GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Canolfan Datblygu ac Arloesi Gofal Sylfaenol a Chymunedol
Datblygu Gofal Sylfaenol yng Nghymru
Primary and Community Care Development and Innovation Hub
Developing Primary Care in Wales

CLUSTER WORKING IN WALES

Resources to help develop your cluster

Part of a set of 3 handbooks for new Cluster Leads and other staff working in or with clusters

October 2019

Contents

A: Cluster working

- Background to primary care clusters 3
- Definition 3
- Structures 3
- Who's who? 4
- Primary Care Model for Wales 6
- Cluster governance 7
- Funding 9
- Cluster meetings 10
- Developing wider cluster working 13
- Employing cluster based staff 13
- Multidisciplinary Teams (MDTs) 16
- Social prescribers / prescribing 18
- Information governance 19

B: Tools, techniques and useful resources

- Use of data to identify population need 21
- Workforce planning 28
- Bids and business cases 30
- Project working 33
- Evaluation 36
- Quality Improvement 39
- Glossary of terms 42
- Summary of published and online resources 42

Further reading 44

Background to primary care clusters

The concept of primary care clusters where primary care services are co-ordinated on a geographical locality basis in Wales was first introduced in 2010. The policy was developed with the Welsh Government's Primary & Community Services Strategic Delivery Programme, *Setting the Direction* where services were co-ordinated on a locality footprint serving populations of 30,000 to 50,000. The GP practice was identified as pivotal to cluster development through working with partners to assess and meet local need. Formal arrangements for GP practices to work collaboratively as clusters to develop services in their locality were established in Wales in April 2014.

Definition

> *'A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities.'*

Source: *The Strategic Programme for Primary Care, 2018*

Structures

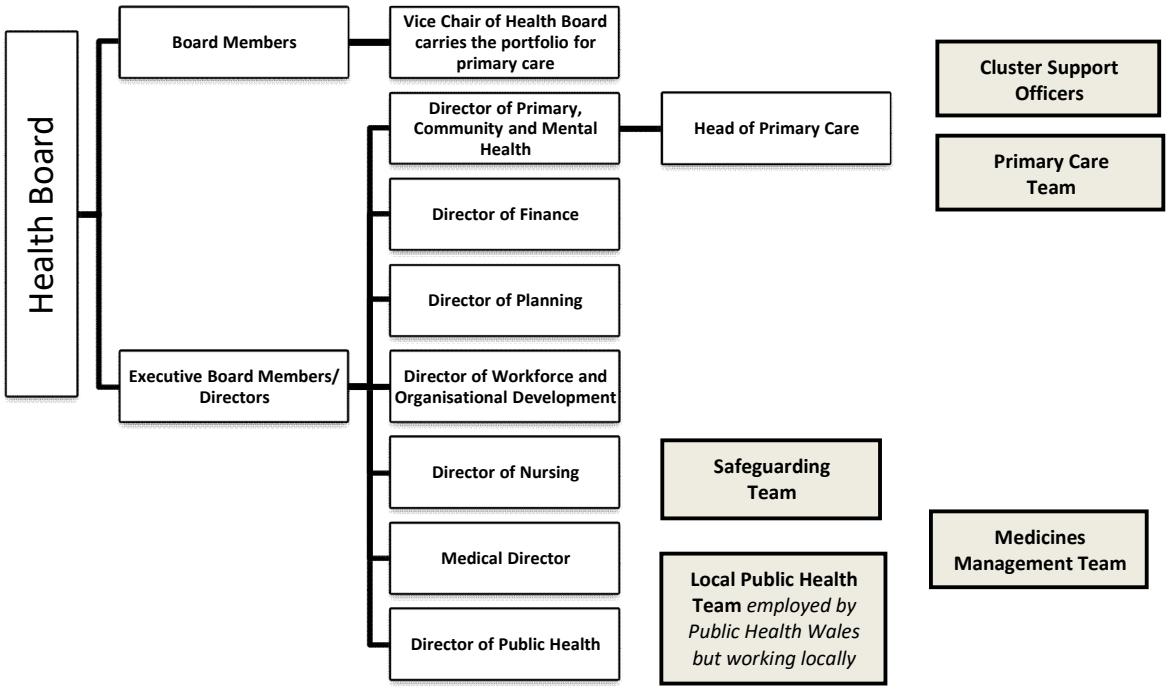
Across Wales, there are 64 primary care clusters. The geographical area and size of the population that a cluster covers is determined by individual local health boards. The number of clusters in each health board area varies e.g. Betsi Cadwaladr University Health Board hosting fourteen clusters with Powys Teaching Health Board hosting only three. Some health boards have subdivided the clusters further into small or larger localities and given them a variety of titles e.g. Neighbourhood Care Networks in Aneurin Bevan University Health Board.

Specific detail about individual clusters or clusters by health board is available via an interactive map and individual health board links via Primary Care One.

Who's who?

As a Cluster Lead, there are key individuals in your health board area that would be useful to familiarise yourself with or get to know (chart below). These are mainly employees or members of your health board committees but also include people working in your area but employed by other organisations.

Chart illustrating health board persons of interest *



*The chart does not list all the roles within the health board.

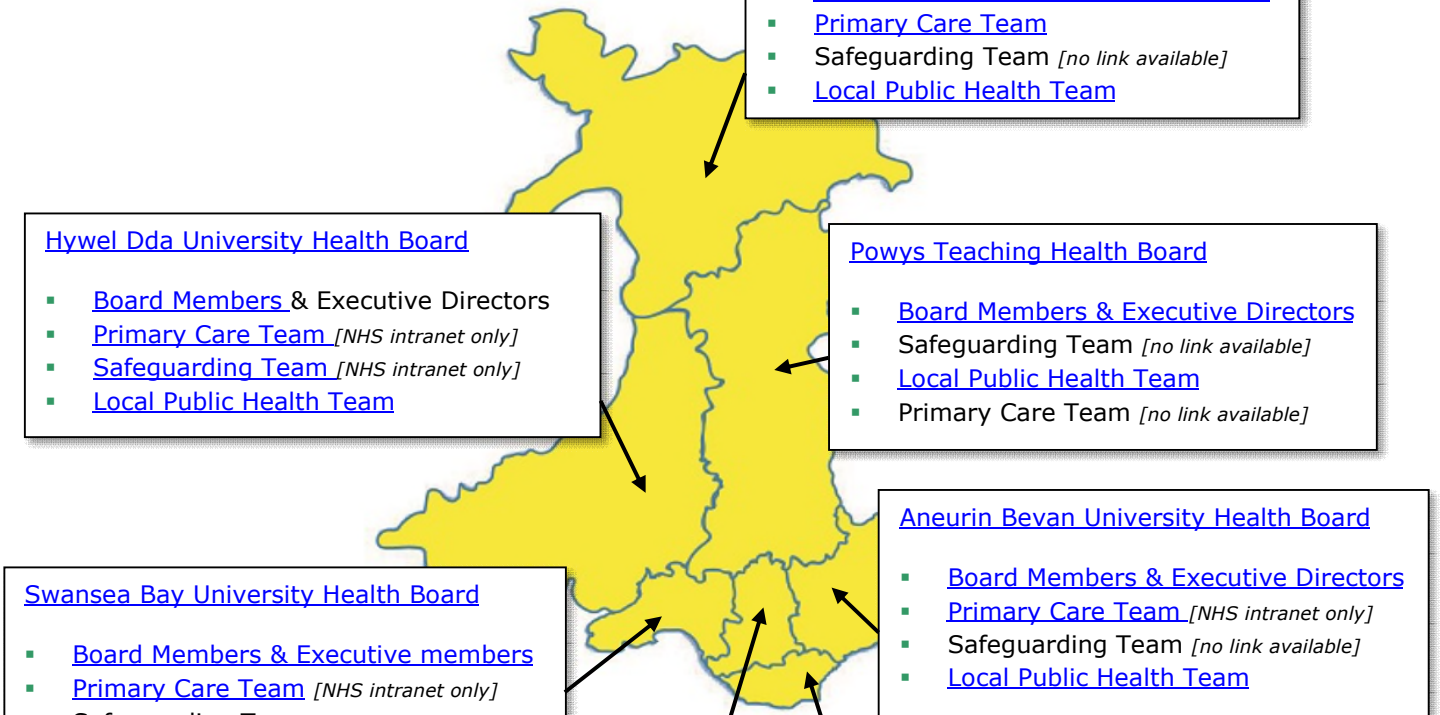
Different health boards have different structures. You will find that the hierarchy for the positions in the shaded boxes vary between health boards, nevertheless, there will be people you may wish to get to know or familiarise yourself with. It is also worth finding out details about the Public Service Board and Regional Partnership Board members covering your area.

