PC 06

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: Bwrdd Iechyd Prifysgol Hywel Dda

Response from: Hywel Dda University Health Board

1) Introduction

a) Clusters have been established across Hywel Dda for over 5 years. Our focus has been on developing these Localities to become increasingly integrated and able to both plan and deliver services for local communities based on population needs and a meaningful understanding of the local context.

b) There has also been significant work undertaken at a Health Board wide level to develop our strategy for a future Primary and Community service which is integrated and provides high quality and responsive care on an equitable basis.

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

a) In Hywel Dda the cluster plans have evolved through discussion on the population health priorities rather than the sustainability and resilience of General Practice. Some of the projects developed have however had positive impacts on reducing demand as well as improving the route to care.

b) Clusters are trying out new workforce models of service delivery. Some are employing cluster paramedics, community and practice based pharmacists and additional nurses to trial new ways of working and help reduce the work load of the GP to free up time to see those more complex patients that need to be seen by a GP. Concerns have arisen though in the resulting increase in indemnity insurance for these staff working out in the community and an All Wales approach is needed to address this. Evaluation of these roles in pending and therefore the level of contribution is yet to be quantified.

c) Clusters have benefitted where there has been strong links with the 3rd sector. This enables them to tap into resources that could more appropriately address some aspects of health and well-being. Carmarthenshire in particular suffers from the loss of the Health & Well Being Facilitator role which previously bridged CAVS, the 3rd Sector and Health and Social Care. However in Pembrokeshire and advanced care planning project has been commissioned from the 3rd sector as has youth counselling.

d) Cluster frailty services have been developed by employing frailty nurses and/or pharmacists which is helping to ease some of the pressure on the workload of GPs and providing a higher quality of service for those frail and vulnerable patients who are at risk of deteriorating. For 2017/18 there needs to be an evaluation of the various models and consideration of how to integrate the new Care Homes DES into these projects to promote further development of the strong MDTs already formed.

e) There is agreement that the cluster can be a forum for discussing broader GP sustainability issues, primarily stemming from workforce challenges and increases in patient demand. This work will be further developed in 2017/18.

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

a) The traditional model of General Practice is no longer seen as the only or even the optimal service delivery model. There is a need to look at alternative ways of working in order to ensure high quality, prudent yet effective care, combined with the need to meet service demand. It is only by trialling new roles through clusters and the Primary Care Support Team (PCST) that we will start to know what the ideal model looks like. This is essential if we want to ensure we have a flexible, skilled and motivated workforce and an integrated health system in Hywel Dda.

b) Clusters are up skilling their workforce and employing other professionals to enhance the MDT. New multi-disciplinary teams have been introduced and include Occupational Therapists, Physiotherapists, Advanced Paramedic Practitioners, Pharmacists, Mental Health Support Workers, Third Sector Support Workers and telephone consultations commissioned remotely. The benefits to date include:

   i) Reducing demand on GP's by addressing and resolving underlying issues that are the root cause of multiple and regular contacts

   ii) Releasing GP's, practice and community nursing staff time to focus on doing what only they can do

   iii) Proactively resolving health and social issues at an early stage, minimizing crisis situations that result in presentation/admission to the acute hospital

   iv) Sustaining people at home following discharge from hospital

   v) Releasing professional capacity by enabling people to maximise their own potential, promoting self management, preventing ill health and dependency

c) Carmarthenshire is unique in Hywel Dda in that all three clusters are integrated with the Community Resource Teams and have strong local authority representation. Discussions have commenced with further evolving local authority engagement in the other two counties.

d) MDT Frailty services have also been implemented on a cluster basis with specialist nursing teams, district nursing team in addition to community teams and the third sector.

e) Clusters are currently measuring contribution against number of referrals into secondary care, admission rates, reduction in number of GP appointments required in practice and staff and patient satisfaction surveys.

f) The Health Board has committed funding to enable the wider primary care professionals to engage in the cluster decision making and project development and delivery. Lead pharmacy, optometry and dental roles have been developed and are being recruited to. It is believed that this will support broader integration and multi-disciplinary working. The benefit of these professional roles has not yet been established with a number of vacancies still being recruited to.

4) The current and future workforce challenges

a) GMS Contractual impacts – Notice has been served on a number of GMS contracts, although two were later rescinded. There are now two Health Board managed practices and a number of practices approaching the Health Board with sustainability of services issues.

b) Workload pressures arising from an aging population with multiple chronic conditions and more complex care needs.

c) Workforce challenges - 30% of GPs expected to retire within the next 5 years. Recruitment of vacancies is increasingly hard due to the geographical location of some Hywel Dda practices. There is also a reluctance of younger GP's to 'buy-in' to the practice with the preference seeming to be for a salaried GP position where the administration that comes with partnership is not present.

d) Training & education – there are low fill rates of GP training schemes in Hywel Dda, across Wales and nationally in the UK. The new bursary offered has demonstrated a significant increase in applications for 2017 from previous years which is welcomed. Education commissioning will need to be adjusted for health professionals dependent on the emerging new models.

e) New and alternative models of care – replacing like-for-like is not only unfeasible but may not the best option. These models are still being developed although early outcomes and feedback from patients is positive. Creating a truly integrated service for the future that promotes collaborative working with other services is dependent on engagement from all.

f) There are currently 53 GP practices, of which 24 have registered populations of below 7,500, these small practices offer strong continuity of service but are increasingly fragile and unsustainable. The Health Board is keen to develop collaborative and integrated future models which would still enable independent contractors to thrive but could grow new robust models around core service delivery. This will also bring new challenges for the future workforce and GP practices, who have rarely worked or collaborated with other practices in this way before.

