STRATEGIC PROGRAMME FOR PRIMARY CARE

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 development framework

Preamble to May 2022 edition

May 2022
Version 1

Purpose of this document

The purpose of this document is to outline the cluster development framework (CDF) as a tool supporting monitoring (quality management) and evaluation of Primary Care Model for Wales (PCMW) and Accelerated Cluster Development (ACD) implementation.

Introduction

The approach taken by the Strategic Programme for Primary Care (SPPC) to monitoring and evaluation enables clusters, health boards, regional partnership boards and other stakeholders to report on and support implementation of the Primary Care Model for Wales (PCMW) and Accelerated Cluster Development (ACD). It should involve constructive reporting of progress to facilitate identification of common areas of difficultly and subsequent realignment of support resources at local, regional and national levels to address these challenges.

The *Monitoring and evaluation plan* outlined a supporting framework for defining intended **outcomes** (implementation quality standards), **maturity** levels (recognising that outcome attainment is a journey), and—where helpful in later editions—**evidential requirements** for both PCMW and ACD. This tool, the **cluster development framework** (CDF), will:

- Provide context to support shared **understanding** the origin and intent of PCMW and ACD
- Provide a framework for:
    - **Organising** and reporting on measures of implementation progress (via a key indicator dashboard, or KID);
    - **Recording** cluster reflections (via a self-reflection tool, or SRT); and
    - **Structuring** peer review conversations (via a cluster peer review, or 360 process).
- Include a module detailing each **PCMW outcome**, going “behind the headline” with narrative, supporting logic and potentially exemplar evidence indicative of cluster **maturity** (foundation; developing; mature)
- Include a module detailing each **ACD outcome**, with supporting narrative
- Have the **flexibility** to be revised periodically, incorporating learning from e.g. national implementation reports, or adding reference to other shared cluster development priorities where indicated (e.g. for Greener primary care or Healthy days at home).

For the May 2022 edition, the framework contains two modules:

- Module 1: Primary Care Model for Wales
- Module 2: Accelerated Cluster Development

For more information on the *Monitoring and evaluation plan*, see the **ACD Toolkit**.

Primary care transformation

Policy and strategic context

The *Well-being of Future Generations (Wales) Act 2015* [**WBFG**][1] requires public bodies to consider long-term impacts of their decisions, to work collaboratively and to prevent persistent problems such as poverty, health inequalities and climate change. It introduced a set of well-being goals that provide a shared vision of the Wales we want to see:

- A prosperous Wales
- A resilient Wales
- **A healthier Wales**
- A more equal Wales
- A Wales of cohesive communities
- A Wales of vibrant culture and thriving Welsh language
- A globally responsible Wales.

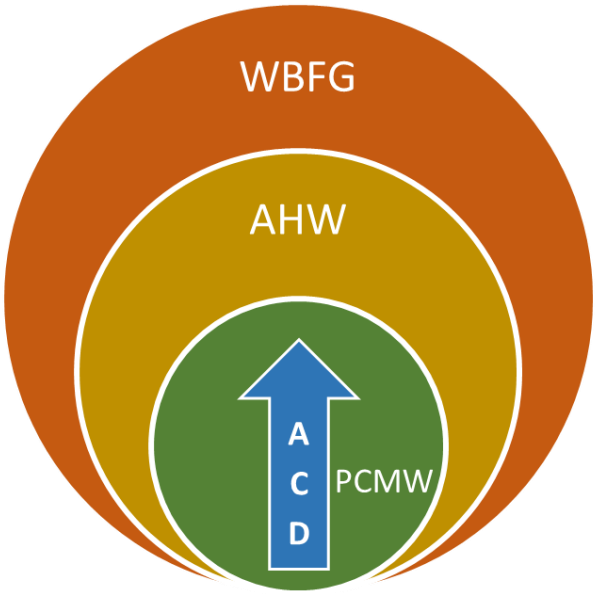
A healthier Wales (WG 2018) [**AHW**][2] sets out the vision of a whole system approach to health and social care focused on health and well-being and on preventing illness. It is informed by the *Parliamentary Review of Health and Social Services* and sets the direction for attaining the corresponding WBFG goal.

The **Primary Care Model for Wales** (**PCMW**) is the transformational model for community-based services, which is a place-based approach to sustainable and accessible local health and well-being care. Emerging during 2017-18, it describes how care will be delivered, now and in the future, as part of a whole system approach to delivering a healthier Wales.

The Wales Audit Office reported in *Primary Care Services in Wales* (WAO 2019) that plans to strengthen primary care were not happening quickly enough.[3]

In keeping with *Programme for Government 2021 to 2026* (WG 2021)[4] the **Accelerated Cluster Development** (**ACD**) programme aspires to accelerate the pace of PCMW implementation towards realising a healthier Wales, doing so in part by separating cluster delivery functions from those of pan-cluster planning and commissioning functions. ACD is the primary care component of place-based care.

[1] https://www.futuregenerations.wales/
[2] https://gov.wales/healthier-wales-long-term-plan-health-and-social-care
[3] https://www.audit.wales/news/plans-strengthen-primary-care-not-happening-quickly-enough
[4] https://gov.wales/programme-for-government-2021-to-2026



Diagrammatic representation of the relationships between the Well-being of Future Generations (Wales) Act 2015 [WBFG]; A healthier Wales *(WG 2018) [AHW]; the Primary Care Model for Wales [PCMW] and Accelerated Cluster Development [ACD].*

Cluster working context

Primary care **clusters** arose from the direction to embrace locality working in *Setting the direction* (WG 2010)[5]. 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 well-being of individuals and communities.[6]

The PCMW was developed based on the initial **Pacesetter Programme**[7] of work undertaken early in the development of clusters with a view to upscaling successful initiatives for delivery across Wales. These projects revealed shareable learning that subsequently informed the model itself:

- Multi-professional teams working at cluster level are the way forward
- Safe and effective systems are needed to direct people to the right person/ team, at the point-of-contact
- Integrated teams can ensure a holistic approach to care, promoting physical, mental and social well-being
- Services must work well across in and out-of-hours to ensure seamless care
- Success also depends upon an informed public who have access to a range of community services.

