Strategic Programme for Primary Care

A Framework for Design and Delivery of Enhanced Services in Wales

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A Framework for Design and Delivery of Enhanced Services in Wales

Executive Summary

Reviewing enhanced services in primary care is an opportunity to deliver the quadruple aims of *A Healthier Wales*. Therefore, this review has implications across the entire health and care system and does not pertain only to primary care.

This document sets out the conditions of and requirements for the health system to support the identification and delivery of enhanced services that provide the right service at the right time in the right place for the people of Wales. The principles described in this document are shared with those already in existence in planning in Local Health Boards, whether secondary or tertiary care. Finally, it identifies actions for Welsh Government, Local Health Boards, and primary care contractors during the COVID-19 Pandemic and beyond.

Recommendation 1: LHBs/WG should first adopt system wide clinical pathways, and then identify the highest value contractual models (which may include enhanced services) to deliver care along the pathways

Recommendation 2: National Clinical Pathways, and standards, must be developed and managed before any national or directed enhanced service is considered.

Recommendation 3: Local Health Boards will localise national pathways to reflect the needs of its population and characteristics of its workforce, including in response to the COVID-19 pandemic

Recommendation 4: Local Health Boards will use an evidence-based pathway development methodology when localising pathways that includes specialists, primary care generalists, nursing and allied health professionals, as well as the patients and carers.

Recommendation 5: Local Health Boards will allocate resources across the whole lifespan and whole system clinical pathways using value based healthcare principles

Recommendation 6: All organisations will adopt a quality improvement methodology when planning, delivering and implementing local versions of national pathways

Recommendation 7: All organisations will ensure data is collected, including patient reported outcomes and experiences, as part of everyday contacts with clinicians and patients

Recommendation 8: All organisations will share data for specific purposes, and learning nationally, to support national pathway development and research and innovation

Recommendation 9: LHBs should consider and implement the models most likely to deliver the highest value outcomes for patents/in a clinical pathway

Recommendation 10: All LHBs should adopt a new national Framework for Enhanced services where all enhanced services fit into one of four categories - The Enabling DES, a Bundled DES, a Chronic Conditions in Clusters DES, a Population DES, or a Generic ES

Recommendation 11: All LHBs should first rationalise the existing enhanced services, using the principles of this document, and establish the new categories of enhanced service before devising enhanced services for *de novo* pathways, unless there is significant clinical need

Introduction

A Task & Finish Group was formed in June 2020 by the Strategic Programme for Primary Care Board under the leadership of the National Clinical Lead for Primary Care with a remit to review Enhanced Services. This review paper describes the current challenges, policy context and issues with existing contractual models. It makes recommendations to how to view current contract mechanisms in the context of the wider health and care system and makes recommendations for what is needed to increase the value of the enhanced service mechanisms, including new enhanced service categories. It finishes with an analysis of current portfolio of services and recommendations for action.

Purpose

The following actions for the Task and finish group were agreed on 5th June 2020 by the Strategic Programme Board for Primary Care;

- To review the effectiveness of the local, national and direct enhanced service contracting mechanisms and make recommendations about their future role as a contractual lever.
- To describe the principles that will ensure enhanced services can be designed to deliver the quadruple aim of A Healthier Wales, and be aligned to the primary care model for wales
- To describe what system and process changes are required for enhanced services to be created with the prudent health care philosophy and delivered using Value-Based health care
- To describe how enhanced services can accelerate the transformation of unscheduled and planned care, and what processes and structures are required to deliver this
- To describe the data collection, analysis and presentational needs of an effective and efficient enhanced service
- To list principles to describe how enhanced services will need to reflect COVID-19
- To describe any alternative contractual mechanisms that can be used in place of enhanced services, including any risks or benefits
- To describe a mechanism for a targeted review of existing enhanced service contracts.
- To conduct a review of content and expenditure of the current portfolio of DESs, NESs and LESs, identifying those that can be de-commissioned, merged, or replaced
- To propose a mechanism for the evaluation, initiation and monitoring of new contracts for discrete areas of service development.
- To provide a prioritised list of conditions, patient groups or pathways for new enhanced services

Task & Finish Group Membership

- National Clinical Lead for Primary Care — Alastair Roeves
- Associate Medical Directors for Primary Care
  - ABUHB — Liam Taylor (Negotiator)
  - CTMUHB — David Miller (in hours and OOH)
- Heads of Primary Care,
  - Chair of the national peer group — Lynne Joannou
- National Clinical Lead for Value-Based Care — Sally Lewis
- Associate Medical Director for Digital
  - C+VUHB — Allan Wardhaugh (and secondary care)
- Strategic Programme
  - Strategic Programme Manager — Stacey Forde
  - Senior Project Manager — Iris Wilmshurst

Method

The Task and Finish Group considered their experiences of designing, negotiating, and implementing enhanced services, principally in GMS. They also sought advice from expert sources including:

- Chief Optometric Advisor
- Chief Pharmaceutic officer
- Chief Dental Officer
- GPC Wales executive (2-hour meeting)
- Primary Care Reference group – expanded to include representatives of Executive Directors of Finance, Planning and Chief Operating Officers of LHBs, as well as Mental Health, Planned Care and Unplanned care – see Appendix 6 for full membership attending this 90-minute event
- AMDs in Primary Care
- Social Care Wales

The T&F group considered published evidence from NHS England and NHS Scotland, as well as academic papers. Existing enhanced service specifications were collected from Wales and England.

Work Plan

Three work streams were created:

1. Where do Enhanced Services fit into the wider health and care system?
2. What would optimised enhanced services look like?
3. Review of current enhanced services and recommendations

What are Enhanced Services?

- Enhanced Services are an important and valuable component of contractual delivery of General Medical and Community Pharmacy and Optometry Services. There are currently 74 in GMS alone in Wales. They form 10% of the total GMS budget and 25% of the current optometric budget. However, consistent implementation of nationally negotiated enhanced services in all health boards is often not achieved, and together with variable local enhanced services, there is a significant variation in contract performance and outcomes.

- The new General Medical Services (GMS) contract was introduced in 2004 and provided a new funding mechanism to reward and incentivise good practice in GMS. It defined a payment mechanism for core services that every GMS Contractor was to provide based on a capitation weighted by age, gender, rurality and care home residency. This Global Sum paid for services that every GMS contractor had to provide without exception at all times ('essential services'). It also paid for a smaller subset of services that could be opted out of, usually temporarily, with the agreement of the LHB ('additional').

- In 2003, the Welsh Eye Care Service was introduced instead of extending General Ophthalmic Services. Since then primary care optometry services have developed to include acute eye care, pre and post op cataract appointments, referral refinement, suspect glaucoma monitoring and low vision rehabilitation services through the Eye Health Examination Wales and Low Vision Service Wales. This is paid by item of service and has remained as separate to General Optical Services and currently accounts for over 25% of optometry services budget. In addition, LHBs opt to provide additional optometry services which are contracted with a small number of practices usually temporarily.

- A separate payment stream was created for services that were entirely voluntarily but would provide care above and beyond what was expected through essential or additional services. These 'Enhanced Services' can be classified in several ways, but the main divisions are;

    - **Directed Enhanced Service (DES)** – Set down in 'Welsh Directions' passed by the Senedd/Welsh Parliament, they direct an LHB to offer a contract to GMS contractors to provide a specific service, or they direct LHBs to establish and operate such a service. The terms of a DES and associated payments are agreed nationally through negotiation between Welsh Government (WG), GPC Wales (GPCW) and NHS Wales representatives.

    - **National Enhanced Service (NES)** - These may appear to be similar to a DES in structure and clinical function but are not set down in legislation. They would be created through negotiation with Welsh Government (WG), GPCW and NHS Wales representatives. An LHB could contract with GMS contractors to provide a NES without any alteration or could choose not to contract a NES at all. Alternatively, the constituent text and costings could be used as a benchmark and LHBs could alter both wording and prices to suit local need. Local negotiations would be between the LHB and the Local Medical Committees (LMC), and any resulting agreed enhanced service would then be a Local Enhanced service.

