GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref: CEO.994.0517
Gofynnwch am/Please ask for: Sian-Marie James
Rhif Ffôn /Telephone: [redacted]
Ffacs/Facsimile: [redacted]
E-bost/E-mail: [redacted]
Dyddiad/Date: 12 June 2017

Swyddfeydd Corfforaethol, Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Corporate Offices, Ystwyth Building
Hafan Derwen, St Davids Park, Job's Well Road,
Carmarthen, Carmarthenshire, SA31 3BB

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

By email: sarah.sargent@assembly.wales

Dear Dr Lloyd

Re: Health, Social Care and Sport Committee Inquiry into GP Clusters

Thank you for your letter of 16 May 2017, regarding the allocation and utilisation of Cluster Development Monies. I apologise for the lateness of my response.

Within Hywel Dda University Health Board, we have been working to develop clusters from being solely GP focussed to more broad population health based Localities. This has been positively received and led to some interesting different models of care being developed in a more integrated way.

For 2017-18 the Cluster Development Monies were notified to us within the allocation letter received 20 December 2016.

For 2016-17 the funding was allocated to us on 5 April 2016.

Within the Health Board, the notification, once received is communicated to the Locality Leads and the Locality Development Managers. The funding is the aligned to a specific cost centre and the Localities are asked to clarify their plans for utilising the funding. The Locality Development Managers then work closely with the financial planning team to ensure that the funds are fully utilised and accounted for throughout the year.

There was no CDM allocation in 2014-15 however the allocations for the other years are outlined in the table below.

	2015-16	2016-17	2017-18
Allocation	770,499 – initial allocation 182,993 – end of year allocation	1,284,166 – WG allocation 409,861 – LHB re-provision	1,284,166 – WG allocation 258,778 – LHB re-provision
Spend	543,631	1,435,249	
Under-spend	409,861	258,778	
% of spend on salaries	15.5%	3.3%	

The under-spend in 2015-16 was then re-provided in 2016-17 to the Localities.

The under-spend in 2016-17 has been re-provided in 2017-18 to the Localities.

The CDM has not been used for any central LHB support to the Localities, this has been additionally supported by the Health Board and in 2015 – 16 funding was made available from Delivery Agreement funding, to enable the Localities to develop integrated leads from other Primary Care contractors such as Practice Managers, Community Pharmacists, General Dentists and Community Optometrists.

We have attached a recent Board paper on the Localities work in 2016-17 which provides an overview of the projects undertaken within each Locality during 2016-17 and the plan for development in 2017-18.

Yours sincerely

Steve Moore

Steve Moore
Chief Executive

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD IECHYD PRIFYSGOL
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	
TEITL YR ADRODDIAD: TITLE OF REPORT:	Cluster Delivery 2016-17
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jill Paterson, Interim Director Commissioning, Primary Care, Therapies & Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Elaine Lorton, Assistant Director of Primary Care

Pwrpas yr Adroddiad (dilewch fel yn addas)
Purpose of the Report (delete as appropriate)

Ar Gyfer Penderfyniad For Decision	Ar Gyfer Trafodaeth For Discussion	Er Gwybodaeth For Information
		✓

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

At the start of 2016-17 the seven Localities (clusters) within Hywel Dda received an increase in their allocated funding from Welsh Government, this was the second year of dedicated recurrent funding.

This paper provides an overview of some of the successes identified in 2016-17, a financial overview of the plans and delivery as well as an indication of the opportunities to further develop the work undertaken by the Localities.

In 2017-18 changes to the General Medical Services (GMS) contract place further emphasis on the development of clusters and how they can become a key feature of the Integrated Medium Term Plans.

Cefndir / Background

In 2011/12 the Health Board formed 7 GP clusters in order to deliver the Quality and Productivity element of the Quality and Outcomes Framework. Prescribing Management Savings were used to support some small initial developments, giving the Localities an introduction to investing for the population.

In 2014/15 this evolved into the GP Cluster Network Development Domain and the following year, 2015/16, Welsh Government provided a dedicated allocation of £770,499 to enable the clusters to start to deliver specific projects, identified from the grass roots of operational service delivery. Towards the end of 2015/16 a further £182,993 was allocated. A total of £409,861 (43% of total allocation) was approved to be re-provided to the clusters in 2016-17 in recognition of their early development and the late allocation of further funding.

In 2016/17 the recurrent allocation to clusters was increased by Welsh Government to £1,284,166. This was supplemented by the agreed re-provision from 2015-16 under-spend by the Health Board resulting in a total budget of £1,694,027.

For 2017/18 cluster allocated funding has been confirmed by Welsh Government and £258,778 re-provided which represents the 2016-17 under-spend.

The Cluster Network Programme has been further enhanced by Welsh Government and aims to :

(a) Strengthen the sustainability of core services through completion of the sustainability assessment framework and longer term business planning for Practice Development Plans and Cluster Network Plans.
(b) Strengthen the focus on access to services; winter preparedness and emergency planning; and improved service development.
(c) Strengthen quality assurance in relation to clinical governance and assurance on specific indicators designated as “inactive” QOF.
(d) Develop more effective collaborative working with community services, including nursing, local authority and third sector to improve the quality of care.
(e) Encourage the development of new models of care, including federations, practice mergers, shared practice support.

The three year Cluster Network Plan, due to be completed by 31st July 2017, will focus on :

(a) Winter preparedness and emergency planning.
(b) Access to services, including patient flows, models of GP access engagement with wider community stakeholders to improve capacity and patient communication.
(c) Service development and liaising with secondary care leads as appropriate.
(d) Review of quality assurance of Clinical Governance Practice Self Assessment Toolkit (CGSAT) and inactive QOF indicator peer review.

The full guidance for the Quality and Outcomes Framework 2017-18 is available : http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=91364.

Asesiad / Assessment

During 2016-17 all the Locality Projects aligned to Health Board Strategic Objectives :

1 To encourage and support people to make healthier choices for themselves and their children and reduce the number of people who engage in risk taking behaviours.	Links to the lifestyle programmes
2 To reduce overweight and obesity in our local population.	2Ts – Foodwise Programme 6/7 Localities – Lifestyle Advocates North Ceredigion – National Exercise Referral Scheme South Pembrokeshire – Healthy lifestyle advisors
3 To improve the prevention, detection and management of cardiovascular disease in the local population.	Links to the lifestyle programmes
4 To increase survival rates for cancer through prevention, screening, earlier diagnosis, faster access to treatment and improved survivorship programmes.	2Ts – Bowel Screening programme Amman Gwendraeth – Dermatology Service
5 To improve the early identification and management of patients with diabetes, improve long term wellbeing and reduce complications.	2Ts, North Ceredigion – Pre-diabetes screening North Pembrokeshire – Home foot check joint service
6 To improve the support for people with established respiratory illness, reduce acute exacerbations and the need for hospital based care.	2Ts, Llanelli – COPD + programme
7 To improve the mental health and wellbeing of our local population through improved promotion, prevention and timely access to appropriate interventions.	North & South Pembrokeshire – Young people’s counselling service

8 To improve early detection and care of frail people accessing our services including those with dementia specifically aimed at maintaining wellbeing and independence.	2Ts – Frailty Project Amman Gwendraeth – Frailty Care Home Service Amman Gwendraeth – Dementia Network Community Memory Clinic Llanelli & South Pembrokeshire – Care Homes medication review service South Ceredigion – Frailty & Chronic Conditions Service North Pembrokshire – Rapid home visiting service North Pembrokeshire – Joint frailty service North Pembrokeshire – Advance Care Planning project South Pembrokeshire – Occupational Therapist in Primary Care
9 To improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners	Llanelli, North Pembrokeshire & South Pembrokeshire – Community Phlebotomy service North Ceredigion – Anti-biotic prescribing
10 To deliver, as a minimum requirement, Outcome and Delivery Framework Targets and specifically eliminate the need for unnecessary travel and waiting times, as well as return the organisation to a sound financial footing over the lifetime of this Plan.	The clusters delivered within budget and identified a wide variety of savings across the system from the investments made.

