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A Planned Primary Care Workforce for Wales

Approach and development actions to be taken in support of the plan
for a primary care service in Wales up to 2018

What is primary care?

Primary care services provide the first point of care, day or night, for more than 90% of people's contact with the NHS in Wales. General practice is a core element of primary care but is not the only element – other services such as pharmacy, dentistry and optometry increasingly provide care directly to the public.

The primary care contribution is also – importantly – about coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs.

These community services include a very wide range of staff, such as community and district nurses, midwives, health visitors, mental health teams, health promotion teams, physiotherapists, occupational therapists, podiatrists, phlebotomists, paramedics, social services, other local authority staff and all those people working and volunteering in the wealth of independent sector and voluntary organisations which support people in our communities.

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1. INTRODUCTION

The Welsh Government launched its new national plan in November 2014 for a primary care service for Wales up to March 2018.

The plan described the principles underpinning the changes in primary care as:

- *Prevention, early intervention and improving health, not just treatment;*
- *Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill health, reduce dependency and effectively treat illness;*
- *Active involvement of the public, patients and their carers in decisions about their care and wellbeing;*
- *Planning services at a community level of 25,000-100,000 people;*
- *The prudent healthcare principles.*

The drive to provide more care at or closer to home requires a system-wide view of health and social care services and the training needed to enable more integrated care to be provided by a range of sectors and organisations. Health boards are already using the NHS Finance (Wales) Act 2014; the development of 64 primary care clusters and the plan for a primary care service in Wales to work with partner organisations in remodelling how services are planned and delivered.

This document fulfils an action in the plan for a primary care service in Wales and aims to further support NHS organisations in Wales by describing the direction required for employed and contracted staff and by putting in place actions to secure, manage and support a sustainable primary care workforce shaped by local population needs and by prudent healthcare principles. It builds on examples of good practice already underway across Wales and establishes the necessary structures and drivers to mainstream the changes they represent.

The document sets out four main areas where action is needed:

1. **Putting in place the foundations for a more robust approach to workforce planning.** Securing the long-term sustainability of the right sized workforce with the right skills to meet the expectations set out in the plan for a primary care service for Wales can only be achieved through a planned approach which takes a whole system view of healthcare. At present there are gaps in data and knowledge of the existing workforce and further clarity about the services which will increasingly be delivered in the community is needed if we are to understand the type of workforce required in the longer term.
2. **Supporting the continuing development of primary care clusters and the sharing of best practice.** The Welsh Government is committed to the role of clusters as a means of transforming primary care. The maturity of clusters and the development of new roles and ways of working for the primary care workforce are inextricably linked. This document therefore sets out action to support cluster development in the immediate and medium term. These actions complement those in the primary care plan.

3. **Investing in the development of the wider primary care workforce.** The long-term sustainability of primary care in Wales will also depend on making the most of the widest possible range of professions and using their skills and abilities, according to the prudent healthcare principles. As part of this, the way in which the primary care workforce is educated and trained needs to be reconsidered in light of a new focus on inter-professional and multi-disciplinary working.
4. **Stabilising key sections of the current workforce.** GPs and the nursing profession are central to primary care and will remain so in the future. It is recognised that both of these groups are currently under considerable pressure. This document sets out actions to be taken in the next year to address a range of issues we face today ahead of new models of working being embedded across Wales.

2. APPROACH TO DEVELOPING THE WORKFORCE

The number of people directly employed by NHS Wales today stands at 84,000 – a 20% increase over the last 10 years and of a third since the National Assembly for Wales was established. In primary care there are more than 2,000 GPs, more than 1,400 dentists and 800 optometrists working in Wales. There are also 2,300 registered pharmacists and 1,400 registered pharmacy technicians who either work in the managed sector or in the 714 community pharmacies distributed across Wales. The NHS workforce accounts for 62% of health boards' expenditure, amounting to almost £3bn a year.

In the face of rising demand for healthcare coupled with a shortage of staff in certain specialities across the UK, we have tended to simply call for more people to be trained in traditional roles and professions. However, while there will always be a need to recruit directly to the NHS, continued growth of the overall workforce based on existing models of service provision is not sustainable. Instead, we must look at working differently and in so doing be guided by two key themes.

Firstly, the majority of the professionals who will be working in the NHS in 10 years' time are already working in the NHS today and in Wales, this is estimated to be as much as 80%. Central to addressing the challenges of increased demand; an ageing population; more people being diagnosed with one or more long-term health conditions and frail and older people increasingly having more complex needs, must be an investment in the skills of the people we already have and equipping them to deliver new models of care.

Secondly, the nature of the work delivered in primary care is also changing. Our starting point is that we want to enable people to live at home independently, with their families, in their communities, for as long as possible. This will require re-designing service models with a strong focus on function rather than form and a fundamental aspect of our strategy must be to identify those services which should in future be delivered in community settings by a range of organisations and professionals. This requires service redesign, across the integrated system, from models of care based on hospital-based services which treat single conditions, to a population-based approach with much greater emphasis on managing co-morbidity and enabling self-management. It will also mean challenging historic boundaries between organisations and sectors to identify those areas where greater flexibility or new roles and accreditations can make a difference, or where new ways of working can be developed which create better integration between professions.

The workforce should be organised around people's needs with a renewed focus on health promotion rather than simply responding to ill health and illness when this has already happened. They should align with a more social model of health - one that requires a different relationship between the professional and the individual, which gives people greater personal responsibility for their health and wellbeing and voice and control over their own actions and the services they receive.

Maximising all the skills and resources available within primary care and ensuring everyone operates at the top of their clinical competence by only doing what only they can do is central to achieving this. It will help ensure a sustainable, efficient and effective service, responsive to patient need and will preserve and promote the

fundamental Bevan principle that it is clinical need which matters when it comes to deciding treatment by NHS Wales.

The Welsh Government has, through prudent healthcare, set a course which has the capacity to make these changes and avoid what the Kings Fund has described as a risk of the NHS being perpetually out of step and continually rebuilding our workforce to do yesterday's not tomorrow's healthcare work. The following prudent healthcare principles must therefore guide the development of the primary care workforce in Wales:

- **Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;**
- **Care for those with the greatest health need first, making the most effective use of all skills and resources;**
- **Do only what is needed and do no harm, no more, no less;**
- **Reduce inappropriate variation using evidence-based practices consistently and transparently.**

3. THE WORKFORCE OF THE FUTURE

Primary care is about those services which provide the first point of care, day or night, and accounts for more than 90% of people's contact with the NHS in Wales. General practice is a core element of primary care and will remain so in the future. It is not the only element however and the future workforce will be shaped by an increased and integrated contribution from a wide range of professionals.

An approach based on teams, which make the most of the skills of this wide range of professionals, will be the core operational model of the future. These teams must increasingly be seen as the foundation for the planning and education of the workforce and the delivery of services - they are the best lens through which to consider the skill-mix needed to meet the needs of local populations and individuals. Irrespective of the wider organisational or contractual relationships that may be in place in any area, it is a multidisciplinary approach, underpinned by clear governance and support, that will provide the most agile and person-centred approach to providing health and social care.

Operationally, professions will be drawn in at different levels and for different amounts of time depending on local need. For instance, at GP practice level a broader range of core skills is likely to be needed on a day-to-day basis, including advanced practice and extended roles for directly-employed practice nurses, healthcare support workers (or specialist skills for GPs for example) or for the regular involvement of district or community nurses.

At a primary care cluster level, practices may work together to identify the sessional support they need from other professions such as pharmacists, optometrists and therapists with those professions operating across a range of practices. At a pan-cluster, or locality level, primary care support teams can help in managing peaks in demand, providing services needed more infrequently or running drop-in centres and health awareness campaigns on a wider geographical basis.

The make-up and skill-mix of the workforce at a cluster level will be based on an understanding of population need, therefore this will vary in different parts of Wales and even within health board areas. Whatever their make-up however, there are core features that the primary care workforce of the future are expected to exhibit.

Table 1 – Core features of the primary care workforce

- 1. Understands and meets the health and wellbeing needs of the whole person with a focus on outcomes.** The primary care workforce must be supported with a range of information on what services are available and it will need to establish a range of networks through which to deliver care. It must also become skilled in identifying needs and planning to meet them. Work set out in the primary care plan on the development of a national directory of services will be central to achieving this aim.
- 2. Is planned from a system-wide perspective, taking into account a range of partners and stakeholders. Plans to deliver universal care, varying the**

intensity and volume according to the needs of individuals, families and local communities. System-wide planning, which takes into account social care and the contribution of carers, the third sector and patients themselves, is the only way in which the broad range of skills necessary to tackle the causes of ill health, many of which will be social rather than medical in origin, can be secured. Addressing these wider causes of ill health, and preventing the development of longer-term conditions is central to addressing unacceptable inequalities in health outcomes.

- 3. Is equipped to deliver anticipatory and preventative care.** Providing a service that improves wellbeing and prevents unnecessary admission to hospital or acute care requires having access to diagnostics in order to manage ambulatory care conditions. Individuals and teams must therefore also have the skills and competencies to drive health improvement and the prevention of ill health.
- 4. Provides people with access to the right professional or other source of help as early as possible.** This is about widening the range of professions that offer advice and provide care. The effective use of multidisciplinary teams and an effective triage approach at practice level will be key to delivering this. In respect of the 111 and out-of-hours services, this means involving a greater range of professions, including pharmacists, nurses and therapists, in directly providing advice at first contact or becoming the first point of referral.
- 5. Facilitates flexible access.** The ways in which people can access services and support must also be widened. This might be face-to-face in the surgery or clinic, by telephone, online, via remote monitoring of care or using telemedicine to access specialist advice from others such as hospital-based professionals. This includes single points of contact located in one place, through building strong links between practices in the community and GP, nurse-led or specialist-based services offered in secondary care or outreach services and community resource teams which operate on the basis of frequent visits.
- 6. Provides improved coordination and continuity of care.** Multidisciplinary teams must have a robust approach to coordinating care in line with any individual's clinical need, or care plan. This could be led by the GP in terms of complex cases; it may be part of the role of district nurses or it could involve the services of a dedicated care coordinator. To do this effectively, any primary care team will need to operate as part of a wider system and have the capability, capacity and supporting infrastructure to effectively manage discharge and referrals.
- 7. Uses the voice of the individual and encourage self-management and independence.** The co-production agenda and the projected increase in demand requires primary care teams to support health board mechanisms for listening to the patient voice and for the teams themselves to be able to act on information which will help them improve quality and performance. Where possible patients must also be supported to play an active role in their own

wellbeing and be encouraged to play an active part in managing their own conditions and care.

