Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 4 – Tŷ Hywel
Meeting date: Wednesday, 7 June 2017
Members pre-meeting: 09.00 – 09.15
Meeting time: 09.15

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Informal pre-meeting (09.00 – 09.15)

1 Introductions, apologies, substitutions and declarations of interest

2 Inquiry into primary care – evidence session 10 – Cabinet Secretary for Health, Well-being and Sport

(09.15 – 10.45) (Pages 1 – 56)

Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport
Grant Duncan, Deputy Director, Primary Care, Welsh Government
Dr Richard Lewis, National Clinical Lead for Primary Care, Welsh Government

3 Paper(s) to note

Inquiry into primary care – additional information from Pen Y Bont Health

(Pages 57 – 58)

Inquiry into primary care – additional information from the Royal College of Nursing Wales

(Pages 59 – 61)

Inquiry into primary care - additional information from Powys Teaching Health Board regarding Cluster Development Monies

(Pages 62 - 63)

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

5 Inquiry into primary care - consideration of the evidence and discussion of the key issues arising from scrutiny

(10.45 - 11.30)

6 Inquiry into medical recruitment - consideration of draft report (2)

(11.30 - 12.00) (Pages 64 - 125)

Agenda Item 2

Document is Restricted

Written evidence from the Cabinet Secretary for Health, Wellbeing and Sport to the Health, Social Care and Sport Committee's inquiry into primary care

The Welsh Government's vision is a social model of health and wellbeing where people have equity of access to the majority of the services they need as close to home as possible. This is set out in *Our Plan for a Primary Care Service for Wales (2014*), backed by a £43 million national primary care fund.

Based on the evidence in Public Health Wales' rapid review of literature *Primary Care in Wales – the future (April 2014),* that planning is most effective when done at a very local level of between 25,000 and 100,000 people. The principles underpinning change and improvement are:

- Collaboration between service planners and providers;
- Prevention, early intervention and improving health and wellbeing - not just treatment;
- Co-ordinated care, where generalists work closely with specialists;
- Active involvement of the public, patients and carers in decisions about care and wellbeing; and,
- Prudent healthcare.

The main catalyst for change at this very local planning level has initially been through the development of clusters of GP practices. Through the national primary care plan, cluster working is now progressing beyond a collection of GP practices into fully functioning arrangements. Primary care clusters increasingly involve the full range of agencies, professionals, services and community resources collaborating to improve health and wellbeing outcomes for their community.

This multi professional, multi sector approach, with the GP at its heart, is flexible and responsive to people's individual needs. It enables primary care to manage changing conditions and rising demands as the population of Wales increases and ages.

The 2016 OECD review of UK health systems was very positive about the Welsh Government's policy on collaboration at cluster level to plan and deliver care and its potential to drive real and sustainable change and improvement.

This written evidence is structured around the eight lines of inquiry set by the Committee, clustering the questions where this makes sense. It reflects both the challenges being addressed and the progress being made.

Line of inquiry 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).

and

Line of inquiry 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 national primary care plan gives strategic direction to the design and delivery of sustainable and effective services to match local needs and circumstances.

In response to increasing demand in what has been traditionally a largely medical model of general care from the GP, a variety of organisational forms for delivering sustainable and accessible care are evolving out of cluster working across Wales. These models have differences in their infrastructure, benefits, and levels of integration, staff employment, contractual arrangements, and economies of scale, financial control, flexibilities and internal support mechanisms responsive to local circumstances.

Models include “super” GP practices, co-operatives, corporate partnerships, social enterprises, limited companies and federations. Examples include the federation of GP practices in Bridgend and the Red Kite social enterprise in the South Powys cluster, both of which form part of the national programme of pathfinders and pacesetters projects.

The learning emerging from this national programme of pathfinders and pacesetters is providing evidence of the potential for collaboration through cluster working to manage the increasing demand on GP services through the development of prudent, multi professional teams. This is either through the more formal models emerging or simply by promoting more collaborative working. Increasingly, cluster working is able to facilitate work between groups of GP practices and services, deploying and utilising staff and resources in more efficient arrangements with greater consistency of service provision.

For example, pharmacists, physiotherapists and social workers are increasingly being appointed to provide support across the cluster population, working alongside individual GP practice teams. There are examples where pharmacists and physiotherapists are training to become prescribers.

This extended general primary care team model is resulting in better access ensuring people are directed to the right professional within the team without unnecessary delays. It also releases GP capacity to improve access for those who do need to see a GP including those people with more complex needs. Aneurin Bevan University Health Board has reported in a three month period, pharmacists replaced 1842 hours of GP time.