The level of integration has also developed :

	GMS	Community Pharmacy	General Dental Services	Community Optometry	Primary Care Team	County Team	Medicines Management	Public Health Wales	Primary Care Nurse Advisor	Local Authority	Third Sector	Councillors / AM / MPs
2Ts	✓			✓	✓	✓	✓	✓	✓	✓		
Amman Gwendraeth	✓	✓			✓	✓	✓	✓		✓		
Llanelli	✓	✓		✓	✓	✓	✓	✓			✓	✓
North Ceredigion	✓	✓	✓		✓	✓	✓	✓		✓	✓	
South Ceredigion	✓			✓	✓	✓	✓	✓	✓	✓	✓	
North Pembrokeshire	✓	✓		✓	✓	✓	✓	✓		✓		
South Pembrokeshire	✓	✓		✓	✓	✓	✓	✓		✓	✓	

2016-17 Locality Delivery Outcomes

Appendices 1 – 7 provide a summary, by Locality, of the planning, delivery and outcomes for 2016-17. Given the relatively small fund provided, there has been a significant level of innovation, often in spite of recruitment, procurement and sustainability challenges.

There is also a strong link between the Population Health Need Assessment undertaken, the prioritisation of plans and the utilisation of available funding.

Some examples include :

Tywi Taf Locality Pre diabetic screening programme : The prevalence of Diabetes in the cluster is between 6-7% and continues to rise annually. The projection for Hywel Dda is a prevalence of 11% within 10-15 years. As part of their 2016/17 cluster funding, the locality developed a screening programme for those identified at high risk of Diabetes. Patients were offered written advice on risk reduction and referral to Foodwise and/or NERS programmes as appropriate. The cluster worked with the Head Chronic Conditions Management and the Education Programme for Patients Wales (EPP) to commission additional Foodwise courses across the locality. The pre diabetes screening programme commenced in

September 2016 and to date 2020 patients have been screened.

Amman Gwendreath Locality Frailty Care Home Service : The aim of the service is to provide a proactive care and support for patients and enhancing the provision of quality care to a defined group of vulnerable patients in the Amman Gwendraeth area. Since the service commenced on 28th February 2016 up to the period 31st October 2016, 133 reviews were undertaken with 78 DNACPR's completed. Every patient has had a medication review with recommendations to stop or reduce medications being sent to the patients GP practice. Questionnaires were issued to patients, families, care homes and GP practices. Feedback received states that there is a high family and patient satisfaction rate, improved relationships with care homes and anecdotal evidence of avoided admissions.

The feedback from patients and families has been overwhelmingly positive with 87% strongly agreeing that they had been positively engaged in the future care of their family member and 79% strongly agreeing that their relatives would benefit from the review meeting which took place.

"I was able to talk about Mum, how she was prior to the dementia, to discuss feelings and best wishes for Mum's care"

Llanelli Locality Cluster Pharmacist : Llanelli's Cluster Pharmacist, Jennifer Richards, is currently carrying out Medication Reviews in Llanelli and Burry Port Care Homes. Four Care Homes have been visited so far with 106 medications being stopped as they were no longer necessary, 661 clinical changes and interventions for the residents and over 42 clinical sessions for a GP saved. Key to this piece of work is patient safety and ensuring patients are on the appropriate medication for their needs. This ultimately supports the patient, reduces the risk of needing a hospital admission, supports the care homes staff and supports the sustainability of service delivery within General Practice.

North Ceredigion Locality Pre-Diabetes Project : The Locality initiated a pre-diabetes intervention which targeted patient education and lifestyle modification. The intervention comprised of a 30-minute one-to-one consultation for those identified as being at high risk of developing type 2 diabetes (having a HbA1c result between 42-47mmols). The 30-minute consultation included the collection of baseline data and information on diet, exercise and the importance of avoiding developing diabetes. These patients were then reviewed a year later. The review found statistically significant positive changes in BMI, waist circumference and HbA1c.

North Ceredigion Locality CRP Testing Project
In line with recent NICE guidelines CRP machines were purchased from Locality funds to promote best practice in antibiotic prescribing. These tests use CRP Levels to influence antibiotic prescribing in patients presenting with respiratory infections. The audit undertaken showed that 6 out of the 7 Practices used the machines. 121 CRP Tests were performed with the majority of patients seen aged between 16 -64 yrs. The audit showed that when used in cases of respiratory infection that it can influence prescribing in 81% of cases. As a result, 75 % of patients required no prescription for antibiotics.

South Ceredigion Locality Frailty Multi-disciplinary Team : The South Ceredigion Locality have developed of a specialist Frailty and Chronic Conditions Team, employing both Nurses and Pharmacists. Since 2015 the team has provided a comprehensive health assessment to 316 patients, a medication review to 343 patients and have ceased or changed 172 medications which are at risk of causing falls. The Team have also offered training and support to Care Homes teams and identified 5 patients with diabetes who were not previously diagnosed and receiving appropriate care.

North Pembrokeshire Locality Advanced Care Planning with Paul Sartori Foundation : The North Pembrokeshire funded the Paul Sartori Foundation, a third sector hospice, to appoint 1.2 WTE Registered Nurses as Advance Care Planning Facilitators. The Project aims to ensure that patients maintain their dignity and autonomy whilst being offered support with care directed by the patient's wishes. In the period October 2015 to September 2016 Paul Sartori Foundation reported that they had received 101 referrals. Men accounted for 45% and women 55% with the average age being 76.8. The total number of contacts with the project was over 600. The biggest referrers into the service were GPs (29%). Self and family referrals were high at a combined 45% - but many of these had been prompted by GPs. Other' referrers were a wide range of CNSs, social workers, therapists and hospital doctors. The team

have participated in many awareness raising events with care homes, assisted living housing schemes and community groups. Over 500 health and social care professionals and 300 members of the public have attended educational sessions.

There is a good body of evidence to show that ACP can reduce avoidable hospital admissions from home and care homes, reduce health care costs, improve patient involvement in decision making, improve satisfaction with care services and reduce stress, depression and anxiety in bereaved family members. A review of North Pembrokeshire GP Practice records show that between March 2015 and March 2017 the number of patients with an ACP in place has increased by 219% from 74 to 162. Many more conversations have taken place but ACPs are not recorded until they are complete. The ACP Project has also evidenced the integration of services such as referral to GPs, DN Teams and liaison with Clinical Nurse Specialists, referral to food banks and other third sector projects, information provided to patients with regard to will advice, body donation, tissue and organ donation and with regard to referral to Social Care and carer assessments.

South Pembrokeshire Locality Health Lifestyle Advisors : Patients aged between 45 and 55 are now eligible to have a free health check in a new scheme being piloted in South Pembrokeshire. Clinics aimed at helping people to understand their risk of developing conditions like heart disease, stroke or diabetes and how they can lower their risk, are being run in Narberth, Saundersfoot, Tenby, Argyle, Neyland and Johnston GP Surgeries. Checks are carried out by one of the HDUHB's Healthy Lifestyle Advisors, who ask a series of simple questions about lifestyle, current medical conditions and any family history of cardiovascular disease. Patients' height, weight, and age are recorded and their blood pressure and pulse are also measured. Following this, personalised advice is provided on how to lower the risk of disease and maintain a healthy lifestyle, with ongoing support to make positive changes. In the first 3 months of the service, 155 patients were seen.

Identified Challenges to Delivery in 2016-17

Although there have been delays to projects caused by procurement processes, the most significant impact has been when recruiting staff to deliver projects.

An audit of 20 recruitment processes across the Localities was conducted with a view to identify the themes around delays and impact on the delivery of Locality projects. Job role development, TRAC processes, interview processes, and commencement delays were reviewed.

- 19 of the 20 roles were Advanced Practitioner roles working to Agenda 4 Change Band 7 or 8A posts.

- Job role development delays range from 2 – 3 weeks mostly, however at the start of the process there were delays of 5 months for the development of job roles, internal approval processes and banding. Some of the delays related to the introduction of TRAC and staff needing to be set up on the system or receive training.

- Delays were incurred between adding a role to TRAC and the advert going live, these range from 8 – 36 days. Reasons relate to the various stages of authorisation.

- Interview process delays were reasonably consistent at 9 -14 days, these relate to the need to provide sufficient time for candidates to prepare and attend interview.

- Delays to candidates starting in post range from 17 to 117 days. The main reasons include notice periods however delays in Occupation Health clearance, sending the offer letter and staff not being released for secondments also had an impact. The shortest delay was when a GP practice recruited on behalf of the Locality.

- Total delays of up to 9 months were cited with 4 months being common. There were also examples of candidates withdrawing a significant period of time into the notice period having been offered better terms or more pay to either stay in existing role or to go to another provider.

Significant levels of frustration are reported regarding these delays and in every instance where a GP practice undertook the recruitment in lieu of the Health Board, the process was significantly shorter.

