PWYLLGOR DATBLYGU STRATEGOL A CHYFLENWI GWEITHREDOL
STRATEGIC DEVELOPMENT AND OPERATIONAL DELIVERY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	23 February 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Cluster Integrated Medium Term Plan (IMTP) Monitoring Report – Quarter 3
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jill Paterson, Director of Primary Care, Community and Long Term Care
SWYDDOG ADRODD: **REPORTING OFFICER:**	Julia Chambers, Business and Risk Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Integrated Medium Term Plan (IMTP) is the key planning document for Hywel Dda University Health Board (HDdUHB) setting out the milestones and actions we are taking in the next one to three years in order to progress our strategy.

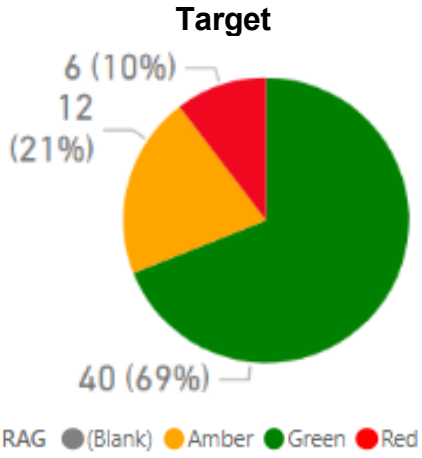
Each Cluster currently has its own IMTP setting out the vision, strategic overview and its priorities, based on the health needs of their population.

Cefndir / Background

Across the seven Clusters IMTPs, 61 objectives were identified for quarterly monitoring. Progress is discussed at each Cluster Meeting and at the Locality Leads meeting.

Asesiad / Assessment

Across the seven Clusters, 58 objectives were identified from the IMTPs. Over two thirds (69%) of these objectives (42) are reporting on target (green) to achieve the outcomes identified.



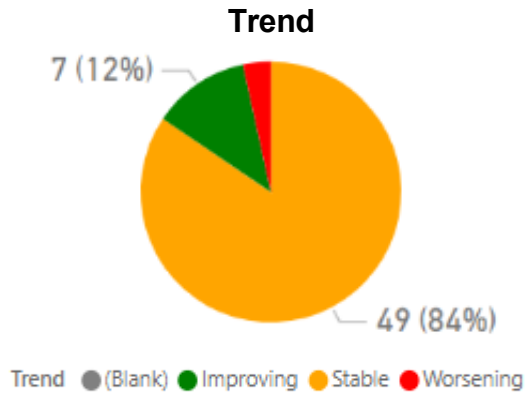
12 (21% of) objectives are of concern (amber) and have identified one or more of the following:

Amber	An amber indicator usually means one or more of the following: -Within 5% of target -A significant forecast overspend against the budget of more than 5% -Delays against critical milestones of more than 2 weeks -Problems with quality, but in the main expected benefits will be realised -Lack of resources which can be resolved by the lead / service -Dissatisfaction or resistance from stakeholders, but this can addressed by the lead / service

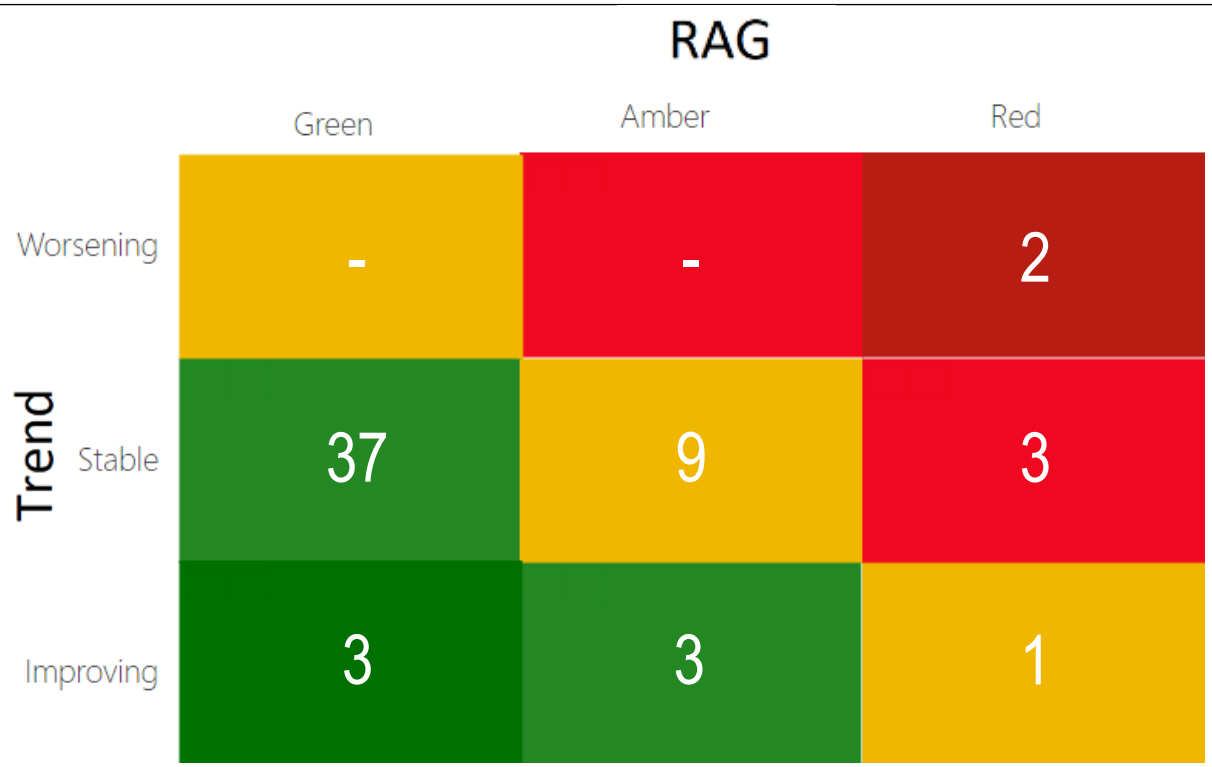
8 (10% of) objectives are of significant concern (red) and have identified one or more of the following:

Red	A red indicator usually means one or more of the following: -Significantly off target -A significant forecast overspend against budget of more than 10% -Delays against critical milestones of more than 4 weeks. -Significant problems with quality and expected benefits won't be realised -Significant lack of resources which cannot be resolved by the lead / service -Dissatisfaction or resistance from stakeholders

12% of objectives (7) have an improving trend (green). 84% of objectives (49) are stable (amber). However, 4% of objectives (2) are deteriorating / worsening (red).



The trend and target (RAG) information will be used to plot objectives on a risk grid (see below). This is used to identify where focused performance conversations are needed. For example, those falling within the green areas are progressing well and no attention is needed. However, those that fall within the red areas should be discussed and assessed to identify what resources / interventions are needed, or indeed if projects should continue if there is no feasibility of achieving their outcomes.



In quarter 2's report it was noted that all objectives (projects) with a deteriorating trend were due to recruitment issues. Several projects have now made progress with recruitment and are indicating that they are now ready to progress, including:

North Pembrokeshire	**Improved Multi Disciplinary Team working through employment of Care Co-ordinators (NP0003)** – Recently recruited 3 x 25hr posts, which are due to start in Feb / Mar 2023.
Tywi / Taf	**To reduce the number and severity of outcome of falls with the 2T's Locality (TT0016)** – Recruited a Clinical Specialist band 7 Physiotherapist who is currently in induction stage. Clinics to commence shortly. **Healthy hearts prevention project aimed at improving whole population cardiovascular health by working in partnership in the 2Ts locality (TT0017)** – a local media campaign launched in January 2023 via radio Carmarthenshire (and social media), and 2 Health Care Support Workers (HCSW) have been recruited.

Appendix A provides an overview of all Cluster projects, including their aim, most recent update, RAG and Trend status.

Argymhelliad / Recommendation

The Strategic Development and Operational Delivery Committee is requested to RECEIVE ASSURANCE with regard to the steps being taken to ensure progress of Cluster IMTPs through the monitoring and development of their projects.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.2 Provide assurance to the Board that the planning cycle is being taken forward and implemented in accordance with University Health Board and Welsh Government requirements, guidance and timescales
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Datblygu Strategol a Chyflenwi Gweithredol: Parties / Committees consulted prior to Strategic Development and Operational Delivery Committee:	Cluster Meetings Locality Leads

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Please refer to paper
Ansawdd / Gofal Claf: Quality / Patient Care:	Please refer to paper

Gweithlu: **Workforce:**	Please refer to paper
Risg: **Risk:**	Risks will be assessed as part of the ongoing monitoring of the cluster IMTPs.
Cyfreithiol: **Legal:**	As above
Enw Da: **Reputational:**	Hywel Dda University Health Board needs to meet the targets set in order to maintain a good reputation with Welsh Government, together with our stakeholders, including our staff
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Consideration of Equality legislation and impact is a fundamental part of the planning of service delivery changes and improvements.