    - **Local Enhanced Services (LES)** – These are contracts that may appear to be similar to a DES in structure and clinical function but are written by local negotiation between the LHB and the Local Medical Committees (LMC). They can be based on a NES or be created *de novo*.

- **Non-GMS**
    - Welsh Eye Care Services (Eye Health Examination and Low Vision Services Wales) could be viewed as being equivalent to GMS Directed Enhanced Services. Established in 2002 and 2003 respectively these services are set out in legislative directions and over and above General Ophthalmic Services (GOS) contract work.
    - An increasing number of LESs are seen in optometry, agreed through local negotiation between the LHB and the Regional Optometric Committee E.g. Optometric Ophthalmic Diagnostic and Treatment Centres (ODTCs).
    - Schemes have been adopted locally in Community Pharmacy including smoking cessation, blood pressure monitoring, emergency contraception, common ailments scheme
    - Although General Dental Services does not have enhanced services in the same format as GMS, the community venues used by dental teams and the skills of the team could provide elements of enhanced services. Dental teams have demonstrated their willing and flexible approach to working differently during the COVID-19 outbreak.

The Case for Change

- Since 2004, Enhanced Services are important tools in General Medical Services and Community Pharmacy and Optometry contracts. They can deliver a higher level of treatment and care to individual patients with specific conditions or defined patient groups, above that normally provided through a core essential service contract. Practices can provide enhanced services to their own registered patients or to patients of other practices, whether functioning at a cluster or LHB level.

- Enhanced services can be negotiated nationally but LHBs may not choose to adopt these enhanced services unless legally compelled. Locally agreed enhanced services are often used instead. Funding may come from Welsh Government or from within LHBs existing budgets. Monitoring of performance against any enhanced service contracts is patchy. Consequently, there is marked variation in service contract, quality and coverage across Wales. The integration of enhanced services with secondary care pathways is uncommon.

- Optometry does successfully demonstrate different outcomes with the Welsh Eye Care Scheme being adopted and delivered to the same standard all over Wales. Also there has been a focus on integration with secondary care and so initiatives to support care of glaucoma and cataracts closer to home have arisen. However, there is less of a focus on primary care.

- The 2018 call from *A Healthier Wales* to transform the entire health and social care system to deliver the Quadruple Aim, using a Prudent Health Care philosophy via a Value Based Health Care delivery vehicle, means enhanced services must be reviewed to ensure that they contribute effectively to the transformation.

- The COVID-19 Pandemic has radically changed how primary care and secondary care are delivered and enhanced services must be reviewed to assess their suitability in the immediate and medium term.

- The Welsh Audit Office report *Primary Care Services in Wales* (October 2019) reported that

    a. “Change needs to happen at greater pace and scale to tackle longstanding challenges and ensure sustainability of these vital [primary care] services.”
    b. “The NHS in Wales aims to shift resources towards primary care. While there is evidence of some resource shifting in this way, change has not been at pace and scale.”
    c. “Faster progress is needed to improve the way that performance and activity is measured”

2. This same Welsh Audit Office report recommended that:
   R1: “The Welsh Government should work with the National Primary Care Board to agree **robust measures of patient outcomes** in their suite of performance measures for primary care, and in doing so, they should look to collaborate with experts in measuring whole-systems outcomes.”
   R2: “The Welsh Government should work with independent primary care contractors to ensure the NHS in Wales has ongoing **access to standardised information about their activity**, to contribute to better planning and design of services.”
   R7: “The Welsh Government should consult with health boards, to agree an approach to **clarifying and standardising the way that primary care expenditure is recorded** and reported.”

R8: “The Welsh Government should work with health boards to evaluate, and if necessary, improve the **effectiveness of the financial framework in supporting a shift in resources towards primary and community care**.”

R9 “As part of the Joint Executive Team process, the Welsh Government should require **health boards to report annually on their progress in shifting resources towards primary care**. The coverage of these reports should not be limited to financial resources and should include other resources such as staff and services. Through this process, the Welsh Government should hold to account the entire executive team of health boards, not just the executive directors for primary care.”

Work Stream 1:
Where do Enhanced Services fit into the wider health and care system?

To review the effectiveness of the local, national and direct enhanced service contracting mechanisms and make recommendations about their future role as a contractual lever.

1. Enhanced Services have traditionally focussed more on the provision of a service than the value they add to the patient or person
2. They are traditionally transactional not transformative
3. They focus on process not outcomes, often at procedures rather than patients, or individuals rather than populations
4. They are viewed by the wider system as small contractual negotiations in a strictly primary care world, rather than high value opportunities to transform system wide delivery of a pathway of care, as required by *A Healthier Wales*
5. Not all existing primary care contractual levers (e.g. APMS) have been used effectively and efficiently

Recommendation 1: LHBs/WG should first adopt system wide clinical pathways, and then identify the highest value contractual models (which may include enhanced services) to deliver care along the pathways

To describe the principles that will ensure enhanced services can be designed to deliver the quadruple aim of A Healthier Wales, and be aligned to the primary care model for wales

Design Principles

The principles for designing and delivering enhanced services should be the same as the principles for design and delivery in *A Healthier Wales*.

10 Design Principles of *A Healthier Wales*	**Descriptor**	**What this means for LHBs**	**What this means for Contractors and clusters**
Prevention and early intervention	health and wellbeing throughout life; anticipating poor health and wellbeing	Designing and Planning pathways to shift resources to emphasise prevention as the highest value intervention	Rewarding primary prevention and population health over secondary/tertiary prevention
Safety	healthcare that does no harm, but enabling people to live, safeguarding from harm	Designing and Planning pathways to deliver prudent healthcare's principle to '*do no harm*'	Rewarding activity that minimises harm and reduces complications
Independence	self-management of health and wellbeing and long-term conditions, independence in their own homes and localities, and rehabilitation as close to home as possible after illness	Designing and Planning pathways to deliver care closer to home, with emphasis on self-care and self-management	Rewarding activities that promote patient/person activation, health literacy and self-care, and delivering services as close to home as possible
Voice	Empowering people to make decisions based on information made available to them, and based on 'what matters' to them	Co-producing pathways with patients/people, carers and communities	Co-producing and delivering pathways with patients/people and carers in the context of their communities
Personalised	services tailored to individual needs; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes	Designing and Planning pathways to deliver individualised care where possible	Delivering 'what matters' to the patient where possible, recognising their individual vulnerabilities
Seamless	services made simple, information shared across service and	Designing and Planning pathways that focus on the patient/person	Working flexibly with colleagues beyond

	geographical boundaries	rather than the services delivering them	traditional professional and rigid IG boundaries
Higher Value	value- achieving better outcomes and a better experience for people at reduced cost; care and treatment which is designed to achieve 'what matters' and which is delivered by the right person at the right time; less variation and no harm	Designing and Planning pathways that allow resource shift to where they deliver the highest value	Rewarding activity that maximizes value to patients
Evidence Driven	using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working	Designing and Planning pathways that are robustly based on evidence and data, including patient reported outcomes	Rewarding practice that is based on strong evidence and ensure quality improvement methods are used to maximise value
Scalable	ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations	Designing and Planning pathways that balance national standards with innovative local delivery and ensuring quality improvement methodology is used to continually improve and spread best practices	Rewarding widespread adoption of good practice across Wales whilst allowing local innovation to test new ways of working and influence future enhanced services
Transformative	ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now	Designing and Planning pathways that embed value based care	Rewarding a different but high value approach to care with a sustainability.