Individual RPB information can be found at:

- Cardiff and Vale of Glamorgan Integrated Health and Social Care Partnership
- Cwm Taf Morgannwg (Rhondda Cynon Taf & Merthyr)
- Gwent
- North Wales Social Care and Well-being Improvement Collaborative
- Powys
- West Glamorgan (Neath Port Talbot & Swansea)
- West Wales Care Partnership (Pembrokeshire, Carmarthen and Ceredigion)

The map below provides links, where available, to individual health board teams. For some teams the link is only available via the NHS Wales intranet pages (HOWIS). For other teams, where there is no information available online, you may wish to contact the health board who may be able to provide you with contact details.

Map of different health board areas and 'who's who' in that area



Betsi Cadwaladr University Health Board

- Board Members & Executive Directors
- Primary Care Team
- Safeguarding Team *[no link available]*
- Local Public Health Team

Hywel Dda University Health Board

- Board Members & Executive Directors
- Primary Care Team *[NHS intranet only]*
- Safeguarding Team *[NHS intranet only]*
- Local Public Health Team

Powys Teaching Health Board

- Board Members & Executive Directors
- Safeguarding Team *[no link available]*
- Local Public Health Team
- Primary Care Team *[no link available]*

Aneurin Bevan University Health Board

- Board Members & Executive Directors
- Primary Care Team *[NHS intranet only]*
- Safeguarding Team *[no link available]*
- Local Public Health Team

Swansea Bay University Health Board

- Board Members & Executive members
- Primary Care Team *[NHS intranet only]*
- Safeguarding Team *[no link available]*
- Local Public Health Team

Cwm Taf Morgannwg University Health Board

- Board Members & Executive Directors
- Primary Care Team *[no link available]*
- Safeguarding Team *[no link available]*
- Local Public Health Team

Cardiff and Vale University Health Board

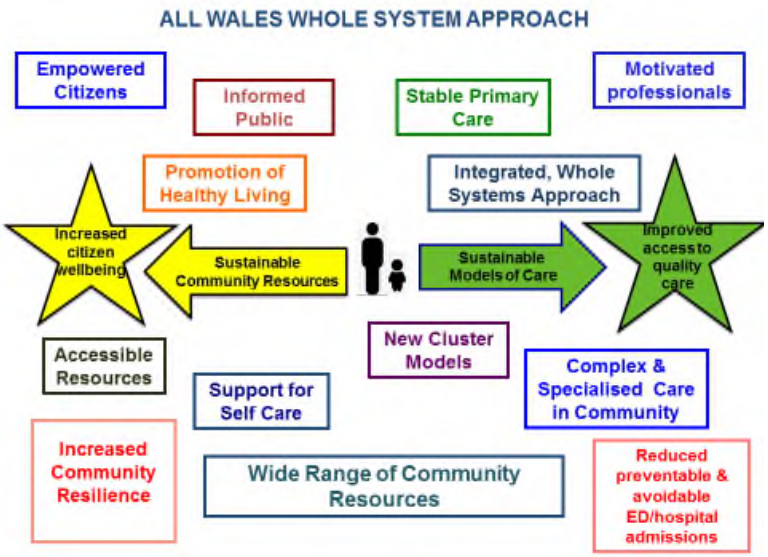
- Board Members & Executive Directors
- Primary Care Team
- Safeguarding Team *[no link available]*
- Local Public Health Team

In every health board area there will be a **Cluster Development Manager** and/or **team** as part of the Primary Care Team or Heads of Service Team who will be able to support you. Please contact your health board to identify your Cluster Development Lead/team.

The Primary Care Model for Wales

The Primary Care Model for Wales (former Transformational Model for Primary and Community Care) describes the whole system approach to sustainable and accessible local health and well-being care. The model emerged as a result of the context and framework set out in government policy *Our Plan for a Primary Care Service for Wales* and investment provided by Welsh Government support innovation and development in primary care at cluster level, health board level and at national level.

Figure illustrating the components of the Primary Care Model for Wales



Source: The Strategic Programme for Primary Care, 2018

Clusters are central to delivering the model and developing the links to the Regional Partnership Boards and the wider community infrastructure to support health and well-being care and deliver the quadruple aims of *A Healthier Wales*.

A *Maturity Matrix* for clusters has been developed to enable clusters to carry out a self-assessment to establish progress against the components of the Primary Care Model for Wales. Further details about the model is provided in the illustration and text below. Using the matrix clusters can identify areas for development and actions necessary to achieve sustainable and accessible local health and well-being care in their area.

Further details of the individual components of the Model can be found here.

Cluster governance

What is governance?

Governance is a broad term that means different things to different people. It includes leadership, stewardship, accountability, assurance, probity, ethical behaviour and control. For the NHS in Wales, governance is defined as:

> *'A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives'.*

Source: *NHS Wales Governance E-Manual*

Governance is the way NHS bodies ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector.

Purpose and relevance to cluster development

The principles of governance apply to any organisation; however, organisations within the public sector are subject to different legislative requirements and are diverse in terms of their structure, scope and objectives. In 2015, the National Primary Care Plan required health boards to agree a set of all Wales governance arrangements to support clusters to develop and mature. As a result, the *Primary Care Cluster Governance 'A Good Practice Guide', 2018* was developed to support health boards and clusters with these arrangements.

The majority of issues you will need to know regarding cluster governance will be noted in the guide.

The guide is accompanied by a Resource Pack which provides a variety of toolkits and templates developed locally around Wales to support cluster governance.

Set out within the Guide are principles for clusters to consider to ensure good governance arrangements:

Key principles for cluster governance

- Set out a clear vision for clusters, promoting the values of the whole organisation
- Clarify the functions of cluster teams, focusing on the purpose and outcomes for service users
- Clearly define roles and responsibilities relating to cluster working
- Develop capacity and capability of the governing body
- Focus on the longer-term sustainability and success of the organisation/team
- Demonstrate transparent decision making and risk management within cluster teams
- Establish effective quality assurance mechanisms
- Demonstrate probity through strong moral standards and leadership based on honesty and decency
- Design an accountability framework for reporting arrangements and monitoring progress
- Engage stakeholders and specify accountability arrangements

For further information:

- *Primary Care Cluster Governance 'A Good Practice Guide', 2018*
- *Good Practice Guide Resource Pack 2018*
- *NHS Wales Governance E-Manual*
- *The Good Governance Pocket Guide for NHS Wales Boards*

Funding

Clusters in Wales are given funding to improve the care and well-being of the communities they serve. Local priorities should be reflected in cluster plans, which in turn align to health board and Welsh Government objectives. Robust financial planning will ensure the aspirations of the plans are resourced and become a reality.

The NHS in Wales relies on taxpayers' money and is expected to spend it wisely. It is important that the people in Wales trust the public services especially when facing times of austerity. *Managing Welsh Public Money* published by Welsh Government sets out the main principles for managing resources in any public sector organisation in Wales. It indicates that everyone working in the public service in Wales shares a personal responsibility for the taxpayers' money.

Health boards are accountable to Welsh Government and service users for financial probity. As this is public money, duties and responsibilities for health boards in Wales are set out in the following:

- The *NHS Finance (Wales) Act* (2014)
- The health board's *Standing Financial Instructions* (SFIs) and *Standing Orders*
- *NHS Wales Planning Frameworks*

Funding is delegated to clusters through Welsh Government allocation to health boards. The funds are usually directed to the relevant budget area within the organisation and managed by the health board. The health board finance team will signpost clusters to relevant expertise and provide advice and training on financial processes and business planning activities.

The *Primary Care Cluster Governance 'A Guide to Good Practice'* provides further details about 'financial arrangements for clusters' including a *Frequently Asked Questions guide to procurement for primary care Cluster Leads.*

Cluster meetings

The cluster meeting provides the opportunity and mechanism to come together to discuss priorities and agree/monitor action to ensure cluster working is conducted effectively. It is important therefore that you get the best out of the time at the meeting to progress the cluster programme.

It is worth considering who is be invited to the cluster meetings. Typically, many cluster meetings consist of core members, who should attend at every meeting and a group of wider members who may be invited to occasional meetings. The cluster core membership will vary in each cluster as will the wider membership.

A typical core and wider membership for cluster meetings may look like that illustrated in the table below:

Core membership	Wider cluster membership
▪ Cluster Lead ▪ GP from each practice ▪ Practice Manager from each GP practice ▪ Cluster Support Officer / Manager ▪ Health Board representative	▪ Other contractor professionals, optometry, dental, community pharmacy ▪ Local Public Health Team ▪ District nurses ▪ Local authority representative ▪ Health board, finance, planning, medicines management team ▪ Community Health Council, lay member, patient representative

It is important to establish who is your core membership and how many of the core members are needed to be quorate. You may also wish to consider when it is necessary and / or appropriate for a core member to send a deputy if they are unable to attend and who this person should be.