Name and Code	Aim	Commentary	RAG	Trend
Two T's				
Support Mental Health needs of our population (TT0001)	Provision of sustained equitable access to Mental Health Services in rural areas. Provision of MIND Active Monitoring Services to ensure the right support at the right time is available for someone with mild to moderate mental health needs in Primary Care Expand MIND Active Monitoring to 11-18 year olds.	Three Mental Health support projects commissioned through MIND are well established within the cluster. These are Community Outreach Clinics,		
Delivery of Mental Health services for young people's mental health across the cluster area with focus on young suicide prevention (TT0002)	Improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come into contact with people at risk of suicide and self-harm and professionals in Wales. Deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm. Provide information and support for those bereaved or affected by suicide and self-harm. Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action	Community Developmet Officer continues networking with Mental Health Organisations, Youth workers and with Active Leisure Centre. Currently actively engaging with Schools and looking to undertake Focus Groups with young people in these settings.		
IRISi Pilot Domestic Violence and Abuse Training (TT0004)	To provide an evidence-based intervention that improves the general practice response to domestic abuse. Increase identifications and referrals of and for patients affected by DVA. Increase knowledge and awareness and challenge attitudes towards equality and domestic abuse, sexual violence and violence against women	Clinical Lead and Advocate Educator appointed and Practices have started to recieve training. The three day training has been completed. PCSM identified as Lead to sit on the monthly steering and Operational Groups. The Clinical Lead SLA and Franchise Agreement has now been agreed and signed by the Health Board.		
To integrate the Community Cardiology model with Primary Care (TT0005)	Reduction in the number of patients with palpitations and AF managed in Secondary Care and corresponding increase in number of patients with palpitations managed in Primary Care. Increase in availability and provision of relevant cardiology diagnostics in Primary Care. Reduction in pathway waiting time (patient presentation, triage, assessment, diagnosis, treatment plan/discharge) for patients presenting with palpitations and AF. Reduction in number of patients with palpitations presenting/referred to A&E/Secondary Care General Medicine	Cardiology Nurse appointed and palpitation clinics continue to be undertaken in each practice. Cardiology Nurse attends MDT with Secondary Care clinicians. Evaluation of this project is currently ongoing		

Name and Code	Aim	Commentary	RAG	Trend
Chronic Disease Management Clinics (TT0007)	Increased number of clinics for Chronic Disease Management. Reduction in backlog of patients waiting to be seen. Improved patient care.	CDM catch-up clinics are held in seven practices. These are for a number of chronic diseases such as Asthma and Diabetes.		
To reduce the number and severity of outcome of falls within the 2T's locality (TT0016)	To reduce the number and severity of outcome of falls within the 2T's locality	Cluster has recruited Clinical Specialist band 7 Physiotherapist who is currently in induction stage within post. Role is to work alongside General Practice to enhance the MDT provision of falls and frailty assessments within 2T's.		
Healthy hearts prevention project aimed at improving whole population cardiovascular health by working in partnership in the 2Ts locality (TT0017)	Healthy hearts prevention project aimed at improving whole population cardiovascular health by working in partnership in the 2Ts locality	This project will be a collaborative project encompassing primary care, community nursing, community pharmacy, dietetics, cardiology, Carmarthenshire County council and public health. The project will be delivered county wide through the use of Band 3 level staff to identify and case find via both practices and community venues coupled with a media campaign. We will aim to improve hypertension management, weight management, alcohol reduction, improved AF management and prophylaxis of primary risk factors of cardiovascular disease to reduce MI and stroke. Post currently out to advert		
Amman Gwendraeth				
My Surgery App (AG0001)	All 8 Practices to be signed-up with My Surgery App by October 2021	All Practices are engaged with the app, all are at different stages of training and implementation.		
Phlebotomy Service (AG0003)	To ensure patients within the cluster have timely access to phlebotomy services.	Practices are able to claim 6 hrs per week from Cluster funds to carry out a Phlebotomy service in Practice. Not all Practices have been able to consistently benefit from this due to capacity issues. Although cluster funding expires in March 2023, there is now a LES that Practices can sign up to where Phlebotomy claims can be submitted.		

Name and Code	Aim	Commentary	RAG	Trend
Social Prescribing (AG0004)	To implement a social prescribing service across the Hywel Dda footprint. To develop a social prescribing framework for the Health Board. Produce a common set of outcomes, principles and standards that are equitable but allow for local ownership in how this project evolves. Build on the outcomes identified by ensuring an evaluation approach underpins the model.	The two Social Prescribers continue to work well within the cluster with regular supervision and appraisals being carried out.		
Optometric Independent Prescribing (IP) & Glaucoma Certificate (AG0005)	To increase the number of Optometrists to gain Independent Prescriber status and therefore facilitate the management of patients with acute eye problems within the primary optometric care setting. To increase the number of Optometrists within the locality with advanced training to hold the Higher Glaucoma Certificate	Cluster funding was offered to Optometrists within the Cluster to undertake the IP qualification as well as a Higher Certificate in Glaucoma. 4 Optometrists have enrolled on the IP course and one is undertaking the Glaucoma certificate. The Optometrists have passed their IP exams. The Optometrist undertaking the Higher certificate in Glaucoma is still completing his hospital placement which is taking slightly longer than planned but once complete, the qualification can be awarded.		
Shadows Depression Support Group. (AG0006)	To make available low level mental health support for patients who want to self-refer, and decrease medicalisation of these concerns	Shadows Depression Support Group provides mental health support to all eight practices within the Cluster. Shadows is a voluntary organization, whose main aim is to bring people together on a regular basis in a safe and enabling environment to enhance their emotional and mental well-being. Most Practices continue to be engaged with the service. Shadows will be attending the next GP Collaborative meeting to provide an evaluation of the service.		
Dermatology Non-pigmented Lesion Clinic / Diagnostic Uncertainty (AG0007)	To improve timely access to specialist diagnostic skills and minor surgery for patients presenting with dermatological disease	A GP Partner within the Cluster has a special interest in dermatology and as such, provides a dermatology service in which all Practices within the Amman Gwendraeth Cluster can refer into directly. All Practices continue to be engaged with the service. Following agreement to increase funding to increase service provision in April 2022, this has been put on hold until 2023/24 in line with other cluster financial commitments.		

Name and Code	Aim	Commentary	RAG	Trend
Mental Health Practitioners (AG0008)	To support patients with skilled non-medical assessments with knowledge of the wider NHS and third sector mental health service landscape. To free up GP time	The project came to an end 30 Nov 2022 in line with the SLAs in place. Discussion around writing a project evaluation will take place at the next GP Collaborative meeting in February.		
Jac Lewis Foundation (AG0009)	We want to provide patients and their families with a real and constructive opportunity to receive appropriate mental health help in a helpful timeframe. We wanted more help for children and their families	The Jac Lewis Foundation provides mental health support to both children and adults to all Practices within the Cluster. JLF provide and train specialist adolescent therapists and can deliver family and play therapy. They utilise the most suitable therapeutic intervention tailored to the patients needs including CBT, counselling, other psychotherapeutic approaches, trauma focused work, group working and EMDR. All Practices continue to be engaged with the service with high numbers of referrals. Following a multi quite exercise earlier this year, JLF have now implemented a walking group within their service which isled and structured by counsellors/play therapists/family therapists as required.		
IRISi Pilot Domestic Violence and Abuse Training (AG0010)	To provide an evidence-based intervention that improves the general practice response to domestic abuse. Increase identifications and referrals of and for patients affected by DVA.	Clinical Lead and Advocate Educator appointed and Practices have started to receive training. The three day training has been completed. PCSM identified as Lead to sit on the monthly steering and Operational Groups. The Clinical Lead SLA and Franchise Agreement has now been agreed and signed by the Health Board.		

Name and Code	Aim	Commentary	RAG	Trend
Lifestyle Clinic (AG0011)	To offer practical and evidence-based access to dietary and clinical advice and support to decrease disease burden from obesity	The Lifestyle Clinic combines the expertise of an MDT led by a Cluster GP and a holistic approach to weight loss to educate and support patients to make better lifestyle choices. The project has evidenced a decreased need for diabetes medication with an emphasis on sustaining health benefits. All Practices continue to be engaged with the service, referral numbers continue to increase. Dr Frater has almost finished writing her education course in lifestyle medicine and is looking for interested clinicians who want to learn more about this work; Dr Frater has already been asked by many clinicians to observe clinics or for further information. The Health Board submitted an Obesity Bid to the Strategic Programme Fund which was subsequently approved, based on this project to enable it to be scaled up Health Board wide.		
Generic Community Occupational Therapy / Physiotherapy Technician - (AG0013)	To bring basic generic tech skills into primary care to help patients to maintain independent living	The Generic Technician has integrated into Practice MDTs and is receiving appropriate referrals.		
Cluster Pharmacist (AG0014)	Rapid clinically safe reconciliation of discharge medication. Improved governance for repeat prescribing for those patients as seen under the project. Fast access to pharmaceutical advice for General Practitioners. Improved cross sector working	One of the Cluster Pharmacists resigned from the post on 13 July 2022. The post has subsequently been advertised twice, an offer was made to one candidate who declined. The post is in the process of going back out to advert and in the meantime, the effected Practices have been allocated the funding to use a locum pharmacist where available.		
Persistent Pain Service (AG0015)	Bring specialist pain services knowledge and MDT working into primary care for timely case management and clinician support and learning	Physio and Clinical Psychologist both in post. Vacancy for Specialist Pain Pharmacist has been out twice with no success but recently, two internal candidates have expressed interest so the post is about to be advertised again. Pain Management Programmes are now up and running.		