There is growing evidence of the positive impact of continuity of care, which studies show is important to people, in avoiding unnecessary demand on unscheduled care. Recent reports from the Health Foundation and the British Medical Journal point to evidence that continuity of care with the same general practitioner for those people with complex co-morbidities and heavy

users of primary care services reduces hospital admissions for that group. With the emergence of multi professional team approaches to care it will be important to ensure at general practice level that the essentials of achieving good continuity of care, such as sharing information and excellent team communication, are in place to avoid undermining opportunities to sustain continuity. It will be important to monitor the growing evidence base and consider opportunities at cluster level when planning services.

The success of the virtual ward model in Powys at avoiding unnecessary admissions to hospitals is well known. There are many other examples of similar models across Wales. In Cardiff and Vale University Health Board, a number of clusters have created nursing posts to help support the most frail, elderly and vulnerable people across the cluster population. This streamlined and coordinated delivery of care at cluster level benefits from the economies of scale brought about from working across a cluster population rather than at individual GP practice population.

Other examples are where cluster pharmacists and frailty nurses go in to care homes to review the care of residents with the aim of optimising medicines management, preventing avoidable clinical events and reducing unnecessary hospital referral and admission. The South Pembrokeshire cluster has invested in a cluster pharmacist to undertake a review of care home patients for each surgery. Reported in March 2017, this has resulted in cost savings of £6,800 in stopped medications. The new directed enhanced service for care home residents, negotiated with GPC Wales as part of the 2017-18 national general medical services contract, will further develop coordinated multi professional anticipatory care.

The national programme of pathfinders and pacesetters is demonstrating the value of clinical telephone triage systems that have the potential to improve access and manage demand on GPs by directing people to the appropriate professional within the multi professional team. This frees up GP time.

A range of triage and call-handling models is emerging to suit different clusters and patient populations. Perhaps the most well-known one is the one covering the GP practices in the Neath Cluster. Allowing different models to evolve, whilst ensuring standardised outcomes and governance frameworks, appears to be effective and there is potential for remote triage systems to be delivered by GPs working from home.

Cluster level planning is well placed to identify and implement action to direct people away from GPs to the services they can access directly for themselves, such as the common ailments service from community pharmacists. Latest reports (April 2017) on the common ailments scheme, currently being rolled out across Wales, show that 85% of patients accessing the common ailment service reported they would have attended their GP or Out of Hours service had the service not been available from their community pharmacy. Dentists and optometrists can see and treat problems which people still go to the GP for. In North East Flintshire and Cwmtawe Clusters, audiologists are now seeing people without the need to be seen first by a GP.

Each cluster, as it matures, has the potential to enable and support co-ordinated care across the whole health and care system. The cluster can work with hospital based colleagues to develop new care pathways and better use of technology, making referrals only when necessary and returning people to the care of the primary care team as soon as possible. Multi professional teams and new professional roles can contribute significantly not only to the sustainability of primary care, and also impact on the unprecedented demand and pressures on unscheduled and scheduled care services in the acute setting.

The South West Cardiff Cluster has challenged the traditional paediatric outpatient model and developed a new one. GPs can now communicate via email with consultant paediatricians for advice with the consultant paediatrician delivering a clinic within a GP practice in the cluster. Care plans are developed jointly between the paediatrician, the GP and the wider primary care team, supported by team meetings after each clinic.

In terms of improving access for people with mental health needs, cluster level working offers an excellent way for health boards, local authorities and the third sector to come together to plan the local primary mental health support services required under part 1 of the Mental Health Measure which sit alongside GP services.

There is increasing awareness of the benefits of the wide range of non-clinical 'wellbeing services', particularly for people who need support for their mental wellbeing. There are examples of clusters introducing social prescribing mechanisms so people are more systematically accessing these services.

In Cwm Taf, there is a scheme whereby GPs are able to refer people with low level mental health needs to Valley Steps, a third sector provider of mindfulness techniques and training in managing stress. This scheme is evaluating its impact on the level of anti-depressant prescribing.

Clusters in Cardiff and Vale, Cwm Taf and Powys have been working with MIND to develop local services. The South East Cardiff cluster has been working with Cardiff MIND to support patients with low level mental health conditions and reported at the end of March this year that 192 people had accessed MIND support since mid-December 2016.

Some clusters are investing in posts to link people systemically to the wide range of non-clinical care and support available locally. Terminology varies; some posts are called community connectors, others are termed link workers. The Torfaen clusters have appointed social prescribing co-ordinators working with GP practices to address wellbeing issues that underlie clinical presentations. This has led to people accessing finance and housing advice improving their mental wellbeing which in turn has reduced demand for GP appointments.