2016-17 Locality Financial Outturn

	2016/17 Recurrent Budget	2015/16 Carry Forward	2015/16 Additional Carry Forward	TOTAL 2016/17 Budget	% Recurrent Budget Utilised	% Total Budget Utilised	Slippage 2016/17
Tywi Taf	190,184	53,524	27,099	270,807	107%	75%	67,381
Amman Gwendraeth	204,012	56,599	29,070	289,681	110%	77%	66,229
Llanelli	202,318	82,977	28,828	314,123	136%	87%	39,318
North Ceredigion	135,540	0	0	135,540	97%	97%	3,639
South Ceredigion	166,227	15,118	23,686	205,031	80%	65%	72,389
North Pembs	206,319	18,216	29,399	253,934	121%	98%	5,137
South Pembs	179,566	19,758	25,587	224,911	123%	98%	4,685
TOTAL	1,284,166	246,192	163,669	1,694,027	112%	85%	258,778

The majority of the Localities spent in excess of their recurrent budget for 2016/17 only falling short due to the carry forward from 2015-16. There has been in excess of a 260% increase in expenditure from £543,631 in 2015-16 to £1,435,249 in 2016-17. This demonstrates an increasing capacity and competency in Localities to utilise and spend their funding wisely.

Future Locality Development Plans

The Health Board has articulated that the Localities will be the key planning and delivery unit for future primary and community services. Although in its infancy, the Localities have increased their momentum in 2016-17 in comparison to the previous year. Their level of integration has grown, there is a level of sophistication in their alignment of priorities and funding plans to their areas of high population health need and these plans align to the Health Board strategic priorities.

With the introduction of the three year cluster network plan, this will lead to the opportunity to utilise these plans as a key feature of future Integrated Medium Term Plan development along with the Clinical Services Strategy and Transformation programme.

There are opportunities to develop pilot evaluations into robust business cases, with the potential to shift resources from the acute sector where plans reduce the need for surge capacity and the reliance on variable pay. Collaboration in the development of business cases across the system will be required, along with integrated clinical discussion to agree pathway and whole system service delivery model changes.

Next Steps for the Primary Care Team are :

- To work as part of the Clinical Service Strategy development group to identify opportunities for service shift and the development of Primary Care as an enabler for system change. Pre-diabetes and frailty whole system services have been identified as the first two opportunities for development.
- To develop capacity and competency for the development of business cases across whole pathways in order to embed plans into the Integrated Medium Term Plan.
- To embed the learning from projects into the Transformation Programme, particularly linking with the Out of Hospital Group.

- To develop a sustainability plan for core services to facilitate future service change.
- Where there are opportunities to role out positively evaluated services within resource constraints to deliver on these within 2017-18.

Argymhelliad / Recommendation

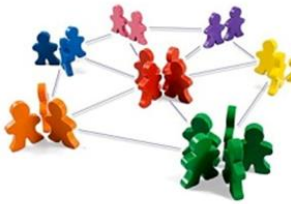
This paper is for information to enable the Board to understand the delivery to date by the Localities and the opportunities for further development.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Cluster work as the potential to impact and reference all Health and Care Standards.
Amcanion Strategol y BIP: UHB Strategic Objectives:	References within the paper.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Identified as appropriate, in the paper.
Rhestr Termau: Glossary of Terms:	Defined within the paper.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board Meeting:	Primary Care Sub Committee Board Organisation Development

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / VFM:**	Defined within the paper
Risg / Cyfreithiol: **Risk / Legal:**	Delivery of the cluster programme is a key policy prioty for the Welsh Government.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Defined within the paper.
Gweithlu: **Workforce:**	Defined within the Paper
Cydraddoldeb: **Equality:**	To be included as part of future service change proposals.

Tywi / Taf Locality
2016-17 Summary Investment Report



Our Network
GP Lead – Dr C Jones
Practice Manager Lead – Laurence Jackman
Locality Development Manager – Victoria Edwards

GP & Practice Manager representation from all eight practices
3Ts Community Resource Manager
Carmarthenshire County Director
PHW Consultant
Senior Primary Care Nurse Advisor
Medicines Management
District Nursing Lead
From 2017/18 Community Pharmacy Lead
Community Optom Lead

Population Health Needs
The 2Ts has a **significantly higher older** population at **22.1%** compared to the Welsh average of 18.7%. Frailty, dementia and the effects of multiple chronic conditions are more prevalent in this population group and can lead to increased demand for both acute and community care services for older people, particularly those aged 85 and more. Locality has seen a significant increase in the diagnosis of patients with diabetes.

Locality Plan Priorities	**Funding Plan Investments**
• Ageing population with multiple complex needs • Recruitment and retention • Rurality	• Band 8a Pharmacists (76.5 hours – 18 month contract – March 2018) • 1 Band 4 Generic Technician (1wte) • MDT Working (inc. Stay Well Plans)

• Capacity • Communication	• Establishment of Pre Diabetes Screening Programme • Commission Foodwise Programmes • Commission COPD+ Programmes • Promotion of Bowel Screening • Education & Training (inc Lifestyle Advocates) • Purchase of Risk Stratification Software (MSDi) • Production of Patient End of Life Care support Leaflet
Key Locality Achievements 2016/17 • Ongoing work with Frail population including continued development of MDT meetings and Stay Well Plans • Development of Pre- diabetes screening programme, including commissioning of foodwise programmes. • Commissioning of COPD+ programmes for 2Ts population • Development of patient leaflet 'Getting Support at the End of Life' • Supported PHW with the Development of a Bowel Screening Awareness Project • GPs have undertaken psychological training / workshop • Continued support for the Lifestyle Advocates Programme	
Qualitative Benefits Identified • There has been positive feedback from patients regarding Pre Diabetes screening programme • Improved patient care arising from greater integration of teams and team working • Care Closer to Home where appropriate • Improved communication with colleagues • Hospital admission avoidance (individual case studies) • Evidence demonstrates that the Generic technician post is resulting in earlier intervention linking with services such as re-ablement to focus on improving functional ability, providing confidence to people to support them to regain their independence. This also enables assessment at an earlier stage of diagnosis, providing appropriate interventions, delaying the need to access commissioned services and acute hospital settings.	**Quantative Benefits Identified** • 2020 patients screened for Pre diabetes and offered lifestyle advice and onward referral to Foodwise and NERS programme • 505 Stay Well Plans completed – these are written care and support plans which include details of carer, health and social care summary, optimisation and maintenance plan, escalation and urgent care plan as described in Fit for Frailty publication published by the British Geriatric Society 2014. In total 976 patients now have Stay Well Plans in place. • 321 direct GP referrals were made to the Generic Technician. The majority of patients were referred with a functional change of low mobility/ falls. • 444 follow up visits were undertaken to 154 patients • 69% of patients were seen within two weeks, with the average time for an assessment being 13 days • 93% of patients were dealt with at source with only 7% referred onto the

• The Generic Tech focuses on a strengths based model of assessment and along with focusing on functional ability addresses the prevention agenda utilising the community as a resource promoting social inclusion.	individual teams. • Reduction in community Occupational Therapy and Physiotherapy waiting lists from 13 weeks to 8 weeks

Plans for 2017/18

- NOAC initiation and monitoring system
- Commitment to provide permanent contracts for our Practice based Pharmacists
- Continued funding for employment of Generic Technician
- Continued support for MDT working and practice based MDT meetings i.e. MDT Admin Support & wi fi subscription
- Development of a Cluster Patient Participation Group

The following will be dependent on the re-provision of all the cluster under spend in 2017/18:

- Completion of Stay Well Plans for patients (20 per 1800 patients)
- Continuation of MSDi contract to enable risk stratification of patients
- Further commissioning of Foodwise programmes to ensure courses are available for screened patients

Funding Committed to Agreed Locality Plans for 2017/18

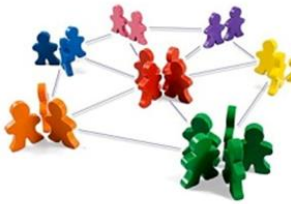
Staffing costs plus travel expenses	£156,286
Support for MDT working	£10,700
NOAC Service	£40,000
Stay Well Plans	£40,000
MSDI	£10,556
Total Budget Plan for 2017-18	**£257,542**
Recurrent Annual Budget	£190,184
SHORTFALL FOR 2017/18 DELIVERY	**£67,358**