In most cases, it is expected that cluster members will reach a consensus where decisions are required to be made. Whether the meeting is quorate and who is in attendance will provide a structure to decision making. You may also wish to consider adopting a voting system for the rare occasion where a consensus decision is not reached.

Below are a few resources to help you if you are new to cluster meetings.

Key elements to consider when forming a cluster	Vision and mission to describe the long term ambitions of collaborative	Terms of Reference for cluster meetings	Cluster Voting System

Chairing cluster meetings

As a Cluster Lead, it is expected you will chair the cluster meeting, as well as other group discussions. You will need to think about the tone, style and venue for the meeting, how to manage the meeting and encourage people to contribute, how to take decisions and which rules you need to adhere to. Different meetings will need different approaches. This section will provide some tips with how to get the best out of the limited time during meetings by good preparation before, effective chairing during and following up actions after the meeting.

4 key areas of personal skill to be a successful Chair:

- Separating your usual role from that of the Chair
- Ensuring people interact effectively
- Ensuring the group maintains a future focus
- Continuously improving the group's performance

Source: Academi Wales

It is vital that all stakeholder organisations and agencies are involved in the cluster work programme and you may wish to think about their involvement in the cluster meetings.

There are different arrangements in different health board areas to support Cluster Leads in their work and for cluster meetings. Examples of these roles can be found in the *Primary Care Clusters: Roles and Responsibilities* section of the *Primary Care Cluster Governance 'A Good Practice Guide' 2018*.

Tips for Cluster Leads when having cluster meetings		
Before	**During**	**After**
▪ Have a process of seeking agenda items from members. ▪ Clarify the meeting's objectives & prepare agenda. ▪ Check that the right people are invited. ▪ Make sure that equipment needed for the meeting is set up and available. ▪ Decide the setup of the meeting room and where visitors will sit, e.g. boardroom style with all around the same table. ▪ Decide if notes are to be taken and who will be writing these. ▪ Develop plans for non-attendance. Check enough members are present for meeting to go ahead and decisions to be made. ▪ Prepare yourself by knowing about the matters to be discussed and the purpose of each agenda item. ▪ Prepare your contributions in advance. ▪ Where possible circulate relevant documents in advance to members. ▪ Prepare yourself by knowing who can contribute to the meeting discussions, how and when.	▪ Arrive on time to check the room. ▪ Create a good first impression, welcome people and clarify everyone's role. ▪ Establish any ground rules. How should people contribute? How will everyone have a chance to speak? ▪ Steer discussions in a structured way and manage the time and the personalities. ▪ Encourage different views and opinions. ▪ Summarise discussions and any decisions made after each agenda item and at the end of the meeting so that people are clear what's been achieved. ▪ Thank everyone for their contributions. ▪ Agree details for any follow up meetings. ▪ Finish the meeting on time.	▪ Ensure that the meeting notes or minutes record the key decisions and actions. ▪ Make sure that any meeting notes or minutes are circulated to participants and anyone else who needs to know what was decided. ▪ Check progress on any actions agreed at the meeting.

(Note: the suggestions in the table above can be applied to any meeting scenario by any person(s) and not just specifically for cluster meetings)

Developing wider cluster working

The workforce is key to developing a seamless health and care system in Wales and addressing the pressures facing GP practices and primary care sustainability to respond to the increasing demands on NHS services. There numerous models operating across Wales to deliver integrated care using the wider health and care workforce. These models include working as multi-disciplinary teams (MDTs), expansion and workload shift to different professional roles, development of non-medical staff to take on new roles and working with the third sector to support care in their communities and develop and support social prescribing opportunities.

Learning from examples across Wales, developing wider cluster working is not without its challenges and does involve the investment of time, but can help with the following:

- Decreasing demand to see GP for some patients/patient groups
- Increasing access, quality of care and provision of longer appointments
- Improve the experience of service users and families
- Improving the management of patients with complex needs
- Increasing the flexibility and responsiveness to population needs
- Increasing the resilience of the GP workforce
- Transformation of service provisions

Employing cluster-based staff

As clusters is not legal entities, you may come across hurdles in trying to employ members of staff and multi-disciplinary teams to work across the cluster footprint. Several different employment options are emerging enabling the recruitment of staff to work across all practices in the cluster and in the wider community. In some way these provide a greater flexibility in terms of employment for both GPs and the wider primary care team such as pharmacists, physiotherapists and advanced paramedics. These employment options vary between clusters and health board areas and all carry some element of responsibility and risk.

Examples include:

- Health board directly employed staff
- Staff employed by one practice on behalf of all the practices
- Alternative models, such as federations of practices within, or between, cluster network or establishing the cluster as charitable status

Regardless of the mechanism of employment, the *Primary Care Cluster Governance Framework 'A Good Practice Guide'* offers tips and guidance on good practice on maturity levels for employment and training. These are described as three levels as illustrated in the table below:

Employment and Training Arrangements		
Level 1	**Level 2**	**Level 3**
Clarity on indemnity issues for all cluster professional groups Robust processes for cluster workforce planning & OD All cluster staff understand the implications of new Data Protection Act (2018) and General Data Protection Regulations	Recruitment processes for all cluster employees are efficient, timely, with focus on values and behaviours of applicants Robust arrangements and contracts in place for managing cluster employees, including pension arrangements Appropriate supervision and mentorship arrangements in place to support all professional staff	Professionals recruited to cluster team are all trained in primary care and/or community environment and experienced in MDT working Awareness of options and employment responsibilities of 'hosting' a service on behalf of other cluster practices and organisations

Employment rights

It is important to understand your responsibilities and the rights of the people you employ or plan to employ such as working hours, continuous service, types of contracts, pensions and paid leave etc.

GOV.UK

Government services GOV.UK provides advice on employment rights.

An employee has extra employment rights and responsibilities that don't apply to workers who aren't employees. These rights include all of the rights workers have including specifically the following:

- Statutory Sick Pay
- Statutory maternity, paternity, adoption and shared parental leave and pay (workers only get pay, not leave)
- Minimum notice periods if their employment will be ending, for example, if an employer is dismissing them
- Protection against unfair dismissal
- The right to request flexible working
- Time off for emergencies
- Statutory Redundancy Pay

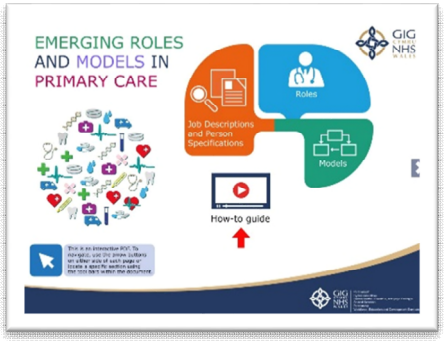
Some of these rights require a minimum length of continuous employment before an employee qualifies for them. An employment contract may state how long this qualification period is. Within the NHS this qualifying period tends to be two years. This is important if employing staff on short term contracts that are continuously renewed and therefore entitling the staff to continuous employment rights and potential unfair dismissal if the contract is terminated after the two-year time period.

Further information about employing cluster staff can be found at:

- *Primary Care Cluster Governance, Good Practice Guide Resource Pack v6* - *Operational and Professional Management Protocol for Staff Employed by the Local Health Board working in GP Practices*

Multidisciplinary Teams (MDTs)

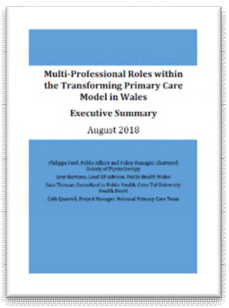
There has been a significant increase in MDT working in the last 20 years in various clinical areas and settings. There are many examples of the expanding roles and their contribution to MDT working in and outside of Wales.



A *Compendium of Emerging Roles and Models in Primary Care* has been developed as an online package for sharing of good practice, resources and lessons learned from across Wales. The compendium includes examples of job descriptions, case studies and contacts for more information.

The new and emerging models of MDT working share some common factors:

- They are based around GP Practices
- They have a focus on case management and support for community care
- They include generalists working alongside specialists
- There is co-ordinated assessments and joint care planning
- Where possible there are named care co-ordinators
- There is a sharing of clinical records



The potential that the wider MDT in Wales can offer to transforming care, treatment and access to services was reported in a survey *Multi-Professional Roles within the Transforming Primary Care Model in Wales* (2018).

The report highlights key messages and learning for anyone developing MDT working plus recommendations of how to get the best value out of this team approach.