[5] http://www.wales.nhs.uk/sitesplus/documents/829/setting%20the%20direction.pdf
[6] https://primarycareone.nhs.wales/topics1/cluster-working/
[7] https://primarycareone.nhs.wales/topics1/pacesetters/

Clusters have a pivotal role in co-delivering the 13 PCMW transformational **outcomes** set out in this framework. They will need to evidence **maturity** using three sets of criteria (foundation; developing; mature). Attaining maturity (Level 3) should reflect integration within a whole-system approach (the model aspiration), whereas levels 1 and 2 reflect progressive transformation of primary care health services.[8]

The ACD programme is delivered through professional collaboratives and clusters. **Collaboratives** bring together general medical, dental and optometric practitioners, pharmacists, nurses, allied health professionals (AHPs) and social care professionals, within their professional groups, to assess **population needs** and service **improvement priorities**. Solutions are developed within collaboratives and through **multi-professional** cluster working.

Pan-cluster planning groups (**PCPGs**) are the mechanisms by which representatives of clusters come together on a county population footprint to collaborate with representatives of the health board and local authority, public health experts, planners and representatives of those services for which professional collaboratives are not appropriate (e.g. services which should only be planned at county, health board/ regional or even national level). PCPGs will provide the local footprint for the tactical delivery of **regional partnership board** (**RPB**) priorities. PCPGs agree a county population needs assessment and a plan on what services are needed, making prudent use of all funding, workforce, and other resources. PCPG assessment of needs and plans must inform and be informed by regional level assessments of need (which are a statutory function of RPBs). They should be viewed as a collective suite of interconnected needs assessments and plans.

That "**cluster working is here to stay**" is reinforced within both *Programme for Government 2021 to 2026* (WG 2021)[9] and the refreshed AHW action plan (2021).[10]

Cluster development and evaluation context

Primary care clusters have developed in different ways across Wales based on their understanding of local needs and circumstances, and with the help of tools issued at national level such as cluster planning guidance[11] and the governance guide for clusters[12].

Clusters have used core funding to support their development or additional funding such as the Primary Care Fund in general and the national pacesetter programme in particular[13], along with the Integrated Care Fund and Transformation Funds to implement specific aspects of their service plans.

[8] "Primary care" applies in its widest sense, encompassing the continuum of primary and community care provision
[9] https://gov.wales/programme-for-government-2021-to-2026
[10] https://gov.wales/sites/default/files/publications/2021-04/a-healthier-wales-actions.pdf
[11] https://primarycareone.nhs.wales/tools/cluster-planning-support-portal/
[12] https://primarycareone.nhs.wales/topics1/cluster-working/cluster-governance-a-guide-to-good-practice/
[13] Although the Pacesetter Programme focused on health board-level innovation and was not specific to clusters, many of the projects funded through the programme related directly to clusters; the SPPC Fund replaced Pacesetter funding from April 2022

Assessment and evaluation of the work of primary care clusters has to date tended to be focused on the impact of these specific programmes of work. Implementation of the PCMW and ACD programme during the transition year (2022-23) marks a new stage in the development of clusters across Wales, offering the opportunity for primary care and wider system colleagues to review progress, share good practice and plan future development within the context of a **national common framework**.

Transformation principles

In 2017 Public Health Wales, acting on behalf of the Directors of Primary and Community Care (DPCC), commissioned University of Birmingham to carry out an external appraisal of the Pacesetter Programme[14]. Learning from the Pacesetter projects identified a number of transformation **principles** that have informed the PCMW and this cluster development framework. The principles are:

- Service developments based on population need, with planning and transformation led through local primary care clusters
- Promotion of healthy living and the de-medicalisation of well-being
- A population focus as the basis for service planning and delivery across local communities
- A more preventative, pro-active and co-ordinated primary care system which includes general practice and community service provision through community resource teams (CRTs) or frailty services
- A whole-system approach through the integration of health, local authority and voluntary sector services, facilitated by collaboration and consultation
- Holistic care for citizens that incorporates physical, mental, and emotional well-being, linked to healthy behaviours
- Integrated, streamlined care on a 24/7 basis, focusing on the sickest patients during out-of-hours
- Greater community resilience through empowered citizens and access to a range of community assets
- Advice and support available to help people remain healthy, with easy access to local services for care when people need it
- Strong multi-professional leadership across sectors and agencies to drive quality improvement
- Technological solutions to improve access to information, advice and care, and to support self-care.

Transformation enablers

Learning from the Pacesetter projects has also identified six transformation **enablers**. These enablers are recognised as key to successful transformation of health systems, both in the UK and internationally. The enablers are:

[14] https://primarycareone.nhs.wales/files/critical-appraisal/critical-appraisal-exec-summary-2018-pdf/

- *Facilitating*: **External facilitation** is made available to general practices to provide additional capacity and expertise in undertaking transformation
- *Leading*: **Clinical and non-clinical leaders** for the programme are identified within the practices and if relevant in local primary care networks and are given the time, support and space to reflect on the transformation process
- *Learning*: **Learning and development** in relation to new skills is available, and there is opportunity to learn from the implementation process through structured reflection on emerging evidence
- *Engaging*: **Stakeholder engagement** with patients, communities and wider clinical networks is embedded throughout with sufficient investment in associated infrastructure, capacity and skills
- *Funding*: **Transitional funding** to enable continuation of existing activities whilst new approaches are introduced and free up capacity for clinical and non-clinical leaders
- *Evaluating*: **Robust evaluation** to provide formative and summative insights against clear objectives and baselines.

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Primary and Community Care Development and Innovation Hub
Developing Primary Care in Wales

Primary Care Model for Wales (PCMW)