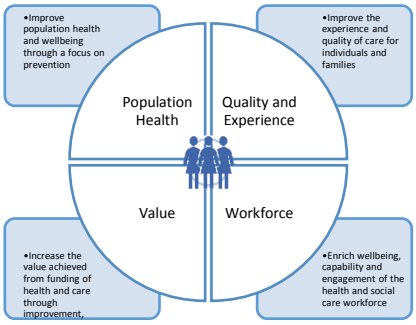
To describe what system and process changes are required for enhanced services to be created with the prudent health care philosophy and delivered using Value-Based health care

To describe how enhanced services can accelerate the transformation of unscheduled and planned care, and what processes and structures are required to deliver this

To describe the data collection, analysis and presentational needs of an effective and efficient enhanced service

Pathways

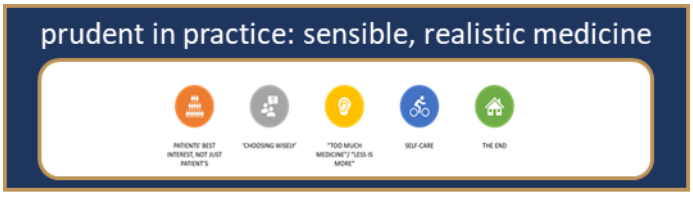
***A Healthier Wales* provides the vision for how the health and social care system will look and feel in 2030. Any route taken for delivering that vision must be built on pathways that are true to *A Healthier Wales*, and that can be built at scale yet travelled at pace.**



A well designed clinical pathway must therefore have the following characteristics as defined in *A Healthier Wales*

- It must fulfil the **Quadruple Aims**
    - Improved Population health & Well-being, Improved Quality, Increased Value, and a Sustainable & Engaged Workforce

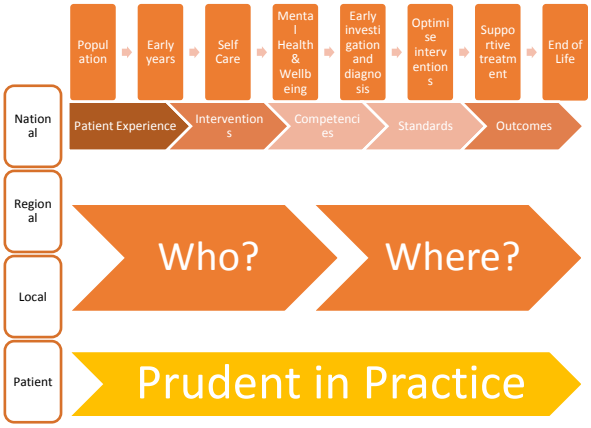
- It must be created using the **10 Design Principles for NHS Wales**
- It must illustrate the **Prudent Healthcare Philosophy**
- It must facilitate use of **Value Based Care** as the delivery vehicle of care.



Pathways exist at different, but related levels.

- High level, national pathways are agnostic of profession or location, but they describe broad principles informed by prudent healthcare philosophy.
- Who provides the services and in which location is properly decided at a local or regional level, informed by knowledge of the population, demographics and geography.
- At individual patient level, 'process map' pathways derived from those high-level ones then guide referral and treatment, ensuring there is application of the prudent medicine principles at the front line

Practically, any clinical pathway must therefore



- be **agreed nationally** and applicable to patient groups, or patients with individual conditions
- be **adaptable locally** according to local population demographics and workforce
- **cover the entire lifespan** from pregnancy to end of life care, and **also the whole system** – prevention, self-management, primary care, secondary care, and specialist care to **facilitate resource shift**
- be delivered to a set of **national standards**
- allow people's **outcomes and experience measures** to be agreed and set nationally
- ensure **data is collected as part of everyday contacts** with clinicians and carers as the pathway is delivered
- use intelligence from this data to prioritise interventions of the highest value and those with the **lowest value will be stop**
- be **continually improved** through research, innovation and quality improvement

Recommendation 2: National Clinical Pathways, and standards, must be developed and managed before any national or directed enhanced service is considered.

Recommendation 3: Local Health Boards will localise national pathways to reflect the needs of its population and characteristics of its workforce, including in response to the COVID-19 pandemic

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Recommendation 6: All organisations will adopt a quality improvement methodology when planning, delivering and implementing local versions of national pathways

Recommendation 7: All organisations will ensure data is collected, including patient reported outcomes and experiences, as part of everyday contacts with clinicians and patients

Recommendation 8: All organisations will share data for specific purposes, and learning nationally, to support national pathway development and research and innovation

To describe any alternative contractual mechanisms that can be used in place of enhanced services, including any risks or benefits

Multiple Contracting Options

Enhanced services are just one possible solution to filling a gap in delivery of care required for a clinical pathway. There are already other solutions available to LHBs.

There are seven possible models of service delivery to deliver part of a clinical pathway through primary and community care agencies.

1. **Essential or Additional Services**
    a. LHBs contract with primary care contractors and services are delivered according to whether they fulfil the existing primary care contract definition of essential or additional services
2. **Traditional Enhanced Services (NES, LES)**
    a. LHBs contract with individual independent contractors to deliver specific services for a fee, where the clinical specification is written into the contract
3. **100% cover using Directed Enhanced Services (DES)**
    a. LHBs ensure that 100% eligible patients receive a desired service under a DES by contracting with alternative providers to deliver the service to patients registered at practices that are not participating in the original scheme
4. **Cluster based schemes**
    a. Instead of individual contracts with practices describing identical activities, an enhanced service can be written so that individual practices can have a shared responsibility to deliver outcomes at the cluster level, with an element of pay for performance at the cluster level and a cluster level indicative budget
5. **Personal Medical Services (PMS) schemes**
    a. For specific patient/person groups where the above options have not worked or are not practicable, then a PMS contract can be offered to practices, which pools the resources of essential, additional and enhanced services to deliver care to a specific patent/person group
6. **Alternative Providers of Medical Services (APMS) schemes**
    a. For specific patient/person groups where the above options have not worked or are not practicable, then an APMS contract can be offered to alternative providers (including third sector) which pools the resources to deliver care to a specific patent/person group
7. **Direct Provision**
    a. LHBs to employ staff to directly deliver the services to a patent/person group where the alternative models do not work or are not practicable

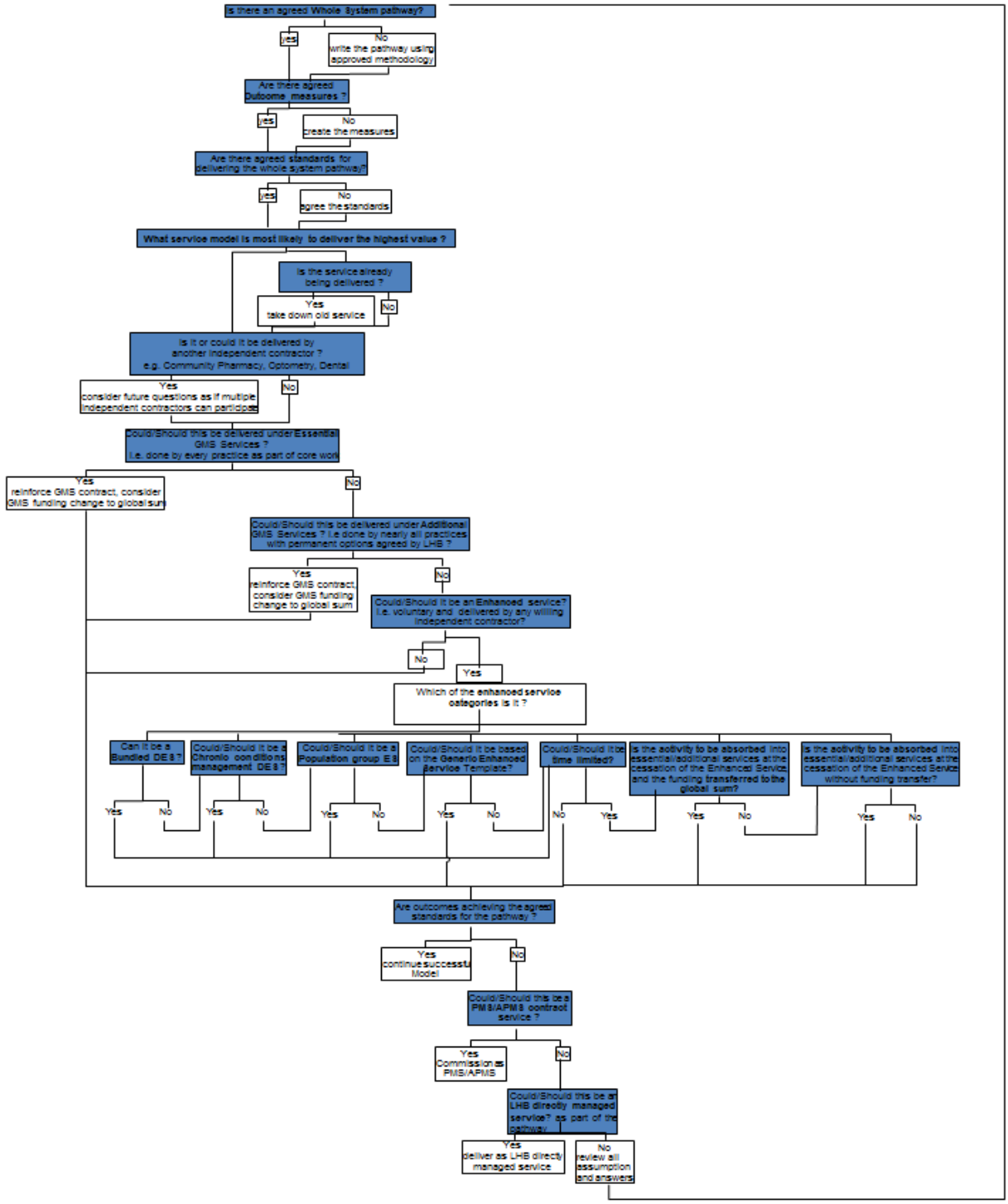
The table below lists some advantages and disadvantages of each of these models:

Model	Advantages	Disadvantages	High Value Examples
1. Essential Services	Every practice does them. Minimum bureaucracy Standard clinical practice should be reflected here	Mission creep if more expected without resource shift	Chronic conditions, palliative care, acute presentations
2. Additional Services	Nearly every practice does them – temporary or permanent opt-out of specific service possible if local workforce problems	Needs GMS contract change	Cervical screening, childhood immunisations
3. Traditional Enhanced Services (NES, LES)	Known model	See introduction	LARC ES DOACs LES Wet AMD referral services Ophthalmic Diagnostic Treatment Centre (ODTC) Services
4. **100% cover using Directed Enhanced Services (DES)**	Known model	No way of enforcing without legislation in WG direction	Anticoagulation DES Eye Health Examination Wales Low Vision Service Wales
5. Cluster based schemes	Proven to work in Tower Hamlets, with significant benefits to outcomes, uses value-based healthcare and empowers clusters to take ownership, and create locally relevant solutions Opportunities to work with social care on defined populations	Require provision of IT and data, and support in Quality Improvement	Cluster Management of Type 2 DM, HF, CKD, CHD in Tower Hamlets
6. **Personal Medical Services-PMS**	Comprehensive care through pooling all GMS resources to support a wraparound service	Not yet attempted in Wales (multiple in England)	Care Homes in Ealing
7. **Alternative Providers of Medical Services-APMS**	Comprehensive care through pooling all GMS resources to support a wraparound service	Not yet attempted in Wales (multiple in England)	Wigan GP practices
8. Direct Provision	Comprehensive care through pooling all resources to support a wraparound service	Concerns raised over efficiencies of managed practices, but this would be for a patient group and more like community services	Some virtual ward models in Wales

Recommendation 9: LHBs should consider and implement the models most likely to deliver the highest value outcomes for patents/persons in a clinical pathway

Choosing which service model to use?

The following diagram overleaf provides a decision-making process to determine the most suitable model to use of providing a service. A text version of the algorithm is available in appendices.



Work Stream 2:

What would optimised enhanced services look like?

A new Framework for Enhanced Services in Wales

Design Principles (building on the 10 design Principles for Wales)

- Enhanced Services should be designed to **minimise bureaucracy and maximise delivery** of the quadruple aims.
- Clinical Pathways should be **designed and managed separately** from Enhanced Services: Clinical Pathways should describe the clinical activity expected, whereas enhanced service contract details describe the operation of the contract
- Where possible the enhanced service should be **outcomes focussed**, with PROMS and PREMS being used to assess effectiveness and value of interventions
- **Data should be collected using existing frontline clinical systems** as part of everyday contacts, not new work
- Data is shared to support **quality improvement** and improved outcomes and discussed at clusters
- Enhanced Service contract **design and administration should be standardised**, whether nationally or locally contracted

Delivery Principles (building on the 10 design Principles for Wales)

- Any Enhanced service when negotiated must be subject to a two week **"garage service"** where LHB Primary Care Team managers are able to review the text and devise FAQs to ensure that the text is fit for purpose.
- **LHB-managed practices should participate** in all enhanced services that are relevant as if they are GMS practices
- LHBs are required to **monitor outcomes and publish** them for comparison with other health boards and clusters
- **Only significant changes** in the clinical pathway should require adjustments to an enhanced service
- Enhanced services should contain **tariffs or multiplier formulae** that explain how changes in activity will change payments

Contractual components

All enhanced services should contain standard sections including

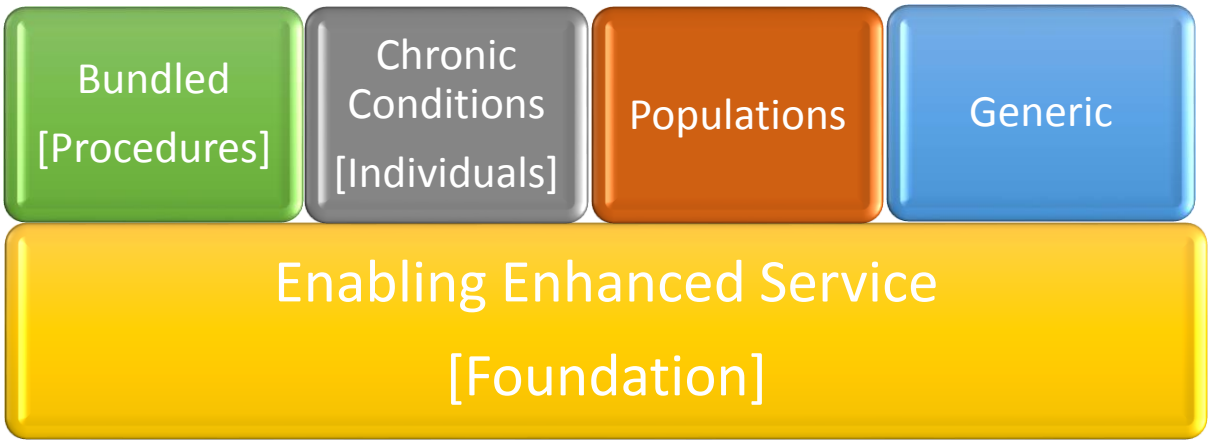
- Which **pathways** or sections thereof are being commissioned
- Agreement of **skills, competencies, accreditation, training** requirements at any individual or practice level
- Any variations to account for **rurality**
- How **Welsh language** Act requirements should be respected
- Any **time limitation** of the contract, a review date and a clear statement of what happens to the activity and finance after withdrawal
- A **notice period** for unilateral withdrawal (both sides)
- Any **data/codes** to be recorded on practice systems
- Which **PROMS** and **PREMS** to be used, or other agreed measures

- How data is to be displayed and shared or published (**information governance**)
- What **procurement** is required and who is responsible
- How **safety** incidents are to be reported
- **Financial remuneration** and claiming mechanisms, including **tariffs or multiplier formulae**
- **Post Payment Verification** mechanisms

How the Enhanced Services fit together

An Enabling Enhanced Service will direct LHBs to provide structural innovations and procedural changes that will allow all other enhanced services to function more effectively and efficiently. The Enabling DES will be offered to all practices for them to engage with these structures and processes, and all other enhanced services will be dependent on this enabling DES as a foundation.

Instead of multiple enhanced services, where possible, three broad overarching enhanced services will be used, each with a different main focus of activity – procedures, chronic conditions or patient groups. A further category – a generic enhanced service – will be available for local enhanced services to be developed to encourage innovation and allow local solutions to very local problems. Successful solutions can then be shared and taken up by other LHBs or nationally within the main categories.