Recurrent Annual Budget

2016/17 Recurrent Budget 2016/17	**£190,184**
2015/16 Carry forward	£53,524
2015/16 Additional Funding received	£27,099
Total 2016/17 Budget	£270,807

Slippage 2016/17 : £67,381 (25% of total budget)

Amman Gwendraeth
2016-17 Summary Investment Report



Our Network :

Dr Sioned Richards	GP Lead/ Tumble Surgery
Wendy Currums	Primary Care Locality Development Manager
David Pickering	Locality Practice Manager Lead (Brynteg Surgery)
Position vacant	Locality Community Optometric Lead
Position vacant	Locality General Dental Lead
John Llewellyn	Locality Community Pharmacy Lead (Brynaman Pharmacy)

GP & Practice Manager : Amman Tawe Partnership, Brynteg Surgery, Margaret Street Surgery, Pen-y-groes Surgery, Tumble Surgery, Coalbrook Surgery, Meddyfa Sarn and Minafon Surgery
County Team Hywel Dda UHB : Carmarthenshire County Director and Clinical Lead Nurse
Public Health Wales : Consultant in Public Health
Hywel Dda UHB Corporate Team : Head of GMS and Medicines Management Pharmacist
Locality Specific Roles : Advanced Nurse Practitioner - Frailty and Cluster Pharmacists
Community Resource Team : Locality Manager

Population Health Needs

- We serve a population of 55,412 in a semi-rural post industrial environment
- Older population than the Welsh and Health Board averages
- Due to a higher proportion of older population, the locality has the highest % of patients on the Asthma, CHD, COPD, Diabetes and Epilepsy registers. These chronic conditions relate to industrial disease
- The locality has a slightly older than Health Board average of males aged between 65 years and 84 years. However, the cohort of people between 15 years

<table>
<tr><td colspan="2">and 24 years is younger than the Health Board average
• The locality has a slightly older than Health Board average of females aged between 25 years and 64 years</td></tr>
<tr><td>Locality Plan Priorities
• Commencement of a Frailty Care Home service consisting of a named GP, Advanced Nurse Practitioner and Pharmacist
• Identify an additional enthusiast individual from within each GP practice to work alongside the current Lifestyle Advocate who will undertake a professional development programme in relation to behaviour change. This will build on the work completed during 2015/16
• Following the development of a Dementia Network Community Memory clinic service in the Amman area of the locality, which has been in operation for a period of time, implement a similar service in the Gwendraeth area of the locality</td><td>Funding Plan Investments
• Frailty Care Home Service – Named GP lead [provided by Brynteg Surgery] 3 sessions per week, 1 x 37.5 hours a week Advanced Nurse Practitioner [on HDUHB secondment for 2 years] and a Pharmacist 1 day per week [provided by Amman Tawe Partnership]. In addition there are travel costs, training hosting costs, training and equipment for the Advanced Nurse Practitioner
• Lifestyle Advocate programme – up to 2 individuals per GP practice
• Dementia Network Community Memory clinic – a GP 2 sessions per month plus room hire
• Phlebotomy service
• IT - Vision 360, Vision In Practice and Vision training days for each GP practice
• 1 x 37.5 hours per week Locality Pharmacist and 1 x 26 hours per week Locality Pharmacist, both on permanent contracts. In addition to their staffing costs are travel, training and equipment costs.
• Dermatology service</td></tr>
<tr><td colspan="2">Key Locality Achievements 2016/17
• Implementation of the Frailty Care Home Service
• Expanded the dermatology service
• Recruited 2 Locality Pharmacists</td></tr>
<tr><td>Qualitative Benefits Identified

GP Care Home Service – Frailty Evaluation
• One case study identified that by undertaking advanced care planning prevented a hospital admission and improved patient experience at home

Advanced Nurse Practitioner Care Home Service – Frailty Evaluation</td><td>Quantative Benefits Identified

GP Care Home Service – Frailty Evaluation
• 78 DNACPR’s completed for frail patients
• 290 care home residents who have all had a medication review with recommendations to stop or reduce

Advanced Nurse Practitioner Care Home Service – Frailty Evaluation</td></tr>
</table>

• Feedback from a GP "Rachel has been able to offer valuable continuity of care to vulnerable patients in nursing and residential homes. Her input in to their management has been invaluable. This has resulted in improved care for these patients and has reduced the amount of GP home visit requests" • Feedback from a patient "Oh she's lovely, she's very caring and explains things so I can understand, I trust her completely" **Dermatology** • Expanded the dermatology service in the Gwendraeth area, thereby bring the service closer to patients.	• 354 direct patient contacts during the reporting period April 2016 – October 2016 of which 107 were classed as acute and would have been seen by a GP resulting in a care home visit **Dermatology** • During the period September 2016 to March 2017, 49 patients were seen and in total 54 procedures were undertaken, which included: ➢ 38 excisions All except one [a BCC] was fully excised and the patient is being carefully followed up ➢ 12 curettage and cautery ➢ 3 punch bx ➢ 1 debulking of tumour

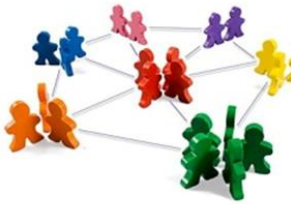
Plans for 2017/18

- Continue with the work of Advanced Nurse Practitioner in the Care Home Service and consider expanding her role with potentially housebound patients and support the Advanced Nurse Practitioner attending a prescribing course
- Develop the role of the two Locality Pharmacists in General Practice. The type of work to be undertaken will include: a] medication reviews, including poly pharmacy reviews b] minor ailments clinics c] drug monitoring d] care home medication reviews e] dealing with daily queries from patients relating to medication f] chronic disease clinics.
- Following the development of a Dementia Network Community Memory clinic service in the Amman area of the locality, which has been in operation for a period of time, implement a similar service in the Gwendraeth area of the locality
- Further expansion of the dermatology service
- Invest in Tegfan project consisting of 10 rooms for cluster use
- Phlebotomy Service
- Continue with Vision 360

Funding Committed to Agreed Locality Plans		**Recurrent Annual Budget :**	
• ANP Care Home Service including travel and training	£ 66,600	• **2016/17 Recurrent Budget**	**£204,012**
• Locality Pharmacists including travel, equipment and training	£105,400	• 2015/16 Carry forward	£56,599
		• 2015/16 Additional Funding	£29,070
		• Total 2016/17 Budget	£289,681

• Dementia Network Memory Clinics • Dermatology Service • Tegfan project • Phlebotomy service • Vision 360 **TOTAL BUDGET PLAN FOR 2017/18** • Recurrent Annual Budget • **Shortfall for 2017/18 delivery**	£ 17,000 £ 10,000 £ 45,000 £ 10, 610 £ 15,600 **£270,210** £204,012 **£ 66,198**	• **Slippage 2016/17** **£66,609** (33% of total budget)

Llanelli
2016-17 Summary Investment Report



Our Network : The following are all invited to every Cluster meeting:

Dr Alan Williams	GP Lead/ Ty Elli Group Practice
Laura Lloyd Davies	Primary Care Locality Development Manager
Julia Wilkinson	Llanelli CRT Locality Manager
Jamie O'Grady	Locality Practice Manager Lead (Ty Elli Group Practice)
Fran McCarthy	Locality Practice Manager Lead (Avenue Villa surgery)
Jennifer Richards	Cluster Pharmacist
Matthew Harvey	Locality Community Optometric Lead
Rachel Davies	Locality Community Pharmacy Lead
TBC	*Locality General Dental Lead*

GP & Practice Manager : Ty Elli Group Practice, Avenue Villa Surgery, Llwynhendy Health Centre, Llangennech Surgery, Fairfield Surgery, Ash Grove Medical Centre, Meddygfa Tywyn Bach, Harbour View Surgery, Andrews Medical Practice
County Team Hywel Dda UHB : Linda Williams, Carmarthenshire County Director
Public Health Wales : Dr Ian Scale, Consultant in Public Health, Beth Cossins Principal Health Promotion Specialist
Hywel Dda UHB Corporate Team : Jill Paterson Interim Director of Commissioning, Primary Care, Therapies, Rachel Pompa Head of GMS, Robert Bevan Medicines Management Pharmacist, Dr Mark Barnard Associate Medical Director - Primary Care , Alyson Lloyd-Thomas Primary Care Nurse Advisor, Kate Iceton Primary Care Service Improvement Manager
Locality Specific Roles : Specialist Nurse Mark Harries COPD, Chris Cottrell Diabetes and Helen Bowler Heart Failure, Sian Fox District Nursing, Kate Rhodes Clinical Psychologist, Dr Savita Shanbhag Macmillan GP Cancer Lead
3rd Sector Spice
Welsh Assembly : Lee Waters AM, Gareth Howells AM Support Staff

Population Health Needs

Population of 60,960

An urban environment within a rural Health Board

The particular features of our population are:

Deprivation – we are the most deprived Cluster in Hywel Dda University Health Board area with 26.4% of the patients living in the most deprived fifth of areas in Wales, above the Welsh average and vastly above the Health Board average of 8.1%

Chronic Conditions: Higher than Health Board average cases of conditions diagnosed and recorded in Chronic Heart Disease and Diabetes.

