Welsh Government FAQ Guide to cluster leads on funding in 2016-17

Where does the funding for your cluster to invest come from?

It comes from our national primary care fund.

We have created the fund to help health boards working with their partners, including working at cluster level, to go further and faster with the pace and scale of modernising primary care. We set this out in our national plan for a primary care service for Wales. http://gov.wales/topics/health/nhswales/plans/care/?lang=en

The primary care fund has 3 priorities:

- Achieving sustainable primary care services;
- Improving access to the right care, at the right time, from the right person;
- Delivering the majority of care locally.

Why do we see primary care as so important?

Primary care is the core element of a sustainable and modern health system. As the population of Wales increases and ages, demand on primary care is increasing. Public expectations are changing and will require new approaches. We are committed to supporting the solutions front line services identify to ensure sustainable services and timely access to the right care.

We want a social model of health and wellbeing, which draws in all sources of help, not just the NHS, with a focus on supporting people to do what matters to them through proactive care close to home from a wide range of professionals and services working in a coordinated way to prevent and anticipate people's needs.

What do we mean when we say 'primary care'?

Building on the strong core General Practice network and we include services provided by dentistry, community pharmacy and optometry, as well as other local NHS services such as community nursing and therapy teams, mental health teams, and health promotion services. We also include in our definition those services for local communities provided by local authorities and the third and independent sectors.

Why are we allocating funding for clusters to decide how to invest?

We believe that those who know local issues best can make the most effective use of community resources by working together to address those local issues. Clusters are the central mechanisms for supporting this way of collaborative working at a very local level.

Cluster working, brings those responsible for planning and funding services together with those responsible for delivering them, enables innovation and local leadership to flourish. Public health teams are providing detailed support to clusters for the development of local needs assessments, helping to ensure that local priorities are based on robust data and information.

Each cluster is unique with its own individual local needs and circumstances although there are many shared priorities across Wales. Each cluster works as part of the health board whose integrated medium term plan sets out health board strategic objectives. As clusters mature, their local assessment of need will increasingly inform and shape health board and other public services plans.

The funding in 2015-16 has been very successful in showing the benefits of cluster working with examples of innovative local solutions. Appendix 1 lists examples of how the funding has been used.

This year, we want all clusters to develop further by drawing in routinely more and more of the other local services not already part of the cluster. For example, dentistry, optometry, community nursing and therapy teams, mental health teams, health promotion services, social services, housing services, education and leisure services, Communities First, and very importantly, third sector services. The 'parent' health board can help facilitate this, making and supporting appropriate connections.

We believe this more multi professional, multi sector make up of clusters will identify what other resources and assets are available to the community to make even more effective use of the funding.

We also want clusters increasingly to take the opportunity to rethink the delivery of services for their populations traditionally delivered in hospital settings - matching services to the aims of prevention and early diagnosis and management.

What can my cluster spend the money on?

This is revenue funding available every year from 2016-17, which means you can invest it recurrently, such as on staff, or you may decide to include some one-off, non-recurrent spend, such as training and education or project work.

To help inform your spending plans, you may find appendix 1 helpful with its examples of what clusters invested in last year and the following which illustrate our thinking. The overarching priority is clusters being able to show how wider primary care professionals and services have collaborated to agree spending proposals. .

Illustrative Examples

Achieving sustainable primary care services

- Staff retention e.g. Career advice to identify opportunities to retain staff through initiatives across the career pathway;
- Expanded Practice Management roles;
- Match clinical commitment to academic, research and leadership opportunities- highlight local opportunities;
- Collaborative recruitment initiatives for new workforce;
- Maximise the potential of My Health on Line;
- Local training to explore demand management including telephone triage systems;
- Consider a collaborative local unscheduled care response in-Hours- exploring the contribution of paramedics, advanced nurse practitioners and salaried GP and other professional roles.

Improving access to the right care at the right time from the right person

- New workforce roles to support existing teams
    - Care coordinators/system navigators;
    - Medical assistants;
    - Physicians Associates.
- Enhanced clinical teams
    - Pharmacists, therapists, paramedics, healthcare support workers.
- Enhanced non-clinical support
    - social workers and access to housing, safety, debt and legal advisers.
- Develop local expertise in wellbeing services and coordinate protocols and pathways for systematic access and referral
- Actions to strengthen anticipatory care planning
    - Long term conditions;
    - End of life care.
    - Vulnerable groups such as
        - Frailty;
        - Mental health;

    - Learning disability.

- Increase local delivery of services to improve the management of people with chronic conditions, such as pulmonary rehabilitation, diabetes structured education,

Delivering the majority of care locally.

- More capacity for your cluster leadership team.
- Organisational development and training activity to support cluster working new models of care, new partnerships with local services etc.
- Activity to map local services and referral protocols and access pathways so people know when and where to go for the right help at the right time.
- Support for Ambulatory Care Sensitive conditions in the community.
- Care coordinators to identify opportunities to develop new pathways and to support transitions in care.
- Community based specialist teams, telephone access for urgent advice.

Can my cluster pool its funding with another cluster?

Yes.

Do I have to produce formal spending plans?

We do not want to bog you down in bureaucracy. As this is public money, it is of course only right there is a 'proportionate' oversight by the health board which remains the accountable body. We suggest you agree a "light touch" approach with your health board on how to capture the following in a **brief** written document on your spending plans:

- Why you think there is a case for this investment for your community?
- What you expect the investment to achieve?
- When you expect to see results?
- How you will know if it is delivering the intended results?

The health board may be able to help, such as offering a basic template or someone to write up your ideas on your behalf.

Is there any help and advice I can access?

Your health board can provide and coordinate help and advice, such as making links between its clusters for sharing ideas where there are similar priorities. The health board will be able to make connections with other sources of help, linking to the Public Health Wales' new Primary care Innovation and Development Hub and other learning from other health boards.