The introduction of the national 111 telephone and website and the local authority information, advice and assistance services, underpinned by a national directory of services will help link people to the range of wellbeing services available locally. The Welsh Government's commitments in *Taking Wales Forward* for a social prescribing pilot for accessing mental health support and a wellbeing bond will all further support more systematic access for people.

Critically, and common to all these examples of change, is the need to involve and work with local communities, families and individuals in a range of different ways. This helps explain the changes and their rationale and to support people to know how and when to access services.

The Welsh Government continually reinforces its expectation to each health board that it adopt a whole system approach to monitoring performance and sustainability. In terms of measuring the impact of change in primary care, information collected routinely on people's outcomes and experiences of primary care is limited. The National Survey measures people's satisfaction on some aspects, including their satisfaction with the service from their GP and making an appointment.

To monitor and benchmark primary care, health boards have collectively agreed and are using a first set of primary care quality and delivery measures. A second more outcome and experience focused set of measures is currently being finalised. The NHS Wales Informatics Service has developed a national portal to collate performance against these measures.

In addition, Wales is now participating in new work being taken forward by the International Consortium of Health Outcomes Measures which should identify how to measure the impact on people of primary care.

For now, the contribution of the primary care service envisaged in the national primary care plan is being largely measured by the impact on the service, such as the number of GP hours saved and number of reduced unplanned hospital admissions. Latest data shows that during 2016 there has been an improving trend in the rate per 100,000 of the population of emergency admissions and emergency readmissions within a year for people with specified chronic conditions such as diabetes and respiratory disease.

Line of inquiry 3
The current and future workforce challenges.

For a sustainable and effective health system, able to respond to people's needs close to home now and in the future, the challenge is to create the skills and workforce mix required for prudent, multi professional integrated teams.

Robust workforce planning is essential in making sure that patients can access appropriate services they need and that organisations match their funding to their priorities. The NHS Wales Planning Framework requires IMTPs to 'include workforce plans that deliver appropriate capability and capacity of multi-skilled primary care teams with the most appropriate professionals delivering care'.

Wales' first Primary Care Workforce Plan (2015) outlines the action at national and local level to develop and invest in the workforce, including GPs, practice and community nurses and therapists, pharmacists, healthcare support workers, paramedics and other clinical staff to provide more care closer to home.

As well as supporting cluster working, the plan includes a number of actions to stabilise core sections of the workforce, including GPs and nurses, by supporting people who want to return to practice or work part-time; exploring how training and working in general practice can be encouraged in areas of greatest need and communicating the opportunities afforded by general practice in Wales.

To monitor the implementation of the national workforce plan and to undertake work best done once for Wales, health boards' directors of primary, community and mental health and directors of workforce and organisational development jointly set up a Primary Care Workforce Group. This group is overseeing training in workforce planning at cluster level, a compendium of new workforce models and roles and action on how health boards' recruitment processes can be improved to support innovation and redesign in primary care.

To deliver the majority of people's care, which is preventative and anticipatory in focus, in local communities, health boards need to attract more professionals to train, work and live in Wales. To lead this, I chair the Ministerial Taskforce on the Primary Care Workforce.

The Welsh Government launched a national marketing campaign in October 2016 to recruit additional doctors, including GPs. Phase two of the campaign, launched on 8 May, is targeting nurses to work in primary care, secondary care and the care home sector. Future phases of the campaign will target pharmacists and allied health professionals.

A major element of the first phase of the campaign was targeting doctors who are about to choose and undertake their specialty training in 2017. As part of the Wales offer that underpinned the campaign, all GP trainees will receive funding towards their final examination fees. Trainees who undertake their training in those areas of Wales that have traditionally found it difficult to recruit will receive a further financial incentive. Trainees who take up a training place in a specified area will be eligible for a payment of up to £20,000.

The campaign and the associated incentives have had some early success particularly regarding those choosing Wales to start their training. The number of GP training places filled at the end of the first round of GP speciality training recruitment currently stands at 84%, which is an increase on the 68% fill rate at this stage last year. It is expected this fill rate will increase further by the end of the process.

To retain the skills and expertise of the existing GP workforce, health boards are increasingly offering more flexible and attractive portfolios and working patterns.

Education and training is fundamental to ensuring the sustainability of the primary care workforce. The Welsh Government is providing £95 million in 2017-18 to support the education of health professionals. This is supporting nurses, physiotherapists, radiographers and a range of health science training opportunities and enabling more than 3000 new students to join those already studying health education programmes across Wales.