Locality Plan Priorities 2016/17

- Frailty – improved care of patients in residential/nursing homes and at home, including mediation reviews; training and education.
- COPD – Continuation and expansion of the COPD+ Exercise & Education programme.
- Further utilisation of the Antioch centre to include expansion of Phlebotomy and Leg Ulcer services.
- Continuation and development of Lifestyle Advocates role and relationship with the third sector.

Funding Plan Investments

- Cluster Pharmacist (temporary contract)
- 4 Phlebotomy Staff (band 2)
- COPD+ Self Management Programme
- Antioch Centre Lease and Call Centre costs
- Ty Golau
- Social Prescriber Spice
- Training, Education and Equipment
- Dementia Training
- Lifestyle Advocates
- Screening Project
- My Surgery Website
- Insight Solutions IT Support

Key Locality Achievements 2016/17

- Cluster Pharmacist in post to carry out Medication Reviews in Care Homes, support relationships and create uniform Cluster documentation and processes.
- Continue to support and promote self management through the COPD+ Exercise and Education Programme.
- Supported the Phlebotomy service to remain accessible to patients in the community in the Antioch Centre and in Burry Port.
- Fully supported the Lifestyle Advocates with every Practice nominating at lease one member of staff to contribute.
- Supported Practices via the Indicative Budget

Qualitative Benefits Identified

- Medication Reviews for patients in Care Homes.
- Safety - Reduction in patient risk by ensuring patients are on the most suitable medication and by stopping any harmful or unnecessary

Quantative Benefits Identified

Cluster Pharmacist:

- **£9,262.77** actual cost saving of stopping medications for Hywel Dda Health Board

medications. The Cluster Pharmacist has produced a Covert Medicine Policy for Care Homes to ensure patients are treated with dignity and respect and appropriately to their capacity. • Improved Care Home education and communication – *Care Home Manager plans to attend next Cluster Meeting.* • Positive patient questionnaire results from the Phlebotomy Service. The Phlebotomy staff have also reported that they prefer this model of working as it enables them to provide a safer and more enjoyable service to the patient. • Positive participant feedback from attending a self management programme.	• **92** hours GP time saved • **661** clinical interventions • **£145,000** value of clinical interventions done by pharmacist • **£6,532** GP time (based on £71 per hour) **Phlebotomy Service:** • Over 18,000 patients have so far received the Phlebotomy service in the community **COPD+ Self Management:** • Over 70 participants have benefitted from the COPD+ Self Management Programme in Llanelli

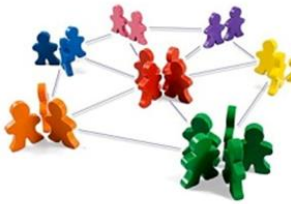
Plans for 2017/18

- Frailty – improved care of patients in residential/nursing homes and at home, including mediation reviews; training and education.
- Social Prescribing SPICE posts and the introduction of time credits
- Chronic Pain Management Toolkit Pilot
- Practice based Chronic Respiratory Nurse
- Continuation and expansion of self management programme including COPD+ and Thriving and Surviving
- Cluster and Practice websites – to improve communication and patient awareness of services
- IT management – to improve uniformity of data capture to facilitate future projects including possible research

Funding Committed to Agreed Locality Plans		**Recurrent Annual Budget :**	
• Staffing costs plus travelling	£122,623	• **2016/17 Recurrent Budget**	**£202,318**
• Phlebotomy Call Centre	£13,021	• 2015/16 Carry forward	£82,977
• Antioch Rent	£12,250	• 2015/16 Additional Funding	£28,828
• Ty Golau	£1,242	• Total 2016 – 17 Budget	£314,123
• Chronic Pain Management	£10,000		
• Self Management	£ 8,000	• **Slippage 2016/17**	**£39,318**

• Training, Education and Equipment £74,500 • **TOTAL BUDGET PLAN FOR 2017-18 £241,635** • Recurrent Annual Budget £202,318 • **Shortfall for 2017/18 delivery £39,318**	

North Ceredigion
2016-17 Summary Investment Report



Our Network : Are all invited to every Cluster meeting:

Dr Sion James GP Lead/ Tregaron Surgery
Michelle Dunning Senior Primary Care Locality Development Manager
Andrew Power Locality Practice Manager Lead (Tanyfron Surgery)
TBC Locality Community Optometric Lead
Dr Monika Gyenes Locality Dental Lead (Portland Street Practice)
Huw Evans Locality Community Pharmacy Lead (Boots Aberystwyth)

GP & Practice Manager : Tanyfron Surgery, Tregaron Surgery, Llanilar Health Centre, Padarn Surgery, Church Surgery, Ystwyth medical group & Borth Surgery
County Team Hywel Dda UHB : Ceredigion County Director, Community and Primary Care Nurse Manager, Community Nursing Team Leader, General Manager, Service Planning co-ordinator
Public Health Wales : Consultant in Public Health
Hywel Dda UHB Corporate Team : Head of GMS, Practice Nurse Advisor, Medicines Management Pharmacist
Locality Specific Roles : Advanced nurse Practitioner
Ceredigion Council Roles : Director of Social Services
3rd Sector Director of CAVO

Population Health Needs

- The cluster serves an approximate population of 47,000
- An older profile (18%) with complex needs (frail and elderly) but also a high student population
- The cluster has an above average (57.8%) of people living within a Rural area
- Diabetes (4.1% of the North Ceredigion population and rising).

- Heart Failure (1.1% of the North Ceredigion population and higher than the National average).

Locality Plan Priorities	**Funding Plan Investments**
• Workforce sustainability (Development of a federation) • Pre-diabetes • Frail & Elderly • Chronic conditions management • Collaborative working across practices (Vision 360) • Reduce inappropriate antibiotic prescribing (CRP testing in Practice) • Test different models of service delivery – Physiotherapy in Primary care	• SLA to carry out Pre-diabetes screening • Salary of dietetic support for pre-diabetic project • PHD student fees to support evaluation of pre-diabetic project • Payment to NERS to increase capacity for pre-diabetic project • Salary 1 WTE Advanced Nurse Practitioner • Salary 1 WTE Frailty nurse • Payment to CAVO for PHW screening project • Population needs assessment workshop • Payment to Practices for backfill time to progress cluster priorities

Key Locality Achievements 2016/17

- Appointed additional Cluster Dental and Community Pharmacist lead which has enhanced our cluster
- Appointed ANP and frailty nurse to work with County frailty nurse (development of frailty team), initially to support Advanced care planning in residential homes and medication reviews.
- Under took CRP pilot and audit results have proven very positive
- Worked with PHW on a smoking cessation via video-conferencing pilot
- Pre-diabetic screening project has shown positive outcomes for patients
- Positive collaboration with Aberystwyth University to change their academic policy to stop students going to the GP for sick notes for minor aliments

Pre-diabetic screening

The possible situation by 2035/36:

- Diabetes currently accounts for approximately 10% of the total NHS budget, but this is projected to rise to around 17% by 2035/36
- Diabetes is projected to cost £39.8 billion overall by 2035/36.
- The cost of direct care for patients is estimated to rise to £16.9 billion (£1.8 billion for type 1 diabetes and £15.1 billion for type 2 diabetes).
- The indirect costs associated with diabetes will increase to approximately £22.9 billion (2.4 billion for type 1 diabetes and £20.5 billion for type 2 diabetes
- Type 2 diabetes is preventable with healthier lifestyle choices.

Patient specific metrics

A recent interim report by Aberystwyth University showed that of the 140 people that had received their annual review

- 9 were reported to have a baseline HbA1C result of below 42, whilst at the review this had increased to 53 people – showing that more people were below the “at high risk” category of developing diabetes.
- 130 people were between 42 and 47mmols at the baseline, and this had reduced to 79 people again showing an improvement in the numbers that were classified as high risk

Foodwise: Over the course of 2016, 8 Foodwise for life programmes were run as part of the pre-diabetic project. Eight programmes were run with 75 participants.

