosis of lung cancer domestic abuse and support services. The Health Boards supports this by providing cover for the practices that take part on the protected learning time programme. In addition to the protected learning time scheme some Cluster networks have now decided to meet on a more frequent basis than the GMS contract stipulates in order to progress their action plan priorities on an accelerated basis.

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

42. Pacesetter project evaluations are based on success in finding solutions to the three ministerial priorities for primary care – increase in sustainability, improved patient access to services and moving care into the community. Individual projects have been delivered and evaluated by each health board, with co-ordination and support provided through a partnership approach between the Primary Care Hub (Public Health Wales), 1000 Lives Team and health board Directors of Primary Community and Mental Health Services. There has been assessment and dissemination

of the shared learning from the programme and national learning events held. The Pacesetter programme is currently tendering for a research/evaluation partner to evaluate activities undertaken thus far and further activities to follow.

43. In addition, Public Health Wales have been providing support, guidance and oversight of the evaluation of the pathfinders / pacesetters to date. A further external evaluation into the benefits and outcomes of this pacesetter investment across Wales is also due to be commissioned by Welsh Government in the next month or so and will we understand, take 9-12 months to evaluate and produce the final report.

44. Regular monitoring reports are submitted to Welsh Government on a quarterly basis for all of Health Board funded pathfinder/pacesetter projects, the IMTP / workforce delivery agreements and the Cluster level funding grants. To inform Cluster network plans each general medical practice produces a practice development plan which sets out how the practice population has been involved in developing their priorities.

Conclusion

45. As highlighted in our submission there has been significant developments across Wales. The Clusters are supporting greater integration between GP practices and also across professional groups, depending on local need. The funding provided by the Welsh Government for Clusters has helped but future flexible funding would be welcomed. Finally while the main source of primary health care are GPs other professional groups provide a vital role in ensuring patients receive the right care at the right time and in the right place.

Annex

English: http://www.nhsconfed.org/resources/2017/02/our-community-ten-actions-to-support-primary-care-in-wales

Welsh: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwiU-rf6rJfSAhXG0xoKHY-EB9wQFggaMAA&url=http%3A%2F%2Fcdn.basw.co.uk%2Fupload%2Fbasw_91238-1.pdf&usg=AFQjCNErVbEBPuz1wV98-fW8XuwdV6ku8Q

[i] Welsh NHS Confederation Policy Forum, January 2017. "Our Community: Ten actions to support primary care in Wales".

Y Gymdeithas Feddygol Brydeinig
Pumed Llawr
2 Pentir Caspian
Ffordd Caspian
Bae Caerdydd
Caerdydd
CF10 4DQ

British Medical Association
Fifth Floor
2 Caspian Point
Caspian Way
Cardiff Bay
Cardiff
CF10 4DQ

BMA
Cymru Wales

PRIMARY CARE (CLUSTERS)

Inquiry by the National Assembly for Wales Health, Social Care and Sport Committee

Response by BMA Cymru Wales

7 February 2017

INTRODUCTION

1. BMA Cymru Wales is pleased to provide a response to the Health, Social Care and Sport Committee's inquiry on Primary care, and specifically primary care clusters.

2. The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow every year. BMA Cymru Wales represents over 7,500 members in Wales from every branch of the medical profession.

OVERVIEW

3. In our 2014 strategy document 'General Practice – A Prescription for a Healthy Future', we acknowledged the Welsh Government's long standing support of the provision of primary care services in Wales; demonstrated by the commitments of successive ministers to deliver a primary care led NHS and its "long-held ambition to make primary care the engine room of the Welsh NHS"[1]. Other previous commitments have included the development of extended and integrated primary care teams and the siting of these teams within purpose built resource centres. In that document we noted our concern that, despite these intentions, we have not seen change on the ground at the pace or scale of what is required to deal with the unprecedented pressures and challenges currently faced by GPs across Wales.

4. As attested in our October 2016 publication, 'An Urgent Prescription for General Practice in Wales', these challenges largely remain. Whilst there has been a greater recognition of these challenges, and some effort to alleviate them (such as the recent suspension of QoF) we strongly believe that greater and sustained momentum is needed. Our 2016 document explicitly sets out the need for urgent action, and offers solutions, in the areas of: recruitment; suitable workforce models; workload; finance; sustainability; and pertinently to this inquiry, clusters. We welcome the fact that the Committee's inquiry will be focusing on these key areas.