£0.5 million is set aside for supporting advanced practice, education and extended skills training in primary care. There will also be a significant increase in education for practice nurse and district nurse education, as well as audiology training places within primary and community settings.

Line of inquiry 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.

The primary care clusters have used their share of the £10 million from the national primary care fund in a range of ways. The £10 million is recurrent and many clusters are investing in additional capacity such as pharmacists, physiotherapist and social workers, as described above.

South Pembrokeshire cluster is investing in new healthy lifestyle adviser roles to make connections between and optimise the time and expertise of health professionals, the third sector, community connectors, healthy lifestyle advocates, and mental health teams, public health teams, schools, local media, national parks and drug and alcohol services. These new advisers have held patient engagement exercises in each of the GP practices to showcase the project.

North Pembrokeshire cluster has invested in nurse facilitators to work with GP practices in identifying people for whom advanced care planning might be most urgent and relevant. These nurses then work with those people to agree care plans. GP practice records show that since the project's inception in March 2017 the number of people with an agreed care plan in place has increased by 219% from 74 to 162.

Neath cluster has invested in more proactive care and support for people at risk of developing type 2 diabetes and has seen the percentage of people supported rising from 22.7% to 64% in the 15 months to March 2016.

Merthyr cluster has invested in embedding the Econsult IT platform on each GP practice website. This offers patients an e mail based consultation. One practice has been using the service for over 11 months and reported in the five months up to March 2016, an estimated average of 22.4 GP appointments were saved per week.

South Wrexham cluster decided to improve the flu vaccination rates for members of the population by investing in additional clinics outside of normal opening hours. The cluster reported at the end of March this year that it had achieved a vaccination rate of 72% for people aged over 65.

The Welsh Government allocated the £10 million to health boards as part of their annual revenue allocations. To promote cluster working and to avoid stifling innovation, the Welsh Government has directed health boards' directors of primary, community and mental health to adopt a 'light touch' in managing this funding and to do all they can to support the drawing up of spending plans at cluster level and their implementation. Where clusters have not been able to spend all their share of the funding in a financial year, the Welsh Government has advised health boards that any underspend must be invested in primary care and to consider re-providing this funding to clusters in the following year.

Cluster working is still relatively new and is evolving across Wales. There have been challenges to work through, such as drawing up and agreeing spending plans early in the year to optimise spending, and the pace of recruitment and procurement processes. There will be further and new challenges. For example, as clusters draw in more local services, there will be more ideas on how to invest and more challenges to the status quo which may prove difficult to work through.

This financial year is year three of the process and should be a smoother year with spending plans in place and people in post from the beginning and clusters increasingly able to see the delivery of results intended from their investment decisions.

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

The Welsh Government's Social Services and Wellbeing (Wales) Act and the Wellbeing of Future Generations (Wales) Act are both clear about the shift to collaborative working to plan and deliver more preventative and co-produced care to help sustain the health and care system now and in the future. This

emphasis on prevention includes securing non-clinical care and support for physical, mental and social well-being. The national contracts for GP services, community pharmacy and dentistry can be tools for leading this shift to prevention.

Prevention itself is a broad concept. A lot of the work already carried out in primary care can be categorised as secondary prevention, defined as activity intended to halt the progression of disease once established by early detection followed by prompt effective treatment. The shift of greater resources into primary care allows for even more targeting of efforts and outreach work that enables more early intervention. For instance, through the national primary care fund, the Welsh Government has invested in pathfinder schemes in Aneurin Bevan and Cwm Taf University Health Boards to reduce inequality in life expectancy of people living in more deprived cluster areas.

These schemes have tested new ways of identifying people at increased risk of cardiovascular disease and to agree action with them to reduce this risk. In March 2017, Aneurin Bevan University Health reported a total of 9,000 people have been assessed across the 4 clusters involved. Cwm Taf University Health Board reported in December 2016 that over 2,000 people have been assessed across the 7 participating GP practices.

The learning from these pathfinders is being shared with the other health boards via a national programme board to inform their service improvements plans.

In Hywel Dda University Health Board, two clusters now run schemes to highlight the benefit of lifestyle changes to people to manage their risk of developing type 2 diabetes.