- Of those 75 patients, 74 completed the programme. The average number of sessions attended within the pilot was 100%
- 90% of participants seeing reductions in their body weight.
- With 22% achieving the target >5% weight loss within the duration of the programme associated with a reduction in diabetes risk.

National Exercise Referral Scheme (NERS): NERS is a Welsh Assembly Government initiative to promote physical activity in those people who are currently inactive or who have certain medical conditions. Exercise has been shown to improve people’s health in many ways. For Example, it reduces the risk of heart Disease, lowers blood pressure, and helps weight loss. It can also help to reduce stress, anxiety and depression, therefore enhancing the participants feeling of well being. NERS has worked collaboratively with us on this project.

- 159 people were referred up to December 2016
- 87 had completed the course; 49 were currently on the programme;
- 34 on waiting list which was increasing.
- 4week review, 16 week review and 1 year review shows positive results in increased activity levels, maintaining or losing weight.

Antibiotic prescribing

The recent publication of the Review on Antimicrobial Resistance calls for a revolution in the way antibiotics are used and a massive campaign to educate people. In line with recent NICE guidelines CRP machines were purchased from Cluster funds to promote best practice in antibiotic prescribing for respiratory infections within the North Ceredigion Cluster

121 CRP Tests performed

Age groups:	16-64	75.2 %
	65-79	22.3%
	80+	2.5%

COPD 6.6%

The audit showed that CRP testing in Practice influenced prescribing in 81% of cases. 75% did not require a prescription for antibiotics and having the test results helped patients to understand that although they felt unwell, they didn't need antibiotics.

Qualitative Benefits Identified

- Patients have told us that they are glad they were told they are at risk of developing type 2 diabetes, so that they could do something to prevent it.
- As I have just completed 16 weeks on the scheme I wish to record how useful I found it. I chose to attend the gym and an aerobics class and when I started I indicated two objectives - one was to be able to walk up the hills in the woods whilst exercising my dog without having to rest and the other to help with depression - I can now walk up hills and I feel the classes certainly help to lift my mood. I have found the exercise to be stimulating and enjoyable, with excellent tuition in both areas. I would recommend the scheme to anyone - I have embarked on exercise regimes in the past but have always fallen by the wayside, but I have completed this course and shall be continuing to attend classes in the future
- Patients welcomed the reassurance of the CRP test to indicate that they didn't need antibiotics at that time despite how they were feeling.

Quantative Benefits Identified

Pre-diabetic project will help reduce type 2 diabetes and the associated on going costs of treating them in the long run.

- Statistically significant changes in BMI, waist circumference and HbA1c occurred over the 12-month follow up period.
- There was also a considerable shift from the number of patients with HbA1c between 42 and 47 mmol·mol-1 (pre-diabetes), in to the below 42mmol·mol-1 category).

CRP pilot

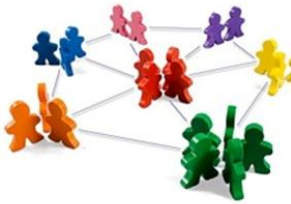
CRP Testing at point of care is effective at influencing prescribing of antibiotics. We have shown that when used in cases of respiratory infection that it can influence prescribing in 81% of cases. As a result, 75 % of patients required no prescription for antibiotics.

Plans for 2017/18

- Continue with the Pre-diabetes project for 3rd and final year of project and submit full evaluation report (including continuing to support NERS capacity)
- Continue with CRP testing in practices
- Continue to develop MDT working with partner agencies
- Implement Vision 360 to enable practices to look after each other's patients and to assist the working of cluster staff
- Progress the physiotherapy in Primary Care model
- Progress development of the diabetes service delivery model in North Ceredigion
- Implement and evaluate the Pulmonary Rehabilitation VC project
- Pilot community pharmacy sessional time within the cluster
- Roll out the mindfulness service

Funding Committed to Agreed Locality Plans	**Recurrent Annual Budget :**
• Pre-diabetic project support for this final year PHD student, Dietetic £ 12,100 • ANP salary & on costs £ 77,626 • Frailty nurse salary & on costs £ 32.968 • NERS for £16,000 • mindfulness service £8,000 • Community Pharmacy time £1,500 • SLA payments (pre-diabetes project) £12,846 **TOTAL BUDGET PLAN FOR 2017-18 £161,040** • Recurrent Annual Budget £135,540 • **Shortfall for 2017-18 delivery £25,500**	• Total 2016 – 17 Budget £135,540 • 2015/16 Carry forward 0 • **Slippage 2016/17 £25,500** (19% of total budget)

South Ceredigion
2016-17 Summary Investment Report



Our Network : Are all invited to every Cluster meeting:

Dr Darren Chant	GP Lead/ Teifi Surgery
Carys Davison	Primary Care Locality Development Manager
Tracey Huggins	Locality Practice Manager Lead (Cardigan Health Centre)
Heledd Hallett	Locality Community Optometric Lead (Specsaver Cardigan)
TBC	*Locality General Dental Lead*
TBC	*Locality Community Pharmacy Lead*

GP & Practice Manager : Teifi Surgery, Ashleigh Surgery, Bro Pedr, Llynyfran Surgery, New Quay Surgery, Meddygfa Emlyn & Cardigan HC
County Team Hywel Dda UHB : Ceredigion County Director, Community and Primary Care Nurse Manager, Community Nursing Team Leader, General Manager
Public Health Wales : Consultant in Public Health
Hywel Dda UHB Corporate Team : Head of GMS, Practice Nurse Advisor, Medicines Management Pharmacist
Locality Specific Roles : Cluster Frailty and Chronic Disease Pharmacist, Frailty and Chronic Disease Nurses
Ceredigion Council Roles : Director of Social Services
3rd Sector Integration Facilitator

Population Health Needs

- Above average percentage of patients aged over 65 requiring regular age and disease related monitoring
- Hypertension & Diabetes increase observed in the cluster. Hypertension is possibly due to greater age of cluster population compared to the other areas.
- Increase in Mental Health and Dementia
- Effectively manage patients aged over 50 requiring regular age and disease related monitoring with health prevention
- We serve a population of 47760 in a rural environment

Locality Plan Priorities	Funding Plan Investments
• New approaches to the delivery of primary care and sustainability - cross referral and skill mix • Effectively manage patients aged over 50 requiring regular age and disease related monitoring • Continue MDT working as this has proven a valuable service change • Mental Health and Dementia • Risk stratification of patients • Appointment of additional full time Frailty and Chronic Conditions Nurse and a Frailty and Chronic Conditions Pharmacist to ensure improved geographic working for the existing staff and additional support for practices on a more regular basis	• 1 x 30 hours a week Cluster Frailty and Chronic Conditions Pharmacist – permanent contract • 1 x 37.5 hours a week Cluster Frailty and Chronic Conditions Nurse – permanent contract • 1 x 37.5 Cluster Frailty and Chronic Conditions Nurse – temporary contract /secondment 22 months up until August 2018 • 1 x 30 hours a week Cluster Frailty and Chronic Conditions Pharmacist – temporary contract until 2 March 2019 Plus travelling costs • MSDi • Vision 360

Key Locality Achievements 2016/17

- Appointed additional Cluster Pharmacist & Cluster Nurse to support the cluster team
- Working with the hospital pharmacy to ensure selected practices can obtain stock of urgent medications, following evening surgery appointments. Pilot underway and working well in Meddygfa Emlyn and Teifi. To be reviewed at the end of the pilot.