Name and Code	Aim	Commentary	RAG	Trend
Healthy hearts prevention project aimed at improving whole population cardiovascular health by working in partnership in the AG locality (AG0016)	Healthy hearts prevention project aimed at improving whole population cardiovascular health by working in partnership in the AG locality	Healthy Hearts steering group meeting regularly and progressing work plan. Initial recruitment drive was not successful. Delay in recruitment of the HCSWs has delayed the proposed start date. Media campaign has commenced and equipment in the process of being purchased.		
Llanelli				
My Surgery App (LL0002)	All 7 Practices to be signed-up with My Surgery App by August 2021	Six out of the seven Practices signed up to My Surgery App and are using it to engage with patients. Ongoing engagement required this year to ensure this digital communication package is utilised to its full potential and linked in with Practice and Cluster websites.		
IRISi Pilot Domestic Violence and Abuse Training (LL0004)	To provide an evidence-based intervention that improves the general practice response to domestic abuse. Increase identifications and referrals of and for patients affected by DVA.	Clinical Lead and Advocate Educator appointed and Practices have started to receive training. The three day training has been completed. PCSM identified as Lead to sit on the monthly steering and Operational Groups. The Clinical Lead SLA and Franchise Agreement has now been agreed and signed by the Health Board.		
Physiotherapy MSK project (LL0005)	Work as an independent practitioner, accepting patients without prior contact or referral from their GP Offer a triage and treatment service for patients who present in the GP practice with a range of complex and common MSK conditions. Manage MSK referrals, including complex conditions that can be most appropriately managed within the surgery Work with GPs and other colleagues to develop and improve referral patters, including reducing pressures on secondary care services (including orthopaedics, rheumatology and pain	Two Physiotherapists are engaging well with all seven Practices in the Cluster. The current demand is manageable.		
Mind Llanelli (LL0006)	Continued to provide an equitable service throughout the cluster Keep access and waiting times to a minimum	Adult counselling and well-being work is ongoing and supported by all seven Practices. Demand for the service is continually monitored to prevent significant waiting times for patients or inappropriate referrals.		

Name and Code	Aim	Commentary	RAG	Trend
Family Wellbeing Service provided by Connecting Youth, Children and Adults (CYCA) (LL0007)	Continued to provide an equitable service throughout the cluster Keep access and waiting times to a minimum	Children and Family Social Prescribing, counselling and well-being work is ongoing and supported by all seven Practices. Demand for the service is continually monitored to prevent significant waiting time for patients or inappropriate referrals.		
Community Pharmacy Mental Health and Wellbeing Project (LL0008)	The Community Pharmacy Mental Health and Wellbeing Project will be a service offered to all adults in the Llanelli Cluster who have been newly prescribed a Selective Serotonin Reuptake Inhibitor (SSRI) antidepressant by their GP. Community Pharmacy dispensers and technicians will deliver the service when patients attend the Pharmacy to collect their medication. The project will specifically offer a Mental Health check providing an opportunity for a supportive conversation, medication advice and signposting to other Cluster services.	Uptake to the service has been slow and changes made to the service spec following consultation with local Community Pharmacy representatives. CPW have agreed and support the changes. Meetings have commenced with the Deputy Chief Pharmaceutical Officer for Welsh Government who are keen to discuss the project with regards to progressing to Hywel Dda Health Board wide and eventually All Wales. This project has been included in Cohort 7 of the Bevan Commission programme.		
Healthy hearts prevention project aimed at improving whole population cardiovascular health by working in partnership in the Llanelli locality (LL0017)	Healthy hearts prevention project aimed at improving whole population cardiovascular health by working in partnership in the Llanelli locality	Healthy Hearts steering group meeting regularly and progressing work plan. Initial recruitment drive was not successful. Delay in recruitment of the HCSWs has delayed the proposed start date. Media campaign has commenced and equipment in the process of being purchased.		
North Ceredigion				
To provide counselling services for children ages 13-17 & 18-30yrs (NC0001)	To provide counselling services for children and adults when they need it.	The contract is running over capacity with a wait list of around 45 patients. The cluster has agreed to fund extra counsellors to remove this backlog to enable patients to be seen in a timely manner.		
My Surgery App (NC0002)	All 7 Practices to actively signpost their patients and staff to use this app	The app is now funded through the practice's with a cluster login for projects. However, no more funds are available to support the project with practice's agreeing to pick up the costs.		
To provide online registration process for new registrants via Campus Dr (NC0003)	To reduce footfall into the surgery for registrations of new patients onto the Practice list. Practices to encourage use of the electronic registration form for all patients	This project has been successful with the new intake of students that started in the university in autumn 2022. This resulted in around nearly 3000 registrations which is much smoother when using the app rather than a standard form.		

Name and Code	Aim	Commentary	RAG	Trend
Continue to deliver Physiotherapy in General Practice (NC0005)	To continue to provide triage and treatment service for patients who present in the GP practice with a range of complex and common MSK conditions. To understand the impact, demands and constraints of service provision	There have been some issues with the recruitment of a 1.0 WTE as it has not gathered the number of suitable applicants as we would have hoped. The physio team are exploring an agency model but in the mean time we are expanding our persistent pain service clinic.		
Set up and deliver Community Catheter Clinics (NC0006)	To set up the clinics in Aberaeron and Aberystwyth to serve the whole cluster population. To provide timely checks and intervention	This project is running smoothly with weekly clinics being held from a surgery. As of spring of this year, we are hoping this project can move over to the county team to enable it to be delivered within secondary care.		
To provide one stop health checks at Gorwelion (NC0008)	To support and work with the mental teams to ensure those with severe mental health needs are able to access physical health checks regularly and with staff they know	The clinic is now running with a steady increase in patients seen month on month. Equipment for the clinics has been ordered and has been delivered. The cluster lead and PCSM have discussed with the service lead the opportunity of expanding the service at year end.		
Haul Arts for wellbeing Artpacks & creative writing (NC0009)	To support those with mental health issues through a social prescribing intervention	The project has worked with patients who are isolated and the cluster are in discussion around a new project for the following year.		
Psychology in Primary Care – Cardio-vascular (NC0010)	To support individuals to make healthy lifestyle choices through the bio-psycho-social model	The project is ongoing with a steady stream of referrals. The cluster have submitted a bid form to the panel to look at cancer care using technology. The cluster are pleased to say this has been approved and we are working with the psychology service in making this a reality.		
Open Eyes initiative in Optometry (NC0013)	To support our optometrists to deliver the Open Eyes initiative	There has been some progress with the project as all training, equipment audits and policy have been completed. A rollout date hasn't been announced but the cluster Optometry lead is speaking regularly with the PCSM.		
Singing for lung health (Skylarks) (NC0014)	To support individuals with lung conditions & breathlessness	The project is running well with a core group of around 20 members attending. The cluster communications officer has been to the service and is preparing communications to share wider with the locality. This project is well received by patients.		

Name and Code	Aim	Commentary	RAG	Trend
Psychology in Primary Care - Chronic pain management (NC0015)	To support individuals with chronic pain to manage their pain through a bio-psycho-social model	The team is becoming larger with a multi disciplinary team that will expand pain support. The roles are now out to advert with interest shown in some posts but some difficulty in appointing a pharmacist has resulted in a RAG rating of Amber.		
South Ceredigion				
Physiotherapy in General Practice (SC0003)	Work as an independent practitioner, accepting patients without prior contact or referral from their GP. Offer a triage and treatment service for patients who present in the GP practice with a range of complex and common MSK conditions. Manage MSK referrals, including complex conditions that can be most appropriately managed within the surgery. Work with GPs and other colleagues to develop and improve referral patterns, including reducing pressures on secondary care services (including orthopaedics, rheumatology and pain clinics) and linked community services.	The physiotherapist left post and we are struggling as a cluster with recruitment. As such, we are looking at a locum model which is being used in Pembrokeshire.		
Area 43 Online Counselling Service for 16 – 25 year olds (SC0009)	Area 43 provide an ongoing service which is supported by all five practices	The project is now renewed until March 2023 and we are looking at a further tender from April 2023 for a year for the entire county.		
Frailty Team (SC0010)	Frailty Team continue to accept referrals from all 5 practices via regular practice based MDT meetings. Both B7 Frailty Nurses now permanent staff members	The demand for the service is high but work is going on with the frailty team to recruit a HCSW to help with the demand and service requirements. We are now waiting for the final employment checks to complete.		
North Pembrokeshire				
Cluster Pharmacist (NP0001)	Rapid clinically safe reconciliation of discharge medication. - Improved governance for repeat prescribing for those patients as seen under the project. Fast access to pharmaceutical advice for General Practitioners. Improved cross sector working	Project ongoing and started the Bevan Exemplar		