8. **Embraces technology and is skilled in its use.** The need to provide wider access, to draw together a broad range of professionals and to coordinate care across a range of previously distinct services can only be addressed through the better and more widespread use of existing and emerging technology. As well as embedding and advocating the use of initiatives such as telehealth, the primary care workforce must be supported by investment in more fundamental ICT infrastructure that allows the coordination and management of patient data.

New models and ways of working that exhibit these core features are already emerging across Wales as a result of clinically-led innovation and services needing to find different and better ways of addressing system demand. Examples of such new models of care are set out in the form of short case studies in **Annex 1**.

4. AREAS FOR ACTION

We have identified four main areas for action:

- Putting in place the foundations for a more robust approach to workforce planning
- Supporting the continuing development of primary care clusters and the sharing of best practice.
- Investing in the development of the wider primary care workforce.
- Stabilising key sections of the current workforce

PUTTING IN PLACE THE FOUNDATIONS FOR A MORE ROBUST APPROACH TO WORKFORCE PLANNING

To support the delivery of more care closer to home action is required to put in place better foundations for a planned and evidence-based shift of services out of acute and hospital settings. The planning approach must be patient-centred, population-based and supported by better information, including in relation to activity. The contribution that can be made by all partners, including the 'informal workforce' of carers, the third sector and patients themselves must be built into planning if a truly prudent healthcare approach to primary care is to be achieved,

The Welsh Government's commitment to primary care clusters is evidence of the importance placed on devolving planning to a level where it can be informed by an understanding of the needs of the local population. Our primary care plan supports the emerging and strong consensus in UK literature that planning and provision of primary care should be undertaken at a relatively small population level, with an optimum size being 25,000 to 100,000 proposed by the Kings Fund.

The plan requires health boards to support the 64 primary care clusters to develop rapidly to draw in all local sources of help to collaborate, to assess local need and better match available financial, workforce and other resources to match that need. Action is already being taken to plan care in this way through population health needs and wellbeing assessments, practice development plans and action plans for primary care services at cluster level.

At a national level, the Welsh Government requires health boards to submit Integrated Medium Term Plans (IMTPs) which set out the priorities for delivery over the coming three years and outline new service delivery models designed to move hospital-based care towards primary care. A review of the most recent IMTPs shows local and national aspects of planning are now being drawn together so actions to be taken in primary care as a whole are informed by local need. At this time however there remains variation across plans, both in terms of the amount of workforce data on primary care, and the degree to which local needs analysis at cluster level informs strategic direction.

To support cluster development, and to create a more consistent approach to cluster plans informing strategic direction, two enabling activities must take place with consistency across health boards.

Firstly, a more rigorous and consistent understanding of the current workforce must be developed. At present, data currently available within primary care tends to stay in primary care. This must be more systematically collated, analysed and fed into the wider system to develop an up to date 'as is' picture from which planning the future workforce can proceed. Alongside a better understanding of the composition and activity of the current workforce, this data also needs to enable a better understanding of existing competencies to be developed. This includes establishing a more robust understanding of the Welsh language capability of the workforce to ensure commitments made in *More Than Just Words* are being met and to respond to recommendations made by the Welsh Language Commissioner's inquiry into the use of the Welsh language in primary care.

Secondly, more must be done to identify the full range of traditionally hospital-based services (or parts of services) which will in the future be delivered in the community. Clear and specific commitments to service redesign in the medium and long-term are a fundamental requirement for successful workforce planning. It is also the most accurate way of forecasting the potential future demand placed on primary care services, understanding what the future workforce will be expected to do and what the long-term investment and training and education of the workforce needs to be.

While the Welsh Government can play a leading role in addressing the data challenge, the identification of services which will be provided outside of hospital in the future must be driven by health boards working with a full range of delivery partners. A systematic review of services must be undertaken which includes consideration of those services which are:

- Currently fully or largely delivered in hospital or other institutional settings;
- Already provided in a community setting by health boards but which need to be expanded, in a manner consistent with the principles of prudent healthcare, both to take on increased demand and to deliver greater preventative and anticipatory care;
- Already provided in the community by local authorities, voluntary organisations and other local services and which though greater integration with patient pathways can deliver improved outcomes.

A range of actions to be taken under the plan for a primary care service for Wales will support this work, including the need for health boards to map all available clinical, workforce, financial and other resources and ensure local pathways of care and referral protocols are captured in an up to date directory of services. Clusters are expected to use all this information to inform their three-year service development plans.

At the same time there are strategic actions the Welsh Government is taking to create a more joined up and system-wide approach to workforce planning at a national level.

Of prime importance in this regard is addressing the alignment between the commissioning of medical and non-medical education. Currently, processes involve discussions with health boards and NHS trusts as well as universities and other education providers. Non-medical training is conducted by the Workforce Education and Development Service (WEDS) with health boards submitting their requirements through the annual returns as part of the IMTP process. Medical training meanwhile, is captured by the Wales Deanery as a separate process.

There is a need to bring these two areas of work together and to consider training for professionals not currently in either system, such as optometrists, in order to develop a prudent workforce where medical and non-medical skills are both part of the overall skill mix, in accordance with need.

The Strategic Education and Delivery Group (SEDG) already considers both medical and non-medical education and training to ensure both sets of requirements receive the same degree of Welsh Government scrutiny. In the longer term, the Health Professional Education Investment (HPEI) review, led by Mel Evans, has recommended the creation of a single organisation with responsibility for strategic workforce planning, education commissioning and workforce design. The Welsh Government is considering its response to this review.

The Social Services and Well-being (Wales) Act 2014 also sets out clear duties for statutory bodies to promote wellbeing and give people a greater voice in, and control over, their care. It requires health board population assessments to be undertaken in partnership with local authorities, alongside a duty to provide information, advice and assistance. The Well-being of Future Generations (Wales) Act meanwhile has placed public service boards and wellbeing plans on a statutory basis and simplified current requirements in regards to integrated community planning. These pieces of made-in-Wales legislation provide a driver for the integration of health and social care workforce which is determined by commonly understood local need.

There follows a series of national and local actions which need to be undertaken to establish a more robust approach to planning the primary care workforce in Wales and getting an improved strategic understanding of the priority areas for investment and support.

Actions – Workforce data and analytics

Action	Lead	Date
Each year, health boards will provide appropriate support and resources to primary care cluster leadership teams in order to map and report the numbers and mix of skills of their current primary care workforce in their primary care service development plans. The role of the NHS Wales Shared Services Partnership (NWSSP) in supporting health boards to do this will be explored.	Health boards	Annually from 2015-16 onwards
This year WEDS will support this work by producing an aggregated understanding of the current		September

workforce, derived from a range of data sources including health board annual returns.		2015
GP contractors, for 2015-16, will publish practice workforce data contained within practice development plans on an annual basis. Health boards will be expected to consider the information contained within these plans to identify actions that can be taken to support recruitment and retention or address other local matters.	Health boards and clusters	Annually from 2015-16 onwards
Health boards' directors of primary, community and mental health will work with WEDS to establish a set of workforce performance measures as part of the further development of the nationally agreed set of quality and delivery requirements and measures for primary care.	Health boards, Public Health Wales and WEDS	By December 2015
The Welsh Government and health boards will use the <i>Practice Sustainability Framework</i> to provide an agreed and consistent basis for reviewing practice vulnerability and identifying appropriate support needed on a short term transitional basis while longer-term solutions take effect.	Welsh Government and health boards	Ongoing from August 2015
Health boards, through the 64 primary care clusters, will undertake an analysis of existing and future Welsh language population need and the support required by the workforce to develop the necessary language abilities. They will be supported in doing this by a statistical bulletin to be published by the Welsh Government. The Welsh Government will then engage with education commissioners and providers to review current arrangements and identify what further steps are required to deliver training programmes which can reflect these needs.	Health boards, clusters and Welsh Government	Analysis by November 2015. Proposed further steps by January 2016.
Welsh Government will work with the Health and Social Care Information Centre (HSCIC) and other bodies to explore the potential for making use of developments under the Workforce Information Architecture Project which would enable practices to record staffing details in real time.	Welsh Government	November 2015
Welsh Government will explore with representative organisations and health boards the most appropriate mechanism for gathering activity and workload data in primary care on an ongoing (potentially annual) basis.	Welsh Government and health boards	November 2015
To strengthen planning capabilities, a skills and	Welsh	February

competency framework for NHS Wales will be developed for use across all levels of NHS organisations. The competency framework will be integrated into existing development activity at a national and local level with identifiable behaviours for staff involved in planning at every level.	Government	2016
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Actions – Service Redesign

Action	Lead	Date
Health boards, in discussion with cluster leads, will identify a priority list of services currently delivered in secondary care settings which can in the future be delivered by primary care, in full or in part. Health boards will also need to take into account the development of new patient pathways where needed and the timeframe and support required for ensuring the delivery of safe services during transition.	Health boards and clusters	By December 2015 as part of the IMTP submission process
The All-Wales Collaborative will consider this information from a national perspective and make recommendations to the Minister for Health and Social Services including in respect of the timing and phasing of resource realignment as a result.	Health board chief executives and All-Wales Collaborative	By January as part of the IMTP evaluation process.