Appendix 1E

Examples of work being taken forward by primary care clusters across Wales.

Information provide by each health board as of 31 December 2015.

Local Health Board	Examples of work being taken forward by primary care clusters
Cardiff and Vale University Health Board	• Employed additional dedicated Pharmacist /Prescribing Advisors in practices to help reduce harm and waste from polypharmacy while maximizing the benefits of treatment, and provide additional specialist support to patients with complex medication regimes. • The cluster has invested in the development of specialist nurses who can provide additional support to the growing health needs for frailty and dementia. These nurses will work across practices and be linked into the Local Community Resource Team, where they will be able to access resources such as therapists, Consultant Gerontologists and the voluntary sector so as to enable patients to maintain their independence and health for as long as possible in the community. • A cluster based Pulmonary Rehabilitation Programme, meaning patients can access the service locally within the Cluster, rather than having to go to University Hospital Llandough. • A community diabetes service with a Diabetes Nurse Specialist working at a cluster level to support patients locally, this service will also provide enhanced information advice and sign-posting, promoting self-care. • More ambulatory blood pressure monitoring (ABPM) is taking place in primary care. This ensures more accurate diagnosis of hypertension (avoids over-diagnosis) whilst reducing workload for doctors and nurses.
Aneurin Bevan University Health Board	• Employing pharmacists to support practices with medicines management. • Practice based social workers to support practice teams and enhance collaboration with Local Authorities. • Developed a Dementia Road Map for professionals, patients and their carers. • Supported a Counselling service in Newport to improve access. • Additional dietetic and physiotherapy support to provide additional support for the implementation of the obesity pathway in Blaenau Gwent.

Abertawe Bro Morgannwg University Health Board	• Improved identification and management of chronic conditions management in primary care. • Supporting Self care. • Development of network-based community services. • Patient Engagement. • Patient Safety.
Hywel Dda University Health Board	• **Frailty -** Practices have nominated a clinical frailty lead and are identifying frail patients utilising a practice based IT system. Patient's identified are having a written Stay Well plan which includes details of carer, health and social care summary , optimisation and maintenance plan, escalation and urgent care plan. GPs have also been given further training in frailty recognition. To date 177 Stay Well Plans have been completed. • **Lifestyle Advocates** - The aim of the Lifestyle Advocates project is to embed a healthy lifestyle and prevention ethos and practice within primary care clusters, by identifying enthusiastic individuals to become skilled advocates of lifestyle behaviour change. • **Pre-diabetes Care** - One cluster has initiated an integrated project to reduce the risk of developing diabetes within their population. This project has GP surgeries working collaboratively with the dietetic department, PHW, 3rd sector, Aberystwyth University, Education for patient volunteers, NERS and lifestyle advocates following NICE guidelines to proactively screen and identify those at risk. Once their risk score is known they are signposted & encouraged to attend the relevant support services, to help them make healthy lifestyle choices. As part of this project the cluster are supporting the Lifestyle advocate Programme and aim to develop this role further in increasing the capacity of the food wise delivery. • **GP Dementia Review Clinic -** One cluster with high prevalence of dementia has recognised this as an area to develop. Representatives of the practices within the locality met to increase their knowledge of dementia in order to both improve practice and also to identify commissioning opportunities. A Community Memory Clinic has been developed from this initiative. The establishment of the clinic was an innovative development as there was no precedent to learn from. • **Paul Sartori ACP Nurses** - Appointment of 1 WTE (2 part-time posts - each linked to specific practices) Advance Care Planning Nurse Facilitators to the Paul Sartori Foundation. The remit of the posts is to assist practices in identifying people for whom

	ACP might be most urgent and relevant, and working with those patients to complete ACPs. The starting point was patients already on the Palliative Care Register, but then also potential candidates among patients with chronic conditions.
Powys Teaching Health Board	• GP Recruitment Campaign - Contribution to an all Powys recruitment campaign (actual total to be agreed based on cost of HCA support). • Support for role of Physician Associate - Funding the employment of one Physician Associate to work in the cluster area, together with funding for mentoring and support costs such as travel. • Setup of 'WebGP' in the 5 practices in the Cluster - WebGP is a website that links patients with their GP Practice through online consultations or 'web-consults'. • Website development for each practice within the Cluster - Supports the introduction of WebGP by ensuring an accessible website in each practice.
Betsi Cadwaladr University Health Board	• Near Patient testing and other equipment to provide equity of access to keep patients away from hospitals. • Access Collaboration – various in house practice projects to improve access to services in primary care. • Additional Staff - Pharmacist based within the practices and shared across the cluster. • Advanced Physiotherapy Practitioner to be based in GP practices, or centrally based if space not available within the surgery. • Diabetes Specialist Nurse clinic.
Cwm Taf University Health Board	• Purchase of **Vision Anywhere** which will enable the practice teams to access contemporaneous patient notes during house visits and care home visits. This will have significant impact on improving patient safety and governance. • Employment of **dedicated pharmacists** to work with and alongside the wider Primary Care Teams. This will free up more time for GPs to focus on consultations and to gain valuable advice regarding medicines use and reviews. It will also improve access as the pharmacists will be able to hold their own clinics. The pharmacists will also be enhancing their skills by completing independent prescribing qualifications. • Appointment of a **behavioural change coach** to work with patients who are frequent

	attendees at practices and whose condition could be managed more appropriately by themselves • Introduction of **WebGP** to enable patients to access advice with regard to self management of conditions • Development of **cluster based primary care wound clinics** and the development of new pathways which support simple to complex wounds therefore releasing valuable time for practice nurses. Will also give practice nurses the opportunity to up-skill in a supportive environment.