Independent contactors

In developing the wider cluster working you may wish to consider the types of core, advanced, enhanced or extended services that are or that could be commissioned for delivery by community pharmacies, community dental practices and optometric practices.

Table providing examples of extended/enhanced services that could be provided by pharmacy, dental or optometry practices

Community pharmacy	Community dental practices
▪ Common ailments ▪ Smoking cessation ▪ Influenza vaccine ▪ Emergency contraception ▪ Substance misuse ▪ Emergency supply ▪ Care homes ▪ Independent prescribing	▪ Urgent treatment ▪ Non-urgent treatment ▪ Patients with special dental needs **Optometric practices** ▪ Low Vision Service Wales ▪ Eye Health Examination Wales

Expanding the portfolios and the services offered by the local contractor professions and others means that patients may not need to visit the GP Practice if their condition or ailment can be managed elsewhere in primary care. Familiarising yourself with what is available locally and signposting patients is key to helping people choose the right health service for their needs.

The Welsh Government's Choose Well campaign encourages people to think and pick the right health service for their illness or injury. The Choose Well website has a range of materials and a search function for local services, including the independent contractors, in a defined postcode area.

Further details of the services available can be found at:

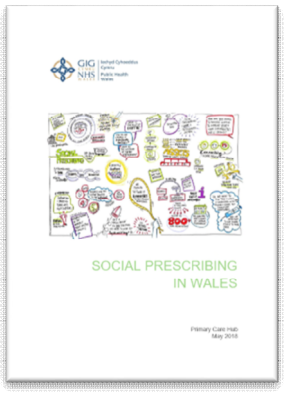
- Community Pharmacy Wales
- Welsh Eye Care Service
- NHS Dental Services

Non-clinical NHS staff

There is a wide and reaching NHS workforce that can be used to develop and support cluster working. The roles of many non-clinical NHS staff groups are already changing to support the increasing demands and new ways of working. You may wish to consider how Practice Managers and GP practice staff, non-clinical staff in other NHS contractor professional settings, e.g. community pharmacy, community dental practices and optometric practices, social services staff groups and third sector staff can support the wider cluster working vision in your area.

Social prescribers/prescribing

There has been much interest in social prescribing and the support it can bring either alongside clinical care or as an alternative in improving someone's health and well-being. Social prescribing schemes can involve a variety of activities e.g. arts activities, gardening, befriending, cooking, healthy eating advice and a range of sports, plus many more.



There are different models for social prescribing across Wales and a variation in the local schemes available. Most are often provided by people working or volunteering in the third sector and usually involves a Link Worker/Care Navigator/Community Connector who works with people to access local support. *Social Prescribing in Wales* (2018) provides a resource on the progress made and social prescribing arrangements in place.

Specific detail about the evidence and examples of social prescribing schemes is available via Primary Care One.

Further information about social prescribing in Wales can be found via the All Wales Social Prescribing Research Network (WSPRN).

Information governance

What is it?

Information governance focuses on ensuring that information is handled in a confidential and secure manner. It is a framework that brings together legal, ethical and quality standards that apply to the handling of information. It applies to sensitive and personal information of both employees and patients. All staff have a responsibility regarding the security of information they access, use and store.

The framework

There are legal requirements, standards and guidance for information handling, some of which are detailed in the table below:

Legislation	Guidance
Data Protection Act 2018	Common Law Duty of Confidentiality
Environmental Information Regulations 2004	Compliance Framework for the Welsh Control Standard for Electronic Health and Care Records
Freedom of Information Act 2000	Confidentiality: Code of Practice for Health and Social Care in Wales 2005
General Data Protection Regulation	International Information Security Standards ISO/IEC27001:2013 and ISO/IEC 27002:2013
Privacy and Electronic Communications (EC Directive) Regulations 2003	Information Quality Assurance
Public Records Act 1958	Information Security
Records Management Code of Practice for Health and Social Care 2016	Information: To share or not to share? The Information Governance Review (Caldicott Review)
	WHC (1999) 7. Preservation, Retention and Destruction of GP General Medical Records Relating to Patients
	WHC (2000) 71: For the Record. Managing Records in NHS Trusts and Health Authorities
	Wales Accord on the Sharing of Personal Information (WASPI)
For further details access Information Governance: NHS Wales Informatics Service	

Organisations, practices and clusters can use a simple self-assessment tool to measure compliance against national standards and identify if information is handled and protected correctly using the *Welsh Information Governance Toolkit*.

Purpose and relevance to cluster development

As new models of care emerge and collaborative working becomes the norm in primary care, it is likely that GP clinical systems are being accessed and used by a range of health professionals not employed by the practice for the purpose of providing direct care. It is imperative therefore that everyone is aware of their legal responsibilities regarding information handling.

It is advised that for all joint working, a Data Controller 'In Common' Agreement should be developed and agreed by all Practices in the cluster. This should set out a lawful and consistent approach to the sharing of information that will benefit the patient whilst protecting the confidentiality of their personal information.

The leaflet, *FAQ: Cluster working and sharing patient information* provides useful information for staff and patients about information sharing for cluster working.

For more information…

NHS Wales Informatics Service provides further details about various aspects of Information Governance. You can also find generic templates and exemplars to support the requirements of data protection legislation and to ensure that you meet the requirements of information governance compliance.

In addition, please refer to your own health board website for further information about information governance.

Using data to identify need

Primary Care Needs Assessment (PCNA) tool

A Primary Care Needs Assessment tool initial proof-of-concept was released in April 2019 to support clusters in using data to identify need and inform planning. For clusters, key PCNA benefits include:

- Core data to support assessing population health - currently found across a complicated array of different products from different intelligence providers—brought together into one tool to describe health needs at various local levels
- A concise summary of relevant strategic context by topic, which supports planning alignment and includes refreshers on some key population health concepts
- Evidence-informed, practical improvement options by topic, any of which could help develop a cluster strategic plan
- Prompts to capture key elements of transparent and inclusive decision making, including recognition of the citizen voice, local assets and partnership opportunities, additional data requirements and initial thoughts on other planning considerations to inform wider discussion

Visit the PCNA landing page to download the tool or review a step-by-step guide to using it.

Relevance to clusters

Health intelligence describes contextualised, analysed information (data and evidence) to inform local action or decision making. Robust primary care cluster plans will therefore be informed by data documenting population health needs and evidence on effective interventions to improve health and reduce inequalities. Data and evidence require careful interpretation; potential actions require prioritisation and implementation plans will need evaluation.

> Local Public Health Teams and cluster development staff within health boards have a key role to play in supporting clusters to undertake these planning tasks

The process

This section of the handbook outlines five key steps to help you think about how to use data to identify need:

1. Start with a good question
2. Identify and appraise sources
3. Analyse and interpret data
4. Present and report information
5. Influence decisions

1. Start with a good question

The utility of any answer generally depends upon the clarity of the question. Intelligence therefore begins with careful formulation of the question. Getting such clarity may involve discussing any of the following:

- The background to the question, context (e.g. for IMTP) or any existing information on the problem
- The decision that the new information will inform (so that the right type of information is sought)
- Whether there is a particular type of measure or key deliverable required (e.g. a time trend; a set of slides for a presentation) and for which audience (e.g. cluster members, public)
- Who will be responsible for doing what to answer the question; who needs to be consulted for input or informed when you have an answer?
- Key activities and how long each step might take
- Any boundaries around the scope of the question, such as time or geographic restrictions
- Any critical success factors (such as direct access to data sources)

Clarity isn't always needed. For example, sometimes more casual exploration of the data from a project will be indicated in order to help identify more specific data requirements. In such cases, intelligence experts are likely to warn of the dangers of over-mining the data due to the probability of generating statistically significant (but unintelligent) associations by chance alone.

2. Identifying and appraising data sources

Health intelligence data products with primary care relevance are produced by multiple organisations within Wales. Information about the products available from established providers can be found via the following links (not comprehensive):

- Observatory Analytic Team (OAT)
- PHW Observatory Evidence Service (OES)
- PHW Welsh Cancer Intelligence and Surveillance Unit (WCISU)
- PHW Communicable Disease Surveillance Centre (CDSC)
- NHS Wales Informatics Service (NWIS) including Primary Care Information Portal
- Welsh Analytical Prescribing Unit (WAPSU)
- Welsh Government Statistics and Research https://gov.wales/statistics-and-research
- NHS Wales Shared Services Partnership (NWSSP)
- SAIL Databank

The above list comprises mostly what can be termed 'routine outputs' i.e. products using data that are collected once but used often. Other (secondary) sources of data or pre-processed analyses include websites that are not intelligence-focussed (e.g. health board, charity, etc.) and assessment reports (e.g. local population or well-being assessments). You may need data from non-health sources, such as a local authority or think tank. You may need qualitative (narrative) rather than quantitative (numbers) data—or both—depending on your question.