Actions – Integration

Action	Lead	Date
Health and social care needs assessment processes will be aligned, as required by duties under the Social Services and Well-being Act (Wales) 2014, through the development of a training specification as part of the implementation plans for the Act.	Health boards and Welsh Government	March 2016
The Welsh Government will work with those who have workforce and service planning responsibilities in both health and social care to jointly consider best practice on workforce planning. This will provide the foundations for the development of a joint process for workforce planning.	Welsh Government	November 2015
Using occupational therapists as an example, a single vision for how assessment for discharge into the community is undertaken will be developed.	Welsh Government and health	March 2016

<p>This will be broadened to other professions such as physiotherapists and social workers who play a key part in admission, discharge and putting care plans in place.</p>	<p>boards</p>	
<p>Welsh Government will evaluate investment in better service models provided through the Intermediate Care Fund to identify areas where joint initiatives between health and social care should be taken forward in the future. It is expected that emerging themes from these and from the national programme of strategic pathfinders will provide an evidence base for the more targeted investment, and joint delivery, of schemes that drive greater workforce integration.</p>	<p>Welsh Government</p>	<p>March 2016</p>

SUPPORTING THE CONTINUING DEVELOPMENT OF PRIMARY CARE CLUSTERS AND THE SHARING OF BEST PRACTICE

At present, cluster working is progressing at different rates across Wales. To a certain extent this is to be expected as the challenges presented in collaborating to meet local need will be varied. For clusters to work effectively however, it is essential they are owned, managed and operated autonomously with their working practices, workforce capacity and skill mix being determined through partnership working between professionals drawn together on the basis of serving the needs of a local population.

The Welsh Government continues to support the development of clusters, most recently through incentives attached to the GP contract and through significant new investment. Building on the additional £3.5m invested in primary care in 2014-15, the Welsh Government has made an additional £40m available for primary care from 2015-16. Of this funding, £6m has been allocated directly to clusters to support the development needs and service priorities they have identified locally. The remaining funding is being invested in a range of service improvements which have been shaped and influenced by clusters.

The plan for a primary care service for Wales seeks to progress clusters from a collection of GP-based services into fully functioning primary care clusters' which draw in the full range of organisations, professionals and services to collaborate in improving health outcomes for their community.

Research into new workforce models in primary care emphasises that such developments are predicated on effective organisational development support and strong leadership skills. It is recognised that primary care clusters need assistance in achieving this and developing the necessary shared values, aims and vision together with a joint understanding of the local context. This will require the active engagement of all stakeholders.

Case studies of successful federated workforce models where collaboration is key also stress the need for such organisational development support is almost always under-estimated and that the effort needed to develop and sustain the new organisation models exceeded initial estimates. Primary care teams in Wales report little capacity for this work at present and a need for support through skilled facilitation, particularly when assessing local need, planning the use of resources and developing plans. While such support is likely to be required more intensively in early planning phases, it will need to be supported to become part of a core element of management resource in the future.

The successful delivery of cluster working also calls for a distributed model of leadership that supports the development of diverse leadership from among GPs and the wider multi-disciplinary team. Reliance on a 'heroic model of leadership' where an individual drives the development of an organisation will no longer suffice in the context of larger and more complex primary care organisations and an increasing number of part-time and sessional GPs. Establishing a wider and more distributed model of leadership requires the development of new career structures, succession planning, active talent management and ensuring leadership reflects the diversity of the workforce.

Health board directors of primary, community and mental health have been tasked with developing a national set of core governance standards for clusters. To support this, a national programme of organisational development for cluster working, tailored to local needs and the levels of maturity of the clusters, will be established. This will include a focus on the core skills needed to lead and work effectively as a team to address the cultural challenge of supporting those who are used to working in smaller teams to become active members of larger collaborative structures and to draw in all sources of help to collaborate at cluster level to assess local needs and plan the use of all available resources to meet those needs.

As the pace and scale of change in reforming primary care increases, and in light of the different approaches emerging across health boards, there is also a requirement to establish a more structured approach to sharing best practice and emerging thinking. Despite the necessity of beginning from local needs, there remains the potential for common themes, issues and lessons to be identified and used for the purposes of developing clusters throughout Wales. The Welsh Government, in partnership with WEDS, has begun to gather information from heads of primary care, and others, to inform the development of a systematic and evidence-based approach to sharing good practice.

The following actions will now be taken to support the onward development of clusters in Wales.

Actions – Understanding and developing clusters

<i>Action</i>	<i>Lead</i>	<i>Date</i>
The NHS primary care leadership team and Public Health Wales will agree an all-Wales action plan to support the rapid development of the 64 primary care clusters. This will include support needed by clusters to put in place succession plans, undertake a skills audit and develop a leadership strategy.	Health boards	September 2015
Directors of workforce and organisational development, and directors of primary care and mental health will work with cluster leads and heads of primary care to establish organisational development plans within organisations, tailored to local needs and the levels of maturity of the clusters. This programme will include the principles of cluster working, their function and a more social model of health. It will also require core skills and competences for all staff to be identified including: leading teams (and meetings), understanding team building, securing collaboration, negotiation skills, understanding finance and budgets, locality planning focussed on local health needs, using workforce data, and developing quality	Health boards Support from WEDS and Public Health Wales	By November 2015

improvement. A national programme will be implemented for those organisational development needs which are common to many or all clusters		
The Welsh Government will work with health boards and other primary care providers to determine the support needed for those taking up new roles within clusters and those practices or organisations who are looking to use such roles. This will enable clear expectations of what new roles can bring to practice and what can be expected from working in primary care.	Welsh Government and health boards Supported by WEDS	February 2016
Public Health Wales will work with the Welsh Government and NHS Wales to develop a tool with which to assess the maturity of primary care clusters in using population based approaches.	Public Health Wales	February 2016
Public Health Wales will establish a primary care collaborative with primary care clusters leads to support population health action.	Public Health Wales	November 2015

Actions – Sharing good practice

Action	Lead	Date
Health boards will use Welsh Government funding to support innovation through investment in their jointly-developed national programme of pathfinder and pacesetter projects across Wales. A small number of schemes across Wales will help test and evaluate new and innovative ways of improving population health outcomes through improving access to and the quality of primary care services, organised under key strategic themes and specific learning outcomes to spread good practice. The programme will be formally evaluated.	Health boards	Ongoing from 2015-16
Develop and launch a suite of online resources to support cluster working across Wales, such as guidance and toolkits for needs assessment, service mapping and developing service improvement plans. The resource will also include contact details of cluster leads and other professionals who are involved in taking forward new models of care as part of a drive to establish a community of practice.	Public Health Wales	November 2015

<p>Develop as part of the online suite of resources a compendium of innovative approaches to care currently in place across Wales. As well as elaborating on potential approaches and detailing specific initiatives as case studies, this work will draw out common themes, barriers experienced and how they were overcome as well as data on performance that has become available since the new models were adopted.</p>	<p>WEDS Supported by Welsh Government, and Public Health Wales</p>	<p>January 2016</p>
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INVESTING IN THE DEVELOPMENT OF THE WIDER PRIMARY CARE WORKFORCE

The delivery of more accessible and prudent healthcare at home or as near to home as possible requires a wider range of professionals working as part of a team. Greater diversification of the workforce will also help people with long-term conditions to manage their own health and medication; maintain their independence by avoiding unplanned admissions to hospital and receive ongoing support following discharge from hospital. In turn, this will free up GPs' time and expertise to care for people with more complex needs. To make this happen, we need to ensure a range of education opportunities is available and that sufficient investment is made in the skills of the people we already have to equip them to deliver new models of care. As part of this process, and in recognition of the role they already play in primary care, actions to further support GPs and nurses are set out in the stabilising key sections of the current workforce chapter.

The case studies at *annex one* demonstrate that health boards are already investing in a diverse workforce and are delivering new models of care. In the next few years the pace of this change must increase in order to deliver the reformed primary care service and prudent workforce Wales needs.

The development of a prudent workforce will take account of the contribution made by **community pharmacists**, who can effectively manage minor ailments which currently make up around 18% of the workload in general practice. Such ailments can be treated using medicines available without prescription and provided free of charge. This thinking informed the development of the *Choose Pharmacy* service, which was established as a pathfinder in parts of the Cwm Taf and Betsi Cadwaladr university health board areas in September 2013 to help people access advice and, where appropriate, treatment for a range of common ailments. The contribution pharmacists can make to community-based healthcare can be further maximised by undertaking medicines use reviews and consultations for acute minor ailments and independent prescribing roles, which need to operate within a framework agreed within the primary care cluster.

Advanced practice pharmacists will contribute to clinical work related to medicines in GP practices. These posts will operate at either large GP practice level or at cluster level, depending upon local circumstances, to deal with the many medicines related issues and problems that arise in primary care. As the advanced practice pharmacist role develops, particularly as they increase the amount of time they spend dealing directly with and prescribing for patients, they will increasingly be associated with individual practices rather than clusters.

Their role will develop to meet specific needs; however all will support the safe and effective use of medicines. This will include supporting the management of patients taking many medicines (polypharmacy) or medicines which require regular monitoring; liaising with hospitals, community pharmacies and care homes to promote medicines safety and reviewing prescribing and repeat prescription systems to improve medicines management, reduce costs and minimise waste. In some GP practices the role of advanced practice pharmacists may develop to deal with minor illnesses and in others they may take more responsibility for the management of

long-term conditions. Clusters and individual practices will need to identify how advanced practice pharmacists can best support their specific priorities around safe and effective medicine use.