[1] Welsh Government, 2015: 'Our plan for a primary care service for Wales up to March 2018'

5. Across the medical profession it is clear that there is widespread support for the concept of cluster working as a means to determine and meet the health needs of the local populace. Given the pressures on general practice it is widely acknowledged that new ways of working and new models of support are much needed. Clusters, if established and resourced effectively, could deliver this, although overall they are not currently at this stage. A survey conducted by BMA Cymru Wales in 2015, which is due to be repeated in the coming months, revealed very mixed reports across the country with some clusters flourishing but others struggling to develop.

6. Since 2013 - when Health Boards were set ambitious targets to establish local bodies with decision making and financial powers - it is clear that the pace of cluster development has not been uniform across the country and that the new money released by Welsh Government in April 2016 has not yet truly transformed services across Wales. Where there has been some transformative development, some of which is cited below, it is important that there is a renewed effort to embed that change; we do not know how sustainable the changes will be in the future without renewed effort.

7. Reports from Local Medical Committees (LMCs) paint a very mixed picture – many show that there remain barriers to cluster working in terms of spending allocated money; lack of clear direction; Health Boards rather than clusters setting the direction; and a need for clear leadership within clusters and a sharing/show casing of good practice and success.

8. Indeed, in 2016 the Welsh conference of Local Medical Committees passed the following motion:

   Conference demands that Health Boards urgently act to

   i. *Reduce bureaucracy and delay in releasing funding to clusters which currently compromises their ability to utilise earmarked funding and deliver services*
   ii. *Work with GPs to develop an effective process to properly evaluate the evolving platforms for delivering cluster working, such as federations.*
   iii. *Demands appropriate access to independent planning and financial experts to support development of clusters and inter-cluster working*
   iv. *Adhere to the "light touch" approach to cluster network funding as envisaged by the Welsh Government*
   v. *Suggests an independent survey of Welsh General Practitioners on their experience of network cluster groups.*

9. GPC Wales is fully committed to cluster networks. For the last two years we have worked with Welsh Government to embed cluster working in the GP contract - and especially in terms of cluster plans which should be closely aligned to HB integrated medium term plans, therefore (in theory) helping health boards to facilitate the transfer of resources towards primary care.

10. From the reports we have received from members and via LMCs it is apparent that clusters will only deliver if there is a fundamental change in attitude by Health Boards, who must devolve decision making and provide clusters with sufficient support and resources (personnel and financial). We believe that clusters should become true legal entities with clearer governance and financial frameworks, which will then enable those clusters that are flourishing to have the tools they need to develop further and sustain delivery, while allowing others to get fully off the ground.

RESPONSE

11. We will now seek to address the questions posed by the Committee; due to the commonality of the answers to certain questions, we have grouped together our stance on the key issues at hand.

Benefits of clusters

12. As previously stated, GPC Wales strongly supports the principles behind cluster working. General Practice is in a very challenging place presently, with ever increasing demand and workload pressures. Working collaboratively with other professionals across health, social and community care can work to both support the viability of individual practices and to develop and deliver effective and holistic services to local patient populations. The fostering of engagement and collaboration with public health, secondary care, key allied health and social care professionals is absolutely essential for the provision of holistic and relevant care; however currently this is variable.

13. Conversely, the impact of clusters failing to deliver or a failure to foster effective relationships can be very significant – the obvious impact is a lowering of workforce morale and a reluctance to engage further (change fatigue, effort and time with no results); the loss of link between GP clinicians and the communities they serve; destabilisation of primary care provision where new ways of working don't deliver; confusion for patients and communities; and of course a waste of precious resources (real or perceived).

14. Thus far the benefits of cluster working, in terms of transforming primary care for the benefit of the patient and GP across Wales, are not as tangible as we would expect at this stage of their existence, and productivity is hugely variable. Our 2015 survey highlighted as such. It revealed some examples of effectiveness and good practice, including:
    - *Developed a stop smoking shop, improved uptake of flu vaccination and smoking cessation services (ABHB)*
    - *One stop social services point of contact (BCUHB)*
    - *Uniform dementia screening within cluster*
    - *Established local dementia and local dermatology networks, and also enhanced obesity advisory training and service*

    Other respondents to the survey were not so positive. A significant number noted that while cluster working had improved local networking and enhanced peer support, palpable progress on service delivery was difficult to evidence. Some respondents cited the involvement of health board management as serving to dilute the effectiveness of local plans. Members also reported a general sense that clusters in practice needed to obtain health board approval before proceeding with plans; of subsequent difficulties in getting resources released; and of issues with regard to procuring staff or equipment thus hindering the release of resources needed to progress.