Name and Code	Aim	Commentary	RAG	Trend
Improved Multi Disciplinary Team working through employment of Care Co-ordinators (NP0003)	To improve lines of communication between the community hubs (Intermediate Care Team and Integrated Community Team) and General Practice and support the continued development of joint Community and Primary Care models of working. To understand ways of working in both General Practice and the Community; bringing together these, to promote a new level of understanding and share purpose in all of the multi-disciplinary roles across Primary and Community Care. Care Co-ordinators will be encouraged to form a strong relationship with their counterparts in the Intermediate Care Hub to improve and enhance the patient journey and to bring professionals together to speed up the responses to patient need.	Currently no service in place but we have recruited to 3 x 25hr posts 2.1WTE due to start in Feb/March 23. Then the [project will be able to start and the 8 practices are engaged to link in with these roles and other stakeholders		
Provision of a Dietetic Led IBS Service in Primary Care (NP0004)	It is proposed that the specialist Dietitian will work across the cluster to agree an alternative dietetic led pathway for the management of newly diagnosed patients with IBS. This will include the delivery of group sessions as well as specialist dietetic clinics delivered in line with evidence based guidance and practice. The Dietitian will work within a governance framework and will be supported by the Dietetic service. Outcomes will be evaluated and reported through the cluster and Healthier Pembrokeshire Operational forum. Timely access to support for patients. Improved patient outcomes and quality of life. Reduction in number of GP appointments in relation to IBS. - Reduction in demand on Gastroenterology. Reduction in cost due to changes in investigation and prescribing	Project has completed. Awaiting the evaluation report.		
Improve access to low level mental health services (NP0006)	Continued to provide an equitable service throughout the cluster. Keep access and waiting times to a minimum. Improve access to services for the population. Extend the current project to enable access for patients with low level mental health needs or with underlying non-medical needs to deal with a range of issues such as housing, welfare benefits and debt	RIF funding has been agreed for the partners for Journey project Nov 2022 to continue this approach of working for additional 2 to 5 years.		

Name and Code	Aim	Commentary	RAG	Trend
Physiotherapy in General Practice (NP0007)	Work as an independent practitioner, accepting patients without prior contact or referral from their GP. Offer a triage and treatment service for patients who present in the GP practice with a range of complex and common MSK conditions. Manage MSK referrals, including complex conditions that can be most appropriately managed within the surgery Work with GPs and other colleagues to develop and improve referral patters, including to reduce pressures on secondary care services (including orthopaedics, rheumatology and pain clinics) and linked community services.	Two Physiotherapists are engaging well with all 8 Practices in the Cluster. The current demand is manageable.		
Bowel Screening (NP0008)	Predicted 30% uptake increase following implementation	Project is Completed and evaluation was done as part of a HDUHB PHW report with Bowel Screening		
eye care services (NP0010)	To increase the number of Optometrists to gain Independent Prescriber status and therefore facilitate the management of patients with acute eye problems within the primary optometric care setting. To increase the number of Optometrists within the locality with advanced training to hold the Higher Glaucoma Certificate	Started the courses and attending university.		
Increase access to defibrillators within the Community (NP0011)	Each Primary Care Optometry Practice within the North Pembrokeshire Cluster will be equipped with an Automated External Defibrillator with up to 4 people from each practice attending hands-on basic life support / CPR training event which includes use of AED's.	The Defibs have been order and these are for the Community Optoms venues within North Pembrokeshire		
South Pembrokeshire				

Name and Code	Aim	Commentary	RAG	Trend
MSK PHYSIOTHERAPY (SP0002)	Work as an independent practitioner, accepting patients without prior contact or referral from their GP. To support one IP Training with the MSK Physio Offer a triage and treatment service for patients who present in the GP practice with a range of complex and common MSK conditions. Manage MSK referrals, including complex conditions that can be most appropriately managed within the surgery Work with GPs and other colleagues to develop and improve referral patters, including to reduce pressures on secondary care services (including orthopedics and rheumatology and pain clinics) and linked community services	Two Physiotherapists 8a (job shared) and the B7 Physio are engaging well with all five Practices in the Cluster. The current demand is manageable. working very well.		
Cluster Pharmacist Respiratory IP (SP0003)	Identify and safely manage according to National guidelines at risk asthma and COPD patients in the South Pembrokeshire cluster Reduce the workload on Primary and Secondary Care during the current crisis through optimal maintenance treatment and equipping the patients with the tools via asthma action or COPD management plan to manage a worsening condition themselves whenever possible. Building relationships with Secondary Care Level, Community Pharmacy/EPP	The project will end 31st March 23. The Project is working very well and is showing great outcomes for patients. 4 out of 5 practices are engaging with this project		
Cluster Youth Resilience Project Children aged 8 to 18 years of age (SP0004)	ExamThe service would be a resilience based therapeutic service for children and young people. The service will be systemic and would support extended family members to help the child recover from emotional distress, ”A Family Wellbeing Service” “Early intervention and prevention for children and young people in improving resilience and wellbeing: 85% by March 2022 The focus of the support will be the child, but the support offered will need to be mirrored in the home environment to ensure the child receives reinforced messages to improve wellbeing. The service would need to provide individualised package of support focussing on the stress triggers that impact on the child’s wellbeing. Collection of data and case stories	We have been unable to recruit to the B6 role after 3 attempts we are now looking at a B5 role and this is currently becoming a difficult conversations due to various reasons on how this would work. So we are ongoing with these conversations. We have also had an expression of interest through a whole Pembrokeshire Locality approach through MIND.		

Name and Code	Aim	Commentary	RAG	Trend
Cluster South Pembrokeshire Integrated Community Team Building Capacity (SP0009)	Identify Patients with long-term conditions who attend the GP practice or engage with multiple organisations frequently to proactively develop a care plan to mitigate unwarranted access demand across the system, or those who fail to engage with the Practice entirely to proactively develop a care plan to mitigate acute/emergency access demand across the system. Diabetes, COPD, Cardiac Referral via the CRT/MDT To build on the existing integrated teams with new or additional roles to enhance multi-professional approaches to care stratification, co-ordination and delivery. To specifically support identified population health needs to increase "Time spent at home" particularly for those people not actively reviewed within the existing MDTs:	All five practices are engaged with the project and other stakeholder from the community. They are key stakeholders as part of all CRT meetings as a allrounder provision of proactive Care and Care Planning.		
MIND/CAB Partners for the Journey. (SP0010)	Extend the current project to enable access for patients with low level mental health needs or with underlying non-medical needs to deal with a range of issues such as housing, welfare benefits and debt	All 5 practices, all cluster stakeholders, optom, dental, pharmacy and HDUHB are engaged with this project. We are currently working with Comms to showcase this project and it has been successful in receiving funding for the next 2 years from RIF funding, which will start from Nov 22. This is a joint project with North Pembrokeshire.		
Cluster Pembrokeshire Referral Review Project: (SP0011)	Undertake a referral audit for 4 weeks to identify opportunities for primary care led referral management	This project will not be starting this year due to lack of interest currently		
Championing Learning Disabilities: (SP0012)	To upskill cluster staff in learning disability (LD) awareness, and to develop meaningful engagement with the LD community in the area. LD Champions in each practice Education sessions Open day Event	All 5 practices to have a identify a LD champion in each practice and to attend an education and training session and each practice to have Admin and a clinical session within their own practice environment.		
Independent Prescribing Primary Care Optometrist (SP0013)	To increase the number of Optometrists to gain Independent Prescriber status and therefore facilitate the management of patients with acute eye problems within the primary optometric care setting. To increase the number of Optometrists within the locality with advanced training to hold the Higher Glaucoma Certificate	Optom is still trying to work with a Secondary Consultant within HDUHB to complete his course of hours worked with a consultant, which is proving to be difficult - He is looking to broaden his scope to work with a another colleague in another HB to gain the experience needed for him to complete this course.		

Overview

- Achievement 2022-23 of the Planning Objective
- National Alignment – Strategic Programme for Primary Care (SPPC), Integrated Locality Planning (ILP) & Accelerated Cluster Development (ACD) current position, Community Infrastructure Programme
- Health Board Strategic Alignment
- Next Phase : Primary & Community Model 2023+
  - Objectives
  - Outcomes
  - Ministerial Priorities
- Programme Support

Planning Objective 5H

By March 2023, develop and implement Integrated Locality Planning groups, bringing together Clusters, Health, Social and Third Sector partners with a team of aligned Business Partners. Establish an integrated locality plan that sets out a clear and agreed set of shared ambitions and outcomes for the population which is aligned with national and regional priorities across the whole health & care system. The Integrated Locality Planning Groups will agree a collective shared budget to support delivery of the Plans, including commissioning of services, and will demonstrate delivery of the following priorities:

- Connected kind communities including implementation of the social prescribing model
- Proactive and co-ordinated risk stratification, care planning and integrated community team delivery
- Single point of contact to co-ordinate and rapidly respond to urgent and intermediate care needs to increase time spent at home
- Enhanced use of technology to support self and proactive care
- Increased specialist and ambulatory care through community clinics

Note - the Integrated Locality Planning groups will operate within a revised framework of governance which will be developed in conjunction with the national Accelerated Cluster Programme

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National Alignment : Strategic Programme for Primary Care

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Primary care is about those services which provide the first point of care, day or night, for more than 90% of people's contact with the NHS in Wales. It coordinates care for the individual, providing access for people to the wide range of services in the local community to help meet their health and wellbeing needs and to specialist care when required. There is a wide range of staff who support and deliver primary and community care services. (Strategic Programme for Primary Care)

Primary care is made up of the following (mostly) contractor services:

- General Practice
- Dental
- Optometry
- Pharmacy

Community service staff includes:

- Community and district midwives
- Community and district nurses
- Health promotion teams
- Health visitors
- Mental health teams
- Occupational therapists
- Paramedics
- Phlebotomists
- Physiotherapists
- Podiatrists
- Social services (and other local authority staff)
- People working and volunteering in the wealth of voluntary organisations which support people in the community.