Patient specific metrics

- 316 Care Home patients received health assessment - 76 by Frailty Nurse & 240 by Frailty Pharmacist
- 343 NOTEARS Medication Reviews - 286 for Care Home patients & 57 for patients in own home
- 172 Medications which are at risk of causing falls stopped/ reduced after NOTEARS review
- 170 Frailty home visits by Frailty Nurse with 2 – 10 follow up actions per patient
- 30 flu vaccinations given by Frailty Nurse
- 27 Education and teaching sessions
- 1823 of clinical interventions carried out by Pharmacist

GP specific metrics

- 94 clinical sessions of GP time saved (3.5 hour clinical session) following a Pharmacist NOTEARS review :
    - 44.4 hours from patient homes review
    - 285.5 hours for Care Homes review

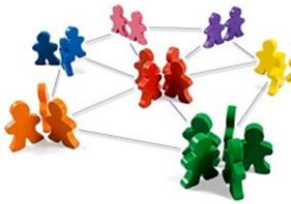
Qualitative Benefits Identified	**Quantative Benefits Identified**
• Health assessments for patients in their own homes • Safety - reduction in patient risk • Reduction in hospital admissions from falling due to Polypharmacy/nursing assessments. 172 medications which are at risk of causing falls stopped/ reduced after NOTEARS review (Potentially reduced hospital admissions) • Care Home Education . • Improved care to patients with the joint prescribing pilot with Teifi Surgery, Meddygfa Emlyn, and Bronglais pharmacy in response to early evening closure of rural community pharmacies and issues for patients obtaining urgent scripts. Emlyn emergency medications box has been used about 10 – 15 times already between 5.30 and 6.30 p.m. – mainly antibiotics. Replacements often arrive the same day following a fax which is then followed up by putting the FP10 in the post - the system is working well.	Benefits described from November 2015 to January 2017 (14 months) • **£**34,623.08 actual cost saving of stopping medications for Hywel Dda Health Board. • **£905,700** value of clinical interventions done by pharmacist • £23,423 GP time (based on £71 per hour) • 172 hospital admissions avoided

Plans for 2017/18

- Continue to build and increase support for the Cluster Frailty and Chronic Conditions Team utilise available funding to appoint Admiral Nurse and a home visiting GP, ANP or APP.
- Continue to develop MDT working
- Progress risk stratification with cluster staff MSDi
- Vision 360 to enable practices to look after each other's patients and to assist the working of cluster staff

Funding Committed to Agreed Locality Plans		**Recurrent Annual Budget :**		
• Staffing costs plus travelling	£190,976	• **2016/17 Recurrent Budget**	**£166,227**	
• MSDi	£12,000	• 2015/16 Carry forward	£15,118	
• Vision 360	£30,000	• 2015/16 Additional Funding	£23,686	
• 2 sessions admin support for cluster staff	£5,536	• Total 2016 – 17 Budget	£205,031	
• **TOTAL BUDGET PLAN FOR 2017-18**	**£238,512**			
		• **Slippage 2016/17**	**£72,285**	(35% of total budget)
• Recurrent Annual Budget	£166,227			
• **Shortfall for 2017-18 delivery**	**£72,285**			

North Pembrokeshire Locality
2016-17 Summary Investment Report



Our Network
Juliet Goldsworthy, Non Clinical Locality Lead
Amanda Whiting, Senior Primary Care Locality Development Manager
Anna Swinfield, Locality Practice Manager Lead (St Davids Surgery)
Andy Britton, Locality Community Optometric Lead (Specsavers, Haverfordwest)
Phil Parry, Locality Community Pharmacy Lead (EPP Pharmacy, Crymych)
TBC, Locality Community Dental Lead

GP and Practice Manager from each surgery: Robert Street, Barlow House, St Thomas, Winch Lane, Solva, St Davids, Goodwick, Fishguard & Preseli Peaks
Paul Smith, Locality Manager, North Pembrokeshire – County Team
Dr Cath Burrell, County Associate Medical Director for Pembrokeshire
Oliver Harries, Advanced Paramedic Practitioner, Welsh Ambulance Service
Jason Bennett, Service Manager, Pembrokeshire Social Services
Ian Scale, Consultant, Public Health
Beth Phillips & Emma Plumb, Cluster Pharmacists

Population Health Needs
The locality serves a population of 64,521 in a rural environment; this is the largest population of the clusters within HDUHB.
The population has an above average percentage of patients over the age of 65 who potentially have the greatest impact on primary care with more chronic illness that will need active management.
The locality has a higher than the Health Board average in disease prevalence for a number of chronic conditions including Diabetes, Asthma, Cancer, COPD, Heart Failure, Cancer, Mental Health, Stroke, Rheumatoid Arthritis and Epilepsy
The locality is a tourist destination and the population significantly increases during holiday seasons.

Locality Plan Priorities	Funding Plan Investments
• GMS Sustainability • Advanced Care Planning • Continued improvement in discharge summaries • Continue to increase self referral in to counselling service • Remote access to patient records with available federated approach to service provision	• 1.8 WTE Cluster Pharmacists – permanent contracts • Laptop x 2 mobile phone x 2 for Cluster Pharmacists • 1.2 WTE PSF ACP Nurses – voluntary sector project • 3.5 WTE Community Phlebotomists • Running costs for Pembrokeshire Counselling • Implementation and running costs for WiFi • Implementation and rollout of Vision 360 & Vision Anywhere • 12 week pilot Home Visiting Service with 1 GP & 1 APP • Pembrokeshire Young Persons Counselling Service – funding for development of a website with direct access booking facility for GPs • Joint frailty pilot with Consultant and Community Frailty Nurse • Tablet for each practice for use with Vision 360/Anywhere • Screen project with the voluntary sector for Bowel, AAA, Breast & Cervical • Foot screening for housebound diabetic patients working jointly with Community Podiatry • Purchase of RCGP Leaflets for parents – When Should I Worry • Practice Managers Conference – four places

Key Locality Achievements 2016/17

- 12 week pilot of Home visiting service with 1 GP and 1 Advanced Paramedic Practitioner with federated access to Vision 360 to access patient records
- Appointment of 1.8 WTE Cluster Pharmacists
- Implementation of remote access to patient records by GPs whilst undertaking home visits (Vision Anywhere)
- Continued increase in the number of patients with an Advance Care Plan in place
- Continuation of the Community Phlebotomy Service
- Continuation of funding for Pembrokeshire Counselling Service
- Establishment of Wifi at each practice
- Direct access booking via website establishment with Pembrokeshire Young Persons Counselling Service
- Pilot of Joint Frailty Clinics run with a GP & Consultant in the Community
- Pilot for foot checks for housebound diabetic patients working jointly with Community Podiatry
- MHOL rolled out in seven of the nine practices

Qualitative Benefits Identified	Quantitative Benefits Identified
• Case Study: Mr B, a 90 year old man with advanced dementia: He lived in a nursing home in Pembrokeshire. A hospital admission a couple of months earlier had caused him a great deal of distress and it had been hard to meet his needs in the hospital setting. His family were invited to an awareness-raising event at the care home. Following this, the family worked with the ACP service and care home staff to produce a document to inform any future best interests decision (and RBID). About 3 months later the patient's health deteriorated suddenly. *"His health suddenly deteriorated in the middle of the night and initially it was felt that he should be transferred to the A&E dept in Carmarthen. However, when we highlighted the RBID documentation and his DNACPR form he remained in (Care Home) and died 12 hours later. We cannot thank you enough for supporting us through the process and allowing Dad to die where we had chosen for him."* • Paul Sartori foundation also have increased awareness raising of ACP, holding events in care homes and sheltered housing. • Some unanticipated benefits have also been realised, such as identifying patient misunderstandings about diagnosis and medication and referral of patients for attendance allowance and other hospice services. • Community Phlebotomy service has improved patient experience and patient sense of being 'valued'. Community Phlebotomy - Reduced spoilt / damaged blood samples & deduced errors / missed venepunctures • Integration of the phlebotomy service within District Nursing / GP Practice has facilitated escalation of others patient needs / signposting to other professionals / services	• Advance Care Planning - 101 referrals & total number of contacts was over 600 (12 months) • 219% increase in Advance Care Plans – 74 – 162 • Over 500 health and social care professionals and 300 members of the public have attended educational sessions throughout Byw Nawr/Dying Matters week. • Expected increase in the % of patients dying in their preferred place of care – information requested from practices but not yet received. • 196 referrals and had 826 patient contacts for Pembrokeshire Counselling (9 months). 127 patients received counselling from the service and 48 patients were signposted to alternative services.