The Welsh Government will support the training and development of advanced practice pharmacists working in patient-facing roles within GP practices and of clinical pharmacists working in the community healthcare teams to ensure the safe, effective and prudent use and supply of medicines.

The contribution that can be made by a range of therapists must also be maximised. **Physiotherapists** can be a first point of contact for people with musculoskeletal conditions, such as back pain and joint pain, which are the cause of a significant proportion of primary care contacts. Advanced practice skills allow therapists to prescribe, where appropriate and to refer to secondary care where necessary. Physiotherapists can also support the 'fit to work' agenda and provide expertise in exercise while supporting self-management.

Occupational therapists can work with people experiencing difficulties returning to work or remaining in work due to illness or disability by, for example, resolving any vocational problems relating to statements of fitness to work following a period of illness and advising employees about the need for any adjustments in the work environment. They can then carry out a detailed assessment of the workplace and the demands of the role and suggest potential solutions including self-management health strategies using the AHP Advisory Fitness for Work Report.

Speech and Language therapists provide specialist assessment, diagnosis and treatment for children and adults with communication and/or swallowing problems. They work with frontline professionals to provide effective identification of children and adults identified at risk of or recovering from speech, language or communication problems to develop an integrated approach to planning treatment.

The assessment of need and planning of care in the community are roles which a range of professionals in primary care are already equipped to undertake. More use must be made of such professionals if a prudent and patient-focused primary care service is to be delivered. In addition to those set out above, **dieticians** specialise in nutritional assessments, which can be used alongside clinical information to enable people to make appropriate lifestyle choices. In so doing their role directly contributes to a co-productive approach to health management, health promotion initiatives and disease prevention programmes. Dietetic-led services based in primary care can also be used for prevention and management of such conditions as type 2 diabetes through targeted diet and lifestyle education programmes or through the creation of dedicated dietetic service for frail elderly to include care and nursing homes.

Clinical psychologists also use a range of assessment approaches to assess and track an individual's skills, personality and emotional wellbeing and by working as part of a wider team can provide treatment for people of all ages, both on an individual and group basis. Their role is often key to establishing a diagnosis of a mental illness or addiction in patients.

Demand for care provided by therapists and other allied health professionals equipped to undertake assessment and treatment is likely to increase as care is increasingly delivered closer to home and with a greater emphasis on rehabilitation and reablement, particularly in respect of Wales' ageing population.

In recognition of this the Welsh Government has agreed a 26% increase in physiotherapy and occupational therapy training places in 2015-16 and a 19% increase in speech and language therapy. NHS Wales must now make sure it provides the models of delivery which ensures this investment is used to best effect.

Another emerging role which will help both diversify the workforce and have an immediate impact on existing GP workload is that of a **physicians associate**. PAs are able to see patients of all ages for a range of issues across acute and chronic medical care, in the surgery, at home or in an out-of-hours setting, referring patients to other services when clinically appropriate. They can also undertake tasks such as prescription reauthorisation and review incoming clinical post and laboratory results. They are further able to run groups for chronic conditions such as diabetes.

PAs are recognised members of the team in many countries and are increasingly supporting teams in the UK. A task and finish group has been established by WEDS to consider how best to take this agenda forward.

Nurses provide care to many patients in primary care and the community. Their roles have been developed in a several ways, including rapid response teams to assist in the management of acute exacerbations of chronic conditions and specialist palliative care nurses who provide a seven-day service. These new and emerging roles and services need to be aligned to the existing primary care nursing services, such as district nursing, to ensure patients receive services in a coordinated manner. Nurses are increasingly undertaking advance practice roles in primary care settings where they are planning care and prescribing medicines, releasing GPs to see those patients who need a medical opinion. The Welsh Government is committed to investing in the provision of education to support the role of the primary care advance nurse practitioner.

Advanced practice education programmes also already include provision for **Advanced Practice Paramedics** to gain the necessary skills to make a wider range of clinical decisions at scene. There are currently 10 fully-qualified advanced practice paramedics in Wales with 28 more undertaking training.

Advanced paramedic practice can improve individual patient experiences, for example, by treating them at or close home and reducing the number of patients who are unnecessarily taken to hospital. It also provides paramedics with an opportunity to extend their skill set, lead on research aimed at making improvements in the way care is delivered in the future and become skilled at working across care settings. In recognition of this, the Welsh Government will explore opportunities for paramedics to be based within community settings, including attachments to primary care clusters.

Healthcare Support Workers providing direct clinical care make up 24% of the NHS Wales workforce and when trained and empowered to undertake suitably-

delegated tasks, they can become an essential component of a more diverse primary care team. Their role is also one that provides some of the greatest potential for joining up health and social care provision and providing the foundation of a more integrated workforce. It is important therefore that a common language for training and progression is developed alongside joint planning with social care services. To support this, the Welsh Government and its partners have developed an NHS Wales Skills and Career Development Framework for clinical healthcare support workers and will explore the potential of extending the scope to encompass non-clinical staff.

Over the last 10 years, the development of additional skills by community **optometrists** has seen this group of professionals take on extended roles in acute eye care, low vision rehabilitation and refining referrals. The *Together for Health: Eye Health Care Delivery Plan* and the *Planned Care Ophthalmic Plan* outline how optometrists can play a greater role in providing ophthalmic services, including by moving services into primary care.

It is estimated more than 60% of cataract patients could be discharged on the day of their operation to optometrists for post-operative care, releasing up to 10,000 hospital outpatient appointments each year. In Wales, patients who have had cataract surgery and are considered to be low risk, will from now on, have their post-operation, follow-up appointment and care at their local opticians instead of returning to hospital. In addition, guidance from the National Institute for Health and Care Excellence (NICE) states community optometrists can monitor people with low-risk glaucoma – those people with a confirmed diagnosis of ocular hypertension or suspected chronic open angle glaucoma with an established management plan. The Welsh Government will work with health boards to explore how the primary care Eye Health Examination Wales Service could be extended to facilitate a quicker and more efficient discharge of patients into primary care.

Optometrists with specialist training, competence and experience – as specified by NICE – can monitor and manage patients with medium risk glaucoma in a community or outreach setting. To support this, the College of Optometrists has developed a skills framework and suite of qualifications for optometrists to extend the scope of their practice in the management of glaucoma patients and optometrists undertaking these roles would also require independent prescribing. The Welsh Government will work with WEDS and universities to explore how optometrists can extend their scope of practice to manage more glaucoma patients in primary care.

Access to oral healthcare can be improved by reconsidering the role of **dental therapists and hygienists**. Under the existing dental contract each patient needs to see the dentist as the first step of their treatment plan. It is estimated however that up to 40% of the work of a dentist could be undertaken by other dental care professionals, including a hygienist or therapist. A pilot of this more prudent approach was undertaken in six practices across Wales and is currently being evaluated. This will inform future contract discussions, including consideration of prototype contract development and changes to the performers' list regulations.

In May 2013, the General Dental Council (GDC) removed the necessity for patients to see a dentist before accessing certain treatments from dental care practitioners.

Following the GDC approval of direct access to dental care practitioners, and in advance of necessary legislative changes, this new way of working was first tested and has now been rolled out to all community dental services in Wales so they can use the full scope of their skills.

This year the Welsh Government has increased the training places for dental hygienists and therapists by 41% in recognition of the changes required to the skill mix within dental workforce teams to deliver care in the longer term.

To facilitate the increased use of these professions by clusters, the following actions will be undertaken to provide further evidence of the advantages that can be delivered by a prudent approach to the primary care workforce. These actions will be undertaken within 12 months of the publication of this plan.

Actions – Investing in the wider primary care workforce

Action	Lead	Date
WEDS will work with health boards and universities to develop an education and training programme for physicians associates in Wales.	WEDS	November 2015
Health boards will review the service specifications of their primary care nursing teams to ensure that the emerging models are coordinated and cost effective. This should include a Wales wide consideration of best practice application.	Health boards	March 2016
The <i>Choose Pharmacy</i> service will be evaluated to further determine how the uptake of pharmacy-led services can be supported by Welsh Government, clusters and health boards.	Welsh Government	October 2015
The Welsh Government will work with postgraduate education providers to develop the range of support available for pharmacists working in primary care, particularly those working in general practice to undertake continuing professional development appropriate to their role.	Welsh Government	March 2016
The NHS Wales Skills and Career Development Framework for Clinical Healthcare Support Workers will be agreed and the Welsh Government and health boards will work with WEDs to explore the scope to encompass non-clinical staff. The potential for a joint framework with social services will also be explored with universities and the Care Council.	Welsh Government and health boards	April 2016
The Welsh Government will evaluate the revised dental contract currently being piloted by practices in order to inform further roll out and a strategy to determine the most prudent ratio between dentists and dental therapists.	Welsh Government	Ongoing from 2015-16
Health boards must proactively identify opportunities for pharmacists, therapies,	Health board directors of	Each year from 2015-

paramedics and other non-medical clinical roles to support work at cluster level and improve access through, providing the first point of contact and making clinical contributions including addressing musculoskeletal conditions, fit for work support and lifestyle management.	primary, community and mental health and cluster leads	16 as part of cluster service needs assessment and service planning
The Welsh Government will work with WEDS and universities to explore how optometrists can extend their scope of practice to manage more glaucoma patients in primary care in Wales.	Welsh Government Supported by WEDS	April 2016
The Welsh Government will support a change to current education programmes to enable all optometrists trained in Wales to have more clinical placements and exit their education programmes with enhanced skills to manage glaucoma patients and be independent prescribers by 2018.	Welsh Government	June 2016
The Welsh Government will work with health boards to explore how the Eye Health Examination Wales Service could be extended to facilitate a quicker and more efficient discharge of patients to primary care.	Welsh Government and health boards	September 2015

EDUCATION AND TRAINING THAT IS RESPONSIVE TO THE NEEDS OF THE PRIMARY CARE WORKFORCE

The Welsh Government already invests a significant amount in education and training each year and recently announced £80m of investment in the wider NHS workforce in 2014-15 with a focus on capitalising on the range of skills in the wider healthcare family and finding ways of enabling everyone to make the best possible contribution they can.