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National Alignment : ILP & ACD

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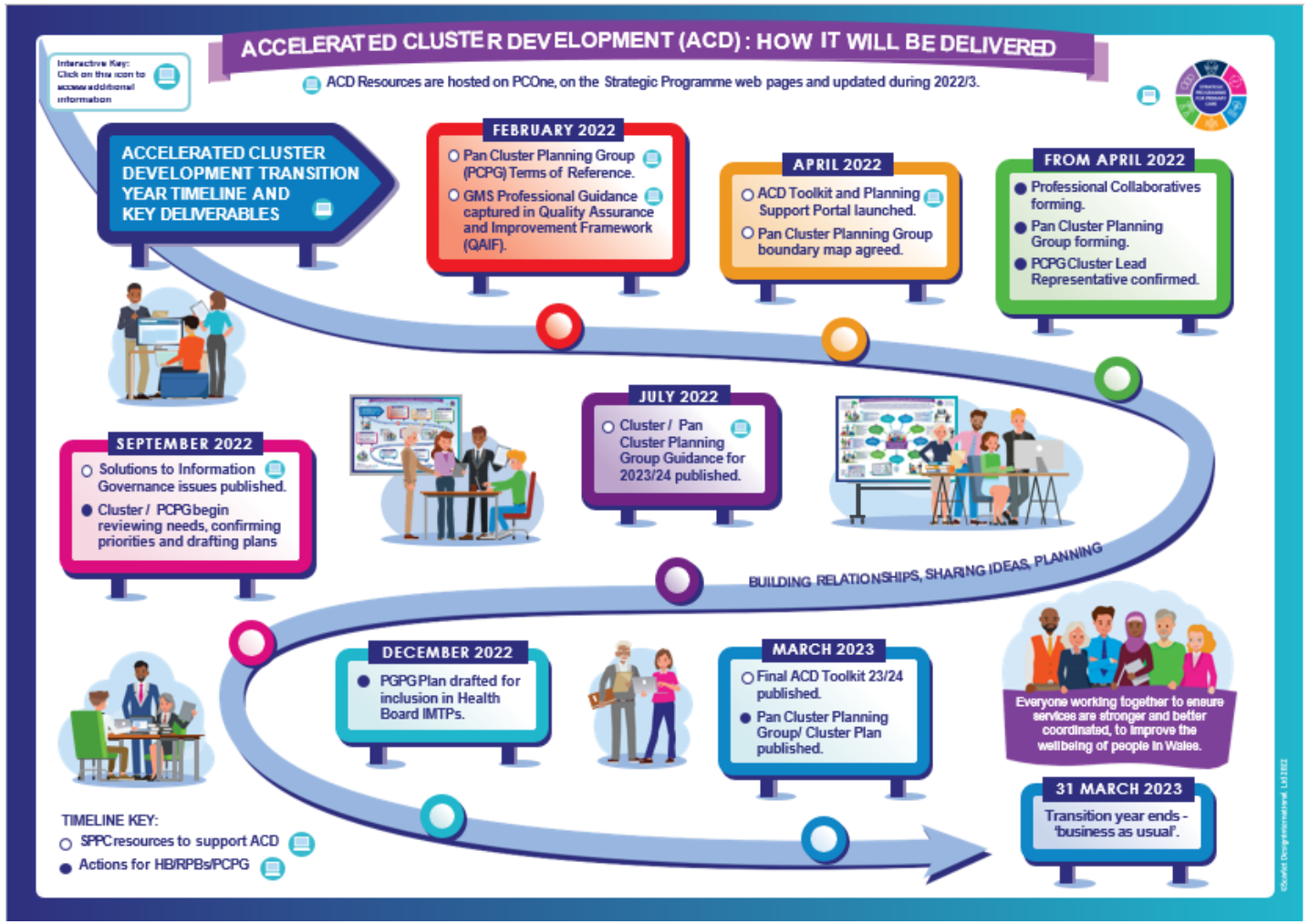

30 point ACD Checklist, position in April 2022 & in October 2022

- 5 actions complete - 13 actions complete
- 3 partially complete - 3 partially complete
- 22 in progress / ongoing - 14 in progress / ongoing

Current checklist review (Jan 2023)

- 15 actions complete
- 2 partially complete
- 13 in progress/ongoing

Risks / challenges :

- Sustainability / capacity issues in key Primary Care areas – especially Community Pharmacy
- 3 Cluster Lead vacancies with no EOI
- Challenging to find time away from clinical duties

- Peer review process completed – focus was on cluster based projects primarily

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National Alignment : Community Infrastructure Programme

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West Wales alignment with the evolving national community infrastructure model :

National elements :

- Risk stratification, proactive MDT care planning & delivery
- Multi-professional place based teams able to respond to presenting and proactive needs
- Integrated whole system planning to meet population needs
- Integrated data to support planning and delivery of multi-professional/agency community care
- Single point of contact / co-ordination of response
- Integrated Community Infrastructure

Regional elements:

- Social prescribing & community connections
- Ambulatory Community Clinics
- Homebased care

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Health Board Strategic Alignment : AHMWW

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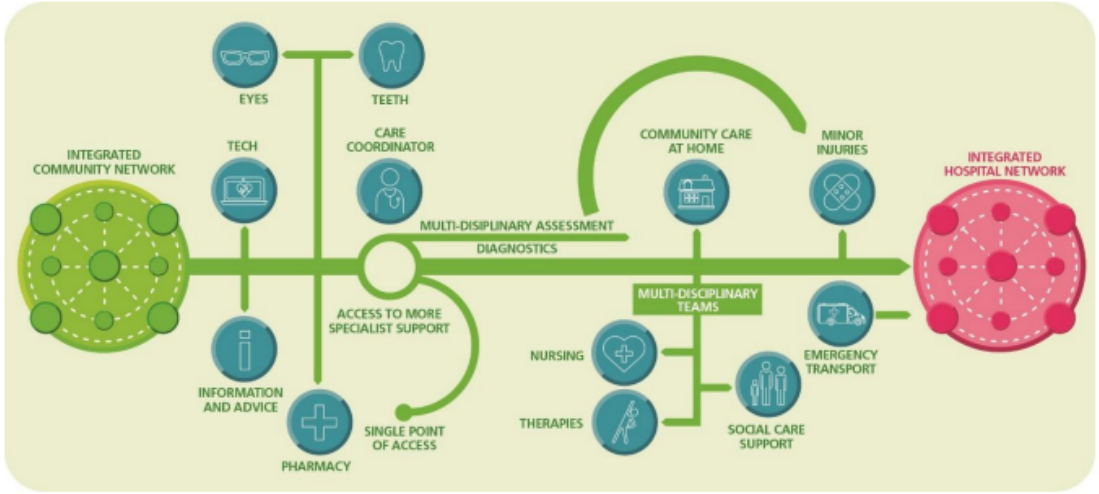

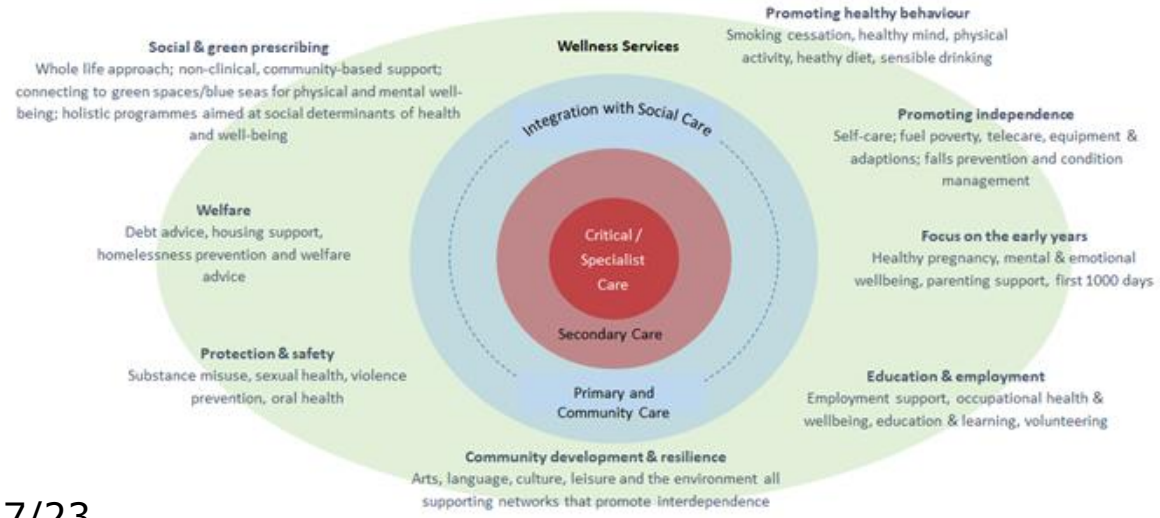

- **Resilient Communities** with an asset based approach.
- Working in an **integrated** way across health, local authority and third sector at place.
- Integrated between **physical and mental health**, services **through the life course** at place.
- **Integrated community networks** providing information, advice, assistance and treatment through interwoven groups, services & professionals engaging with local populations.
- **Community beds & community hospitals** with a focus on recovery, rehabilitation and the commissioning of alternative community based care.
- **Health & wellbeing centres** aligned to Integrated Community Network areas which support integrated service delivery more locally.
- **Multi-disciplinary teams** which wrap around individuals and families with the right skills to support needs without onward referral freeing up GP time to respond to people with more severe or complex needs.
- **Care navigators** to support system place based delivery.
- Ensuring timely discharge from hospital through enhanced capacity and processes to fully implement **discharge to recover & assess**.