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

a) Cluster working has enabled innovative approaches to health promotion for a well and happy community. Development work to support Primary Care staff in using 'asset based' approaches in everyday contacts – supporting individuals to think about how they themselves might find novel solutions to social as well as medical difficulties – has been made possible through cluster working.

b) Hywel Dda UHB Clusters have particularly invested in a The *Lifestyle Advocates: Promoting Health in Practice* development programme which works to embed a healthy lifestyle and health promotion ethos within surgeries and pharmacies. (A first year evaluation of this programme is available).

c) Increased action to extend the opportunities for support to quit smoking, support for healthy weight in pregnancy and community resilience projects have also been developed through Health Board primary care funds.

d) Two clusters have invested in pilots to run an Acute Home Visiting Service to address an element of GP workload, release practice capacity for other work, and develop shared clinical services across practices. Visiting is a demand on practice resources because of rurality and ageing population. Pilots aim to establish if organisational barriers can be overcome and if further work is worthwhile.

e) The 2Ts has used their cluster funding to employ a Generic Technician who is based within the Community Resource Team but only receives direct GP referrals, being based with the social work team has up-skilled her to pick and be able to address some of the social prescribing needs for patients referred to her. The 2Ts have also employed 3 practice based pharmacists who work within the GP practices undertaking medication reviews, clinics where appropriate etc. to reduce the need for patients to see GPs for routine medication issues thereby freeing up GP and practice nurse time.

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

a) Primary and community health care services have a significant contribution to make to population health improvement and addressing inequities in health.

b) Primary care health workers are more directly aware of the wider social determinants of health affecting the people they see every day. A direct example would be the health and work agenda. Primary care plays a pivotal role in the management of sickness absence and sees individuals experiencing the negative health consequences of workless-ness. In addition, illness caused, or exacerbated, by the workplace may present in primary care.

c) Health professionals within primary care can impact on health behaviour change in relation to smoking, alcohol, diet, exercise, sexual health and protection from sunlight as well as supporting mental well being.

d) Modern approaches that address healthy choices: health literacy, self efficacy, resilience, locus of control and social capital are beginning to feature in discussions at Cluster level as the new partnerships develop.

e) The majority of immunisation programmes are implemented through primary care. In addition, the detection of outbreaks as well as the management of infectious disease contacts is supported by primary care. Primary care providers have an important role to play in prevention, transmission and control of many diseases including communicable diseases.

f) Health Needs assessment lies at the heart of all action. Practices and Clusters are practised in describing their populations as a precursor to making their annual plans. The local Public Health Team has been supporting the development of these Assessments and in improving the methodology used to better inform planning and funding decisions.

g) Two clusters now run pre-diabetes projects – highlights the benefit of having a brief intervention discussion on lifestyle changes to help those at risk, reduce their risk of developing type 2 diabetes.

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

a) Clusters are at different levels and all are developing and adding to their membership, with Pharmacy, Dental and Optometrist leads making a valuable contribution in some.

b) A draft maturity development framework has been discussed but this needs to fit within the emerging Health Board integrated primary and community strategy. The Health Board is committed to the Locality (cluster) as the model of service planning and service delivery.

c) The Pacesetter programme has been particularly helpful as a forum for sharing good practice across Wales. The All Wales Heads of Primary Care Group has also shared lessons from cluster working and development to enable cross organisational learning.

d) Within the Health Board, bi-annual Big Proactive Care events are held to share learning from clusters, pacesetters and broader primary and community service improvements.

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

a) Clusters are evolving rapidly. Although they have only held devolved budgets for less than 2 years, in Hywel Dda prescribing management savings were awarded to clusters in the two previous years. This has enabled cluster to develop priorities and deliver services based on population health needs.

b) Learning is constant, particularly regarding financial governance, procurement and recruitment however when lessons are learnt these are shared at bi-monthly Locality Development Network meetings.

c) Primary, Community and corporate team staff are aligned to clusters to enable sufficient support to be made available, this includes dedicated Locality Development Managers.

d) Work is needed over the next year to formalise a wider membership of clusters and align to the IMTP in a more structured way.

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

a) Hywel Dda Health Board has invested in specific evaluation skills and project management training to aid evaluation of projects. All clusters have and will continue to have access to this development as well as to coaching skills to facilitate better communication and collaborative working skills.

b) Through the University links, Aberystwyth University have offered to undertake the evaluation of the pre-diabetes project.

c) Public Health Wales have already undertaken an evaluation of the Lifestyle Advocates programme and will support with the evaluation of the CRP project.

d) Clusters are expanding their membership to include representation from Social Services, Community, Secondary Care, Welsh Ambulance Services Trust & Optometry.

e) An evaluation programme has been developed in order to provide assurance to the Health Board in addition to enabling the consideration of whether projects need to be scaled up or funded sustainability from core funding sources. One example of and evaluation is the high levels of data are being collated by the frailty team. This includes their activity levels, referrals, clinical interventions and cost savings, all of which provides evidence of success. There has been some challenge from GPs regarding the level of evaluation and assurance required by the Health Board.