- Enhanced Services should fall into one of five distinct categories:
  1. The Enabling DES
  2. A Bundled DES
  3. A Chronic Conditions in Clusters DES
  4. A Population DES
  5. A Generic ES

1. **The Enabling DES** – this creates the basic building blocks to facilitate the delivery and management of all other enhanced services
    1. **Structural** interventions
        a. A **website for publishing pathways**, easily edited
        b. An **agreement to record patient contacts with standardised templates, SNOMED-CT/Read codes**
        c. A **website for publishing outcome data** at national, LHB and cluster level and, with agreement, contractor level
    2. **Procedural** interventions
        a. **Adoption of high-level national pathways, that** are whole system and whole lifespan
        b. Locally tailored delivered as decided by LHB
        c. **Standardised methodology for pathway development** e.g. Canterbury
    3. A **Learning Health & Care System**
        a. Data collection
        b. Data analysis
        c. Taking actions to improve outcomes
        d. Sharing learning locally and nationally
        e. Changing pathways as a result
        f. Acting on unwarranted variation early
        g. Shifting resources to where they deliver highest value
        h. LHBs support local enhanced services to be developed using a generic enhanced service template, test it and share any learning nationally, supporting scaling up of proven LESs to DESs.
    4. A Tariff of costs, or principles of an activity multiplier formula for making payment adjustments, nationally negotiated

    Further detail is provided in Appendix i

2. **A Bundled DES** – an overarching ES that builds on the **Enabling DES** and provides a common specification for multiple but similar procedures. Where separate pathways, conditions or patient groups require similar interventions or procedures, a single enhanced service can be used to cover all these situations, rather than a separate enhanced service for each.
    a. The focus is on **procedures or interventions**
    b. The components of the enhanced service should be applicable to all the situations, with explicit exceptions.
    It consists of:
    c. a **Generic Template** – containing the essential features that every Enhanced Service must possess
    d. a list of the **associated pathways** (or components of pathways) covered
    e. a **tariff** of costs, or **multiplier** formula for adjusting payments with activity
    Examples:
        a. High risk drug monitoring
        b. Very high-risk drug monitoring
        c. Surgical/Gynaecological procedures
        d. Vaccinations & immunisations

An example could be drug monitoring. Currently there are separate enhanced services for DMARDs (which vary by LHB), Lithium and DOACs. These drugs all require regular blood tests and dose

adjustment. Dose or testing regimes written into enhanced services can rapidly go out of date and mean a renegotiation of the enhanced service is required. Oversight of the testing regime is a governance requirement but LHBs often do not discover there may be a problem until PPV detect in appropriate claims, or an undetected lack of claims may mean no testing is occurring. The enhanced service should describe the requirements of the service in terms of compliance with an agreed pathway, without specifying the clinical detail. New IT developments mean that alternative models of delivery may be desirable but not currently in the enhanced service

3. **Chronic Condition in Clusters DES –** overarching ES that builds on the **Enabling DES** provides a common specification for management of specific long-term conditions based on cluster footprints, but engaging individual practice teams
    a. a **Generic Template** – containing the essential features that every Enhanced Service must possess
    b. An **indicative budget** (set by the LHB)
    c. **Outcome and Process measures** set at the **cluster** level
    d. a **tariff** of costs, or **multiplier** formula for adjusting payments with activity
    e. A list of the **associated pathways**
        Examples:
            a. Type 2 Diabetes
            b. COPD and Asthma
            c. Heart Failure
            d. Chronic Kidney Disease
            e. Coronary Heart Disease
            f. Stroke (including Atrial Fibrillation and anticoagulation)

4. **Population DES**
    a. Where **patient or people can be grouped by a common set of characteristics that are not limited to a disease or condition, a** single enhanced service can be used to cover all these groups, rather than a separate enhanced service for each.
    b. The components of the enhanced service should be applicable to all the situations, with explicit exceptions.
    c. The focus is on **populations**
    a. a **Generic Template** – containing the essential features that every Enhanced Service must possess
    b. An **indicative budget** (set by the LHB or RPB)
    c. **Outcome and Process measures** set at the **cluster** level
    d. a **tariff** of costs, or **multiplier** formula for adjusting payments with activity
    e. A list of the **associated pathways** or a definition of a **patient/person group**
        Examples: Care Home residents, Homeless, Asylum seekers, Place-based care

5. **Generic Enhanced Service – a simple** ES that builds on the **Enabling DES** and provides the minimum standard specification for a service that is not covered by the above three categories.

Recommendation 10: All LHBs should adopt a new national Framework for Enhanced services where all enhanced services fit into one of four categories - The Enabling DES, a Bundled DES, a Chronic Conditions in Clusters DES, a Population DES, or a Generic ES

Work Stream 3:
Review of Current Enhanced Services and recommendations

To describe a mechanism for a targeted review of existing enhanced service contracts.

T&F group reached consensus agreement for the method to be used for reviewing 74 existing Enhanced Services in Wales:

1. List all Enhanced services (DES, NES and LES) currently or recently in operation (appendix X)
2. Group the ES into similar clinical subjects
3. Map each ES to one of the following categories for nearest match
    a. Enabling DES
    b. Bundled DES
    c. Chronic Conditions in Clusters DES
    d. Population DES
    e. Other
4. Identify any pathways already in existence that they could be linked to
5. Consider which contractual model (according to checklist) could be applicable

To conduct a review of content and expenditure of the current portfolio of DESs, NESs and LESs, identifying those that can be de-commissioned, merged, or replaced

Bundled DES

The following enhanced services 28 can be rationalised down to 8 enhanced services in the 'Bundled DES' category.

1. Dermatology
    a. Minor Surgery Fee (DES)
    b. Dermatology (LES)
    c. Extended Minor Surgery (LES)
2. Very High-Risk Drugs
    a. Oral Anticoagulation with Warfarin (DES)
    b. Administration of Enoxaparin to Mechanical Heart Valve Patients with a Subtherapeutic INR (LES)
3. High Risk Drug Monitoring
    a. Shared Care Drug Monitoring (near patient testing) (NES)
    b. Lithium / INR Monitoring (LES)
    c. Shared Care (LES)
    d. DOAC's (LES)
4. Treatment room
    a. Gonaderelins(LES)
    b. Phlebotomy (LES)
    c. Wound Care (LES)
    d. Zoladex (LES)
    e. Anciliary Clinical Services (LES)

5. Vaccinations
    a. Childhood Immunisation Scheme DES
    b. Influenza & Pneumococcal Immunisations Scheme (DES)
    c. HPV Vaccinations (LES)
    d. Immunisations (excluding DES - Childhood Imm & Influenza & Pneumococcal Imm)(LES)
    e. MMR (LES)
    f. Pertussis (LES)
    g. Rotavirus (LES)
    h. Meningitis (LES)
6. Sexual Health
    a. IUCD (NES)
    b. Depo - Provera (including Implanon)(LES)
    c. Sexual Health Services (LES)
    d. Ring pessary (LES)
7. Vasectomy (LES)
8. Minor Injury Services (NES)

The following 23 enhanced services can be rationalised down to 7 enhanced services in the 'Chronic Conditions in Clusters DES' category.

Chronic Conditions in Clusters DES

1. Cardiology (LES)
2. Diabetes
    a. Care of Diabetes (DES)
    b. Care of diabetes (LES)
    c. Gateway Diabetes (DES)
    d. Initiation of GLP1s (NES)
    e. Monitoring of GLP1s (NES)
    f. Initiation of Insulin (NES)
    g. Monitoring of Insulin (NES)
3. Mental Health
    a. Depression (NES)
    b. ADHD (LES)
4. Multiple Sclerosis (NES)
5. Musculoskeletal
    a. Orthopaedic (Upper Limb GPwSi Service/Clinical assessments) (LES)
    b. Osteopathy (LES)
    c. Physiotherapy (LES)
    d. Osteoporosis (NES)
    e. Osteoporosis (LES)
6. Respiratory
    a. Respiratory (inc COPD) (LES)
7. Substance Misuse
    a. Drug Misuse (NES)
    b. Alcohol Misuse (NES)
    c. Drugs Misuse (LES)
    d. Methadone (LES)
    e. Substance Misuse (LES)

The following 17 enhanced services can be rationalised down to 8 enhanced services in the 'Population DES' category.