This funding is being used to support 2,498 new students to undertake education programmes and the continuation of education for 6,881 students already in training. These opportunities include extra places on training courses for a range of professions, many of whom have a direct impact on primary care provision. Such additional training will increase the capacity of the NHS to develop community-based models of care by ensuring the availability of a wide range of healthcare professionals who are able to work together in the interest of their patients. In addition to the traditional professional roles supported through this funding, successful advanced practice and extended skills programmes continue to be developed, as does an approach to supporting the development of healthcare support workers.

There is a need to consider the return that is made on this investment in light of demographic, service and policy changes, not least the desire for more care to be delivered closer to home. To inform this the Minister for Health and Social Services

commissioned the Health Profession Education Investment (HPEI) review in August 2014. This review has recently published its recommendations.

The review supports the view that education investment is currently disproportionately aligned with the medical profession through a variety of mechanisms, including the current Service Increment for Teaching (SIFT) funding. The mechanisms in place to educate and train the medical workforce have changed dramatically since the time this funding mechanism was introduced and the recommendation of the HPEI review is that this is no longer appropriate and should cease. Instead, funding should be used to support the wider range of health professionals across Wales. This will require a fundamental rethink of the education and training funding mechanisms across Wales and provides an opportunity to reset the balance between medical and non-medical training budgets in a way which can advance the principles of prudent healthcare.

There are further ways in which education provision in NHS Wales needs to be revised. The primary care plan envisages a different way of delivering services in the community and the need for the workforce to receive education and training to equip individuals to work in that environment. But the current approaches result in large parts of the training being delivered in hospitals. This must change with the emphasis of training programmes refocused to ensure a wider number of care settings are included and that students and trainees are exposed to the challenges of providing care in the community. This must be seen as an integral part of training rather than simply a disposable experience. With a core focus of future primary care delivery being on multidisciplinary teams, it is also important that the way in which professions are trained emphasises the importance of developing a team-based working culture. One way of doing this is through a multi-professional approach to training where those who will be working together are trained together.

With regards to the content of training, this must primarily be driven by individual health boards' determination of what is required to meet local need. However, as a population-based and preventative approach to care develops further, core skills to equip staff to respond to this agenda will become important. Consideration must therefore be given to such training as health-based planning (including health economics, understanding population health), co-producing outcomes with patients, patient self-management and the use of ICT (including telehealth and telemedicine, call management and data handling). The Welsh Government will work with WEDS, Public Health Wales and education providers to ensure a suite of such training is made available.

Health boards will also need to ensure the primary care workforce is suitably skilled in brief interventions about a range of key determinants of ill health (such as excessive alcohol consumption, smoking and obesity) and are aware of services in their area, which can help maximise prevention and increase people's wellbeing. This will ensure primary care services play a full and active role in health boards' performance against key health indicators.

The Welsh Government will, with the support of a range of delivery partners, undertake the following actions to refocus the education and training of the NHS

Wales workforce to create a more flexible approach that supports the increased focus on multidisciplinary working and the need to develop new roles:

Actions – Education and training

<i>Action</i>	<i>Lead</i>	<i>Date</i>
Through discussion with primary care leadership teams across Wales, the Welsh Government will continue to invest in advanced and extended skills such as non-medical prescribing and advance practice education.	Welsh Government and health boards	Ongoing during 2015-16
<p>The Welsh Government will work with a range of partners to:</p> <ul style="list-style-type: none"> ○ Consider whether any of the centrally- funded NHS programmes could be delivered within shorter timeframes by maximising the full number of weeks in a year. ○ Establish how Wales can move to a position where multi-professional training is the normal method of education for centrally-funded NHS programmes of education with common learning platforms as far as possible. ○ Expand the range of care settings in which training can be undertaken. ○ Identify areas which would build upon the experiences of learning wards and translate these into community settings. 	<p>Welsh Government</p> <p>Supported by with local health boards WEDS, the Wales Deanery and education providers.</p>	Work to be undertaken during 2015-16 with implementation to take place in 2016-17 subject to detailed proposals
The Welsh Government will work with stakeholders to establish a different funding mechanism for doctors in training which removes the tension between the Wales Deanery and health boards when determining the training landscape across Wales.	Welsh Government and the Wales Deanery	
The Welsh Government will work with stakeholders to develop a comprehensive framework for work experience and apprenticeship opportunities within NHS Wales and wider care settings.	Welsh Government	
The Welsh Government will develop and agree with health professional regulators a mechanism which will enable regulators and stakeholders to work together on issues effecting developments in	Welsh Government	September 2015

Wales, where professional groups work beyond their traditional boundaries, such as those involved in advanced practice or extended skills.		
The Welsh Government will work with health boards to identify common education and training requirements necessary for the workforce to gain the skills to plan care on a population basis and to deliver new models so that a standard approach can be taken across Wales.	Welsh Government and health boards Supported by WEDS and training providers	Ongoing during 2015-16
The Welsh Government will work with health boards to build a consistent understanding of what can be offered through advanced practice and to embed the All Wales Advanced Practice Framework across Wales, backed by associated governance. Health boards will be required to demonstrate how they have used the broader skills of these practitioners.	Welsh Government	Ongoing during 2015-16
The Welsh Government will work with delivery partners to exploit e-learning across Wales across the full range of professions. This will be done through making use of the existing NHS Employee Staff Record system (ESR) wherever possible.	Welsh Government and NHS Wales Shared Services	March 2016
The Welsh Government will work with WEDS to determine a more robust process for putting in place backfill arrangements to support education programmes and how these could be funded.	Welsh Government and WEDS	March 2016
NHS Health boards to consider how funding used to provide free accommodation for all F1 trainees could be used in more targeted ways to deal with recruitment and / retention issues in primary care.	Welsh Government	April 2016
Public Health Wales will develop and implement training programmes for front line primary care staff to support a population approach to primary care and to embed prevention as treatment by making every contact count This will be supported by tools with which to record health promotion interventions as part of routine healthcare encounters.	Public Health Wales	Programmes made available by December 2015 with wider rollout in 2016

To support a stronger population health focus in primary care, Public Health Wales will produce guidance on prevention and early intervention elements of all Together for Health delivery plans.	Public Health Wales	September 2015
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STABILISING KEY SECTIONS OF THE CURRENT WORKFORCE

The main aim of this workforce plan is to ensure action is taken now to achieve a planned and more diverse primary care workforce but there is also a need to address existing issues so the quality and safety of delivery can be maintained and the existing workforce supported. Taking action now will also create the best possible conditions for the transition to the vision for primary care set out in the plan for a primary care service for Wales.

Health boards have committed to working with the Welsh Government to develop an evidence-based framework to assess the sustainability of GP practices. They have been working with GPC Wales and other partners to develop a practice sustainability framework to provide a holistic way of reviewing practices' vulnerability and providing appropriate support. This support, which is envisaged to be exceptional in nature, is intended to help practices on a short-term transitional basis while longer-term solutions to meet population need can take effect.

Some of the challenges in primary care are specific to two professions which have historically been core to general practice: nurses and GPs. Wales is not alone in facing challenges - many of them are common across the UK and internationally - but it is clear that there is a need for action to be taken at a national level to support work already underway locally.

Nursing

The community nursing landscape has changed significantly in recent years with new teams and services being introduced alongside the traditional district nursing service. The totality of the community nursing workforce now needs to ensure that each facet has clarity about its purpose, function, structure and integration. Case loads and referral systems need to be robust and consistent with the principles of prudent healthcare. To achieve this, health boards need to review service specifications for community nursing teams to ensure an effective, efficient and coordinated service for patients.

Examples of challenges and opportunities in the specific sections of the nursing professions are:

- School nurses face a challenge of clarity in their strategic role in school settings and ensuring that their practice focuses on both policy implementation and outcomes. School nurses can make a significant contribution to school populations' wider health needs such as sexual health;
- Health visiting services have identified the need to appropriately use the skills of others in their teams as they move away from their traditional case holder structures. Developing the skill mix within health visiting teams will allow the development of the role community nurses and advanced nursery nurses. This change is needed to deliver the Health Child Wales programme;

- Learning disability community teams are re-examining their roles in light of the reviews of placements for people with learning disabilities. They are building capacity for care provision in the community rather than the current model of managing challenging behaviour in an inpatient setting. Young people with learning disabilities need interventions from other professionals alongside learning disability nurses and the link between the community learning disability team and inpatient services needs to be developed;
- Mental health community nursing services are currently experiencing an increased demand from a range of drivers such as an increase in community treatment orders and the growth in older people with dementia.

IMTPs show that work to maximise the contribution made by nurses is underway. Health boards plan to accelerate the up-skilling of nurses, including through extended skills, for example, in relation to decision making, assessment and prescribing. There are plans to increase advanced practice roles that provide greater autonomy up to and including diagnosing and prescribing treatment for minor ailments, in order to create a more flexible workforce. This includes a number of initiatives such as non-medical prescribing and advance practice education for primary care nurses.

A number of health boards have also set up internal nurse banks to create a pool of community nurses which can be deployed at times of particular strain avoiding the need to use high-cost agencies. This deployment can and does include deployment to GP practices.

The role that can be played by healthcare support workers through delegation is also being explored in a number of areas to alleviate pressure and to provide a more prudent balance to the workforce. The Career and Skills Framework for healthcare support workers will identify the types and levels of preparation needed for delegated tasks to be undertaken.