Plans for 2017/18

• Cluster Pharmacists – Supporting sustainability for practices, work plans include on the day authorisation of repeat medication requests, medication

changes as a result of discharge letters, medication reviews with patients, face to face rheumatoid arthritis reviews, routine thyroid blood monitoring, asthma/COPD reviews with a review of respiratory prescribing, medication review of patients in a nursing home, review of a practice repeat prescribing process, polypharmacy reviews, attending practice meetings, providing training for practice reception staff on reauthorisation of scripts, DMARD monitoring and liaison with the Dietetic Team to change scripts for SIP feeds

- Paul Sartori Foundation – Advance Care Planning and care home education aiming to keep patients at home when appropriate
- Pembrokeshire Counselling – Primary counselling service reducing attendances at Practice and within A&E
- 2.5 WTE Community Phlebotomists for six months – Cost effective support to the DN Teams, providing care by the appropriate person at the appropriate time
- Vision 360 & Vision Anywhere – Supporting sustainability and allowing service development with a federated approach
- Wifi for GP Practices – Supporting sustainability and allowing the expansion of MDT working with partner organisations
- Practice Managers Conference – networking and education

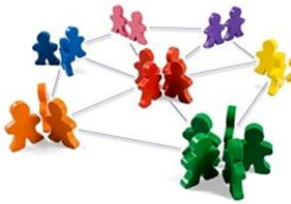
Funding Committed to Agreed Locality Plans

Cluster pharmacists 1.8 WTE	£100,440
Wifi	£4,000
Vision 360	£6,000
Paul Sartori	£53,445
Community Phlebotomy (2.5 WTE for six months)	£28,500
Pembrokeshire Counselling Service	£11,000
Practice Managers Conference	£800
Expansion to HVS	£10,000
Rollout of Frailty Clinics	£10,000
TOTAL BUDGET PLAN FOR 2017-18	**£224,185**
Recurrent Annual Budget	£206,319
Shortfall for 2017-18 Delivery	**£17,866**

Recurrent Annual Budget :

2016/17 Recurrent Budget	£206,319
2015/16 Carry Forward	£18,216
2015/16 Additional Funding	£29,399
Total 2016/17 Budget	£253,934
Slippage 2016/17	**£8,000** (3% of total budget)

South Pembrokeshire Cluster
2016-17 Summary Investment Report



Our Network

Dr Richard Bury - Locality Lead
Lucie-Jane Whelan – Locality Development Manager
Kirsty Gilling - Locality Practice Manager Lead
John David-Neyland Pharmacy - Community Pharmacy Locality Lead
Roger Rees - Community Optometric Lead
TBC - Locality Dental Lead

GPs & Practice Managers from all 5 practices
County Director & Commissioner for Pembrokeshire
General Manager Community & Primary Care –Pembrokeshire
Locality Manager South Pembrokeshire
County Associate Medical Director - Pembrokeshire - OOH GP
Community & Primary Care Nurse Manager, ANP Fragility, CNS Heart Failure
Welsh Ambulance Service NHS Trust
PHW Consultant
Clinical Development Manager Paul Sartori Foundation
Pembrokeshire County Council
Cluster OTs
Cluster Pharmacist
Healthy Lifestyle Advisors
Health & Wellbeing Facilitator

PAVS and a Community Connector for the local area
Pending representation from Secondary Care and Mental Health

Population Health Needs

- Fragility/ Falls
- Increase in Mental Health & Dementia
- Cancer
- COPD
- CVD
- Diabetes/obesity/education programmes.
- We serve a population of 54,315 in mainly rural area with 99.1% of the cluster classified as Rural across 5 practices the largest practice having 24,658 patients to the smallest 3,592.

Locality Plan Priorities

- GMS Sustainability.
- New approaches to the delivery of primary care.
- Occupational Therapists
- Healthy Lifestyle Advisors
- Pharmacist.
- ACP

Funding Plan Investments

- 1 x 37.5 Cluster Pharmacist will prescribing by May 2017 course funded by cluster. Permanent after March 2017.
- 2 x Occupational Therapists – 1 WTE and 0.88WTE
- 2 x Healthy Lifestyle Advisors – Band 5 , 37.5hrs and Band 4, 30hrs (but from 1st April 2016 band 4 will be 15hrs) total 52.5
- ACP – Paul Sartori
- Community Ph*lebotomy Service 12 weeks (55hrs)*

Key Locality Achievements 2016/17

- Appointment of Healthy Lifestyle Advisors Project employed through Narberth Surgery - 37.5 hrs & 30hrs.
- Appointment of Occupational Therapists – Employment of 2 x OT 1 WTE and 0.88 following on from the successfully pacesetter project in Argyle Medical Group Practice
- Appointment of a Cluster Pharmacist 1 WTE – cluster funded the pharmacist prescribing course and she is now has a permanent contract from March 2017.
- ACP – working in the practices & nursing homes to continue the increased and uptake.
- Continuation of the Community Phlebotomy Service.
- 7 x CRP machines purchase for all 5 practices to use but no consumables purchased.

- Access to the Pembrokeshire Young Persons Counselling Service
- Education talks taken place for all clinical professional staff with Secondary and Acute Consultants.
- Flu Education Talks
- POCT Equipment purchased and consumables for HLA project.
- Lifestyle Advocates Training in four of the practices.
- CAVO Screening with PHW
- Expand multi- disciplinary working across the South cluster area.
- Working with the ANP Fragility and CNS Heart Failure supporting them imbed in to the area with equipment from IT, to ECG machines and a bladder scanner.
- Health Promotion Events in two of the practices Saundersfoot and Narberth surgery.
- An additional PPG within the group – Narberth Surgery.

Qualitative Benefits Identified

- Positive patient feedback and successful lifestyle changes

  "I feel much more positive about life, I've taken your advice and walk at a faster pace while out with the dog, me and my daughter have contacted Stop Smoking Wales and I can see that my change in attitude is also helping to motivate my daughter, who has her own issues"

- Improved patient safety in Nursing Homes – Pharmacist.
- Education within practices/nursing homes.
- Set up COBWEB in all practices – Pharmacist
- Holistic OT assessments which proactively resolve health & social care problems at an early stage.
- Improved advice, support and liaison between professionals.
- Reducing falls, improving safety and confidence enabling people to engage in daily life.
- Positive patient feedback for community phlebotomy service – increased patient satisfaction.

Quantative Benefits Identified

- **£6,800** actual cost saving of stopping medications in Care Homes
- **£36,500** value of contributions by the Pharmacist in the 5 practices**.**
- 20 saved GP appointments per day from Pharmacist medication reviews**.**
- Potential reduced admissions from Occupational Therapist timely response**.** The Occupational Therapists have had seen 196 new patient referrals since the OT's where employ on 14th Nov 2016 as part of the cluster team. This being the case reduced admissions situation are around 2 to 3 per month cost £3000 per month over a year this could potentially be £36k
- 143 patients assessed by healthy lifestyle advisers – 60 under 3 month review.
- 290 community phlebotomist appointments per month (mean) resulting in saved DN time to focus on more complex and end of life patients.

- ACP with Paul Sartori to embed them within the practice to support the patients who wish to discuss Advance Care Planning and also visited the nursing homes for Tea Parties to raise awareness.

Plans for 2017/18

- Build on the Pharmacist model to include independent prescribing from May 2017 - cardiovascular focus.
- Build on Occupational Therapist role to enable them to see the patients in a more timely manner**.**
- Continue Paul Sartori Foundation ACP Team – Working out of the practices direct approach with patients.
- Build on Healthy Lifestyle Advisor project including the Living Well Living Longer project to work.
- Utilise the POCT testing equipment & consumables within the Healthy Lifestyle Project
- Introduce CMAT Physiotherapy /service model into Locality meetings.
- CAVO screening project
- Address education needs for patient and professional**.**
- Further develop the CRT model with the County Team.
- Develop a schools project as a test bed with Argyle Medical Group Practice using the Donaldson approach working jointly with a local school, HDUB, Primary Care, PHW, GP, Practice Manager, and Service Improvement Team.
- Progress the Vision 360 or EMIS anywhere with the cluster area to enable more mobile working.
- Continue to work with Secondary Care colleagues to improve working with clinical discharges.
- To improve the MHOL experience within practices.
- Expand MDT across the Locality.
- Scoping Meeting with the Practice Managers every other month to the cluster meetings to scope you projects.

Funding Committed to Agreed Locality Plans

Pharmacist	£50,756
Occupational Therapists x 2	£95,058
Healthy Lifestyle Advisors x 2	£36,789
Community Phlebotomy Service	£8,112 (12 weeks)
TOTAL BUDGET PLAN FOR 2017-18	**£190,715**
Recurrent Annual budget	£179,566
Shortfall for 2017-18 delivery	**£ 11,149**

Recurrent Annual Budget

- **2016/2017 Recurrent Budget** **£179,566**
- 2015/2016 carry forward £19,758
- 2015/2016 additional funding £25,587
- **Total 2016 – 2017 budget** **£224,911**

- **Slippage 2016/17** **£8,012** (4% of total budget)