Both the general medical services and community pharmacy contracts have been used to enable proactive primary care for care home residents to prevent unnecessary admissions to hospital and review the care of people recently discharged from hospital back to their care home. The national diabetes delivery group is developing a directed enhanced service for preventative diabetic care. Primary prevention is concerned with activity to prevent the onset of disease by altering some factor – such as the environment or behaviour – that impact on health outcomes. We know that access to healthcare in itself accounts for as little as 10% of a population's health and wellbeing. This is why a collaborative approach to health, formalised through the Wellbeing of Future Generations (Wales) Act, is key. This recognises investment in quality housing, strengthening the school curriculum in relation to health and wellbeing, provision of good and stable employment, opportunities for active travel amongst others are all contributors to population health outcomes.

Primary care cluster working can support primary prevention, both through provision of services and through appropriate signposting. Health professionals can provide advice to improve health behaviour in relation to smoking, alcohol, diet, exercise, sexual health as well as supporting good

mental health and wellbeing. They can also signpost to specialist services – such as smoking cessation. Many world renowned immunisation programmes are delivered through primary care.

As public health teams and primary prevention services increasingly collaborate with local health professionals who have knowledge about the needs of individuals, families and communities through clusters, service planning and delivery will better match population need and tackle inequalities in health outcomes.

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

The pace and scale at which the clusters are maturing varies between and within health boards. Some clusters remain largely groups of GP practices while others are actively involving other local services, not just those of the NHS but also from local authorities and the third sector. This wider collaboration is enabling innovation and fresh thinking to flourish with examples given throughout this paper.

The national professional lead for primary care, Dr. Richard Lewis has been monitoring the development of clusters. The messages from his 2017 assessment are very encouraging, including increases in the percentage of clusters whose membership now includes other primary care providers, local authorities and the third sector.

The all Wales organisational development programme provided by the Public Health Wales primary care innovation and development hub aims to support each cluster with meeting its development needs. This has included a number of national and regional workshops. Around 40 cluster leads are benefiting from the hub's Confident Leaders programme. This national support is generating local activity such as workshops for clusters in Aneurin Bevan on social prescribing to improve access to wellbeing services.

The hub has commissioned Bangor University to work with stakeholders, such as cluster leads, to develop and evaluate a formal tool to measure the maturity and ongoing support needs of primary care clusters. This tool will draw on Dr Lewis' work to assess the progress of cluster working and is expected to be available later this year.

The hub has developed GP One and Primary Care One websites to provide a wide range of information including a compendium of good practice to support cluster planning and development.

The national primary care leadership team has undertaken work on the governance required to enable successful cluster development. As learning surfaces, further national and local work will be needed to support the development of each cluster in line with its own development needs. The

development of IT systems to enable cluster level working is an example of a strategic enabler which is being supported by collective action at a national level.

While the Welsh Government will continue to avoid being overly prescriptive, it will continue to scrutinise action by health boards to strengthen and develop cluster working. I asked health boards to present their progress to me and a panel of senior officials in October 2016. I will be holding another conference this autumn.

My priority is to create a supporting environment for clusters to grow according to their own individual needs and circumstances. This was the intention of allocating £10 million from the national primary care fund for clusters to decide how to invest in their own priorities and this is widely acknowledged as having been successful in demonstrating the benefits of cluster collaboration.

Line of inquiry 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.

The vision in *Setting the Direction* (2010) enjoyed support and some progress was made with encouraging GP practices to collaborate in GP cluster networks through incentives in the national contract for general medical services.

It is the evidence from the literature review produced by Public Health Wales in 2014 and *Our Plan for a Primary Care Service for Wales* backed by the nearly £43 million primary care fund, which has generated real momentum.

Strong leadership is one of the five themes of the national primary care plan and it is this leadership which has brought the vision to life and is delivering change.

At a national level, I continue to reinforce primary care and cluster working as my priority. I chair a Ministerial taskforce to lead and oversee primary care workforce needs. Alongside this, the lead health board chief executive for primary care and lead professional for primary care co-chair a newly formed national primary care board. The overarching purpose of the board, which met for the first time in March, is to identify and tackle common barriers which need a strategic solution. It involves key stakeholders alongside representatives of all health board executive functions.

The health boards' directors of primary, community and mental health work together as a peer group to oversee work best done once for Wales. Their

priorities for 2017-18 are service sustainability, contract reform and mental health.

Public Health Wales, with funding from the national primary care fund, supports the directors through its primary care innovation and development hub. The hub has a number of work streams, including coordinating the national programme of pathfinders and pacesetters, providing organisational development for cluster working and mapping evidence of social prescribing models.

At a regional level, the partnership boards, established under the Social Services and Wellbeing (Wales) Act, have a vital leadership role in demonstrating the benefits of collaboration at this level to achieve integrated health and social care.