Cluster development framework: Module 1

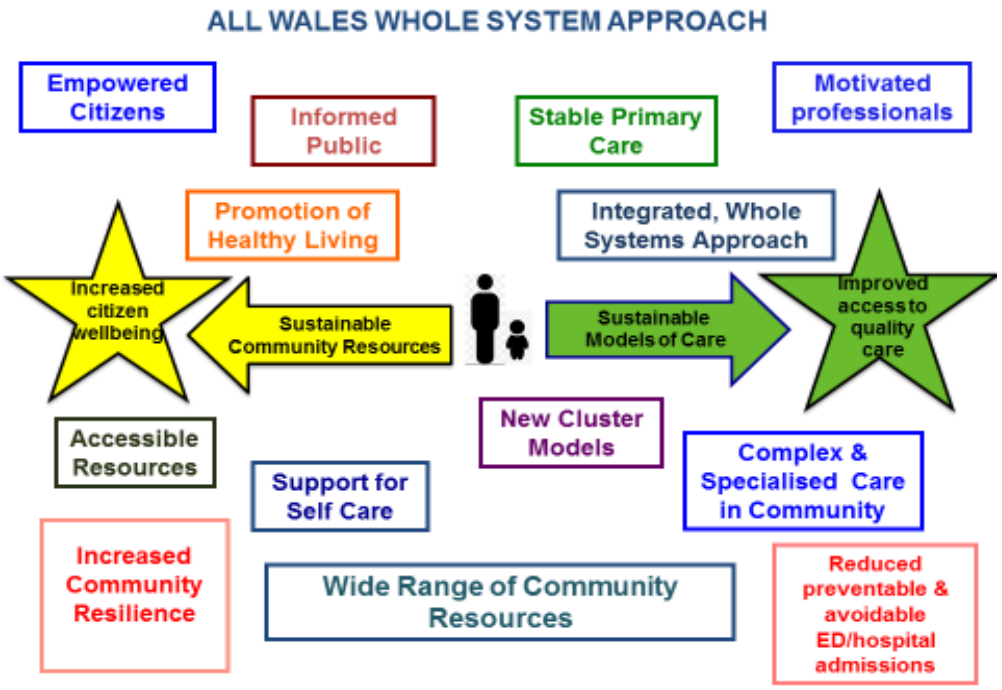
May 2022
Version 1

1.1 About the Primary Care Model for Wales

1.1.1 Introduction and origins

The **Primary Care Model for Wales** (PCMW) describes how care will be delivered locally, now and in the future, as part of a whole-system approach to deliver *A healthier Wales*.

In 2015 Welsh Government directed some of the **Primary Care Fund** into a national **Pacesetter Programme**[15], providing funding to health boards with the goal of testing and evaluating new and innovative ways of working to achieve sustainability, improve access, and deliver more care in the community. The activities and learning arising from this first round of Pacesetter projects informed a working model that articulated the transformative changes needed to fulfill their collective ambitions. Referred to initially as the "emerging model", it was endorsed by the **National Primary Care Board** (NPCB) as the **Transformational Model for Primary and Community Care** in March 2018. Later that year (November) it was adopted by the **Strategic Programme for Primary Care** (SPPC) as the Primary Care Model for Wales. The early model was depicted diagrammatically as follows:



A **language update** was commissioned by Welsh Government, who issued a revised narrative in April 2019[16]. Also in 2019, Public Health Wales (on behalf of Welsh Government) commissioned a consortium of Miller Research, the Institute of Public Care and Bruce Whitear Consulting to devise an

[15] https://primarycareone.nhs.wales/topics1/pacesetters/
[16] https://primarycareone.nhs.wales/files/sharing-practice/primary-care-model-for-wales-april-2019-pdf/

approach to monitor and evaluate PCMW implementation[17], under the guidance of a steering group. Until this point the model has been described as having nine key components to **cluster maturity** and four key components to **infrastructure maturity**. In preparation for monitoring and evaluation, this differentiation was removed to reflect recognition that both clusters and local health boards (LHBs)/ regional partnership boards (RPBs) have perspectives on what is needed to deliver all aspects of the model, and to give better visibility to the discrete elements formerly lumped together as "infrastructure". Further amendments were made to the language describing the PCMW during the course of the commission itself and following the subsequent introduction of **Accelerated Cluster Development** (ACD)[18], to ensure **alignment of terminology** and to maintain a common **focus on outcomes**. The aspiration of the PCMW is captured by the following 13 outcomes:

PCMW outcome 1
An informed public

PCMW outcome 2
Empowered communities

PCMW outcome 3
Support for well-being, prevention & self-care

PCMW outcome 4
Local services

PCMW outcome 5
Seamless working

PCMW outcome 6
Safe & effective call handling, signposting & triage

PCMW outcome 7
Quality out-of-hours care

PCMW outcome 8
Directly accessed services

PCMW outcome 9
Integrated care for people with multiple care needs

PCMW outcome 10
Cluster estates & facilities support multi-professional working

PCMW outcome 11
Cluster IT systems enable cluster communications & data sharing

PCMW outcome 12
Ease of access to community diagnostics supporting high-quality care

PCMW outcome 13
Finance systems designed to drive whole-system transformative change

The PCMW focuses not on a set location of provision—but on how health, social care and partners **collaborate** at a regional and local level to provide seamless **place-based care** with direct access to a wider range of multi-professional support and practitioners. It is designed to meet the needs of individuals, with a greater emphasis on **keeping people healthy** and well.

[17] https://primarycareone.nhs.wales/files/strategic-programme/acd-monitoring-and-evaluation-plan-pdf/
[18] https://primarycareone.nhs.wales/tools/accelerated-cluster-development-toolkit/

1.1.2 Confirmation of PCMW as the theory of change

Put simply, a **theory of change** is a "comprehensive description and illustration of how and why a desired change is expected to happen in a particular context"[19]. An objective of the commission was to confirm the model as the theory of change, through providing **assurance** to the steering group and wider stakeholders that all components of the model were clearly articulated and that the scope of the PCMW was **consistent** with primary care transformation policy and literature.

To approach this the consortium carried out:

- Semi-structured interviews with members of the project steering group
- Semi-structured interviews with staff supporting primary care in each health board (including Heads of Primary Care; Associate Medical Directors; Workforce and Organisational Development staff)
- Facilitation of two mini focus-groups at a Confident Practice Managers meeting
- Desk-based review of the logic (see 1.1.3), progression between draft maturity levels (see 1.1.4) and the language used within each outcome
- Cross-referencing of PCMW outcomes with relevant national and international evidence via a non-systematic literature review to confirm, test, adjust or revise them—as well as to identify any gaps in their scope.

The consortium summarized the above in a paper delivered to the steering group that concluded that there was at least some degree of **national policy and evidential support** for each outcome and was thus valid to test these with stakeholders during subsequent engagement activities.