Population DES

1. New UK residents
    a. Asylum Seekers & Refugees (from 1st April 2008) (DES)
    b. Asylum Seekers & Refugees (from 1st April 2008) (LES)
    c. Migrant Workers (LES)
    d. New UK Residents (LES)
2. Care Homes
    a. Care Homes (DES)
    b. Care Homes (LES) expired
    c. Home Enhanced Care Scheme (LES)
3. Homeless
    a. Homeless (DES)
    b. Services to the Homeless (NES)
4. Learning Disabilities
    a. Learning Disabilities DES
    b. Learning Disabilities (LES)
5. Lifestyle
    a. Smoking Cessation (LES)
    b. Living Well Living Longer (LES)
    c. Lifestyle Advice (LES)
6. Students
    a. Student Patient Registration (LES)
7. Services for Violent Patients (DES)
8. Frail
    a. Virtual Ward (LES)

Other uncategorised existing Enhanced Services

The following enhanced services are better delivered through alternative mechanisms, and not considered as enhanced services; for example, essential or additional services, LHB direct provision, discretionary payment schemes, or cluster-level funding projects.

1. Access
    a. Extended Surgery Opening (DES)
    b. Nurse Triage (LES)
    c. Access (LES)
2. Mental Health (DES) Expired – Education
3. Local Development scheme (LES)
4. Transport/Ambulance costs (LES)
5. Prescribing Enhanced Service (LES)
6. Domiciliary MAR Charts (LES)
7. MDT
    a. Chiropody (LES)
    b. Counselling (LES)

Identify any pathways already in existence that Enhanced Services could be linked to

National clinical networks have been working on some high-level pathways, and the NHS Executive may take on some functions in this space. Using the Canterbury methodology, Cardiff & Vale UHB has now launched 100 pathways designed by Secondary and Primary Care Clinicians and published on their HealthPathways website. This website has had over 58,000 visits since its launch.

What alternative contract models are available for these revised format enhanced services?

The consensus of the T&F group is that LHBs could consider providing some or all of the services currently delivered by enhanced services via alternative contractual models.

Bundled	**Essential**	**Additional**	**NES**	**DES**	**Cluster**	**PMS**	**APMS**	**Direct provision**
Dermatology				YES	YES			YES
Very high-risk drugs		YES		YES	YES			YES
High risk drug monitoring		YES		YES	YES			YES
Treatment Room	YES	YES		YES				
Vaccination	YES	YES		YES	YES			YES
Sexual health		YES		YES	YES			YES
Vasectomy				YES	YES			YES
Minor injury		YES		YES	YES			YES

Chronic Conditions	**Essential**	**Additional**	**NES**	**DES**	**Cluster**	**PMS**	**APMS**	**Direct provision**
Diabetes	YES	YES		YES	YES			YES
Mental Health Review	YES	YES		YES	YES			YES
MS	YES	YES		YES	YES			YES
MSK	YES	YES		YES	YES			YES
Respiratory	YES	YES		YES	YES			YES
Substance Misuse		YES		YES	YES	YES	YES	YES

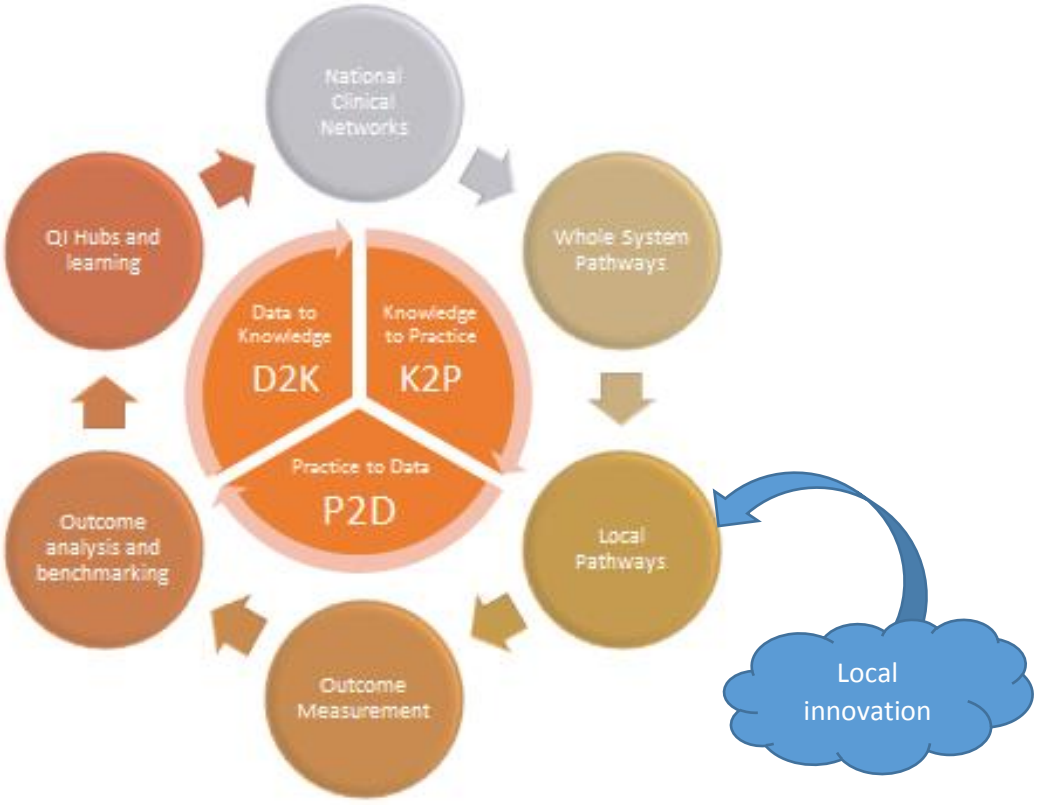
Population	Essential	Additional	NES	DES	Cluster	PMS	APMS	Direct provision
New UK residents	YES	YES		YES	YES	YES	YES	YES
Care Homes	YES	YES		YES	YES	YES	YES	YES
Homeless	YES	YES		YES	YES	YES	YES	YES
LD	YES	YES		YES	YES	YES	YES	YES
Lifestyle	YES	YES		YES	YES			YES
Students	YES	YES		YES	YES	YES	YES	YES
Services for Violent Patients				YES	YES	YES	YES	YES
Frail	YES	YES		YES	YES	YES	YES	YES

Other	Essential	Additional	NES	DES	Cluster	PMS	APMS	Direct provision
Access	YES	YES			YES	YES	YES	YES
Education	YES	YES	YES		YES			YES
Local development			YES		YES			
Transport					YES			YES
Prescribing		YES			YES			
MAR Chart	YES	YES		YES	YES			YES
MDT					YES			YES

To propose a mechanism for the evaluation, initiation and monitoring of new contracts for discrete areas of service development

Evaluation and Monitoring

The diagram illustrates the cyclical nature of pathway development and evolution. National authoritative bodies, such as National Clinical Networks, comprised of broad system-wide professionals with additional patient voice, will produce high-level clinical pathways. In describing services, these will be largely agnostic of profession and location, but describe standards and competencies. The pathways will be localised at health board and cluster level and sometimes regional level, and these will provide detail about where and by whom services will be delivered.



By **monitoring defined and standardised outcomes** (PROMS, PREMS) the service is evaluated on its delivery of what matters to patients, not simply measures of process. This is an essential component of the **Value-Based Healthcare** equation and enables monitoring of compliance with the standards set by networks, and **benchmarking** with peers (both nationally and internationally). The learning derived from this analysis can inform **quality improvement** work, locally and nationally, and is fed back to National Clinical Networks where it informs further iteration of clinical pathways. This data is also then available for **compliance** monitoring by central bodies such as the NHS Executive.

This will not stifle local **innovation** – indeed it will support it by encouraging the development of local enhanced services which will be tested using this mechanism and learning shared regionally and nationally, to encourage **spread at scale and at pace**.