At health board level, the vice chair has overall responsibility for primary care and holds the directors for primary, community and mental health to account. The directors of primary, community and mental health work closely with executive leads for workforce and planning. Professional leadership comes from the medical and nursing directors, the directors for therapy and health sciences and associate medical directors. Health boards as integrated organisations are working to shift the focus of leadership towards primary care. This is evidenced through Board oversight and scrutiny of activity, and their planning processes.

At a cluster level, each cluster leadership team is taking action to identify and address its own development needs. Their work is supported by a variety of different arrangements put in place by health boards. These arrangements will evolve as the clusters mature.

Line of inquiry 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.

A number of new ways of working are being tested as part of the national programme of pathfinders and pacesetters. These schemes are being evaluated locally and will also be formally externally evaluated in 2017-18. Schemes include multi professional support teams deployed across health boards to address pressures on general medical services, clinically led telephone triaging of calls to GP practices and new organisational forms such as federations and social enterprises for delivering sustainable services. During 2017-18, the programme will draw in new proposals as health boards either stop unproven schemes or begin to mainstream the successful ones.

Central support to local change is extensive. The Welsh Government works closely with health boards through the national primary care board to reinforce the importance of primary care development. To back our national primary

care and workforce plans, we have created a national primary care fund of nearly £43 million. We have launched a national primary care recruitment campaign. Alongside this, we are working closely with health boards on a national approach to developing capital investment proposals for primary care.

Leadership and support for cluster working is provided by the health boards' directors of primary, community and mental health, who commission practical support from Public Health Wales' primary care innovation and development hub. The hub agrees a prioritised programme of work with health boards' directors of primary, community and mental health. In 2017-18, this programme includes the continuation of the coordination and evaluation of the national programme of pacesetters and leadership and organisational development programme for clusters, national Primary Care One website with a compendium of good practice and other useful information and a primary care quality improvement programme.

Each cluster is on its own individual journey of maturity and there are challenges to working in this collaborative and very local way. New behaviours at all levels are needed and there has and will continue to be much learning. The work by Dr. Lewis and the tool being developed by Bangor University will support clusters to understand their progress and to prioritise action for their future development.

The success of developing primary care as the mainstay of a sustainable, accessible and effective health system will be monitored using the nationally agreed sets of quality and delivery measures.

Over time, cluster success will be judged through improvement in the health and wellbeing outcomes of cluster populations, the secured sustainability and stability of primary and community care and its contribution to a successful integrated whole system approach to health services in Wales.

Founding a Federation progress report April 2016-March 2017

Background:

Bridgend East Community Network (BECN), with the help of ABMU LHB, had been successful in securing Welsh Assembly 'Pathfinder' funding, to explore the feasibility of establishing a 'Federation' of General Practices. With the help of legal advice from BAVO, and guidance from a consultancy firm 'Mutual Ventures', a not for profit company limited by guarantee was established, Pen-Y-Bont Health (PYB).

The PYB mission statement is, "The relief of sickness and the preservation of wellbeing through the delivery of community based, co-ordinated and accessible services."

Achievements

a) Managerial/Technicalities

1. Initially there seemed to be a disconnection between the upper echelons and those lower down the LHB managerial pyramid. This hindered progress of the PYB development, until senior LHB representatives engaged directly with PYB.
2. Regular meetings from latter half of 2016 with the LHB to try to tackle some of the stumbling blocks e.g. Funding issues, Pensions, Procurement issues, contract arrangements, that were exposed in the development of PYB.
3. Appointment of accountants.
4. Appointment of a project manager (albeit still hosted by one of the constituent Practices).

b) Projects

1. Karuna tier1, counselling services, funded from BECN, co-ordinated through PYB.
2. Call-handling for out of hours (OOH) services during Protected Learning Time (PLT) events across ABMU. Funded by ABMU, delivered by PYB.
3. Successful bid to deliver GP medical services to Parc prison. Funding through G4S, delivery by PYB. Currently in prelimmary scoping and set up phase. Due to commence in next month or so.
4. Successful bid to deliver appropriate medical advice to patients at high risk of having a stroke, when they also have atrial fibrillation (AF). Funded by the Stroke Implementation Group (SIG). Required collaborative working with Interface Clinical Services (ICS) Ltd. Short timeframe of 10weeks. Patient consultations completed. Various feedback meetings to sign off work in next few months.