1.1.3 Derivation of PCMW logic models

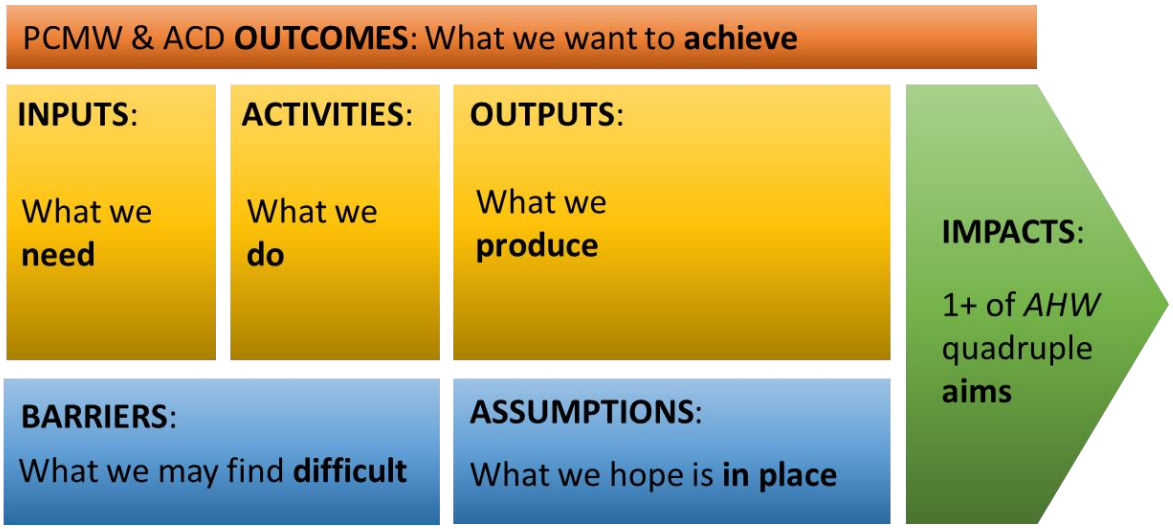
Logic offers a recipe for articulating how we will get from where we are now to where we want to be in the future. **Logic models** can thus help sense-check the elements that must come together to successfully plan, deliver and evaluate PCMW (and ACD) implementation by teasing out:

- *Inputs*: What we **need** to invest/ have in place to support our activities
- *Activities*: What we **do** with those inputs
- *Outputs*: What we **produce** as a result of our activities
- *Outcomes*: What our products will **achieve** for people or for services
- *Impacts*: High-level, ultimate ambitions e.g. the quadruple **aims** of *A healthier Wales* that we are working towards as a health and social care system[20]
- *Barriers*: What we may find **difficult** to influence or overcome (e.g. external factors)
- *Assumptions*: What we hope is already **in place** (supportive conditions, etc.).

[19] https://www.theoryofchange.org/what-is-theory-of-change/

[20] Improved population health and well-being; Better quality and more accessible health and social care services; Higher value health and social care; A motivated and sustainable health and social care workforce

These elements are depicted in the following diagram:



A further objective of the commission was to develop supporting logic models for each PCMW outcome, ensuring they were able to reflect differing **levels of maturity** on the transformation journey and were **co-produced** with key stakeholder input.

To approach this the consortium carried out:

- Development and refinement of a logic model template in a presentation format suitable for stakeholder testing and incorporating essential context (*A healthier Wales*; Well-being of Future Generations (Wales) Act 2015)
- Engagement with primary care practitioners in managerial and operational roles across each health board to discuss possible inputs (resources), activities, barriers, enablers (assumptions) and unintended consequences of the proposed outputs under each outcome
- An internal workshop to synthesize workshop findings and populate revised logic models.

The consortium delivered draft logic models in an Excel workbook to the steering group for review; these were accepted as a **starting point** for further testing and refining with wider system stakeholders, including local authorities and the third sector, as well as those in primary care. Note:

- The logic models would ideally be referenced when carrying out self-reflection or in preparation of peer review (as per the PCMW/ ACD monitoring and evaluation plan[21])
- Revisions should integrate feedback from stakeholders and wider developments e.g. learning from peer reviews or Health and Social Care Regional Integration Fund 2022-27 projects[22]
- Future models could to best practice examples (especially the inputs and activities elements).

[21] https://primarycareone.nhs.wales/files/strategic-programme/acd-monitoring-and-evaluation-plan-pdf/
[22] https://gov.wales/health-and-social-care-regional-integration-fund

Ultimately, in the context of the present document, the availability of logic models ensures a line of sight between each outcome and the **evidential requirements** suggested as a means to demonstrate attainment.

To review the logic models for each PCMW outcome, see **Appendix 1**.

1.1.4 Description of PCMW output maturity levels

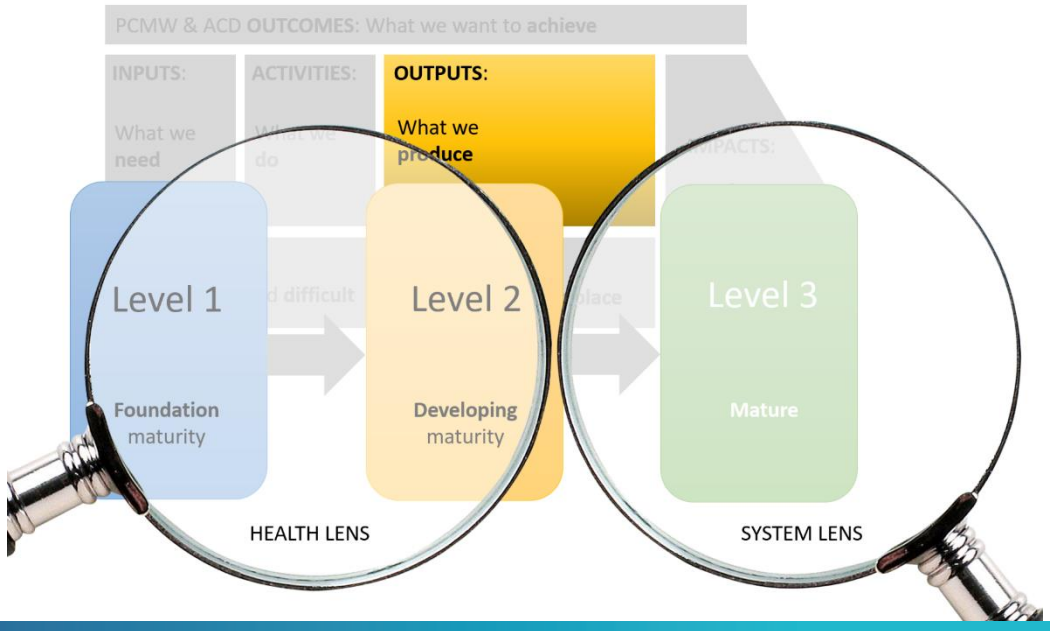
PCMW outputs within the aforementioned logic models are grouped into three relative **maturity levels**. These are:

- Level 1: **Foundation** maturity
- Level 2: **Developing** maturity
- Level 3: **Mature**

While many logic models set out a pathway to time-linked outcomes (via short, medium, and long-term outputs), steering group discussion with the consortium concluded the above would be a more fitting sub-categorization for evidencing PCMW implementation progress, as attainment will not necessarily be sequential. The levels are intended to strike a **pragmatic balance** between:

- Maintaining a focus on the unique contribution of primary care (and clusters in particular)
- Recognizing the wider, whole-system contribution to health and care system transformation.