At a national level, the Welsh Government has responded to nursing recruitment challenges by incentivising return to practice through removing the cap on numbers for the five universities currently running return-to-practice (RtP) courses and by providing funding for recruitment drives. As a result, in 2014-15, 73 returnees were re-trained, compared to 16 in the previous year.

Encouraging both nurses and health visitors to return to practice is a prudent approach to increasing the nursing workforce with the cost implications being considerably less than training a pre-registered nurse – approximately £1,700 compared to £38,000. Returners bring a wealth of knowledge with them and the training time is significantly less (on average, it takes between 15 and 18 weeks to complete the RtP programme compared to three years on a pre-registered course), which means an increase in experienced professionals can be secured at pace to meet pressing demands.

In 2015-16 the Welsh Government has further strengthened this approach by commissioning WEDS to develop and manage an all-Wales return-to-practice

campaign. Through a targeted radio and social media campaign in March 2015, 42 returners were secured this year. With an increase in the number of people returning to practice it is essential that higher education institutions and NHS Wales respond by developing ways to support returners in placements and employment.

The Welsh Government has sought to increase the supply of nurses in the longer term by increasing the number of nurse training places under the 2015-16 education commissioning round by 22%. In addition, 40 nurse training places in the 2015-16 training round have been made available for healthcare support workers who can use prior experience to enter directly onto year two and will gain accreditation in two years rather than three.

To further support the development of the primary care nursing workforce the Welsh Government and its partners will undertake the following actions

Actions – Nursing

<i>Action</i>	<i>Lead</i>	<i>Date</i>
Further modelling of nursing workforce numbers, with a particular focus on the needs of primary care will be undertaken by WEDS to inform future education commissioning.	WEDS and health boards	November 2015
The current return to practice campaign will be reviewed by monitoring the take-up of RtP places and further roll-out in 2015-16 will be considered.	Welsh Government and WEDS	February 2016
WEDS will work with higher education institutes to increase the current 80 return-to-practice programmes with places being funded by the Welsh Government and monitor the impact of the increased pool of nurses on the primary care workforce	WEDS	Ongoing during 2015-16
The Welsh Government will explore the development of a refresher course and additional support, for those who have an active PIN but have not worked in a clinical setting recently and lack confidence to return.	Welsh Government	December 2015
Health boards will review the role and contribution of primary care nursing services, including the role of the primary care nurse in wider population strategic health issues in primary care clusters.	Health boards	Ongoing in 2015-16
The Welsh Government, working with health boards and WEDS will develop a framework to identify the contribution of consultant nurses and clinical academics in primary care and align this to the community nursing research strategy and the post registration career framework.	Welsh Government, health boards and WEDS	November 2015
The Welsh Government will support the implementation of an evidence-based tool to be	Welsh	From September

used in a triangulated methodology to assist in the local identification of staffing requirements in district nursing community teams.	Government	2015
The Welsh Government will provide support, including funding, for nurse leaders in primary care clusters to ensure the development of nurse-led multidisciplinary teams to manage patients and facilitate discharge from hospital.	Welsh Government	From September 2015

GPs

GPs will continue to have a key clinical and leadership role in primary care in the future, taking responsibility for professional standards, providing clinical leadership and working directly with those people with complex needs which can only be met by a GP's skills. They will however increasingly need to be supported by a wider and more diverse team of primary care professionals whose work is coordinated around the person so that, collectively, they can provide a holistic service that promotes physical, mental and social wellbeing rather than just the absence of ill health. GPs in Wales are already engaged through their work in the ongoing development of clusters, networks and new models of delivery.

In their most recent IMTPs, a number of health boards have identified difficulties practices are having in recruiting GPs and it is known that practices in rural areas often have more pronounced recruitment issues due to a range of factors including limited resources and a lack of infrastructure for families.

Such recruitment difficulties are accompanied by:

- Challenges in retaining older and more experienced GPs as part of a trend towards early retirement which itself is being exacerbated by pension reform being undertaken by the UK Government;
- A change in working preferences with the traditional practice partnership model no longer seen as the preferred or desired arrangement in part due to the additional administrative and workload burden;
- An increase in sessional-based work and a trend for both male and female GPs to work part time;
- Increased popularity of locum working and an ability for locums to undertake work based on personal preference rather than service need (for example, sessions that do not include house calls);
- A poor perception of general practice as a career choice with evidence the speciality is not as popular as acute or secondary care.

Wales, like the rest of the UK, has had a traditional model of general practice, dominated by independent partnerships – GPs, or partnerships of GPs, have owned their own practices and worked as independent contractors providing primary care services to the NHS. However, as a result of the changing GP workforce and the challenges outlined above, a more mixed economy is likely to develop in the future as more people opt to work as locums or as salaried GPs directly employed by

health boards. While the majority of practices are likely to continue to be GP-owned partnerships in the future, health board-managed practices could develop in some parts of Wales in response to recruitment challenges.

At a local level health boards are already considering locality or cluster-specific solutions to support the recruitment and retention of GPs. They will need to continue to do so in a way that listens to and supports frontline professionals and the Welsh Government expects all boards to regularly monitor the progress of such actions and to be proactive in identifying workforce matters which need to be tackled.

In addition, while the nationally-negotiated General Medical Services contract model will remain the principal one in Wales, health boards are able to put in place other contractual arrangements for GP practices, depending on the needs of the local population, the type of services to be provided and the workforce issues faced.

At the same time the GP workforce community and its representative bodies must engage fully with the prudent healthcare agenda the Welsh Government has set out. It is only by operating as part of a wider multidisciplinary team, where each profession acts at the top of their clinical competence and undertakes the work that only they can do, that the primary care service in Wales can effectively respond to growing demand while also improving access. It is also through prudent healthcare that the most fundamental and long term re-balancing of the workload of GPs can be achieved.

At a national level, the most recent statistics show that the total GP workforce in Wales passed the 2,000 mark for the first time in 2014. Meanwhile, the number of registered patients per GP practitioner has fallen by 5.5% since 2004 and now stands at an average of 1,582. These figures are encouraging and represent sustained achievement in primary care in Wales.

The Welsh Government has also undertaken the most radical reform of the GP contract of any of the four home nations by agreeing with GPC Wales a new two-year contract which cuts more red tape from GP workload. The return of 102 points to core funding in the quality and outcomes framework (QOF) means that since 2014-15 around 40% of the total QOF points associated with red tape and bureaucracy have been removed. It also means GPs will have more time to care for the most vulnerable people with complex care needs, in particular, people who are frail and elderly.

As well as removing an administrative burden, this is a clear indication of the trust the Welsh Government has in the professionalism of GPs and their use of clinical judgement. The two-year GP contract also underpins the reform agenda set out in the primary care plan, provides stability for practices and a good platform to continue improvement of the provision of core services provided by GPs.

To further support these changes, the Welsh Government will over the next year work with key partners to deliver a series of key actions in relation to the GP workforce, based on a strategy of:

- Retaining experienced GPs and supporting those who wish to return to practice;
- Making it easier for those who wish to step back from full-time work to be retained in the workforce on a different basis;
- Exploring how training for, and working in, general practice can be encouraged in areas of greatest need;
- Communicating the opportunities afforded by general practice in Wales to spur recruitment in the medium and longer term.

The actions set out below are about ensuring the future sustainability of the GP profession in Wales so it can continue to play a leading role in delivering primary care services in Wales.

Actions – General Practice

<i>Action</i>	<i>Lead</i>	<i>Date</i>
Undertake a future supply and demand exercise to inform future GP training numbers. While previous exercises, most notably in 2012, have sought to identify the impact brought about by retirement, prudent healthcare principles must now be factored in so that a reasonable estimation of the current workload of GPs that would be undertaken by other professionals is considered in future projections.	WEDS, Wales Deanery and Welsh Government	September 2015
Develop, in conjunction with the service and a range of delivery partners, a national recruitment campaign that highlights the essential contribution made by general practice and the opportunities a career in Wales provides.	Welsh Government, health boards and Wales Deanery	September 2015
Work with health boards to set out a refreshed offer for GPs in Wales, elements of which will be expected to be offered or facilitated by every health board. This will include: <ul style="list-style-type: none"> • An occupational health service being made available to all GPs. • Opportunities for career development, including flexible portfolio career schemes or specialist training. • Streamlining of the GP returners scheme in Wales to make it more focused on identifying the strengths of potential returners so that 	Welsh Government and health boards	March 2016

<p>maximum opportunity can be made of this group of experienced professionals.</p> <ul style="list-style-type: none"> • Additional support for the development of a GP retainer scheme that has a wider scope of eligibility that would include those GPs for whom a change in working patterns may be an alternative to early retirement. This will include innovative ways of retaining experienced GPs who may be considering leaving, including through the use of fixed-term salaried positions. • Exploring actions that can be taken in regards to sessional thresholds arising as a result of professional indemnity insurance. • Reduce/streamline 'back office' management functions through the provision of expert HR support and advice (including employment law advice and legal support) support for recruitment (including pre-employment checks) and payroll management. This support would be provided through the NHS Wales Shared Service Partnership. • Improved access to e-learning through a practice being linked into the NHS Employee Staff Record (ESR) system. 		
<p>Develop a new approach to incentivising general practice in Wales, both in terms of entry into training and the taking up of practice in under-doctored areas. Considerations will include:</p> <ul style="list-style-type: none"> ○ Proposals for a voluntary bonding scheme to encourage recently-qualified GPs to practice in an area that has been difficult to recruit to or which is an area of significant need. ○ The reimbursement of student fees accrued during the duration of medical school where an individual decides to pursue a career in general practice. This could include refunding students' fees or paying a fee premium on top of the GP salary which equates to the level of fees incurred, on an incremental basis dependent on the service commitment provided to Wales. ○ Health boards will consider how funding used to provide free accommodation for all F1 trainees could be used in more targeted ways to deal with recruitment and / retention issues in primary care. 	<p>Welsh Government, the Wales Deanery and other partners</p>	<p>November 2015</p>