15. One of the long term aspirations of Welsh Government strategies such as *Setting the Direction* (2010) and later *Delivering Local Health Care* (2013) has been to develop 'locality working' structures responsive to the specific needs of the populace, informed by public health data and with the autonomy to act on this intelligence. While each cluster does maintain links with Public Health Wales and receives information on public health issues, the interface could be improved. As a result we remain to be convinced this aspiration has become reality, or that it is driving cluster working or priorities.

16. As has been widely reported, in recent years consultation rates and numbers have dramatically increased while the needs of many patients have become much more complex. The recent relaxation of QoF by Welsh Government until March 2017 is an acknowledgement of these pressures and will allow practices greater capacity to deal with them and focus on patient care. In our survey of clusters in 2015, 69.1% of respondents said that cluster work had adversely affected their clinical time. Engaging in cluster work thus has a consequence on direct clinical contact, and any engagement in such work must therefore have a demonstrable benefit to practices in addressing wider pressures.

Funding

17. We welcomed the extra £43m announced by Welsh Government for primary care, £10m of which was handed directly to the 64 primary care clusters. We wrote to all cluster leads in May 2016 urging them to think carefully about how this money could be used to most effectively to transform primary care. In that letter, we outlined a number of suggestions that cluster leads may wish to look at, this included: widening access to community pharmacists, musculoskeletal specialists and other specialists within practice; the establishment of a cluster-wide home visiting service consisting of a multi-disciplinary team; and new ways of triaging patients.

18. Unfortunately, we have become aware of significant delays in the release of these funds by Health Boards. As clusters do not exist as true legal entities many of the staffing solutions described previously require health boards to employ these staff, and the need to follow bureaucratic procurement processes means that monies have not been spent in many areas. Worryingly, we have also had reports of Health Boards using cluster under-spending to prop up services which should be resourced by other monies, outside of the cluster budget. We would expect Health Boards to demonstrate that all posts and services established through cluster funding are new and that cluster funding is only used for the purposes it was intended.

19. Clusters currently lack the facility to 'roll-over' funds into the next financial year and we would suggest that allowing the 'roll-over' of the monies would encourage longer term planning and alleviate some of the problems described in terms of processes. Currently the delays in accessing funds, coupled with the inability to roll-over funds, means that all too often very short term spending decisions are made which do not offer the best value for money. We would argue that, where a project has been approved but there has been unavoidable delay in procurement / recruitment, for instance, then provided that money has been ring-fenced against the appropriate project it should be carried over and made available at the earliest opportunity.

20. Clusters leads should work with all partners to consider how available funds can be best spent on delivering service transformation. We believe that direct access to budgets, with clear financial accountability structures, would ensure this could be done in a timely manner.

21. We strongly believe that there needs to be greater clarity on what cluster resources are being spent on. This forms part of a much wider need for the work and purpose of clusters to be more visible.

Sustainability and workforce

22. Our recent survey of members showed that 82.1% of respondents were worried about the sustainability of their practice. While the increased peer support available from cluster networks is hugely positive, it remains extremely worrying that 74.8% of respondents reported that the health of staff within their practice had been negatively impacted by workload pressures.

23. We believe that as a priority established clusters need to convene teams to consider both practice and cluster sustainability at a strategic level. As part of this there is a need to consider how clusters can work more closely with each other (including the use of "at scale" models) and evaluate whether there is a need to enhance (in some cases, build) relationships with consultant colleagues, social care and those from other professions (e.g. optometrists, pharmacists).

24. The exploration of alternative models, such as practice federations, is necessary to address sustainability challenges. The GPC UK document 'Collaborative GP networks', offers food for thought (rather than detailed guidance) for the establishment of new structures with varying levels of involvement and integration. There is a need for greater working at scale to share costs and resources (e.g. workforce and facilities), which clusters cannot enable due to their lack of status as legal entities. Federations of practices could exist within, or between, cluster networks and could potentially offer greater flexibility in terms of employment options both for GPs and the wider primary care team such as pharmacists, physiotherapists, and advanced paramedics.