Accordingly, levels 1 and 2 are best viewed via health-focused lens (and are thus **developmental**) and Level 3 via a whole-system lens (and is thus **aspirational**). There is more work to do to ensure that Level 3 outputs do indeed reflect whole-system perspectives (including those of local authorities and the third sector).



1.2 Framework for the Primary Care Model for Wales

The following tables combine previously published narrative with maturity level description taken from the PCMW logic models, for each outcome. At each maturity level logic models (Appendix 1) identify:

- Key inputs
- Key activities
- Possible barriers
- Key assumptions

PCMW outcome 1: An informed public

The PCMW recognizes the importance of actively nurturing an informed public.

Providing a template for good service and explaining its benefits is critical to success as it can educate and empower people to take ownership of their own health. Communication strategies require a strong focus on care to promote new models and service developments to both the public and professionals.

Cultural differences between geographical areas may require a variety of approaches to effect behaviour change. Healthcare professionals use brief interventions and should take every opportunity to provide advice to help people make positive lifestyle choices. When people understand the importance of self-responsibility, they are more likely to adopt habits that maximise their health and well-being.

Criteria for maturity assessment
Foundation (L1): Understanding amongst all cluster members on what messages they currently communicate to the local population
Foundation (L1): Understanding of how the cluster's key stakeholders are involved in communicating and engaging with the local population and their priorities
Foundation (L1): Understanding of the range of systems through which the cluster partners currently communicate with the local population
Developing (L2): Agreement on key messages for local communication, aligned with national priorities, and plan for reviewing and updating these
Developing (L2): Plan for how the cluster will use a range of systems to communicate with the local population
Mature (L3): Cluster Public Communication and Engagement Strategy (including vision, purpose and function of the Cluster) that has been signed-off by Cluster Leadership Team and is publicised and in active use
Mature (L3): Key cluster stakeholders are aware of their role in and actively involved in delivering the Strategy
Mature (L3): Wide-range of established systems and channels through which the cluster can communicate and engage with the local population

PCMW outcome 2: Empowered communities

The PCMW recognizes the fundamental importance of community empowerment.

People are encouraged to make informed choices with the help of their local care team and by including them in the design of their local services and using feedback on user experiences. Local champions can share their positive experiences of health and community care, and interviewing and coaching techniques are usually effective in motivating people to change their habits.

Criteria for maturity assessment
Foundation (L1): Understanding of the options for engaging and involving service users in service design and agreement on an approach
Foundation (L1): Understanding and widespread support for use of behaviour change and shared decision-making techniques by professionals working in the cluster
Developing (L2): Plan for how the cluster will systematically gather feedback from its local population
Developing (L2): Plan for how service user representatives will be involved in the design of cluster services and assets
Developing (L2): All members of cluster team trained in behaviour change techniques, including Making Every Contact Count
Developing (L2): All members of team trained in shared decision-making techniques and use Making Choices Together for a few prioritised conditions
Mature (L3): All new and redesigned local services and assets are developed through co-production with service user representatives and taking into account service user feedback
Mature (L3): Service users who make informed choices on all care and treatments
Mature (L3): IT systems that support shared decision-making are in place
Mature (L3): Digital options that enable service users to access care quickly and easily are commonplace
Mature (L3): Local cluster champions promote and support new initiatives

PCMW outcome 3: Support for well-being, prevention & self-care

The PCMW seeks to enhance support for well-being, prevention and self-care.

When people and carers are able to make decisions about their treatment, they are more likely to practise self-care and take responsibility for their health. There are a range of local resources available to promote self-care and self-referral, and technology can help with monitoring, self-care and communication.

Criteria for maturity assessment
Foundation (L1): Understanding of what services in the cluster and in the third sector promote well-being and self-care and what gaps exist
Foundation (L1): Understanding of options for cluster signposting and care navigation systems
Foundation (L1): Understanding of options for systems to systematically identify people in the local population who need support
Foundation (L1): Understanding of smart technologies that support self-care and self-monitoring
Developing (L2): Plan for how gaps in local services that promote well-being and self-care will be filled
Developing (L2): Plan for how signposting and navigation systems will direct service users to information and support for self-care
Developing (L2): Plan for how smart technologies that support self-monitoring and self-care will be adopted by the cluster
Mature (L3): Wide range of local resources that provide information, advice and support on well-being and self-care are available, and these are promoted through the cluster signposting/ navigation
Mature (L3): Smart technologies to support self-monitoring and self-care, especially for long-term conditions, are in widespread use

PCMW outcome 4: Local services

The PCMW acknowledges a preference to receive care closer to home and the need for making greater use of local assets.

Healthcare professionals can now refer to a greater range of services, which provide up-to-date information and advice on health and well-being. These local services must be easily accessible, easy to maintain and meet the needs of the community.

People will be able to talk to their health teams in a range of ways—by phone, email or video call—to help decide on the best treatment for them.

The model ensures that local health services are stable and can respond to future demands, while support from health boards can help vulnerable GP practices.

Criteria for maturity assessment
Foundation (L1): Understanding of community health and well-being requirements amongst cluster members based on local needs assessments
Foundation (L1): Understanding of existing cluster services and assets, including gaps
Developing (L2): Plan for addressing gaps in existing cluster services and assets, with priorities linked to health and wellbeing requirements of the cluster
Developing (L2): Understanding of potential methods and technologies enabling service users to access support and advice from healthcare teams
Mature (L3): Wide range of community services established for care and treatment, tailored to needs of the community and addressing access and health outcome inequalities
Mature (L3): Systems are in place to empower people with differing levels of health literacy and/or disability or impairment to access advice, care and treatment
Mature (L3): Range of methods is available for initial contact with health teams regarding support, advice and treatment (e.g. phone, email, video-call)
Mature (L3): Consistent arrangements are in place for signposting people to community resources
Mature (L3): Comprehensive, up-to-date directory of local services is available to all cluster members, consistent with information available through 111 platform and DEWIS Cymru
Mature (L3): Cluster services with direct access/ self-referral routes are promoted e.g. community pharmacy, optometry, audiology and physiotherapy services
Mature (L3): Cluster teams use national and local clinical audits and value-based healthcare approaches to drive up quality and improve outcomes for patients

PCMW outcome 5: Seamless working

The PCMW aims to enable seamless working.

When staff work across different departments, it increases efficiency and ensures the local community can access clinical, social and managerial expertise. Coordinated teams include professionals like pharmacists, physiotherapists, social workers, paramedics, physicians' associates, occupational therapists, mental health counsellors, dieticians, third sector workers and other local authority staff, who manage the everyday needs of the local population.