All the **BLUE** and **GREEN** bits

Our Primary & Community Model 2023+

Our People

- Team of business partners wrapped around place based teams
- Keyworker accommodation and cost of living support
- People culture plan

Support & retain our workforce

Safe & high quality care

Our Patients

- Professional collaboratives will ensure priorities set, pathways and services delivered are safe, sustainable, accessible and kind.
- All planned, urgent & intermediate care pathways will be developed collectively across the whole system
- Recovery & rehabilitation
- Palliative & End of Life Care
- Dementia & frailty

Grow & train our workforce

- **Right-sized multi-professional place based teams able to respond to presenting and proactive needs**
- **Homebased care development in partnership with LA & independent sector**
- Skills & succession planning
- Research & innovation

Accessible & kind care

- Single point of contact / co-ordination of response – urgent, intermediate, routine & proactive (24/7)
- **Improved primary & community care access including core diagnostics**
- **Ambulatory Community Clinics**

World-class infrastructure

- Integrated data & business intelligence to support planning and delivery at place
- **Integrated Community Infrastructure – Health & Wellbeing Hubs**
- Green health & sustainability
- Co-ordinate & manage resource consumption at place
- Market stability – care homes, domiciliary care, primary care
- Primary Care Contract Reform

Healthier communities

- **Risk stratification, proactive MDT care planning & delivery**
- Preventions plan at place aligned to wellbeing plan
- Public health screening & prevention

Sustainable services in partnership

- Integrated whole system planning to meet population needs (ILP & ACD) at place with common set of agreed ambitions & priorities
- RPB & WWCP alignment incl RIF
- PSB alignment
- Regional carers strategy

Positive impact beyond

- **Grow & measure the impact of social prescribing/community connections**
- Proactive place based engagement with population & stakeholders
- **Integrated community networks & teams**

Our Future Generations

Our Population

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Primary & Community Objectives

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- To deliver the shift of focus and resource from reactive treatment and care to **preventative and proactive care** through "growing the green (& blue)".
- To reduce inequalities in health outcomes through a focus on **place-based service models** adaptive to population need and the configuration of local assets but based on **regional principles and standards**.
- To wrap our services around our population to deliver seamless integrated care so that people only need to **go to hospital when absolutely necessary and for as short a time as clinically required**.
- To offer **world-class environments, response and experience** for our population which is flexible and adaptive in their community.

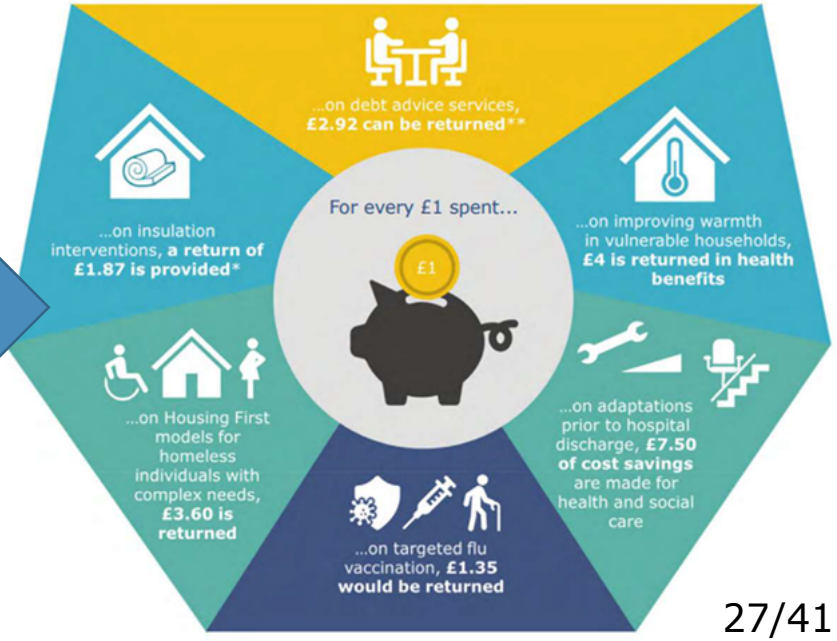
Varies significantly at place.

19 years difference in life expectancy between least and most deprived areas.

Proportion of households in four financial well-being categories in Wales. Data provided by the University of Bristol Personal Finance Research Centre.

Significant benefit from investment in social, community and preventative models.

Mainstreaming key RIF & cluster projects.



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Primary & Community Outcomes

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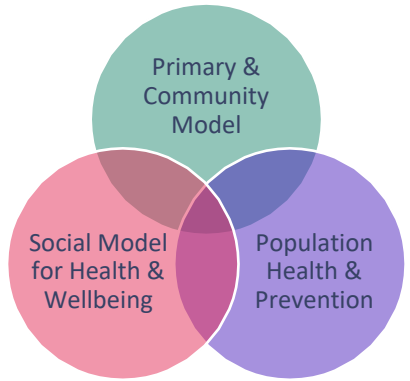
What is your vision for your service area over the next 12 months? What will be the impact of your vision?	What are your priorities for the next 12 months?
• **20%** capacity growth in social prescribing activity to support a growth in community resilience • **5%** capacity growth in proactive community care contacts to support the growing acuity and fragility of people in the community through community nursing teams. • Increase in intermediate care "community beds" to support care for people in our "virtual ward" by **103** • **34%** increase in ambulatory community clinics as earwax and continence services are further embedded.	• Grow & measure the impact of social prescribing/community connections • Right-sized multi-professional place based teams able to respond to presenting and proactive needs • Risk stratification, proactive MDT care planning & delivery • Integrated community networks & teams • Homebased care development in partnership with LA & independent sector • Improved primary & community care access including core diagnostics • Ambulatory Community Clinics • Integrated Community Infrastructure – Health & Wellbeing Hubs

Alignment of this priority objective with other key elements of the Health Board Strategy – particularly to support the out of hospital components – these are the "Growing the Green" component parts collectively.



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Ministerial Priorities : Improved Access to GP Services

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

	Priority area(s)
Key focus should be on delivering	Improved Access to GP Services
Baseline	Practices are required to have one site (if they have a split site or a branch surgery) open from 8.30am to 6pm, with telephone access from 8am to 6.30pm. With the introduction of the unified contract from 1 April 2023 there is a move of Phase 1 Access standards (previously in QAIF) into the core contract. Phase 2 Access Standards remain in QAIF and are optional.
Quarter 1:	
- **Milestones**	• All practices are available on the telephone from 8am – 6.30pm • All practices have doors open on their designated site from 8.30am to 6pm • All practices are submitting data for Phase 1 as part of the move to the unified contract • QAIF monitoring in line with GMS contract requirements
- **Actions**	• Contract monitoring mechanisms are in place for quarterly review with reporting through to the Access Forum • Failure to comply will result in identifying a contract breach and remedy
Quarter 2:	
- **Milestones**	• All practices are available on the telephone from 8am – 6.30pm • All practices have doors open on their designated site from 8.30am to 6pm • All practices are submitting data for Phase 1 as part of the move to the unified contract • QAIF monitoring in line with GMS contract requirements
- **Actions**	• Contract monitoring mechanisms are in place for quarterly review with reporting through to the Access Forum • Failure to comply will result in identifying a contract breach and remedy
Quarter 3:	
- **Milestones**	• All practices are available on the telephone from 8am – 6.30pm • All practices have doors open on their designated site from 8.30am to 6pm • All practices are submitting data for Phase 1 as part of the move to the unified contract • QAIF monitoring in line with GMS contract requirements
- **Actions**	• Contract monitoring mechanisms are in place for quarterly review with reporting through to the Access Forum • Failure to comply will result in identifying a contract breach and remedy

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Ministerial Priorities : Improved Access to GP Services *(continued)*