Cluster Leadership & maturity

25. As noted previously, there is significant variation in terms of the maturity of clusters and their stage of development. Where clusters have succeeded, it is largely where individuals have shown proactive leadership to develop and operate a successful model. This under-resourced time commitment is additional to other practice and clinical responsibilities and most cluster leads, we understand, are not remunerated for this role despite the level of responsibility and commitment it entails.

26. LMC reports suggest that smaller practices (especially single-handed practices) and those with unfilled vacancies often find it difficult to engage with cluster development. They also report that practice and cluster plans are overly prescriptive, and that there is a need to allow for strategic development and thinking time at both practice and cluster level to enable onward development of this model. We reiterate the call made in our *'Urgent Prescription for general practice in Wales'* for appropriate training and support to be provided to enable clusters to deliver as anticipated. A good working relationship between all parties is essential to this.

27. LMCs have revealed frustration around the timeliness of feedback and with regard to seeing actual movement on projects, leading to a general perception that cluster work will not lead to a return in value. Supporting the provision of timely and relevant information and feedback, as well as a greater degree of wider communication on cluster work (and spend), is essential for ensuring professional engagement

28. A recurrent theme from our members is that there is insufficient space for clusters to act autonomously, and at arms-length from Health Boards. This, coupled with the aforementioned delays in releasing finance, severally hampers the effectiveness of clusters to act upon their own plans and deliver according to local needs. The knock-on effect these experiences is that they deter individuals from prioritising engagement with their cluster – at a time of enormous pressure on healthcare and healthcare professionals there needs to be some visible value and purpose to cluster working.

CONCLUSION

29. GPC Wales has long supported the concept of cluster working; to us it presents an opportunity to alleviating the endemic pressures of workload, recruitment and sustainability for General Practice in tandem with the delivery of relevant, timely and more holistic care through the greater use of multidisciplinary teams and partnerships. In this way, clusters can help all partners work seamlessly to meet the physical and mental health and social care needs of local

populations – and if truly working to potential, can foster a more social model of care with wider stakeholders and agencies in society (for instance, housing, education, transport, leisure environment, carers, and the third and independent sectors). Although being uniformly a long way from occupying this space presently, clusters should clearly regard this as the end goal.

30. The views gathered from our membership across Wales, as outlined throughout this paper, suggests that clusters are not currently fulfilling their potential or developing at an even pace and that some barriers to effective working remain. However it is evident that there has been improvement over the last twelve months with the availability of the new resources.

31. GPC Wales welcomes the commitment made by Welsh Government by investing in, and driving, moves to cluster working. GPC Wales remains committed to playing a full and active role in ensuring that clusters develop effectively and that they deliver sustained change – indeed, some are now showing signs of making a difference to patients and services in their areas. It is now vital that all clusters are enabled to deliver this, and that the delivery is sustainable.

32. In our view, the actions now needed include:

- The effective use of cluster monies must be a priority. Cluster leads must consider how available funding can be best spent on making the working day less pressured, with the goal of transforming service availability and care to patients.
- The necessary governance frameworks must be put in place to enable clusters to act autonomously and at arm's length from Local Health Boards.
- Appropriate training and ongoing support should be put in place across Wales to enable clusters to deliver effectively.
- Enable clusters to have direct access to budgets as a means of avoiding delays to the delivery of new services and to support innovation and empowerment.
- Allow the carry-over of resources if attached to an approved project but not yet delivered through no fault of the cluster.
- Provide an effective means of showcasing and sharing best practice across Wales to further stimulate the development of the clusters.
- Look at a means for developing and supporting additional "at scale" working that supports a sustainable future for general practice in Wales.
- Evaluate cluster initiatives; we consider this essential in order to ensure return on investment, learn lessons and share to best practice.

Royal College of General Practitioners
Coleg Brenhinol Meddygon Teulu

12 April 2017

The role of GP clusters as a means of transforming primary care

RCGP Wales welcomes the opportunity to respond to this inquiry. The Royal College of GPs Wales represents a network of around 2,000 GPs across Wales, aiming to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

Clusters have been in existence since 2013, the aim being to promote collaborative working between health and social care organisations including the third sector.