Coordinated teams break down barriers within local health and social care systems to promote seamless working and cultural change, which benefit the community.

Additionally, there are joint contracts, shared working spaces and learning sessions, and opportunities for professionals to rotate between different sectors. There are many models that promote collaborative working, such as federations and social enterprises.

Criteria for maturity assessment
Foundation (L1): Agreement of the vision, purpose and functions of the cluster amongst Cluster Stakeholder Board
Foundation (L1): Cluster Lead in post
Foundation (L1): Cluster governance framework with robust processes for cluster decision-making, risk management and accountability for all partner organisations
Developing (L2): Agreement on cluster operational model for multi-disciplinary team working
Developing (L2): Cluster workforce plan that is based on an assessment of population needs and cluster skills/ capacity requirements
Developing (L2): Primary care training placements for cluster staff across disciplines
Developing (L2): Cluster strategy that is shaped by cluster data and intelligence and that supports multi-professional team working
Developing (L2): Cluster recruitment/ sustainability plans agreed to ensure stability of primary care
Mature (L3): Cluster model that promotes a multidisciplinary approach and integrated care
Mature (L3): Contractual arrangements for cluster staff that ensure effective lines of accountability, robust indemnity and pension arrangements
Mature (L3): Promotion of cluster partnership working
Mature (L3): All cluster professionals are supported by appropriate training, clinical supervision and mentorship arrangements
Mature (L3): The services within the cluster, including GP practices, are stable, sustainable and employ a workforce trained in a cluster environment and multi-professional team working

Note: This outcome had been referred to as "MDT working" and "Effective cluster working" in earlier model descriptions.

PCMW outcome 6: Safe & effective call handling, signposting & triage

The PCMW aims to ensure people are directed to the right help at the right time.

Safe and effective telephone systems are designed to direct people to the most appropriate professional or service. Telephone advice is appropriate for many people's needs and, if given by a suitably experienced professional, it can safely and effectively reduce the number of face-to-face consultations. This telephone model, which assesses the urgency of the call, can direct people to the best service for them.

For example, the telephone system could direct people to:

- Clinical professionals, including optometric and dental professionals, who can manage eye, tooth and oral health problems; community pharmacists who can treat common ailments and deal with medication-related problems; and physiotherapists who can manage musculoskeletal problems;
- Local non-clinical services, when appropriate, with referrals assisted by link workers or teams that provide non-medical support.

Criteria for maturity assessment

Foundation (L1): Understanding amongst all cluster members of strengths and weaknesses of existing call-handling, signposting, clinical triage/ telephone first systems and processes used across all cluster members

Developing (L2): Agreement amongst cluster members on operational models for call-handling, signposting and clinical triage systems, based on best practice and including:

- Guidance and protocols
- Service user feedback systems
- Appropriate IT systems
- Appropriate training and refresher courses
- Processes for regular risk assessment and audit

Mature (L3): Safe and effective call-handling and triage systems in operation and enabling service users to access appropriate information, advice and care from both clinical and non-clinical services

Note: This outcome had been referred to as "First point-of-contact" in earlier model descriptions.

PCMW outcome 7: Quality out-of-hours care

The PCMW advocates quality care for people needing advice or treatment outside of usual hours.

The redesigned 111 service manages people with urgent needs in the out-of-hours period. Thanks to good communication systems, professional teams have access to up-to-date clinical records, which is essential so people receive appropriate care, especially those with complex conditions and/or at the end of life. Where appropriate, it is imperative that 111 and out-of-hours services are supported by the timely and contemporaneous notes from in-hours services.

The 111 service is supported by a national virtual directory of services and also signposts people to local services and sources of help at any time of the day. Since March 2022 this service is available pan-Wales and offers the NHS a wider opportunity to review patient flow and how patients access urgent care in a timely manner. Further information can be found at: https://www.111.wales.nhs.uk

Criteria for maturity assessment
Foundation (L1): Systematic patient feedback systems embedded in 111/ GP OOH services
Foundation (L1): Equitable access to emergency/ urgent dental treatment in line with national specification
Foundation (L1): Flexible workforce solutions that enable professionals to work and consult remotely
Foundation (L1): Flexible geographic boundaries to enable patients to access OOH primary care services locally, regardless of where they are registered
Foundation (L1): Establishment of consistent policies on management of e-consultations, base and home visits
Developing (L2): OOH advice and care delivered by multi-professional team across all core disciplines (e.g. pharmacists, nurses, doctors, paramedics)
Developing (L2): Access into timed slots for urgent primary care centres
Developing (L2): Script sign off between clinical teams in 111 & OOHs
Developing (L2): Standardised pathways for common issues requiring OOH care (e.g. management of blocked catheters, end of life care, crisis mental health response) across cluster
Mature (L3): Use of digital technology to improve patient experience and efficient service delivery
Mature (L3): OOH, 111 staff, pharmacists & other appropriate staff have access to relevant, integrated, up-to-date records through the Welsh Clinical Portal and/or Welsh Community Care Information System (WCCIS) or similar systems
Mature (L3): Specialist skills available during OOH period through regional working (e.g. mental health specialists)

Note: This outcome had been referred to as “Urgent care” in earlier model descriptions.

PCMW outcome 8: Directly accessed services

The PCMW advocates direct access for people to a wide range of community services.

People will be able to access a range of local health services that may include:

- Community pharmacists for advice and treatment for a range of common ailments;
- Optometrists for advice and treatment of routine and urgent eye problems;
- Dentists for toothache and oral health;
- Physiotherapists for musculoskeletal problems;
- Audiologists for hearing problems.

Not all of these services are available everywhere, but they will develop over time and local services will be responsible for communicating the local offer.

Criteria for maturity assessment
Foundation (L1): Direct access options are an integral part of engagement processes for cluster stakeholders (including local authority/ social care)
Foundation (L1): Direct access opportunities, including potential for co-location of services, are identified within cluster needs assessments and workforce plans
Foundation (L1): Routes to inform public of direct access services have been identified and public engagement strategy determined
Developing (L2): Services with greatest potential to benefit from direct access developments are prioritised within cluster plans and business cases
Developing (L2): Infrastructure requirements for high-quality direct access services (e.g. facilities, IT systems, equipment) are determined including co-location of complementary services where possible
Developing (L2): Direct access services are designed in accordance with best practice criteria and outcomes
Mature (L3): Direct access services are underpinned by financial mechanisms that ensure a whole system approach to strategic planning
Mature (L3): Cluster services with direct access/ self-referral routes to the full range of multi-professional staff are promoted e.g. community pharmacy, optometry, audiology and physiotherapy services
Mature (L3): Evaluations of direct access services inform workforce and infrastructure requirements at national level
Mature (L3): Direct access services in community settings are routinely monitored and evaluated, with specific measures in place to track patients as they move between services

Note: Direct access elements are integrated across other outcomes, notably: An informed public; Support for well-being, prevention & self-care; Local services; Safe & effective call-handling, signposting & triage; and Quality out-of-hours care.