5. Bid to deliver care to patients with Type 2 diabetes who require injectable agents to manage their conditions. Collaborative work with various pharmaceutical companies to provide software, and educational training for staff hoping to deliver the service. Draft contract returned with our comments and proposed costings. Awaiting ABMU decision on funding.
6. Establishing PYB website. Engagement with IT/marketing company. Plan to develop specific patient education video clips. Ongoing.

c) <u>Ongoing and still to do</u>

1. Explore employment law, feasibility for future staff, clarity over pensions awaited from WAG, or Powys Federation model?
2. Explore medical indemnity for future staff.
3. Work with various organizations eg Universities, Public Health, Schools, Sports Wales, around developing a programme to encourage children to live healthier lives.
4. Update fellow GPs through a feedback session ?PLT.
5. Projects and services as outlined above.
6. Medical cover for OOH, across ABMU during PLT sessions.
7. Consider the feasibility of delivering a minor ops service.

Summary

The Federation has spawned Pen-y-Bont Health, a not for profit social enterprise business, that aims to work with the LHB plus other sectors of health and social care, but is independent of the LHB. To my mind, it still does not as yet address governance issues within the Network for all parties, but does provide a means of getting a coherent response from all Practices. As PYB matures it is hoped that it can work with the LHB and other partners towards the mission statement mentioned above.

There has been some good progress over the last 6 months in particular. The funding through the 'Pathfinder' work has been crucial to allow the clinicians and practice managers time to meet, discuss, and develop ideas, without compromising their respective practices. There has been a greater appreciation, and trust that pooling GP resource can help deliver services in a more universal, standardized way. There has been a sense of excitement at finally being able to put into practice some of our ideas.

Dr. Ian O'Connor.

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Agenda Item 3.2

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26 May 2017

Sarah Sargent
Deputy Clerk
Health, Social Care & Sport Committee
National Assembly for Wales
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Dear Sarah

Thank you for your email dated Friday 12th May requesting more information relating to two points generated during the evidence session given to the Health, Social Care & Sport Committee on 11th May. Please note our responses to the two areas below:

1. Possible indemnity issues associated with a wider range of professional staff working in, and with, GP practices

As the range of health professionals employed by and working within/alongside primary care grows, the potential for maximising the scope of practice of professionals and developing new ways of working to meet need also grows. It is essential there are adequate levels of protection for the public, employers and employees through careful planning and design, risk identification, appetite, mitigation and management, clear lines of reporting and accountability, along with, but not exclusively, adequate indemnity arrangements.

Employers, including the National Health Service and those within the independent sector for example, General Practices, have vicarious liability for the activity or actions taken (or not taken) by their employees, connected with their employment. Employers are vicariously liable for those providing services by way of a contract for services (who may consider themselves to be self-employed) provided that they exercise a degree of control over the way that those services are provided.

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NHS employers have indemnity arrangements in place for their organisation and their staff. For example, in Wales, this function is fulfilled via the Welsh Risk Pool, which is effectively, an indemnity insurance scheme for NHS Wales. There is an equivalent risk pooling scheme in Northern Ireland. The Clinical Negligence Scheme for Trusts (CNST) is established in England, and in Scotland, NHS workers are covered by the Clinical Negligence and Other Risks Scheme.

Employers in the independent health care sector should ensure they have appropriate indemnity insurance in place to cover their vicarious liability, and any prudent employer does have such cover. Some independent sector providers require those working for them, particularly if the practitioners are working in a locum capacity, to have personal indemnity cover. GPs should be careful to ensure that they have sufficient cover under their group policy to cover all members of staff and all the services being provided by those staff.

Individual healthcare professionals have to declare that they have a relevant indemnity insurance to cover the services that they provide, as a condition of their registration with their professional regulator.

Members of professional bodies and trade unions may or may not be afforded indemnity cover as part of their membership offer, dependent upon the professional body's criteria. The Royal College of Nursing indemnity scheme does not apply to a member's work undertaken in fulfilling a contract of employment, because that employer's vicarious liability applies.

2. Different operating models across the 64 clusters makes it difficult to plan strategically

Effective strategic planning is reliant upon several factors, including a shared vision, robust data and evidence and agreed outcomes. The means by which this is achieved can be impacted on by the challenge of ensuring all key stakeholders are informed, engaged and able to influence; the availability and accessibility of reliable, contemporaneous datasets spanning a range of measures; joined up IT systems that maximise the opportunity to quantify, share and analyse data; along with sharing and mainstreaming good practice and learning from less positive practice.