How can Clusters assist in reducing demand

There is no doubt that clusters are currently improving the lines of communication and encouraging collaborative working between general practices, district nursing, health visiting, social services and the third sector. When these agencies work together, services for the local population can be planned and coordinated to suit local need and there is real potential to ensure that citizens are empowered to make choices regarding the most appropriate service to use, and the community has the resources to provide them. This in turn enables people to access care in a timely manner.

The emerging primary care team

RCGP Wales supports the continued development of multi-professional, multi-disciplinary working to help manage the increasing demands on General Practice. There has already been cluster involvement in developing roles for pharmacists, social workers, physiotherapists, nurse practitioners for example. There is still more need for clarity in relation to how these roles fit into the existing models of care and any new models of care, including the need for competency frameworks, governance and indemnity, to ensure that they can be utilised to their full potential.

The current and future workforce

The current workforce is facing a shortage of GPs and this will impact on cluster working. There has been a decrease in the number of full time equivalent (FTE) GPs, due to changing working patterns with evidence that many doctors are choosing to work less than five days a week to cope with the increased intensity of managing complex chronic conditions. There is also evidence that some areas have rapidly declining numbers of GPs and are struggling to recruit despite the total number of GPs in Wales remaining the same. This is not helped by current workforce modelling which does not identify current full time equivalent numbers. Effective cluster working will not negate the need for more GPs, whatever the model of service delivery.

Funding of Clusters

The monies allocated by Welsh Government to clusters are administered via LHBs which has meant that it is subject to the LHBs' financial governance framework. Clusters have a small budget in health and social care terms and at times the bureaucracy surrounding spending has been seen as restrictive. Feedback following the RCGP, LHB and Welsh Government engagement events held in 2016 highlighted inconsistencies between LHBs in relation to support for cluster leads. The inability to carry over unspent cluster monies when LHB procedures delay the spending process, has specifically been highlighted as limiting innovation, when small sums of money are involved.

Cluster Maturity

It is evident that cluster maturity varies across Wales, with some clusters being well developed and engaging participants across all sectors. It seems that the extent of engagement is dependant on a variety of factors but in many cases it again is related to the stability and sustainability of the member organisation. GPs are expected to attend cluster meetings to fulfil part of the GMS contract and the more mature clusters have enabled members including GPs to 'buy-in' to cluster working.

Local and National leadership

For clusters to continue to work towards improving population health outcomes and target health inequalities, consistent leadership is essential. The RCGP Wales, LHB and Welsh Government engagement events in 2016 have highlighted that his has been variable between LHBs. There needs to be clear lines of communication to ensure that innovation or activity intended to reduce inequalities does not unintentionally create a postcode lottery and any learnings should be shared and rolled out across other clusters if considered appropriate. Due to changing LHB structures and following the publication of the Welsh government's Primary Care plan, there needs to be guidance on how this is implemented. A

move to providing more community based care will need a shift in resource, over and above the current funding for clusters.

In closing, clusters could be an excellent vehicle for innovation and change but they will need more support and investment to achieve the scale envisaged in the Primary Care plan. It is also vital that clusters are more involved in the integration of secondary and primary care services than is currently the case.

Meri Huws
Comisiynydd y Gymraeg
Welsh Language Commissioner

Agenda Item 4.1

Comisiynydd y Gymraeg
Welsh Language Commissioner

Members of the Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA
SeneddHealth@AssemblyWales

17/03/2017

Dear Committee Members

The Public Health Bill

I am writing as you scrutinize the details of the Public Health Bill to ask you to consider proposing amendments to the Bill in order to deliver the improvements required to the provision of pharmaceutical services in Wales.

Part 6 of the Bill relates to pharmaceutical services and includes measures to improve those services by placing requirements on relevant organisations. I have consistently argued that the Bill provides an excellent opportunity to improve the provision of pharmaceutical services through the medium of Welsh. A statutory inquiry into the Welsh language within primary care, 'My Language, My Health', held in 2014, highlighted a clear clinical need for Welsh language primary care services. The inquiry also highlighted the current inconsistencies is the provision of Welsh language primary care services, including pharmaceutical services. In its strategic framework for Welsh language services in health and social care, ‘More Than Just Words’, the Welsh Government committed to improve the provision of Welsh language primary care services. The introduction of new legislation relating to pharmaceutical services is a perfect opportunity to achieve that goal.