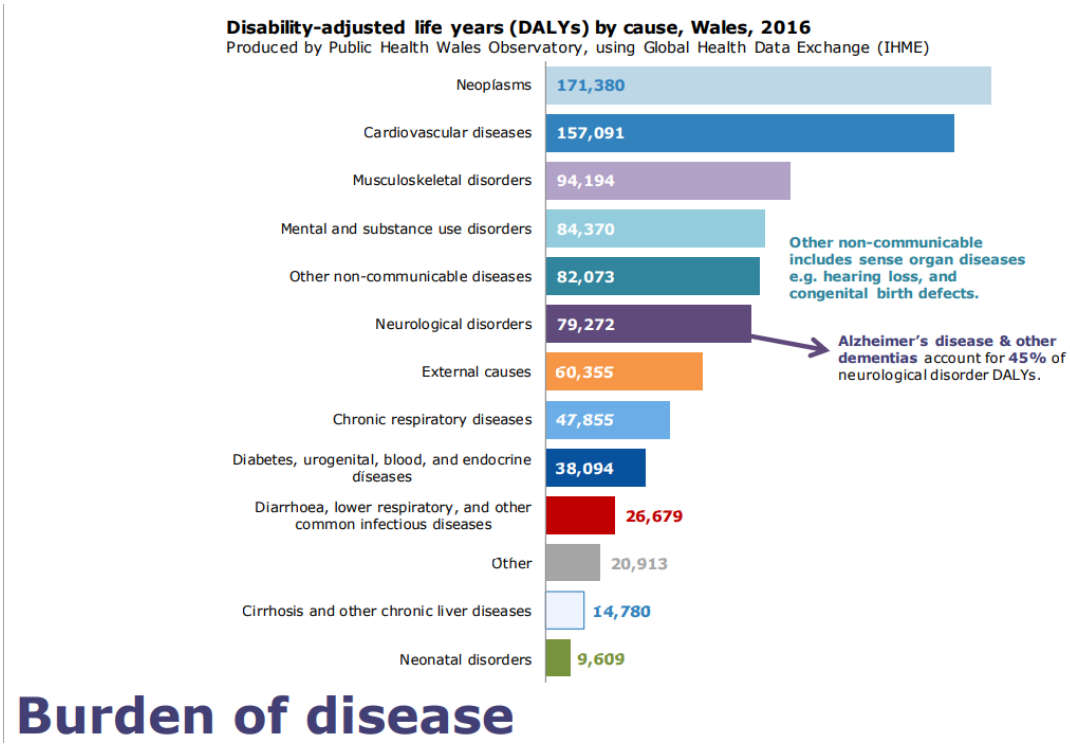
To provide a prioritised list of conditions, patient groups or pathways for new enhanced services

Pathways to Prioritise

When considering which pathways and which enhanced services to develop first, LHBs need to consider those pathways which are likely to have the greatest impact and where a population or patient group has the greatest need. LHBs also need to consider conditions or patient groups where the tools of managing a service or pathway are already in existence.

Burden of Disease in Wales

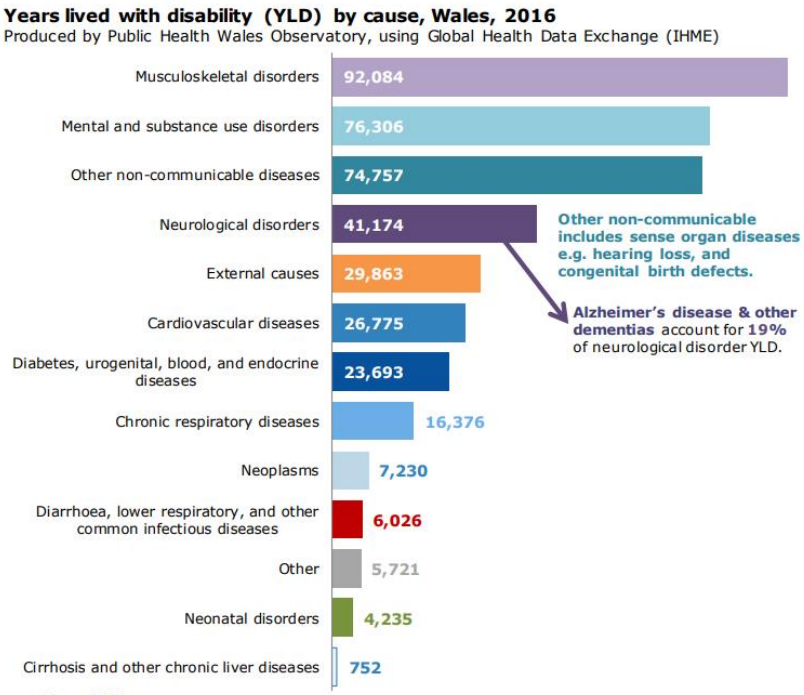
Public Health Wales reported the *Burden of Disease in Wales in* 2016 and described, nationally, the impact of clusters of conditions on mortality and morbidity in quantitative terms. These are likely to contribute to the majority of consultations with GPs and nurses, pharmacists and optometrists, and AHPs in the community. In the first chart below the length of the bar represents DALYs (disability-adjusted life years) – where one DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability



[1 DALY = the sum of years of life lost (YLL) and years lived with disability (YLD)]

This chart shows the top 5 disease groups are cancer, cardiovascular disease, musculoskeletal disorders, mental health & substance misuse, and non-communicable disorders (including sensory organ loss and congenital disorders).

When considering just years lived with disability, the disease groups change in order: musculoskeletal, mental health & substance misuse, other non-communicable conditions (including sensory organ loss and congenital disorders), neurological conditions (including dementia) and finally 'external causes'.



Burden of disease

[YLD – years lived with disability, the number of incident cases in the period is multiplied by the average duration of the disease and a weight factor that reflects the severity of the disease on a scale from 0 (perfect health) to 1 (dead).]

Secondary Care

We also need to consider the secondary care admissions & OPD data. The data from January 2020 shows the numbers of OPD referrals to secondary care for the top 15 specialties.

Trauma & Orthopaedics	15867
General Surgery	11584
Ophthalmology	9173
Ear, Nose and Throat	8587
Gynaecology	8284
Dermatology	6639
Cardiology	5840
Urology	5641
Gastroenterology	4787
Paediatrics	4491
Oral Surgery	3998
Adult Mental Illness	3451
Respiratory Medicine	3437
Rheumatology	2730
General Medicine	2447

Availability of PROMS and PREMS

Where patient reported measures already exist, these could help steer LHBs to deliver any related pathways before others as it would be straightforward to monitor the impact of the enhanced service or other contractual model.

ICHOM Patient Reported Outcomes that are already available;

1. Stroke,
2. Atrial Fibrillation
3. Hypertension
4. Heart failure
5. Diabetes
6. Chronic Kidney Disease
7. Coronary Artery Disease
8. Low back Pain
9. Hip & Knee osteoarthritis
10. Cataracts
11. Macular Degeneration
12. Depression & Anxiety in Adults
13. Depression & Anxiety in Children & Young Adults
14. Older person
15. Overall Adult Health

A national Patient Reported Experience Measure (PREM) is already available in Wales.

List of Prioritised Conditions or Patients Groups or Pathways for new Enhanced Services

Based on the above three factors, the T&F group recommendation prioritising the development of the following conditions or patient groups for *de novo* enhanced services.

Chronic Conditions in Clusters DES

1. Stroke,
2. Atrial Fibrillation
3. Hypertension
4. Heart failure
5. Diabetes (Type 1 and Type 2)
6. Chronic Kidney Disease
7. Coronary Artery Disease
8. Low back Pain
9. Hip & Knee osteoarthritis
10. Depression & Anxiety in Adults
11. Depression & Anxiety in Children & Young Adults

Population DES

1. Frailty (Virtual ward/population segmentation)

To list principles to describe how enhanced services will need to reflect COVID-19

COVID-19

Then consensus of the Task and Finish Group is that

- Initiation of an enhanced service or pathway must be consistent with the lifesaving or life-changing priorities described in the WG Essential services group review paper
- Remote consultations (digital, telephone and video) will remain as default modes of consultation, although face to face consultations will be necessary to a currently unquantifiable extent
- Infection control Principles as applied in the COVID-19 ear will need to be considered in each enhanced service
- Use of PPE (e.g. allowing time for donning and doffing) will need to be considered in each enhanced service
- Finance reimbursement will need to take into account the extra PPE and time that may be required to perform the tasks

Recommendation 11: All LHBs should first rationalise the existing enhanced services, using the principles of this document, and establish the new categories of enhanced service before devising enhanced services for *de novo* pathways, unless there is significant clinical need

Recommendations

Recommendation 1: LHBs/WG should first adopt system wide clinical pathways, and then identify the highest value contractual models (which may include enhanced services) to deliver care along the pathways

Recommendation 2: National Clinical Pathways, and standards, must be developed and managed before any national or directed enhanced service is considered.