<ul style="list-style-type: none"> ○ Expansion the academic fellows scheme to cover West and North Wales. The parameters of the scheme would need to change to ensure the service element was a dominant feature of the scheme. 		
<p>Amend legislation in relation to GP performers with the aim of making it easier for GPs, who are on a Performers' List in England, to work in Wales for a period up to a maximum of six months (within a 12 month period) without the need to make a full application to be included on a health board's performers list. This proposal is currently being developed for consultation.</p>	<p>Welsh Government</p>	<p>August 2015</p>
<p>Work with the medical schools in Wales to continue the approach already adopted to increase the proportion of general practice/community placements medical students are exposed to. This will build on the work being undertaken as part of the C21 programme offered by Cardiff University where greater emphasis is being placed on theoretical learning combined with hands-on experience of a wide range of care settings. It will also build on the greater emphasis on community/primary care within the graduate entry programme in Swansea University.</p>	<p>Welsh Government, Wales Deanery and Welsh Medical Schools</p>	<p>September 2015</p>
<p>Work with health boards and employers to explore a code of practice for locums. This work will bring greater standardisation to the services which can be expected of locums across Wales, thereby maximising their benefit as cover when needed and providing greater equity of patient experience.</p>	<p>Welsh Government</p>	<p>December 2015</p>

ANNEX 1 – SHORT CASE STUDIES OF NEW MODELS OF PRIMARY CARE

Integrated Gower Team (IGT), Abertawe Bro Morgannwg University Health Board (ABMU)

Due to a long history of little provision and difficulties in the supply of domiciliary care for residents in the rural Gower area of Swansea, resulting in long delays in hospital discharges, people struggling to cope at home often with end-stage complex health problems and people not being able to return home to die in the terminal stages of an illness, it was decided to develop a new model of integrated domiciliary care for the Gower area.

Key features

The team is made up of both local authority and health board care staff and they provide a more efficient domiciliary service for residents of the Gower; the team is also co-located with the district nursing team. Full use is made of all the team members and the form of the clinical encounter is tailored to the needs of the patient. Patients benefit from continuity of care with their health professional, as this model allows for a better understanding of the patient's needs and hence more appropriate and shared care planning. There has been a willingness on behalf of the local authority and the Health board staff to work in a collaborative way to avoid waste, the duplication of services and to provide a better service to patients. The model has been successful due to effective and regular engagement with all the stakeholders, as well as the number of volunteers who agreed and were committed to joining the new team and to making a real difference.

Outcomes to date

- Patients receive community-based, fully co-ordinated services that are designed to support them and provide them with the chance to retain control of their lives
- There is currently no waiting list for domiciliary care within the Gower area, therefore patients can be discharged from hospital as soon as they are medically fit
- Patients within the hospital and home setting now have access to a responsive domiciliary care service
- There is continuity, quality and safety in care provision.

The IGT has provided the foundation for the full integration model for the three community health and social care hub teams. The three hubs have staff groups from the local authority and health board, which include; community nursing, social work, occupational therapists, physiotherapists and a large fully-integrated home care team. All staff are co-located in the three hub sites in Gorseinon Hospital, the civic centre and the Beacons Centre in SA1. There are also smaller satellite hub sites across the city. The integrated team will provide a one stop shop and bring care much closer to where people live. The teams will work in a preventative way with service users in their homes and communities, along with full administrative support.

The hubs mark an important step in bringing services together, improving communication and providing a more joined up service to older people and younger disabled adults in Swansea.

Advanced Musculoskeletal Physiotherapy Practitioner in Primary Care, Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Health Board is currently piloting the employment of two advanced musculoskeletal physiotherapists and two extended scope practitioner physiotherapists across four GP surgeries in Gwynedd. This pilot was started due to GP recruitment difficulties, the fact that musculoskeletal disorders are the most common reason for repeated GP consultations, accounting for approximately 30% of all GP consultations and because evidence suggests rapid access to musculoskeletal services can reduce the amount of time people are off work and prevent an acute problem becoming long lasting.

Key features

Advanced musculoskeletal physiotherapists, who are senior clinicians capable of making decisions about the correct course of action/treatment, work in GP practices and act as the first point of contact on behalf of the GP, offering a viable alternative to GP consultations for patients who have musculoskeletal issues. Their role encompass tasks that previously would have been undertaken by the GP, including assessment and management, joint injections, requesting diagnostics and independent prescribing. They play a critical role in reducing demand on primary and secondary care (for example, orthopaedic and clinical musculoskeletal assessment and treatment service waiting lists) and keeping services within the community, promoting independence and improving the patient experience.

Outcomes to date

From the early feedback received, the pilots have been highly successful from the point of view of:

- Releasing capacity for GPs to take on a more medical caseload
- Patient satisfaction - people are seen very quickly and have a full assessment by an advanced practitioner
- Patient pathway is improved, i.e. right advice, right person, first time
- Reduction in referrals to the Clinical Musculoskeletal Assessment and Treatment Service or secondary care
- Working in this integrated way also enables effective succession planning, by up skilling the extended scope practitioner physiotherapist workforce within the field of independent prescribing, non-medical referring rights and injection therapy.

Although the pilot has yet to be formally evaluated, the Health Board is considering rolling this out to other practices, starting with those practices that have GP

recruitment difficulties and/or imminent retirements.

Community Pharmacy based 'Triage and Treat' Service – Hywel Dda University Health Board (HD)

This service was established in two community pharmacies (Tenby and Saundersfoot) alongside other unscheduled care provision in the area, following the closure of the minor injury unit (MIU) in Tenby. People with injuries were regularly signposted by pharmacies to the MIU, GP or A&E but it was evident that pharmacies could offer a treatment service for some common, low level injuries if focused training was provided. Working with a cohort of enthusiastic community pharmacists, pharmacy staff were trained to provide advice, assessment and treatment for common injuries, including minor abrasions, minor wounds, removal of foreign bodies, minor burns, strains and sprains and wash out of eyes.

Key features

The Triage and Treat service is made up of community pharmacists who act as the first point of contact for advice and support on low level injuries (with onward referral if needed). The service diverts some care away from GPs and A&E and offers a means of providing care closer to people's homes, enabling patients to manage their own conditions and making more effective use of existing staff and resources. Key to its success was staff enthusiasm, full engagement of local pharmacies, Community Pharmacy Wales, the Welsh Ambulance Services NHS Trust, health board staff and the community health council, as well as a robust communication plan. Specialist support, training and advice were provided to pharmacy staff by an emergency nurse practitioner.

Outcomes to date

- Cost savings have been made as the Triage and Treat service costs are less than those for attendance at A&E
- Positive comments received from users of the service
- More efficient use of skills, time and resources
- Strengthened links with other unscheduled care providers

Collaborative Working Pilot between Advanced Paramedic Practitioners and Pembrokeshire GP Out of Hours Service (OOHS) – Welsh Ambulance Services NHS Trust (WAST)

This pilot was primarily established as a result of a short fall in the GP out-of-hours cover across Pembrokeshire and involved the Welsh Ambulance Services NHS Trust and Hywel Dda University Health Board working collaboratively to find a solution to the problem. It was agreed that advanced paramedic practitioners would

assist the GP out-of-hours with the triaging of telephone calls, the provision of advice and guidance to other health care professionals ringing in to the service and where appropriate, undertaking house calls, on behalf of the GP, in order to avoid unnecessary hospital admissions.

Key Features

Collaborative working across clinical and professional boundaries, early access to a senior clinician capable of making decisions about the correct action to follow and the pooling of resources during times of high demand or low capacity are key features of this model. All team members involved were enthusiastic about and saw the value in undertaking this pilot, as well as being committed to reducing the number of hospital admissions, where appropriate.

Outcomes to date

- No adverse impact on WAST practitioners' ability to deal with own workloads
- Increased skills, knowledge base and confidence of advanced paramedic practitioners
- Improved working relationships between the two hard-pressed services
- Reduced hospital admission rates
- On scene times reduced during the second month of the pilot
- More efficient and timely service provided.

Integrated Pathways: Community Diabetes Model – Cardiff and Vale University Health Board

As part of this model, a named diabetologist (from secondary care) is allocated to each GP practice and is committed to undertaking two practice visits per year to undertake virtual clinics, with the aim of providing advice and expertise to GPs and practice nurses in order to enable diabetes care to remain and be managed within the community.

Key Features

This model sees primary and secondary care practitioners working collaboratively to provide integrated diabetes care management which is closer to the patient's home. The model relies on alternative ways of working, including the use of virtual clinics and enables GPs to access rapid advice and expertise from the diabetologist within one working week. Practice nurses also have access to a diabetes specialist nurse facilitator who provides mentorship to those practices involved in diabetes care.

Outcomes to date

- Better integration of diabetes care management pathways
- Improved working relationship between primary and secondary care
- Care provided closer to the patient's home

- 30% reduction in referrals to outpatient departments
- No waiting lists for new diabetes patients
- Reduced referrals for process measures (for example blood pressure)
- Reduced referrals for complications
- Staff have improved skills, confidence and job satisfaction in the management of type 1 and type 2 diabetes.

Amman Tawe General Practice Model – Abertawe Bro Morgannwg University Health Board

The Amman Tawe Partnership was formed by three GPs from two former Amman Valley and Pontardawe practices when they made a successful bid to take over a neighbouring Upper Swansea Valley practice which had become vacant following the resignation of the two GP partners. The partnership now serves approximately 12,000 people across Carmarthenshire, Neath Port Talbot and Powys, has contracts with both Abertawe Bro Morgannwg and Hywel Dda university health boards and is the largest Neath Port Talbot-based practice. The merger has provided an opportunity to build and test an alternative model of primary care, working in partnership with the health boards, local authorities and third sector.