Nevertheless, the Bill as it stands makes no specific provision for Welsh language services. In my response to the general principles of the Bill during the Committee’s Stage 1 scrutiny, I drew attention to the need for further consideration of the relevance of the Welsh language to some of the Bill’s provisions. The Committee’s report on the general principles of the Bill referred to this. The Cabinet Secretary responded to the matter by indicating that health boards would be required to consider the need for Welsh language services when assessing pharmaceutical needs, as required under the Bill. I understand that these assessments will measure local need for pharmaceutical services. It is not clear for me why the provision of Welsh language pharmaceutical

Welsh Language Commissioner
Market Chambers
5–7 St Mary Street
Cardiff CF10 1AT

0845 6033 221
post@welshlanguagecommissioner.org
Correspondence welcomed in Welsh and English

0845 6033 221
post@comisiynyddygymraeg.org
Croesewir gohebiaeth yn y Gymraeg a’r Saesneg

comisiynyddygymraeg.org

welshlanguagecommissioner.org

Comisiynydd y Gymraeg
Welsh Language Commissioner

services should be dependent on the results of an assessments of local need. Other kinds of Welsh language services do not depend on proof of local demand, for example, local authorities must provide services in accordance with the Welsh Language Standards.

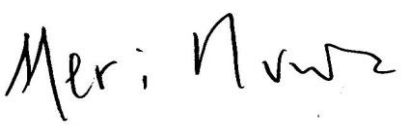
I believe that it is reasonable to expect every pharmacy in Wales to provide certain Welsh-language services, for example, bilingual signs. Over recent years, work has been done to enable pharmacists to produce bilingual labels and warnings related to drugs. The Bill provides an opportunity to ensure that pharmacies in Wales offer such basic services bilingually. I do not see why assessments of pharmaceutical needs are required in order to ensure that such services are available in Welsh as well as English. This could be achieved by placing relevant requirements on all pharmacists to provide some basic services bilingually on the face of the Bill.

The Welsh Government is currently considering how to increase the use of Welsh in the primary care sector as part of its discussions on the Standards and their application to the health and social care sector, in accordance with the provisions of the Welsh Language (Wales) Measure 2011. It is not yet clear to what extent the requirement to provide services in Welsh will be placed on pharmacists nor what kind of requirements will be placed on them. Given that, we should not miss the golden opportunity provided by the Public Health Bill to make some improvements to the provision of Welsh language pharmaceutical services, by ensuring that basic services, such as those referred to above, are available in Welsh in every pharmacy in Wales.

I trust that you, as members of the committee and party spokespeople on health and social care, agree that the opportunity provided by the Bill to ensure greater consistency in the provision of Welsh language pharmaceutical services in Wales, in line with objectives of ‘More than Words’, should not be missed.
I ask you to consider introducing relevant amendments to the Bill, in accordance with your powers to do so, in order to ensure better services for Welsh speakers in Wales.

A copy of this letter has been sent to the Culture, Welsh Language and Communications Committee.

Yours faithfully,



Meri Huws
Welsh Language Commissioner

Cc: Members of the National Assembly of Wales’s Culture, Welsh Language and

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Cyfansoddiadol a Deddfwriaethol
National Assembly for Wales
Constitutional and Legislative Affairs Committee

Rebecca Evans AM
Minister for Social Services and Public Health

29 March 2017

Dear Rebecca

Public Health (Wales) Bill

Thank you for your **letter of 10 March 2017** outlining your response to our recommendation in our **Report on the Public Health (Wales) Bill**.

You reject our recommendation that the Bill should be amended to ensure enforcement authorities are fully aware of their human rights obligations because:

> "Local authorities are already bound by and are very familiar with their obligations under section 6 of the Human Rights Act 1998. They are therefore well versed in the duties placed upon them. In view of this I believe it would be unnecessary and inappropriate to add specific provision on the face of the Bill, and could unintentionally lead to confusion if such a provision was included in this Bill and not in other legislation."

However, human rights issues facing public bodies have been highlighted on a number of occasions recently.

First, a report by the Human Rights Commission ***"Is Wales Fairer: The state of equality and human rights 2015"*** identified seven key challenges facing Wales as "major, entrenched inequalities and human rights abuses that will require substantial efforts of public, private and third-sector organisations and of individuals to reduce them".