Recommendation 3: Local Health Boards will localise national pathways to reflect the needs of its population and characteristics of its workforce, including in response to the COVID-19 pandemic

Recommendation 4: Local Health Boards will use an evidence-based pathway development methodology when localising pathways that includes specialists, primary care generalists, nursing and allied health professionals, as well as the patients and carers.

Recommendation 5: Local Health Boards will allocate resources across the whole lifespan and whole system clinical pathways using value based healthcare principles

Recommendation 6: All organisations will adopt a quality improvement methodology when planning, delivering and implementing local versions of national pathways

Recommendation 7: All organisations will ensure data is collected, including patient reported outcomes and experiences, as part of everyday contacts with clinicians and patients

Recommendation 8: All organisations will share data for specific purposes, and learning nationally, to support national pathway development and research and innovation

Recommendation 9: LHBs should consider and implement the models most likely to deliver the highest value outcomes for patents/people in a clinical pathway

Recommendation 10: All LHBs should adopt a new national Framework for Enhanced services where all enhanced services fit into one of four categories - The Enabling DES, a Bundled DES, a Chronic Conditions in Clusters DES, a Population DES, or a Generic ES

Recommendation 11: All LHBs should first rationalise the existing enhanced services, using the principles of this document, and establish the new categories of enhanced service before devising enhanced services for *de novo* pathways, unless there is significant clinical need

i. Appendices

Appendix i

The Enabling Directed Enhanced Service

i) This unique enhanced service contains the interventions ('building blocks') that must be in place for the maximum value to be produced from any future enhanced service
ii) These 'enablers' are composed of
    (1) **Structural** interventions
    (2) **Procedural** interventions
    (3) A **Learning Health & Care System**
    (4) A Tariff of costs
    And together they result in improvements in outcomes for patients and the population
iii) The Enabling Enhanced Service directs LHBs to contract with primary care practices so that the contractors are required to use or consider to use enabling interventions (whether structural or procedural) in delivering care to patients. The Enabling Enhanced Service directs LHBs to provide the building blocks for contractors to use.
iv) The Enabling Enhanced service is time limited as it is expected to be adopted by all practices and for the professional clinical behaviour change to become embedded in essential services in time.

v) Enabling Procedural Interventions
(1) Use of '**Pathways'** to design and deliver services relating to specific conditions, cluster of conditions or patient groups
    (a) At a national level, the pathway must describe the person's or patient's
        (i) ideal experience
        (ii) interventions to produce that experience
        (iii) competencies to deliver the interventions
    (b) Local Health Boards then interpret these national level pathways to describe
        (i) Who delivers the interventions with patients/people
        (ii) Where the interventions are delivered
        whilst taking into account the local population needs and workforce availability, which may rapidly change.
    (c) The **extent of each pathway** must cover
        (i) the **whole health and care system**, specifically describing, where appropriate,
            1. Prevention & Population Health & Well being
            2. Self-Care & Self-Management
            3. Mental Health
            4. Early investigation and diagnosis
            5. Optimisation of Interventions
            6. Supportive Treatment
            7. Rehabilitation & Reablement
        (ii) **across the whole life span**, specifically describing, where appropriate
            1. antenatal care
            2. early years
            3. adolescent and young adult

4. Vulnerable Groups
5. Life Stage Transitions (Leaving Home, New job, Retirement)
6. Working Age
7. End of Life Care

(d) **Pathways must be co-produced by a national authority within NHS Wales** (including lead specialist, a GP (or other relevant primary care contractor), a nurse and an allied health professional, with patient/carer representatives using an established methodology) using an established methodology (e.g. Canterbury) but will be adapted locally by an equivalent group with LHB support using an established methodology.

(e) What this means for primary care practices

(i) Clinicians will have a clear understanding of how the care of a patent or person should be delivered locally, given the prevailing conditions, population needs and available workforce

(ii) Clinicians in primary care practices should use or consider using these pathways when planning care with or delivering care to individual patients

(iii) Clinicians in primary care practices should consider where appropriate the stage of life of the patient or person and tailor their care where possible

(iv) Clinicians in primary care practices, or their elected representatives, should contribute to the localisation of pathways

vi) **Enabling Structural Interventions** include

(1) An LHB **website** that describes 'pathways for patient care of related to specific conditions, clusters of conditions or patient groups'

(a) The website is accessible to all members of the Primary Care Team, Cluster and LHB employees

(b) The website can be rapidly edited by approved editors to reflect any changes in how a pathway needs to be delivered (for example in response to changes in COVID-19 incidence)

(2) **Approved Read Codes/SNOMED CT codes** that are used by primary care clinicians to record clinical data in a standardised way

(a) To ensure clinical records are recorded using a standardised set of codes to ensure accuracy

(b) To ensure data extraction and analysis is possible to monitor effectiveness and value of the pathway

(3) **An outcomes Dashboard website**

(a) Accessible to all members of the Primary Care Team, Cluster and LHB employees

(b) The Dashboard Website displays up-to-date measures for pathways

(c) It displays comparative data for each LHB

vii) A Learning Health and Care System

(a) Use of **Quality Improvement Methodology** for each pathway

(b) National Outcome measures

(i) Patient Reported Outcome Measures and Patient Reported Experience Measures

1. To be used in interactions between clinicians and patients to help plan and monitor a patient's care

2. To be used to assess performance of the pathway
3. To be used to assess performance of an LHB

(c) **National Standards**

(i) Agreed national minimal levels of achievement for delivering a pathway

(d) Feedback of Learning from good practice

viii) A Tariff of costs, or principles of an activity multiplier formula for making payment adjustments, nationally negotiated

Appendix ii

Membership of Expanded Primary Care Reference Group

Liam Taylor - Chair (LT)	Chair of the Primary Care & Community Reference Group
Alastair Roeves (AR)	National Clinical Lead for Primary Care & Community Care
Sue Morgan (SM)	National Director and Strategic Lead for Primary and Community Care
Stacey Forde (SF)	Strategic Programme PMO
Anne Marie Cunningham (AMC)	NWIS Associate Medical Director of Primary Care
Nicola Phillips (NP)	NWSSP Head of engagement and support services Primary Care
Claire Osmundsen-Little (CO)	NWIS Finance Director of Finance
Gail Powell (GP)	Aneurin Bevan UHB - Health Visitors and School Nurses
Jo Mower (JM)	CTM UHB - National Collaborative Commissioning Unit)
Julie Denley (JD)	CTM UHB - Mental Health
Lynne Cronin (LC)	Cardiff and Vale UHB - PCIC
Mike Jenkins (MJ)	Welsh Ambulance Service NHS Trust- Regional Clinical Lead (SE)
Richard Bowen (RB)	111/OOH
Robert Morgan (RM)	RCGP
Phil White (PW)	GPC Wales
Stephanie Griffith (SG)	Social Care Wales
Mark Walker (MW)	Senior Medical Officer Primary Care
Paula Hopes (PH)	Swansea Bay UHB - Mental Health and Learning Disability DU
Kerrie Phipps (KP)	National AHP Lead for Primary and Community Care
Rohini Mohan (RoM)	Clinical Lead Community Dental Service SBUHB
Chris Commins (CC)	Assistant Director of Finance ABUHB
Barbara Ryan (BR)	Chair Welsh Optometric Committee
Craige Wilson (CW)	Deputy COO - Swansea Bay UHB
Hazel Powell (HP)	Health & Social Services Group WG
Peter Howard (PH)	GPC Wales
Sharon Miller (ShM)	HOPC
Joyce Kenkre (JK)	Academic link
Sarah O'Sullivan-Adams	WG Audiology & Ophthalmic policy

Appendix iii

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