GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

PRIMARY CARE

Clusters: Past, Present and Future

SOUTH POWYS

August 2019

WHO WE ARE

South Powys Primary Care Cluster is made up of 4 GP practices - Brecon; Crickhowell; Hay on Wye and Ystradgynlais; with a combined list size of approximately 45,580 patients.

BACKGROUND

The cluster has a high level of maturity, with collaborative working embedded and partner participation consistent. The cluster group formed in 2012 to deliver the primary care model that integrates primary/community care to provide better access for patients, high quality services and support sustainability by promoting new ways of working. The group has since widened to include the Community Pharmacy; Social Services; PAVO; PTHB Finance and Commissioning Department; PTHB Planning and Localities and Red Kite Health Solutions.

Red Kite Health Solutions are a community interest company formed in 2015 to deliver health and wellbeing services to South Powys and surrounding areas, to help support the ongoing challenges of GP recruitment.

Red Kite HEALTHCARE SOLUTIONS CIC

WHAT WE HAVE DONE

The cluster have focussed on the integration of the Primary Care Team which now includes Pharmacists, Pharmacy technicians; Optometrists; Physiotherapists; Community Connectors; Active Monitoring for mild to moderate mental health problems and Social Prescribing by MIND. These have all been recognised by Welsh Government under the All Wales Primary Care Model. Citizens have felt empowered by the development of strong patient health focus groups and the introduction of new technology to improve the quality of patient care. Pharmacists have started using Skype to discuss medication issues to prevent unnecessary travel and the repatriation of secondary care services i.e. dermatology.

CLUSTER DEVELOPMENT

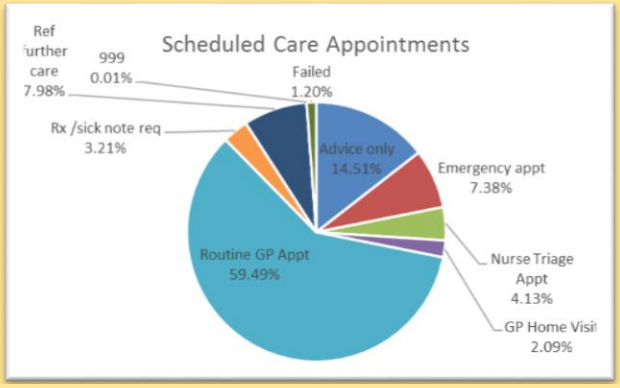
- Introduction of 3rd sector Community Connectors, attached to each Practice to support statutory service providers.
- Introduction of 3rd sector MIND Practitioners and PTHB Online CBT system 'Silver Cloud' to support GP Practices and Community Mental Health Services.
- Introduction of Cluster Pharmacist Team to support services.
- Development of a Community Interest Group for the GP Network.
- Virtual Wards and Community Resource Teams with a MDT approach to discuss and implement patient specific care plans, so that they can have all their care at home without admission or an emergency referral.

KEY ACHIEVEMENTS

Following the success of Nurse Telephone Triage in 2015, Total Nurse Triage was introduced in 2017. The initiative was introduced to ensure patients would see the most appropriate clinician within a suitable timescale. This has been implemented successfully since February 2017. The positives from this model of working have been improved access, improved quality, improved patient experience; reduction in wasted appointments; improved practice moral; higher level of practice development across all staff groups and also greater multi-disciplinary team working.

The pie chart shows clearly the outcomes, where 15,999 phone calls were received into Haygarth practice between March 2017 and June 2019. The percentage of routine GP appointment was 59.49 out of 100%, where 40.51% were dealt with minimal GP involvement.

59.49%	9,518	Routine GP Appointment
14.51%	2,322	Advice Only
7.98%	1,276	Referral for further care (bloods, urine etc. or optician/dentist etc.)
7.38%	1,181	Emergency GP Appointment
3.21%	514	Prescription
4.13%	660	Nurse Appointment
1.20%	192	Failed encounter (patient could not be contacted when telephoned)
2.09%	335	House Visit
0.01%	1	Advised to contact 999



Prior to Nurse Triage, the wait for a GP appointment was in excess of 14 days. This was reduced by 25% with many appointments available the next day or within a few days. Routine appointment times for all GP's increased from 10 to 15 minutes, allowing GP's more time to deal with complex and unwell patients.

WHATS NEXT?

With the implementation of a large part of the All Wales Primary Care model, the clusters future intentions include:

- Integrating social care within the cluster i.e. Social workers and HCAs within the District Nurse/Virtual Ward Team
- Development of Cluster wide ideal staffing models
- Delivery of transformational models for primary and community care, with clinical change programmes to tackle the 'Big Four' causes of ill health and disability in Powys.
- Improving; Performance monitoring and reporting, Capacity for service planning & evaluation to support Cluster development, Access, Long term conditions management, Information Technology usage, Practice Sustainability, Language and accessibility standards, a skilled workforce, Strong leadership and improving Eye care, Dental Services & Medicines Management.

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