The data you need may thus already be to hand—but it can be a challenge to find the cherry you want within this 'fruit salad' of choice. Options to mitigate this challenge include the following:

- Clusters and other primary care data users are encouraged to seek assistance from their Local Public Health Team to identify the most relevant sources of information and for advice on how to best use it.
- For signposting to data/intelligence products of particular relevance to primary care, please refer to the *Primary care intelligence compendium*,
- The PHW Observatory hosts a series of topic pages that bring together information on Observatory products, key websites, key data sources, key evidence sources and additional evidence and data sources.

If you wish to select sources directly, basic screening questions may be useful:

a) Is it relevant to this question?
b) Is it accurate enough (will it answer the question within resources)?
c) Is it recent enough?

What if the data you need don't seem to exist anywhere?

Sometimes you won't find an existing data source that passes these screening questions. Options include:

- Creating synthetic estimates (e.g. local exercise based on national survey results)
- Using proxy measures (e.g. levels of alcohol consumption may predict harm from alcohol misuse)
- Carry out bespoke data collection (e.g. conduct a survey, do an audit, health needs assessment focussed on a particular issue)
- Conclude there are no suitable data available nor sufficient resources for gathering new information

Gaining a good awareness of the limitations of a given data source can be quite challenging. It is worth considering the following as a checklist:

- Specificity (the data collected for another purpose)
- Sensitivity (can we detect the change we are looking for?)
- Predictive value (correct prediction of disease)
- Relevance (to the question being asked)
- Timeliness (reflective of the current situation)
- Completeness (description of the population of interest)
- Representativeness (if a sample, do the data reflect variation)
- Accuracy and validity (a true reflection and clinically valid indication)
- Consistency (over time or with other related sources of data)
- Coding quality/data standards
- Quality assurance process (the data cleaning process)

3. Analysing and interpreting data

With the data source(s) identified, the next step is to undertake analysis by utilising epidemiological and statistical knowledge in conjunction with clinical/local insight for value-added interpretation. Assuming the first bit will be delegated to an analyst, helpful questions to inform your agreement of the planned approach include the following:

- Are we proposing the right outcome measure (e.g. prevalence, rate, odds)?Are we going to look at the data by person, place or time?
- If making area-based comparisons, how will this be standardised to account for variation in population characteristics (e.g. aged standardised rate)?
- Are we applying the right statistical method?
- Has identifiable patient information been protected?
- Will we use templates (e.g. Excel) to help quality-assure outputs/provide inbuilt error checking?

When the analysis is complete, you may find the following technical questions helpful when interpreting the results with your analyst:

- Was the data fit for statistical manipulation (e.g. coding issues, banding, use of synthetic variables that may lessen the value, etc.)?
- Were there any effects from suppressed data (e.g. low numbers excluded)?
- Do summary statistics obfuscate differences (e.g. when comparing localities an overall deprivation score may not reflect wide variation within an area)?
- Are there any potential sources of confounding (an additional variable that influences an association between variables of interest) or bias?
- How do we determine whether the findings are significant (e.g. use of confidence intervals or p-values) or down to chance?
- Are we more interested in a point estimate or a time trend?
- Do the results correspond to any existing research or local evidence?
- Are there opportunities to cross-reference data sources, to verify our analysis findings or provide a fuller picture?

Interpretation also entails considering what the data imply (in the context in which they will be used) and for whom are these implications important (different groups may have different perspectives). You may:

- Ask local staff/people for their interpretation, as some data types do require a high degree of familiarity (e.g. GP practice mergers; service-specific hospital catchment areas, local cancer network boundaries, etc.)
- Ask clinicians about clinical issues (e.g. for insights into coding issues, clinical—as opposed to statistical—significance of results, etc.)

4. Presenting and reporting data as information

- Packaging the results of an analysis into a presentation or report for stakeholders to ensure their comprehensive understanding of the data requires skill. For example, charts might include most of the following elements: A descriptive title (and perhaps figure number, if for a report)
- A note on the data source and year (e.g. QOF 2017-18, noting the publication year may differ from the year to which the data pertain)
- The population the data pertain to (e.g. local authority residents or cluster registered population)
- Axis and series labels
- Units (e.g. crude count, rate, %, etc.)
- Values on each series (where there is no data table)
- Confidence intervals (e.g. around a prevalence proportion)

Intelligence needs to be applied to text as well as to charts or tables. Some tips for intelligent writing (e.g. for a business case) include:

- Tailor the style to the intended audience
- Tailor the content to the decision
- Be consistent (e.g. spacing, capitalisation) with attention to spelling and grammar (this demonstrates care in production)
- Be selective in terms of what you comment on (aiming to create more signal and less noise)
- Use a clear document structure
- Refer to all included figures and tables within the text
- Ensure tables receive the same attention to detail as for charts
- Note any important data limitations or interpretation caveats within the text

The following points may be useful when communicating local variation from a comparator position:

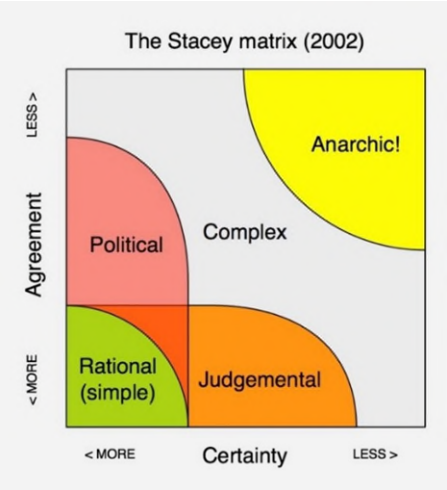
- Variation is a natural phenomenon and can be healthy. For example, it can be a deliberate result of innovation in primary care settings that seeks to test improvements in processes or deliver better care outcomes.
- Variation that is observed (or more precisely, measured) in a healthcare context may be referred to as inequality.
- Inequality that is judged to be both avoidable and socially unjust is termed inequity, which is sometimes alternatively described as unwarranted variation.

- An analysis does not provide an explanation for what may account for this at the indicator level. There are many potential reasons for variation—both positive and negative, such as demographic make-up; geography and its effect on access to services; quality improvement activities; programme implementation characteristics; resource constraints; knowledge of best practice; availability of quality improvement expertise; strength of evidence for effective improvement intervention; sustainability-related issues; etc.
- Those providing local primary care services are best placed to reflect and consider (within a supportive peer review environment) the relevance of potential explanations for any variation documented by an analysis.
- Where variation is apparent, the first step should always be to verify the accuracy of the analysis by consulting the original data source; unintended errors are possible. Understand that variation shown by an analysis is typically a 'best guess' at a single point in time. Variation is more fluid as this snapshot suggests, so measurement at another time point could show a different picture.

5. Using data to influence decisions

Information overload, conflicting data, stale figures, unidentified caveats, complex infographics and poor presentation are example factors that can impede data-informed decisions. Data (or evidence) presented as technical advice are not, however, the only influence on decision making. Other influences include personal beliefs, public opinion and political considerations (local or national).

Ultimately, these factors combine to result in decisions that can be characterised in different ways, as outlined by the Stacey matrix (2002).



In situations where there is reasonable certainty over what the data/evidence is telling us, and also a good level of agreement in opinions between those interpreting it, decision making tends to be simple or rational.

Less agreement over strong data/evidence results in political decision making.

Less compelling data/evidence in the presence of aligned opinion results in judgemental decision making.

Workforce planning

What is it?

Workforce planning is a process of systematically identifying what an organisation needs in term of size, skills, diversity and quality of its workforce organised in the right way, within budget, to meet the objectives of the organisation.

Who does it?

Although workforce planning may appear to be straightforward, it is taking place in a complex environment and many of the actions and solutions identified may take a longer period of time to put into place. You may wish to seek advice from someone with expertise in workforce planning either within primary care or your health board. Each health board has a Workforce and Organisational Development team with expertise to advise and in some cases help you with workforce planning.

Historically, strategic workforce planning for NHS Wales was one of the functions of the Workforce, Education and Development Services (WEDS) until it became part of Health Education and Improvement Wales (HEIW) in October 2018. Sitting alongside health boards and NHS trusts, HEIW has a leading role in the education, training, development and shaping of the healthcare workforce in Wales.

Purpose and relevance to cluster development

The substantial changes in population demographics and health care needs means that the workforce needs to be fit for purpose to respond to immediate needs, while adapting to deliver the future care models. Getting the right balance requires a robust understanding of the population needs and the nature of workforce pressures locally and nationally and what can be done to address them in the short and the long term.