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

	Priority area(s)
Key focus should be on delivering	Improved Access to GP Services
Baseline	Practices are required to have one site (if they have a split site or a branch surgery) open from 8.30am to 6pm, with telephone access from 8am to 6.30pm. With the introduction of the unified contract from 1 April 2023 there is a move of Phase 1 Access standards (previously in QAIF) into the core contract. Phase 2 Access Standards remain in QAIF and are optional.
Quarter 4:	
- Milestones	• All practices are available on the telephone from 8am – 6.30pm • All practices have doors open on their designated site from 8.30am to 6pm • All practices are submitting data for Phase 1 as part of the move to the unified contract • QAIF monitoring in line with GMS contract requirements
- Actions	• Contract monitoring mechanisms are in place for quarterly review with reporting through to the Access Forum • Failure to comply will result in identifying a contract breach and remedy
Risks	Current GMS Regulations do not have clauses around access to services, therefore any remedial notice needs to be issued under a failure to deliver essential services which could be open to challenge
Outcomes	Access monitored through contractual mechanism
Alignment with workforce plans	N/A
Alignment with Financial plans	QAIF funded through GMS allocation
OPTIONAL	
Digital / Technology Opportunities	• Work in train to develop patient facing videos (Pocket Medic) on how to access primary care services to improve patient understanding of service provision and availability, which will hopefully improve service accessibility

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Ministerial Priorities : Improved Access to Community Pharmacy Services

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

	Priority area(s)
Key focus should be on delivering	Improved Access to Community Pharmacy Services
Baseline	97 Community Pharmacies across Hywel Dda; all have signed up to deliver the Clinical Community Pharmacy Service (CCPS) A New Prescription has seen new investment into Community Pharmacy to support a shift from "items dispensed" to wider service provision.
Quarter 1:	
- **Milestones**	• Rolling contract monitoring processes in place with issues for escalation raised via the Primary Care Contract Review Group (PPCRG) • Confirm number of new IP training places with HEIW
- **Actions**	• Ensure contractual compliance with opening times • Ensure appropriate accreditation compliance • Ensure contractual compliance with provision of CCPS and review activity data • Review and development of enhanced services through the Enhanced Services group • Review of the number of IP Pharmacists and associated service provision
Quarter 2:	
- **Milestones**	• Rolling contract monitoring processes in place with issues for escalation raised via the Primary Care Contract Review Group (PPCRG) • Annual contract visiting process to be developed and implemented
- **Actions**	• Ensure contractual compliance with opening times • Ensure appropriate accreditation compliance • Ensure contractual compliance with provision of CCPS and review activity data • Review and development of enhanced services through the Enhanced Services group • Review of the Pharmaceutical Needs Assessment
Quarter 3:	
- **Milestones**	• Rolling contract monitoring processes in place with issues for escalation raised via the Primary Care Contract Review Group (PPCRG)
- **Actions**	• Ensure contractual compliance with opening times • Ensure appropriate accreditation compliance • Ensure contractual compliance with provision of CCPS and review activity data • Review and development of enhanced services through the Enhanced Services group • Review provision of the flu programme

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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

Ministerial Priorities : Improved Access to Community Pharmacy Services *(continued)*

	Priority area(s)
Key focus should be on delivering	Improved Access to Community Pharmacy Services
Baseline	97 Community Pharmacies across Hywel Dda; all have signed up to deliver the Clinical Community Pharmacy Service (CCPS) A New Prescription has seen new investment into Community Pharmacy to support a shift from "items dispensed" to wider service provision.
Quarter 4:	
- Milestones	• Rolling contract monitoring processes in place with issues for escalation raised via the Primary Care Contract Review Group (PPCRG)
- Actions	• Ensure contractual compliance with opening times • Ensure contractual compliance with provision of CCPS and review activity data • Review and development of enhanced services through the Enhanced Services group • Review of the Pharmaceutical Needs Assessment • Review provision of the flu programme
Risks	• Risk to provision of enhanced services due to locum cover • Risk to reduction in opening times outside of core requirements (mainly evenings and weekends) due to staffing pressures • Premises not modernised for delivery of wider service provision • Mentorship for IP training not available to enable completion of IP course • Continued risk of short term pharmacy closures due to staffing deficits
Outcomes	Wider range of services provided through Community Pharmacies
Alignment with workforce plans	Linked to the Primary and Community Services Academy
Alignment with Financial plans	Aligned to allocation for contract
OPTIONAL	
Digital / Technology Opportunities	• Work in train to develop patient facing videos (Pocket Medic) on how to access primary care services to improve patient understanding of service provision and availability, which will hopefully improve service accessibility • Use of technology to enable patients to take BP, height, weight and self-report into the clinical system

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Ministerial Priorities : Improved Access to Dental Services

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

	Priority area(s)
Key focus should be on delivering	Improved Access to Dental Services
Baseline	2022-23 and 2023-24 are testbed years for the nationally proposed programme of NHS dental contract reform. Hywel Dda has 29 Dental Practices in contract reform and 7 remained on a UDA contract. Current Regulations remain extant.
Quarter 1:	
- **Milestones**	• Maintaining current level of NHS dental service provision • Set volume metrics in accordance with UDA and Contract reform baselines.
- **Actions**	• Ongoing work with the LDC and contractors on the current contract guidance for contract reform • Ongoing discussion with Welsh Government over the contract management metrics and availability of data • Commissioning of new dental contracts to replace contract resignations • Monitor achievement against the baseline using BSA data when available
Quarter 2:	
- **Milestones**	• Maintaining current level of NHS dental service provision
- **Actions**	• Ongoing work with the LDC and contractors on the current contract guidance for contract reform • Mid year reviews undertaken • Ongoing discussion with Welsh Government over the contract management metrics and availability of data • Discuss support/remedial actions through an agreed improvement plan • Complete Carmarthenshire procurement process and award contract
Quarter 3:	
- **Milestones**	• Maintaining current level of NHS dental service provision
- **Actions**	• Ongoing work with the LDC and contractors on the current contract guidance for contract reform • Ongoing discussion with Welsh Government over the contract management metrics and availability of data

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Ministerial Priorities : Improved Access to Dental Services *(continued)*

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

	Priority area(s)
Key focus should be on delivering	Improved Access to Dental Services
Baseline	2022-23 and 2023-24 are testbed years for the nationally proposed programme of NHS dental contract reform. Hywel Dda has 29 Dental Practices in contract reform and 7 remained on a UDA contract. Current Regulations remain extant.
Quarter 4:	
- Milestones	• Maintaining current level of NHS dental service provision
- Actions	• End of Year position estimated • Ongoing work with the LDC and contractors on the current contract guidance for contract reform • Ongoing discussion with Welsh Government over the contract management metrics and availability of data • Temporary transfer of mobile dental services to the Carmarthen hub
Risks	• Increase in the number of contract terminations thus reducing the provision of NHS dental services • Reduction in the number of patients able to access urgent dental care • Inadequate guidance to support contract monitoring on a consistent level across Wales
Outcomes	• Potential reduction in the level of NHS dental service provision
Alignment with workforce plans	• WNWRS due to be rolled out into dental practices from April 2023, however workforce issues across the dental professional groups has previously been cited as being a factor in a reduced ability to deliver NHS dental services
Alignment with Financial plans	• Dental contracts commissioned within ring fenced allocation
OPTIONAL	
Digital / Technology Opportunities	-

Ministerial Priorities : Improved Access to Optometry Services

	Priority area(s)
Key focus should be on delivering	Improved Access to Optometry Services
Baseline	Optometry contract changes were negotiated in 2022 and will be subject to implementation throughout 2023. There will be a focussed shift on moving services from secondary care Ophthalmology services to Primary Care Optometry services however the detail of this is currently unknown. baseline of 206 per month – 20% growth by March 2024 = 250 per month or 2835 episodes in 23/24
Quarter 1:	
- Milestones	• Supporting national contract implementation
- Actions	• Contract implementation as and when agreements are reached and issued to Health Boards • Supporting the transition of clinical services from Ophthalmology to Optometry in line with nationally agreed clinical protocols
Quarter 2:	
- Milestones	• Supporting national contract implementation
- Actions	• Contract implementation as and when agreements are reached and issued to Health Boards • Supporting the transition of clinical services from Ophthalmology to Optometry in line with nationally agreed clinical protocds
Quarter 3:	
- Milestones	• Supporting national contract implementation
- Actions	• Contract implementation as and when agreements are reached and issued to Health Boards • Supporting the transition of clinical services from Ophthalmology to Optometry in line with nationally agreed clinical protocols

Ministerial Priorities : Improved Access to Optometry Services *(continued)*

	Priority area(s)
Key focus should be on delivering	Improved Access to Optometry Services
Baseline	Optometry contract changes were negotiated in 2022 and will be subject to implementation throughout 2023. There will be a focussed shift on moving services from secondary care Ophthalmology services to Primary Care Optometry services however the detail of this is currently unknown. baseline of 206 per month – 20% growth by March 2024 = 250 per month or 2835 episodes in 23/24
Quarter 4:	
- Milestones	• Supporting national contract implementation
- Actions	• Contract implementation as and when agreements are reached and issued to Health Boards • Supporting the transition of clinical services from Ophthalmology to Optometry in line with nationally agreed clinical protocds
Risks	• Delay in contract implementation at a national level will impact on the ability to commission services • No national restriction on who can provide services which could have a financial impact
Outcomes	• Unable to quantify without specifics of the clinical services to be commissioned from contract negotiations
Alignment with workforce plans	• WNWRS is due to be implemented into Optometric Practices from April 2023
Alignment with Financial plans	• Allocation for the new contract has been based on historical activity however there are limitations on this calculation and there may need to be further consideration to capping or limiting some service provision if there is a forecast overspend
OPTIONAL	
Digital / Technology Opportunities	-