Cynulliad Cenedlaethol Cymru
Bae Caerdydd, Caerdydd, CF99 1NA
SeneddMCD@cynulliad.cymru
www.cynulliad.cymru/SeneddMCD
0300 200 6565

National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA
SeneddCLA@assembly.wales
www.assembly.wales/SeneddCLA
0300 200 6565

Secondly, a **report based on the human rights roundtable discussion** held in partnership by the Equality and Human Rights Commission, Children's Commissioner for Wales and the Older People's Commissioner for Wales in July 2015 stated that:

> "There are opportunities for the human rights agenda in Wales to be developed further at both Welsh Government and public authority level, as well as in grass-roots projects developed by third sector and community organisations.
>
> Perpetuating a purely rosy narrative on human rights in Wales is unhelpful and is often a block to positive and evidence-based change. Therefore, authenticity is important in discussions on the state of human rights in Wales. Even if good policies are in place, implementation is central to ensuring people's human rights and promoted and protected."

Finally, in its judgment in the **Christian Institute and others (Appellants) v The Lord Advocate (Respondent) (Scotland) [2016] UKSC 51**, the Supreme Court gave a clear warning about the dangers of legislation simply relying on a public authority being aware of its human rights obligations. In paragraph 101 of its judgment, the Supreme Court said that guidance was needed in order to reduce the risk of disproportionate interferences that breach human rights.

While the issues raised in both the above reports and the Supreme Court judgment include human rights abuses in non-devolved areas, they are also completely relevant to human rights abuses in devolved areas. We believe that the principles and safeguards noted in both the above reports and the Supreme Court judgment can, and should, be applied generally to all human rights interferences, and particularly to the exercise of powers of entry.

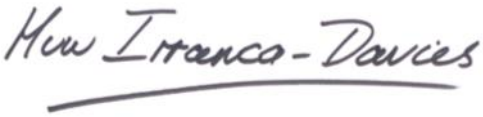
We are not persuaded by your argument that amending the Bill as we suggest would lead to confusion because it is not included in other legislation. This is an opportunity for the Welsh Government to take the lead in placing even greater emphasis on human rights obligations.

In light of the above, I would be grateful if you would reconsider our recommendation and table an appropriate amendment to the Bill.

We look forward to hearing from you in due course.

I am copying this letter to the Chair of the Health, Social Care and Sport Committee.

Yours sincerely



Huw Irranca-Davies
Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.
We welcome correspondence in Welsh or English.

Rebecca Evans AC/AM
Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol
Minister for Social Services and Public Health

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-L/RE/0144/17

Huw Irranca-Davies AM
Chair of the Constitutional and Legislative Affairs Committee
National Assembly for Wales
Ty Hywel,
Cardiff Bay
Cardiff
CF99 1NA

18 April 2017

Dear Huw,

Public Health (Wales) Bill

Thank you for your letter dated 29 March.

I recognise the intention behind the Committee's recommendation and am in full agreement that compliance with human rights obligations is of the utmost importance. However, my view remains that a specific amendment to refer in general terms to compliance with Convention rights on the face of the Bill would be unnecessary and inappropriate, given the existing overarching statutory duty that a public authority is under in respect of human rights obligations, and the specific restraints in the Bill directed at the exercise of enforcement functions. I am mindful of the need to use legislation to impose specific obligations or otherwise change the law; and not to make superfluous provisions, which have the potential to cast doubt on the overall coherence of the law, and on the operation of specific restraints on the use of the powers.

Specifically, a series of safeguards have already been included on the face of the Bill in relation to how powers of entry and inspection are to be exercised by authorised officers. These provide additional protection for homeowners and ensure that powers of entry are exercised in an appropriate and proportionate manner. By way of example, amendments were agreed at Stage 2 proceedings on 23 March which provide that if the occupier of premises is present when a warrant is being executed, the authorised officer will need to provide their name, documentary evidence that they are an authorised officer, and supply the occupier with a copy of the warrant.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Correspondence.Rebecca.Evans@gov.wales
Gohebiaeth.Rebecca.Evans@llyw.cymru

It is my view that the insertion of specific, practical safeguards such as this is a more focused and sustainable method of protecting individual rights than a more general reference to human rights obligations which would replicate the existing duty of enforcement authorities to act compatibly with Convention rights under section 6 of the Human Rights Act 1998 ("the HRA duty") in the performance of their functions.