PCMW outcome 9: Integrated care for people with multiple care needs

The PCMW aspires to provide integrated care for people with multiple care needs.

Effective working means GPs and advanced practitioners have more time to care for people with multiple needs, who are often elderly with more than one illness, at home or in the community. As a result, significantly longer consultation times are needed to assess, plan and coordinate anticipatory care.

People with both health and social care needs can be supported by uninterrupted care from community resource teams and other integrated local health and care teams.

Welfare, housing and employment problems can be better managed through a whole system, multi-professional approach. Coordinated teams are also well placed to care for acutely ill people who can be treated at home and at community centres. These community teams can also facilitate a faster discharge from hospital.

This seamless model offers a more proactive and preventative approach to care, and when people are treated earlier, they respond better to advice and support for self-care, which results in better outcomes and experiences for people and carers.

The model can potentially offer a wider range of planned care for the community, including outpatient appointments and treatments, and diagnostic tests. It could also reduce referrals and unplanned appointments, allowing hospital staff to focus resources on those who require hospital care and on planned specialist care.

Criteria for maturity assessment
Foundation (L1): Identification of people in the cluster with more complex needs
Foundation (L1): Understanding of the cluster's professional capacity and skills to deliver complex care
Developing (L2): Multi-professional teams that care for people with more complex needs are in operation
Developing (L2): Specialist care required by those of register of people with complex care needs is delivered closer to home
Mature (L3): CRTs, Frailty and Integrated Health and Care teams support complex care through a multi-professional team approach within primary care/ community settings
Mature (L3): Virtual wards and community hubs are used to care for acutely ill people, with hospital specialists working alongside cluster teams
Mature (L3): Increased range of planned care delivered within the community, with local access to specialist expertise and diagnostics

PCMW outcome 10: Cluster estates & facilities support multi-professional working

The PCMW aims to ensure that cluster estates & facilities support multi-professional working.

The Primary Care Model for Wales must be supported by an effective infrastructure designed for enhanced multi-professional working.

Criteria for maturity assessment
Foundation (L1): Understanding of the cluster estates and facilities requirements related to cluster working
Foundation (L1): Understanding of the cluster's current infrastructure related to community diagnostic services and prioritisation of development needs
Developing (L2): Plan for how the cluster will address deficiencies in infrastructure related to community diagnostic services, with significant deficiencies escalated with key stakeholders
Mature (L3): Cluster estates and facilities are fit for purpose, sustainable and support multi-professional working and training

Note: This outcome had been referred to as part of “infrastructure” and “How to support transformation” in earlier model descriptions.

PCMW outcome 11: Cluster IT systems enable cluster communications & data sharing

The PCMW aims to ensure that cluster IT systems enable communications and data sharing within the cluster.

Local health facilities and data systems must be flexible and responsive to future changes and support multi-professional working and telephone systems.

Criteria for maturity assessment
Foundation (L1): Understanding of the IT infrastructure requirements related to effective cluster working
Foundation (L1): Understanding of the cluster's current IT infrastructure and prioritisation of development needs
Developing (L2): Plan for how the cluster will address deficiencies in IT infrastructure, with significant deficiencies escalated with key stakeholders
Mature (L3): IT systems in place with secure designs that support and promote multi-professional cluster working

Note: This outcome had been referred to as part of “infrastructure” and “How to support transformation” in earlier model descriptions.

PCMW outcome 12: Ease of access to community diagnostics supporting high-quality care

The PCMW aims to ensure ease of access to community diagnostic services that support delivery of high-quality care.

People should be encouraged to use digital options to seek and receive care, while providing departments with direct access to services in the community that can deliver quality care closer to home.

Criteria for maturity assessment
Foundation (L1): Understanding of the infrastructure requirements related to effective cluster working within community diagnostic services
Foundation (L1): Understanding of the cluster's current infrastructure related to community diagnostic services and prioritisation of development needs
Developing (L2): Plan for how the cluster will address deficiencies in infrastructure related to community diagnostic services, with significant deficiencies escalated with key stakeholders
Mature (L3): Members of the cluster team have direct access to a range of community diagnostic services

Note: This outcome had been referred to as part of “infrastructure” and “How to support transformation” in earlier model descriptions.

PCMW outcome 13: Finance systems designed to drive whole-system transformative change

The PCMW aims to ensure that finance systems are designed to drive whole-system transformative change.

This involves plans to actively move services/ resources out of hospitals into the community, underpinned by financial systems that locate resources where service users need them.

Criteria for maturity assessment
Foundation (L1): Understanding of how to access advice/ support for financial decisions
Foundation (L1): Understanding of local systems and processes for developing a business case, with sources of expertise and support
Foundation (L1): Assurance that cluster budget management is compliant with Standing Financial Instructions and associated financial policies
Foundation (L1): Identification of key skills and expertise to affect transformational change
Developing (L2): Timely funding and recruitment processes for the effective engagement of staff and recruitment of high-quality professionals to new roles
Developing (L2): All Cluster Leadership Team members have developed financial skills to effectively engage in financial debate, discussion and challenge
Developing (L2): The Cluster Leadership Team is aware of funding opportunities outside usual cluster budget processes
Developing (L2): Effective financial planning for the cluster including regular monitoring of spend and robust management of plans throughout the year
Developing (L2): Time and resources are allocated for cluster project planning, delivery, monitoring and evaluation
Developing (L2): Business cases for projects should be drawn up (from the outset) and included in IMTPs to facilitate core health board funding that mainstreams successful initiatives
Mature (L3): Key skills and expertise are resourced to affect transformational change (including for shifting resources from secondary into community care and transitional costs identified)
Mature (L3): Process for prioritising cluster projects ahead of the planning year is in place, ensuring all decisions on spending priorities are reached collaboratively among stakeholders (including local authority/ social care)
Mature (L3): Financial regimes support longer-term planning and sustainability
Mature (L3): Cluster developments are integral to health board IMTP and other organisational planning mechanisms; and inform plans developed by Regional Partnership Boards

Note: This outcome was not formulated within earlier model descriptions.