In 2019, workforce planning became an integral part of cluster intermediate and medium term plans (IMTPs). Effective workforce planning is central to cluster development enabling clusters to deliver the services needed to provide quality patient care to the populations they serve.

The workforce planning process

There are numerous resources available to aid workforce planning. In Wales, a planning approach has been offered in the *Workforce Planning. Guidance and Resources*. It provides a step by step guide to workforce planning in NHS Wales and considers the workforce planning approach laid out within the NHS Wales Planning Framework. It describes workforce planning as a six-stage process described in the table below.

Stage 1:	Understand your population/healthcare environment
Stage 2:	Talk to your stakeholders
Stage 3:	Create a vision and define outcomes
Stage 4:	Forecast future service and workforce configuration
Stage 5:	Articulate key actions or changes required to deliver a vision & outcomes
Stage 6:	Describe ongoing governance and delivery mechanism

To support workforce planning within a cluster, alternative templates have been developed by HEIW to aid clusters with their workforce plans. These describe workforce planning in twelve easy steps which are based on the six stage process but a redesigned to take clusters through a thinking process to enable them to develop their workforce plan.

For more information...

Please refer to your own health board who can provide you with further information about available templates and guidance and their availability to help you with workforce planning at practice level or cluster level.

Further information can be found in the following resources:

- *Compendium of Emerging Roles and Models in Primary Care*
- *Multi-Professional Roles within the Transforming Primary Care Model in Wales*
- *Royal College of General Practitioners – An Expanded Team*
- *Primary Care Cluster Governance, Good Practice Guide Resource Pack v6, Workforce Planning*

Remember...

There is value in asking for expert help in preparing your workforce plans.

This section should be read alongside the sections on **Employing cluster-based staff** and **Use of data to identify population need**.

Bids and business cases

What are they?

A bid or a business case is the way you prove to the person or organisation you are asking for investment from that the product or project you are pitching is a sound investment.

The term bid or business case tends to be used interchangeably and the format and the detail they contain will vary depending on who the audience for the bid or business case is. If the thought of writing a business case is daunting, by thinking of the task as described in the box below may make it a simpler and more manageable exercise.

A bid or business case is:

- **A justification**
  At its core, a bid or business case is your justification for doing something; an explanation of why your practice or cluster should take on a certain project or expenditure.

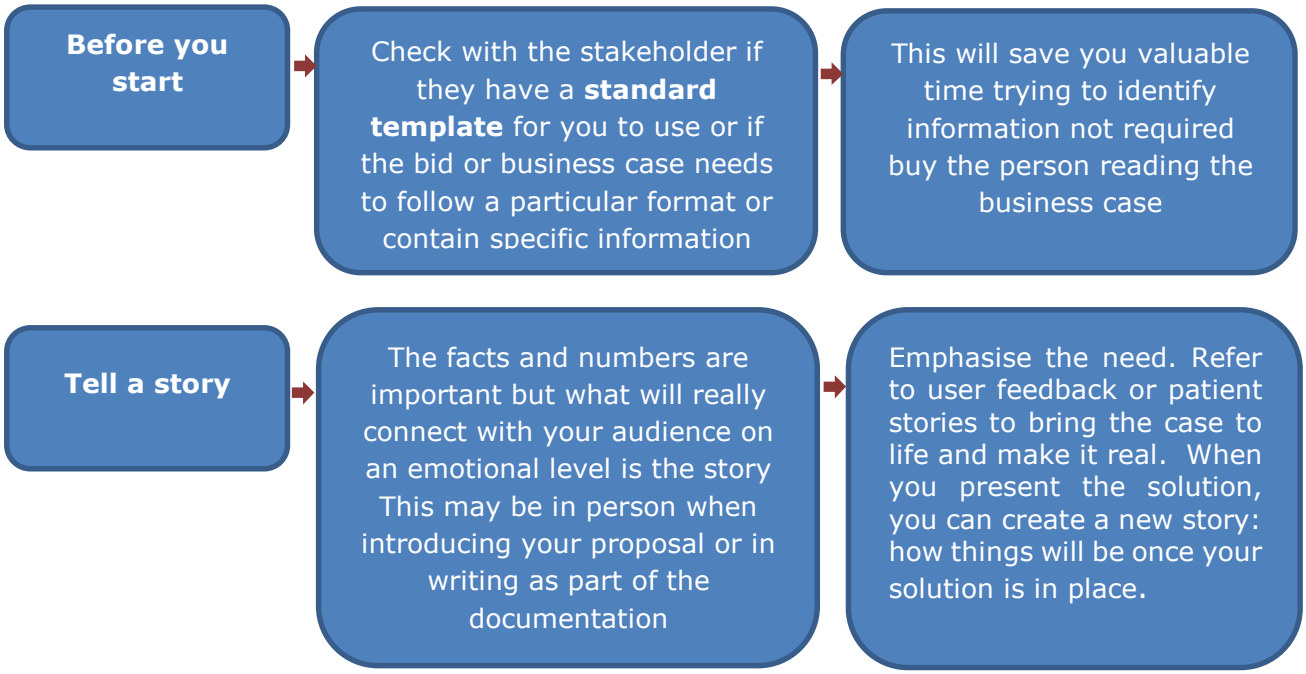
- **It's just a piece of paper**
  It's just a document usually taking the form of print. Some people present business cases using visual presentations or video, but usually cluster bids tend to be focused on the basic documentation. Often there are standard templates provided by the commissioner which aid the development of a business case.

- **It can be simple or complex**
  A good business case doesn't need to include everything to be powerful, but it does need to focus on the essentials which are covered overleaf. It might be accompanied by a strong verbal argument or it might not. It might include next steps, or it might not.

Purpose and relevance to cluster development

Across NHS Wales, where there are resource constraints, funding decisions need to be fully considered before committing resources to new or ongoing initiatives. Often multiple programmes are pursuing the same funding stream and proposals need to be prioritised. Whenever asking for new or further resources, a robust bids or business case can help to gain approval and where asked financial resources from cluster stakeholders. It is commonplace for health boards and other stakeholders to require a written bid or business case proposal before committing resources.

Preparing the bid or business case



There are many templates and approaches to writing bids and or business cases and your stakeholder may have a preference.

Writing the proposal - the basics

1. What is your case?
▪ It is the justification for the investment ▪ It doesn't have to be complicated but enough to get the message across ▪ Describe the problem you are trying to address ▪ Support with any evidence or data to data to back this up ▪ How does this link to the stakeholders priorities/align with policy?
2. Give options & possible solutions
▪ Include any options for addressing the problem / need ▪ Describe what some of the solutions might look like ▪ What would happen if nothing was done and no investment was made?
3. List expected impact and benefits
▪ What will be the impact of your proposal? ▪ What positive outcomes might be expected? ▪ Think beyond your own scope of practice? ▪ Are there benefits that will be realised elsewhere by a different part of the health and care system? ▪ How could you quantify these? ▪ Is there published evidence to back up your claims?

4. The project and it's risks

- What is the scope of the proposal?
- What will the main goal be?
- How long will it take to accomplish it?
- What actions are included in achieving the goal? Which are excluded? (because they're unnecessary or should be saved for a later project)
- What are the risks of taking on this work, include opportunistic costs?
- What's the point of taking on these risks? Does the benefit outweigh the risk?

5. Describe resources required

- What resources are being requested?
- Are you asking for all the resources or will some come from other sources?
- What amount of money will go to each resource needed?
- If there are labour resources or capital investment and what's a range you can expect to pay for each resource: what would be the lowest vs. a highest?
- Address where you expect the funds to come from?

6. Outline a project plan

To include:

- **Overall goal/aim:** clear and direct connection to your problem
- **Objectives:** SMART (specific, measurable, achievable, relevant, timely)
- **Scope:** a bit more detail on boundaries. What's in and what's not?
- **Scheduling:** your proposed timeline
- **Deliverables:** tangibles, what are the final impact / product expected?
- **Milestones:** are there phases? What needs to be done at each phase?
  Measures: how will we measure success of each deliverable?
- **Communication:** how and who are you going to communicate with?
- **Staff:** who is involved and actively working on the project?
- **Dependencies:** what are the dependencies of the tasks in our project?
- **Budget:** an estimate breakdown of costs

7. The Executive Summary

- It goes first in the documentation but write it last
- Simply a one page summary of the proposal
- Think of your 'elevator pitch' on paper, or a cover letter for your C.V.
- The simplest way to do it is to give quick summaries of:
  - The problem
  - The solution
  - Costs & potential return
  - Time frame
  - Who is involved

8. Finally

- **Use the right medium:** think about slides, infographics, other visuals.
- **Accentuate the need:** go back through each part of your proposal and reference this need often.
- **Plan some likely questions:** prepare your answers with stats and facts.