In addition, I brought forward amendments at Stage 2 in direct response to the Committee's earlier recommendation that it should explicitly state on the face of the Bill that public bodies will be the enforcement authorities for Part 2 of the Bill. These amendments go a step further than the Committee's original recommendation by explicitly naming the enforcement authorities – namely local authorities for all premises and vehicles, and involvement of the police in relation to vehicles as they have the power to stop private vehicles. These amendments ensure that only organisations who are already bound by and well versed in the HRA duty will be the enforcement authorities.

There is already well-established general guidance in place under the *Code of practice for the exercise by police of statutory powers of entry, search and seizure (PACE Code B),* which applies both to the police and to local authority officers investigating offences, and places clear emphasis on acting in accordance with the Human Rights Act 1998. I am also content to confirm that when preparing specific guidance on enforcement powers under Part 2 of the Bill, we will take the opportunity to remind enforcement authorities of the need for them to act in accordance with their existing obligations under human rights legislation, and for them to provide appropriate training to enforcement officers.

I am copying this response to Dr Dai Lloyd AM, Chair of the Health, Social Care and Sport Committee.

Rebecca

Rebecca Evans AC / AM
Y Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol
Minister for Social Services and Public Health

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA - P/VG/0496/17

Dr Dai Lloyd
Chair
Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

19 April 2017

Dear Dai,

Further to my letter to all AMs on 2 March informing them of the decision by the Chief Statistician for Wales that monthly NHS activity statistics will be published on a single day, I can now confirm the first set of data will be published on 20 April at 9.30am. It will be on the penultimate Thursday of most months thereafter.

The Chief Statistician outlined in his blog 'Improving the coherence of monthly NHS statistics' that moving to publish the monthly NHS activity releases on one day will provide a more rounded and integrated picture of activity and performance and give a more coherent view of the NHS in Wales.

I would welcome feedback from the Committee on the new statistics once published. They will be available at: http://gov.wales/statistics-and-research/nhs-activity-performance-summary/

If members feel it would be useful to have a briefing from statisticians on this, we would be happy to facilitate. If you would like to arrange, please contact John Morris, head of health, social services and population statistics, at: morris.john@wales.gsi.gov.uk / 0300 0251401.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

Rebecca Evans AC/AM
Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol
Minister for Social Services and Public Health

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA(P)/RE/0463/17

Assembly Members
National Assembly for Wales

18 April 2017

Dear Assembly Member,

At the stage 2 consideration of the Public Health (Wales) Bill by the Health, Social Care and Sport Committee I committed to provide Assembly Members with further detail of the nutritional standards already in place in hospitals and schools, and plans with regard to nutritional standards.

Directions and guidance are already in place in hospitals for patients, staff and visitors in relation to healthy eating. These include mandatory food and fluid nutrition standards for patients, mandatory healthy food and drink vending standards, and guidance for food and drink served to staff and visitors. Work is continuing with stakeholders to further improve food and drink provision, including:

- Welsh Government officials are reviewing the recommendations made by the Public Accounts Committee following the publication of their report into hospital catering and patient nutrition in March 2017 and will be taking appropriate action;

- A dedicated NHS Wales Informatics Service resource is being introduced. Standardised “Once for Wales” documentation will support and improve the quality and safety of patient care through improved recording of nutrition assessments and care plans. The development is expected to take three years, and the design will incorporate clinical decision support to improve patient safety and early identification of risk for patients.

In schools, the Welsh Government introduced legislation to improve food and drink provided across the whole school day. The Healthy Eating in Schools (Nutritional Standards and Requirements) (Wales) Regulations 2013 set out the types of food and drink that may be provided; and define the nutrient content of school lunches.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Correspondence.Rebecca.Evans@gov.wales
Gohebiaeth.Rebecca.Evans@llyw.cymru

Standards are also being developed for care homes for older people and early years settings. Legislation is not required to do this.

For older people's care homes, nutritional standards and guidance will be included as part of the new regulation and inspection arrangements to be introduced from April 2019 as part of the Regulation and Inspection of Social Care (Wales) Act 2016.

For early years settings, more detailed food criteria will be developed to underpin Standard 12 of the National Minimum Standard for Regulated Child Care 2012 for food and drink in early years settings.

To support compliance, inspection and buy in from the sector and inspectorate, support materials and training will also be developed. Early discussions with the relevant inspectorates have been positive and a dietitian is working with Welsh Government officials to develop the standards.

My officials are now considering options to support implementation and compliance of the new standards.

Rebecca

Rebecca Evans AC/AM
Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol
Minister for Social Services and Public Health

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Agenda Item 8

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