Ministerial Priorities : Improved Access to Community Services

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

	Priority area(s)
Key focus should be on delivering	20% capacity growth in **social prescribing** activity to support a growth in community resilience
Baseline	Current baseline of 206 per month – 20% growth by March 2024 = 250 per month or 2835 episodes in 23/24
Quarter 1:	
- **Milestones**	**660 episodes in quarter**
- **Actions**	GP clusters agree scale and scope for Elemental CRM – Co-ordinate GP cluster comms, starting in Pembrokeshire New SP to be using Elemental CRM - Ensure all new SP can access and are fully trained on system
Quarter 2:	
- **Milestones**	**705 episodes in quarter**
- **Actions**	GP cluster implement Elemental CRM in practices ID GP liaisons per Practice F2F set up per practice Training and comms completed for GP and AHP per practice
Quarter 3:	
- **Milestones**	**720 episodes in quarter**
- **Actions**	Community referrers and partner agencies are aware and linked (as per requirement) to Elemental CRM Scope referral reasons from data and ensure they are reflected in the partner bodies who refer in to and out of the SP service
Quarter4:	
- **Milestones**	**750 episodes in quarter**
- **Actions**	Reflect on highlighted need and gaps within communities to deliver social model for health & wellbeing.
Risks	Failure of Elemental CRM implementation – no through system reporting for HB SP investment, including PC link. Local teams not reporting.
Outcomes	An additional 20% social prescribing contacts by end of year – consistent growth in activity. To deliver the shift of focus and resource from reactive treatment and care to **preventative and proactive care** through "growing the green (& blue)". To reduce inequalities in health outcomes through a focus on **place-based service models** adaptive to population need and the configuration of local assets but based on **regional principles and standards**. To wrap our services around our population to deliver seamless integrated care so that people only need to **go to hospital when absolutely necessary and for as short a time as clinically required**
Alignment with workforce plans	Workforce employed by partner agencies / partnership agreements / SLAs in place

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Ministerial Priorities : Improved Access to Community Services

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

	Priority area(s)
Key focus should be on delivering	5% capacity growth in proactive community care contacts to support the growing acuity and fragility of people in the community through community nursing teams.
Baseline	Average community nursing activities : 70,620 per month (source Civica) 751,756 recorded activity Jan-Dec 2022
Quarter 1:	
- Milestones	**214,506 episodes in Q1**
- Actions	• Finalise and implement Civica reporting dashboard – Gareth Beynon • Review of Community nursing skill mix and workforce needs to meet demand – 5% growth is unlikely to fully meet assessed demand – HoN • Transfer planned ART activity to community nursing teams (Pembs)
Quarter 2:	
- Milestones	**217,152 episodes in Q2**
- Actions	• Sickness and absence reviews & support • Recruitment to fill vacancies or review skill mix – HoN & Professional nursing leads
Quarter 3:	
- Milestones	**219,798 in Q3**
- Actions	• Pending outcome of HEIW and SPPC activities
Quarter4:	
- Milestones	**222,444 episodes in Q4**
- Actions	• Pending outcome of HEIW and SPPC activities
Risks	Recruitment, retention & sickness absence.
Outcomes	**873,900 episodes in 23/24** (118,626 increase in recorded activity compared to calendar year 2022)
Alignment with workforce plans	No additional workforce needed for 5% growth. All Wales 7 days working in community model due for implementation October 2023
Alignment with Financial plans	No additional staff pay costs needed for 5% growth – **potential for increase in travel costs.** 7 day workforce model, if no additional headcount required there will be **additional enhanced rate impact & cost pressure.**
OPTIONAL	
Digital / Technology Opportunities	Civica refinement of data entry and reporting may change the basis for counting activity – All Wales Programme. No community PAS limiting factor

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Ministerial Priorities : Improved Access to Community Services

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	Priority area(s)
Key focus should be on delivering	Increase in intermediate care "community beds" to support care for people in our "virtual ward" by **103**
Baseline	*Carmarthenshire : BCCC = 4 against target 52 – pending info on baseline capacity* *Ceredigion : BCCC = 0 against target 21 – total interim care beds commissioned = 25* *Pembrokeshire : BCCC = 9 against target 38 – total community capacity ART & CaHT = 57 (10 aligned to BCCC)* *BCCC baseline of 13 and target 111*
Quarter 1:	
- **Milestones**	22 additional community beds created through employment of homebased care support workers (from baseline)
- **Actions**	Carmarthenshire – additional recruitment to support 12 additional patients at home Ceredigion – additional recruitment to support 5 additional patients at home Pembrokeshire – additional recruitment to support 5 additional patients at home & clear scoping and recruitment of responsible individual & registered manager
Quarter 2:	
- **Milestones**	47 additional community beds created through employment of homebased care support workers (from baseline)
- **Actions**	Carmarthenshire – additional recruitment to support 14 additional patients at home Ceredigion – additional recruitment to support 5 additional patients at home Pembrokeshire – additional recruitment to support 6 additional patients at home & registration as a domiciliary support service & completing process to be on PCC commissioning framework for care.
Quarter 3:	
- **Milestones**	72 additional community beds created through employment of homebased care support workers (from baseline)
- **Actions**	Carmarthenshire – additional recruitment to support 10 additional patients at home Ceredigion – additional recruitment to support 5 additional patients at home Pembrokeshire – additional recruitment to support 10 additional patients at home & onboarding of joint apprentices into vacant posts to support 5 additional people at home
Quarter4:	
- **Milestones**	98 additional community beds created through employment of homebased care support workers (from baseline)
- **Actions**	Carmarthenshire – additional recruitment to support 12 additional patients at home Ceredigion – additional recruitment to support 6 additional patients at home Pembrokeshire – additional recruitment to support 8 additional patients at home

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Ministerial Priorities : Improved Access to Community Services

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	Priority area(s)
Key focus should be on delivering	**34%** increase in ambulatory community clinics as earwax and continence services are further embedded.
Baseline	Baseline includes continence, leg ulcers and earwax micro-suction which is currently only in place in Ceredigion. Approx. 27,537 episodes in 22/23 and target of 37,028 episodes in 23/24 following full implementation and streamlining of earwax micro-suction
Quarter 1:	
- **Milestones**	**8,064** community clinic episodes
- **Actions**	All Community Clinics to be recorded on WPAS & reporting dashboard created Phase 2 of Earwax Clinics
Quarter 2:	
- **Milestones**	**9,050** community clinic episodes
- **Actions**	Phase 3 of Earwax Clinics Scoping of further clinic demand
Quarter 3:	
- **Milestones**	**9,500** community clinic episodes
- **Actions**	Earwax clinics fully implemented Assessment of capacity for further activity by clinic staff Finalise Business Case for Ambulatory Clinic development
Quarter4:	
- **Milestones**	**10,414** community clinic episodes Business case consideration for future funding / resource shift
- **Actions**	Pending subject to business case review
Risks	Higher than anticipated demand results in long waiting lists. Challenges in recruitment & retention
Outcomes	Increase in Community based clinics with clear model proposed for future development
Alignment with workforce plans	To form part of the HEIW led community workforce programme
Alignment with Financial plans	22-23 FYE Earwax funding agreed £686,420 – Confirmed spending plan 22/23 £354,2228. Additional funding for 23/23 based on current agreement = **332,192 & pay increase**. Assumed no unagreed investments in current plan (previous plans indicate 649,127 for further ambulatory care development)

Programme Support

GIG CYMRU NHS WALES
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University Health Board

Planning Objective for Integrated Locality Planning will evolve to **Transforming Integrated Primary & Community Care**

Executive Sponsor : Director of Primary, Community & Long Term to chair the Programme Delivery Group

Senior Responsible Officers : County Directors x 3 and Assistant Director for Primary Care will become SRO for each of the key themes taking a lead on delivery of the priority projects whilst developing the whole theme :

Our People :
- Right-sized multi-professional place based teams able to respond to presenting and proactive needs
- Homebased care development in partnership with LA & independent sector

Our Future Generations :
- Integrated Community Infrastructure – Health & Wellbeing Hubs

Our Patients
- Improved primary & community care access including core diagnostics
- Ambulatory Community Clinics

Our Population
- Grow & measure the impact of social prescribing/community connections
- Integrated community networks & teams
- Risk stratification, proactive MDT care planning & delivery

Programme Manager – 1 x Band 8A to support whole programme alignment and delivery

Project Officers – 4 x B5/6 aligned to each of the themes supporting one of the SROs under the supervision of the Programme Manager

Data Analyst – 1 x Band TBC to support the developing of better community and primary care data, reporting, etc

Finance Partner – 1 x Band TBC to support the development of the community model including business cases for resource shift based on impact

Funding Source - TBC ?SPPC