Further information and example templates can be found in the following resources:

- **Project working** section of this handbook
- *Primary Care Cluster Governance, Good Practice Guide Resource Pack v6 - Business case development and cluster project planning*

Project working

"A goal without a plan is just a wish."
Antoine de Saint-Exupéry

NHS Wales is responsible for delivery of an increasing number of high-value programmes and projects. As a result, staff with project management knowledge and skills are valuable to NHS Wales.

What do we mean by project working?

A project is temporary; it should have a defined beginning and end. A project is a series of interrelated activities undertaken to achieve a specific result within a set time frame and budget.

Planning is something which comes naturally to most people, we plan activities every day, some simple such as what you are having for dinner or how you are getting to work to more detailed actions such as organising a holiday. A project is not hugely different.

Using booking a holiday as an example of a project

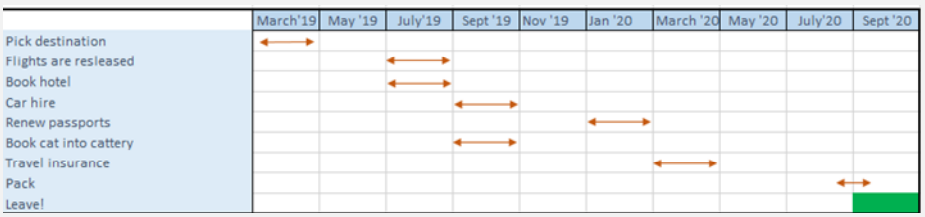
What you want to achieve (GOAL) - a fantastic holiday in 12 months' time.

When we plan a holiday there are key things we do:

- What date are we going?
- What is our budget?
- Who is coming?
- Where are we going?
- How will we get there?
- Where will we stay?

Some of these actions you will do early (flights and hotel?) some later, (packing).

When we look at developing a timeline start at the end point and work backwards so we want to go to Florida in September 2020 we could start to create a timeline, or plan of what we need to achieve it may look a little bit like the chart below.



Most simple projects would look similar to this example. More complex projects may need more detailed plans.

Projects, regardless of topic all have common characteristics, namely they:

- are unique and not part of 'business as usual' processes
- have a defined start, duration and finish
- consist of a series of pre-defined activities designed to deliver a service or product
- use pre-defined resources
- deliver change
- carry risk

Project working does not need to be complex, is not mysterious and should not be something to fear. Project working or project management is about applying knowledge and tools to meet the requirements for the project.

Projects always involve a sequence of tasks that demand different resources and skills and resources are brought together to achieve a particular aim. The combination of resources is unique to the project and usually includes people with different skills, time, equipment, materials and finance.

Typically, projects have five key areas:

Each area or activity should be underpinned with a suite of documents to work through, providing audit and governance trails for the project.

Project documentation can be tailored to suit the specific project be it a simple project or a more complex project as described in the tables below:

A simple project would typically include:
a plan on a page
a project brief
a project structure
a project initiation document (including a project schedule and risks/issues log)
progress and/or exception reports
a closure report (including any evaluation, lessons learned and follow on actions)

More complex projects may also require:
a business case
a communications plan
a stakeholder map
equality & health impact assessments
decisions log
project board reports
gateway reviews
benefits review

For more information…

There are many good resources available online which can give you a greater depth of knowledge of project working, but simple can be better when it comes to project planning. You may wish to start with a plan on a page.

There are many different types of project management training opportunities and qualifications from short masterclasses to more formal accredited courses. Listed below are two well-known examples accessed in Wales:

- PRINCE2 (Projects in Controlled Environments) one of the most recognisable methods for effective project management, used widely across the UK in the public and private sector.
- APM (Association for Project Management) provides a free online resource outlining definitions, terms, process used in project management.

Useful resource: *Practical Project Management workbook* (Eliesha Cymru & Public Health Wales)

Delegate workbook
PPM v9 20191004 FI

Remember…

You don’t have to be trained or have a qualification in project management, just make sure you cover the stages and use templates and tools to help you.

Evaluation

This section provides an overview about the importance of evaluation and will point you in the direction of further guidance and support.

What is evaluation?

For the purpose of this handbook, evaluation is described as:

> *'a structured process of assessing the success of a project/programme in meeting its goals and to reflect on the lessons learned'*

Purpose of evaluation?

Evaluation is important for the following reasons:

- To assess whether a project has achieved it's intended goals
- To understand how the project has achieved its intended purpose, or why it may not have done so
- To identify how efficient the project was in converting resources into activities, objectives and goals
- To assess how sustainable and meaningful the project was for participants
- To inform decision makers about how to build on, improve or discontinue a project

Relevance to cluster development

As clusters develop and test new ways of working, evaluation provides a means to ensure changes are benefits and allows you to decide whether to continue, improve or stop something you are introducing or implementing. Evaluation is vital in demonstrating cluster working, value for money and is critical when seeking funds for continuation or mainstreaming of services.

Useful resources

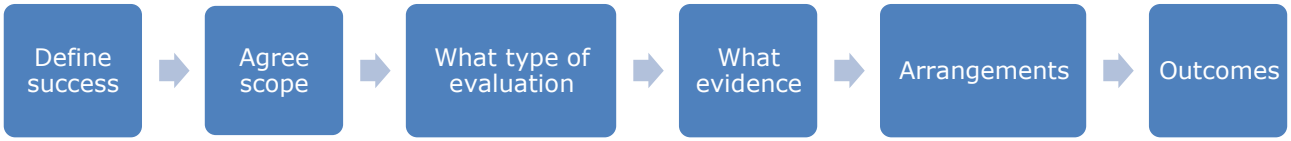
There are numerous resources available to support you in planning and completing an evaluation. In particular:

Data Cymru has developed an online *Introductory Guide to Evaluation.*

Evaluation resources prepared by the Primary & Community Care Development & Innovation Hub are hosted on *Primary Care One.*

The evaluation process

A simple representation of the evaluation process is illustrated below:



What would good look like? What is it you are trying to achieve?

What is the evaluation question?

Formative or summative? (see table below)

What evidence and/or data is needed? What is available? Any special research processes to be followed?

Skills required, timescales, resources, specialist support

So what?

How will findings be shared?

You will need to decide early on what type of evaluation you wish to undertake. There are several different types of evaluation but the most common classification identifies two kinds:

	Formative	Summative
Goal	To assess the feasibility or potential of a project, programme, policy or intervention to allow modification before full implementation	To assess the extent that a project, programme, policy or intervention has achieved it's intended outcome(s)
Purpose	To enhance learning	To prove/provide evidence that the project, programme, policy or intervention is effective
When	Occurs before and during implementation	Occurs after implementation
Frequency	Occurs on a continuous basis	Occurs at a point of time

Economic evaluation is also often used to assess a project's or intervention's value for money.

Planning your evaluation

Although evaluation is often thought of as an activity at the end of a project, it is generally better to start thinking and planning for evaluation at the earliest opportunity, usually at the design stage and very beginning of the project.

Once you have decided on the type of evaluation the following stages will help to shape the evaluation:

Stage	Example
1. Identify the context	What is the evaluation question? Can you describe the situation/problem? What is the activity/population need/diagnosis?
2. Identify the outcome(s) and/or benefit(s)	What is it you want to evaluate? What are the most important/relevant activities/benefits/outcomes that can be attributed to the intervention?
3. Measurement of outcome(s) and/or benefit(s)	How can you demonstrate success? Can you define the activities/benefits/outcomes and are they measurable?
4. Re-measurement	When can and should you evaluate? Can you gather information of the activities/benefits/outcomes over time, person and place?

To evaluate a project, it is helpful to have an agreed reference against which to ascertain success. A helpful way of thinking through a project and the evaluation is using a visual representation of the planned activities, outputs and expected results. There are various models and frameworks to aid you with this, but one of the simplest types and commonly used framework is a LOGIC MODEL.

A logic model tells the story of the project or programme in a diagram and a few simple words. It shows a causal connection between the need(s) you have identified, what you do and how this makes a difference, e.g., for individuals and communities. An example of a Logic Model Framework below:

Input	Activities	Outputs	Outcomes	Impact
Resources e.g. material, people, time	If you have access to the resources then what activities are planned to be undertaken	If you accomplish your planned activities, then you will deliver the amount of product/ service intended	If you accomplish your planned activities then there will be benefits in specific ways	If these benefits are achieved then certain changes and impacts will occur

Quality improvement

What is quality?