Whilst the 64 clusters currently in existence are at varying levels of maturity in terms of infrastructure and planning, there remains a challenge in attaining a level of comparable data on a regional or national level. Strategic planning related to clusters must be based on a depth of understanding of population need, the evidence base

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on which services to meet that need are designed and delivered, and the professional groups best placed to meet that need. The Royal College of Nursing in Wales is developing primary and community nursing role descriptors which will be available late summer to inform strategic planning processes going forward. This work will describe the unique contribution nurses as a professional group make in terms of coproducing with individuals, communities and populations in promoting health, prevention, early detection and management of acute and chronic ill health spanning the whole life cycle.

Alongside strategic planning to meet population need, it is essential that an all Wales approach to workforce planning is undertaken. Some time ago, the Royal College of Nursing and British Medical Association identified a series of key questions related to the development of a sustainable general practice nursing workforce - http://www.weds.wales.nhs.uk/sitesplus/documents/1076/doc%20Practice%20Nurse%20Development%20for%20Wales.pdf . Essentially, these questions remain unanswered.

As clusters mature, this, along with a unified approach to employment practices, must be established if a sustainable workforce is to be secured. Equality in terms of pay, terms and conditions may actively attract nurses and healthcare support workers to work within the primary and independent sectors, which would help realise the strategic intent of providing more health services in or as near to people's homes as possible.

Overall, there is great opportunity to develop the role of nurses and nursing via the cluster model, including nurses in clinical leadership roles, specialist and advanced nurses realising their full scope of practice managing complete episodes of care, in conjunction with nurses having a strong voice, influencing the way in which the needs of the population are met.

Kind regards

Yours sincerely

TINA DONNELLY, CBE, TD, DL, FRCN, CCMI
DIRECTOR, RCN WALES

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-17-17 Papur 4 / Paper 4

Inquiry into primary care
Information from Powys Teaching Health Board

Please find below answer to the questions contained in your letter to the Chief Executive dated 16 May 2017.

1. **When are you notified by the Welsh Government of your CDM allocation for the financial year ahead;**
   The Cluster development monies have been formally notified to Powys as part of the Allocation letters for 2017/18. For 2015/16 this was formally notified to PTHB via the in-year allocation letter dated 15th June 2015, and for 2016/17 in the revised allocation letter dated 5th April 2016.
2. **At what point in the financial year is the CDM Funding provided to you by the Welsh Government;**
   The funds are available to PTHB to draw down at any point in the year after formal allocation notification has been received.
3. **What is the process for you to release that funding to the individual clusters in your area;**
   Clusters and Cluster leads are notified of the funding available as soon as it is known. Clusters together with support of PTHB Locality management teams then agree the schemes and investments for the forthcoming year, and funds are released thereafter as and when required. These funds are not vetted by the Executive Team for approval, however Clusters were reminded in all years that spend should be in line with their Development plan and guidance from Welsh Government in regard to access and sustainability
4. **What were your total CDM allocations for the financial years 2014-15; 2015-16; 2016-17; 2017-18;**
   No allocation was received for 2014/15, funding for 2015/16 was £272k, and for 2016/17 and 2017/18 it is £453k.
5. **What was the total CDM spend for the financial years 2014-15; 2015-16; 2016-17 (with an explanation of any variance between spend and allocation);**
   No allocation was received in 2014/15, whilst all funds for both 2015/16 and 2016/17 have now been fully utilised. Given the in-year start up in 2015/16, there was a small slippage in spend for some schemes which was carried over and subsequently spent in 2016/17. All 2016/17 funds were utilised in 2016/17.
6. **A breakdown of what the CDM was spent on, including central LHB support to clusters;**

A breakdown of the spend by cluster for the two years funds have been received is attached. No funds have been directed to central LHB support.

7. **On average, for the past three years, what percentage of the CDM funding was held centrally to fund salaries of posts based in clusters.**
   No funds are held centrally for PTHB support to Clusters. Management support to clusters is met out of core PTHB funding. All posts funded by the Cluster funds have been Primary and Community care staff over and above pre-existing staffing. These include £49k for the HCA Care of the Elderly time limited project in 2015/16 accounting for 18% of funding and £17k (6%) on Physician Associates. In 2016/17 £152k has been spent on Urgent Care Practitioners and Physician Associates representing 32% of the allocation, these posts being employed directly in GP Practices

I trust that this provides sufficient information for the Committee, I am very happy to provide further details as and when necessary

Regards

ALAN LAWRIE
Deputy Chief Executive and Director of Primary & Community Care
Dirprwy Brif Weithredwr a Chyfarwyddwr Gofal Sylfaenol a Chymunedol
Powys Teaching Health Board/Bwrdd Iechyd (Addysgu) Powys

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