Key Features

The model is based on the Alaskan NUKA co-ownership/stakeholder model of care which moves away from the throughput approach, towards one that fosters the principles of self-help, empowerment and choice. The clinical workforce now includes the three GP partner 'directors', five part-time GP associates, two advanced nurses and pharmacy practitioners supported by healthcare support workers and a reconfigured practice management team. Plans are in place to recruit advanced psychological and physical therapists, engage a frailty consultant and support and analyse the development and outcomes of the model with a PhD academic post.

The key features of the service model are:

- Co-production – working with staff, service users and the community in order to deliver a more effective healthcare service with better local outcomes;
- Putting frail and vulnerable service users first and coordinating daily team discussions and work flow;
- Making services easily accessible – through flexibility, clear procedures and the use of community assets;
- Managing chronic conditions - through the development of clear communication pathways who all those involved in the care;
- Resilience - developed through clear communication, effective leadership, appropriately trained workforce and opportunities for continuing professional

development.

Outcomes to date

- Staff are engaged: a training needs analysis has been completed, areas for development identified and personal development plans developed for all clinical and clerical staff (41 in total)
- Practice training and development plan developed; phase one has included up-skilling receptionists in call management (in-house) and customer care (Bridgend College), minor illness management for the advanced practitioners; non-medical prescribing planned to support their roles, for example in the management of chronic conditions
- Telephone triage/consultation has been introduced across all sites: calls are answered in all six sites every morning and the three GP partners work their way through each list entry and allocate the best /most suitable person to deal with that request.
- Patients and stakeholders are engaged, for example, through invitations to three Meet your GP sessions (more than 300 attendees) over the past year, gradually winning support for the concept, as demonstrated in recent independent questionnaire commissioned by Hywel Dda University Health Board as part of the recent contract award process.
- Appointments and availability have all increased due to the changes, with more patients seen, the proportion shifting from the GPs to the new alternative clinical staff, the creation of the new roles enabling the GPs to focus their work on more complex cases.
- Reduction in do not attends: only 11 recorded for March 2015, down from approximately 70 at the same time the previous year.
- Engagement with third sector and local authority to plan development of community transport support.

Minor Oral Surgery Service – Aneurin Bevan University Health Board (AB)

In April 2014, the health board commissioned two primary care-based minor oral surgery services from primary care general dental providers (who have appointed maxillofacial consultants/oral surgeons). This service was needed because of a large volume of referrals to hospital-based services which, with the right alternative model, could be done closer to home. As a result of this activity going into highly specialist HDS services, there was significant pressure on hospital maxillofacial departments and the health board was breaching referral to treatment time targets.

Key Features

This model sees primary and secondary care practitioners working collaboratively to provide dental care closer to people's homes. Such collaborative working also ensures timely access to a senior clinician, thus reducing demand on secondary care services and keeping services within the local community, thereby promoting

independence and improving the patient's experience.

Outcomes to date:

- In 2014-15, around 2,200 cases had been undertaken in a primary care setting which would have previously been undertaken in hospital-based services;
- The impact has been significant with the health board forecasting achieving its 36-week referral to treatment time target for maxillofacial treatment for the first time in many years and patients waiting between two to eight weeks for treatment;
- Care is provided closer to the patient's home;
- More efficient use of skills, time and resources.

Cylch Caron Integrated Resource Centre – Hywel Dda University Health Board

(HD) The Cylch Caron area is defined as Tregaron and the three adjacent electoral divisions, Aberaeron, Lampeter and Llandysul. Current services for people with care needs are fragmented with separate systems, structures, facilities, governance arrangements and ways of working. This is exacerbated by the Tregaron region being deeply rural, with a dispersed elderly population living in hard-to-reach properties, many of which are unsuitable for modification. Added to this, community services are delivered in unsuitable premises. The Cylch Caron model, which is still at the outline business case stage, aims to provide a new hub/integrated resource centre which provides extra care housing, flexible integrated health and social care, general medical services and pharmacy services. It will be developed by November 2016, with all services commissioned by March 2017.

Key Features

This model will see the integration of local authority, health, social and community staff working collaboratively to provide integrated care, which will enable the provision of high-quality, efficient and sustainable health and social services which serve more people closer to their homes, the provision of flexible services which meet the projected increase in service demand over the next decade and beyond, the reduction in health and social care spend, the provision of support for independent living and the ability to meet appropriate care, energy and legislative standards.

Outcomes to date

The model is still for consideration at the outline business case stage, however the benefits of this approach are many and include the following:

- Improved integration and team working
- Improved professional development opportunities for staff

- Improved access to services and information on a single site
- Better working environment and equipment
- Reduced social and psychological isolation
- Safe, affordable housing and confidence to residents that they can remain in their own community regardless of their age
- Provision of care closer to the people's homes
- Improved tenant wellbeing and greater opportunities for tenants to maximise income and increase personal wealth, leading to wider economic benefit to the community

Social Enterprise in South Powys – Powys Teaching Health Board

GP representatives from the four South Powys medical practices have agreed to collectively proceed with the establishment of formal joint working arrangements based on a social enterprise model.

Key Features

This model relies on the establishment of a new platform from which the practices can work jointly, and essentially, have a legal identity in its own right. To be at its most effective, joint working requires this new platform from which services can be developed on a locality-wide basis, without any one practice being required to take on a disproportionate level of risk.

The model is inward looking in that it looks to:

- Increase the efficiency of some existing general medical services across the four medical practices;
- Secure GP and other staff resource to deploy as required across the four medical practices;
- Share back-room administrative functions more efficiently across the four practices;
- Share practice management expertise and resource;
- Enter in to supply contracts on behalf of the four medical practices to achieve more cost effective outcomes.

The model is also outward looking in as it seeks to:

- Take responsibility for a wider range of enhanced services delivered via the four medical practices;
- Take responsibility for the efficient delivery of a range of services currently being delivered by the health board and others;
- Take responsibility for the efficient delivery of a range of services that have traditionally been delivered by a secondary care provider;
- Work with a wide range of stakeholders to develop an ambitious, innovative and locally-owned approach to the challenges faced by South Powys.

Outcomes to date

Outcomes are currently emerging as this model is still embryonic. However the key outcome indicators are:

- An organisation firmly focused on the delivery of effective, high-quality health services in South Powys, while supporting the sustainability of general medical services within the area;
- An organisation of high-quality, well-managed and with a strong sense of ownership and commitment from those working within it;
- An organisation which is run not just by GPs, but others too, including community staff and third sector representatives;
- An organisation that has transparent, well-developed and regularly-tested corporate and clinical governance arrangements;
- An organisation fully committed to the reinvestment of any financial surplus into further development of local health services.

Primary Care Support Unit (PCSU) & Community Resource Team (CRT) – Cwm Taf Health University Board (CT)

The primary care support unit consists of salaried GPs, nurses and healthcare assistants who are employed by the health board. At the present there are 18 salaried GPs, six of whom have been recruited in the last three months. The unit has been in existence since 2002 and over this time it has provided support to GP and community services. It is supported by a management team and clinical director.

Key Features

The primary care support unit provides support to health board-managed GP practices; enables the mobilisation of clinical staff when the need arises (particularly to those GP practices that are failing or in difficulty); supports GP practices which have short and long-term recruitment problems and enables principal GPs across Cwm Taf to participate in specialist training and or services by providing backfill. A number of the salaried staff also deliver specialist services such as dermatology or palliative care roles, in addition to GP sessions. The primary care support unit also consists of a primary care nursing service, which serves the same objectives but from a nursing perspective. The primary care nursing services supports other projects such as oral care, lymphoedema, tissue viability and the home oxygen therapy service. The primary care support unit is now actively involved in supporting practices in delivering the inverse care programme of work.

Outcomes to date

- Address recruitment issues by allowing salaried GPs and nurses to experience working in Cwm Taf;
- Provide a supportive team and environment for newly-qualified GPs to consolidate their learning;
- Support locality GPs and nurses to develop themselves and their practices;
- Improve and increase the level of primary care services available to patients;
- Improve the quality of care delivered;
- Promote and raise the profile of Cwm Taf to attract high calibre GPs to the area;
- Resulted in nine salaried GPs joining GP partnerships within Cwm Taf practices;
- Resulted in the successful transition of a practice through to managed status and then back to independent status;
- Facilitated support and mentorship to less experienced practice nurses and healthcare assistants.

Ashgrove Surgery, Pontypridd – Cwm Taf University Health Board

Key Features

In 2007, Ashgrove Surgery, in Pontypridd, which currently looks after approximately 17,000 patients, invested in a pharmacist to join its busy team (initially on nine hours which was increased over time to 34 hours a week in 2013); the main driver was to release the GPs within the practice to undertake their core GMS tasks. The pharmacist continues to be responsible for undertaking medicine management review tasks, as well as monitoring and advising on prescribing issues and supporting the nurses' chronic disease clinics.

Outcomes to date

The employment of a pharmacist has demonstrated the following benefits:

- GPs are released from undertaking tasks that could be done by someone else, supporting the prudent healthcare agenda;
- Pharmacy expertise is retained and delivered in-house;
- The pharmacist provides a good link between community and secondary care, particularly in cases where there are challenges around discharges;
- The pharmacist has a good knowledge and understanding of the issues facing the local area (having previously worked as a community pharmacist and the locality prescribing adviser), which has proved to be beneficial.

Within the practice, prescribing clerks help the pharmacist order and process repeat prescriptions. The prescribing clerk's role is an administrative one, undertaken by

two part-time staff and has proved to be extremely beneficial - between April 2014 and March 2015, 45,803 requests were made for repeat prescriptions. Any queries about prescriptions or any 'acutes' (people who have ignored their medication review reminders or those requesting medications not on their repeat prescription) are directed by the prescribing clerks to the pharmacist