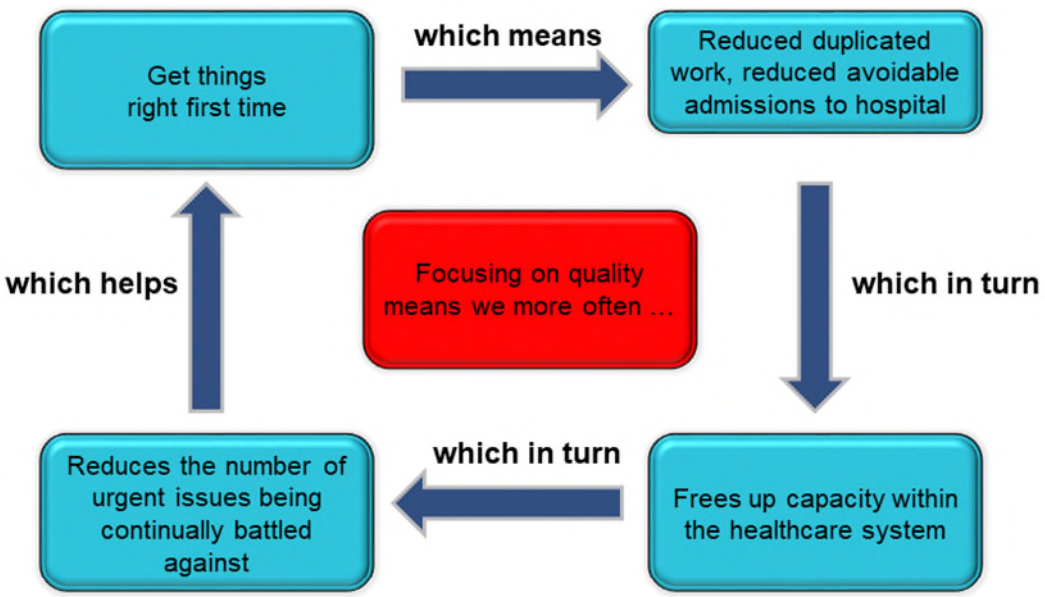
Quality simply means the achievement of the desired objectives in the most efficient and effective manner, with the emphasis on meeting and satisfying the needs and 'what matters' to patients. It is not necessarily the most expensive way to do things. On the contrary, it is a call for efficiency and value. It is not necessarily the provision of luxury items or services. It is a product or a service that is patient-centred, equitable, timely, efficient, effective and safe, and that is continuously evaluated and improving.

Quality is tangible and is measurable. A health care system can be divided into three components:

- Structure (human and physical resources)
- Process (the procedures and activities of care and services)
- Outcome (the results of care and services).

Each of these components has a number of quantifiable elements that can be accurately defined and measured. And if it can be measured, it can be improved!

Why focus on quality?



What is quality improvement?

One way of improving outcomes is by using the tools and techniques of Quality Improvement (Q.I.). Quality improvement can be defined as the process and sub processes of reducing variation of performance or variation from standards in order to achieve better outcomes for patients, staff and the effective management of resources. The key focus here is the ability of this process to identify and act on variation. It is a process of enhancing or redesigning processes to control outcomes. Activities must revolve around person centred care, as the driving force for any improvements. There are a number of specific activities, skills, and tools that are necessary to accomplish Q.I.

The preferred method and approach in NHS Wales for Q.I. is The Model for Improvement with PDSA Cycles. Training in this method and is delivered through a national programme, Improving Quality Together (IQT) across NHS Wales, social services and some public and third sector organisations. It is also integrated into a number of learning and development programmes which are either delivered nationally or locally, including Higher Education Institution curricula. IQT provides a common and consistent language and approach for quality improvement across Wales, which focuses on a person-centred approach.

The Model for Improvement with PDSA Cycles

The Model for Improvement with PDSA cycles was developed by Associates in Process Improvement (www.apiweb.org) in 1996, promoted widely by the Institute of Healthcare Improvement and was adopted by NHS Wales as the roadmap and compass to improvement.

The Model for Improvement with PDSA cycles is structured around two main sections:

The first section, framed as 3 questions, provides a with direction; the current position against that direction; and lastly an idea of how to get there:

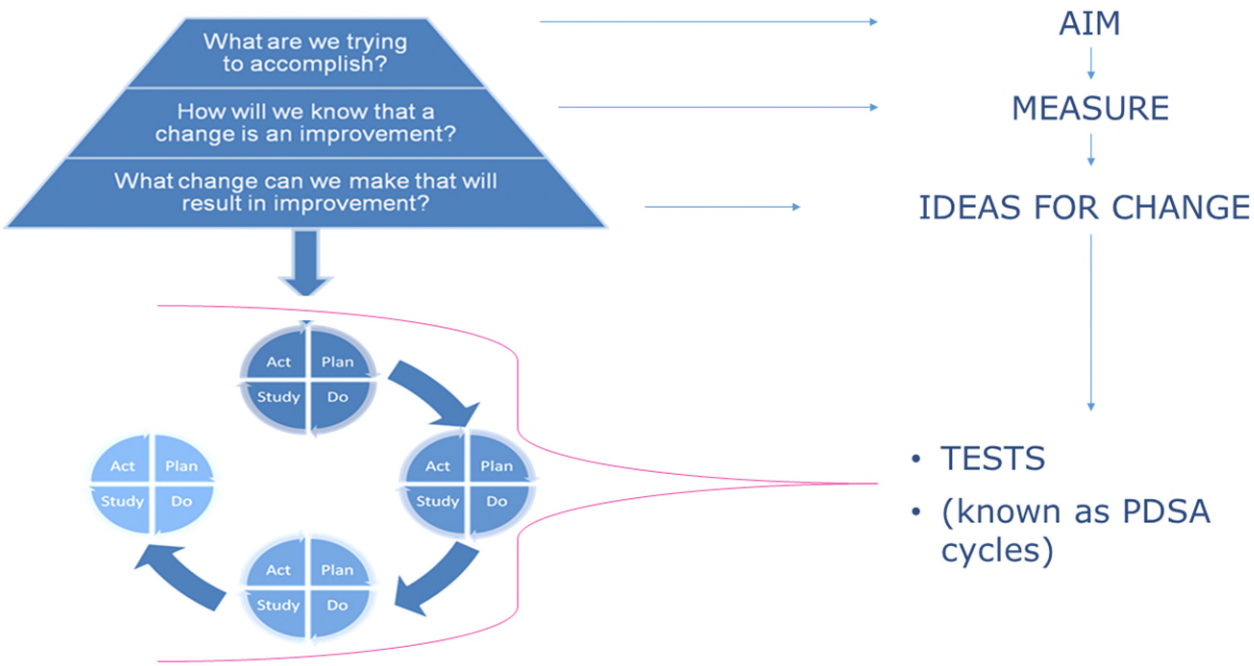
1. What are we trying to accomplish?
   This is the AIM and provides direction.

2. How will we know that a change is an improvement?
   These are the MEASURES and describe our current and future position.

3. What changes can we make that will result in an improvement?
   These are the CHANGES that tell us how we are going to get there.

The second section involves the testing of improvement activity using PDSA cycles : Plan, Do, Study and Act.

Figure illustrating the Model for Improvement (Institute for Healthcare Improvement) with PDSA Cycle



For further information:

- See the *Quality Improvement Guide*
- To read more about how you can get help for the 1000Lives team with QI visit 1000Lives
- To learn more about Quality Improvement, get in touch with 1000Lives IQT Team at 1000LivesImprovement@wales.nhs.uk
- Follow on Twitter @1000LivesWales

Glossary of terms

Whether you are new to working with the NHS or whether you have been working in the health sector for some time, it can be difficult to get used to some of the language and terms that are used. Often jargon is used or different terms are used to describe the same issue(s).

The Primary and Community Care Development and Innovation Hub have developed a glossary to explain a variety of terms commonly used in Wales in more detail. This was initially prepared to support the Pacesetter Programme but is relevant and useful for anyone working in or with NHS Wales.

The glossary provides brief definitions and explanations of terms used regularly in NHS Wales and is presented in two sections.

- Section 1- Glossary of General Terms
- Section 2 - Glossary of Terms for Indicators and Evaluation

The Glossary is hosted on Primary Care One.

Summary of published and online resources

A list of all the resources, published documents and links referred to in the three guides and links to access these online is provided in the **Summary and quick read guide**.

The **Cluster Working in Wales Handbooks** have been organised into three separate guides. They have been designed to be complementary and will be most effective if used collectively, sharing knowledge, ideas and advice to support effective cluster working. Signposting to information and resources is also included, in order to create the best conditions for cluster working and development.

To download the handbooks go to the Resources section of Primary Care One.

We have taken all reasonable steps to identify the sources of information and ideas. If you feel that anything is wrong, would like to make comments or provide input to any revisions of the handbooks please contact us at PrimaryCare.One@wales.nhs.uk