Accelerated Cluster Development (ACD)

Cluster development framework: Module 2

May 2022
Version 1

2.1 About Accelerated Cluster Development

2.1.1 Introduction and origins

Accelerated Cluster Development (ACD) arose in response to a **cluster survey** conducted in December 2020 and **reflective thinking** by cluster leads to address three principle **improvement objectives**:

Autonomy	• Legal status • Independent capacity and capability • Long-term funding • Separation between GMS, GP contracts and cluster work
Coherence	• Core similarities • Learning and sharing • Branding
Engagement	• Providing rapid practical advice • Clusters able to advocate for patients • More collaborations • Being sought out by new partners

ACD is seen as key to:

- Fully embedding the Primary Care Model for Wales
- Providing “care closer to home”
- Organising primary care to support delivery of place-based care
- Enabling a focus on population health and well-being.

ACD aspires to deliver:

- Enhanced **integration**
- More services **closer to home**
- Improved **multi-professional** working
- More effective primary and community **voice**
- Better care **based upon need**
- **Sustainable** cluster working
- **Empowered** clusters leading to **better care** for patients.

The aspiration of ACD is captured by the following seven outcomes:

ACD outcome 1
Enhanced integrated planning between clusters, health boards & local authorities

ACD outcome 2
Wider range of services delivered across a cluster, meeting population priorities and need, closer to home

ACD outcome 3
More effective leaders across the primary care system, collaboratives and clusters

ACD outcome 4
Improved equity of cluster care service provision based upon local need

ACD outcome 5
Improved multi-professional & multi-agency services delivered

ACD outcome 6
Effective, efficient and long term sustainable cluster workforce and services

ACD outcome 7
Empowered clusters with increased autonomy, flexibility and vision

2.1.2 Key ACD implementation structures and relationships

ACD sets out distinct roles for **pan-cluster planning groups** (PCPGs), professional collaboratives, and clusters. PCPGs:

- Are charged with meeting cluster population health need through effective and robust planning and service delivery
- Operate at county level to commission a suite of multi-agency integrated services
- Are strongly linked to regional partnership boards (RPBs)
- Comprise members representing collaborative cluster leads; senior social services leadership; local NHS leadership; third sector partners; local public health; allied health professionals; nursing; community health council; mental health; and secondary care.

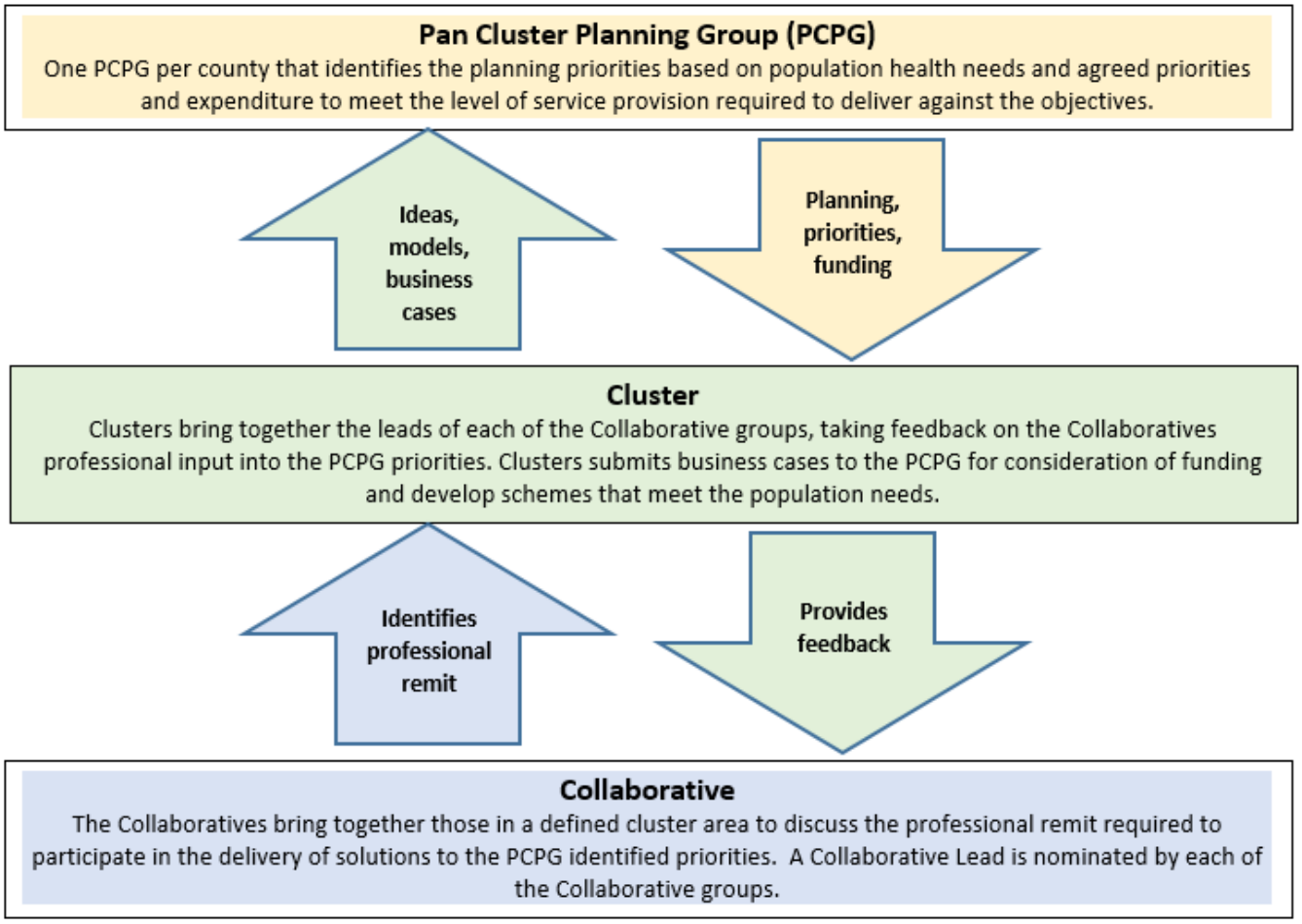
Professional collaboratives provide cluster-level professional input into PCPGs and comprise:

- Pharmacy collaborative
- Optometry collaborative
- General practice collaborative
- Dental collaborative
- Other collaboratives based upon professional issues e.g. community nursing; allied health professionals; and social care.

Primary care **clusters** provide delivery of:

- PCPG-commissioned services at cluster level (or via more than one cluster together)
- Multi-professional, multi-agency integrated primary and community health, social and third sector services.

Depicted visually, these structures interrelate as follows:



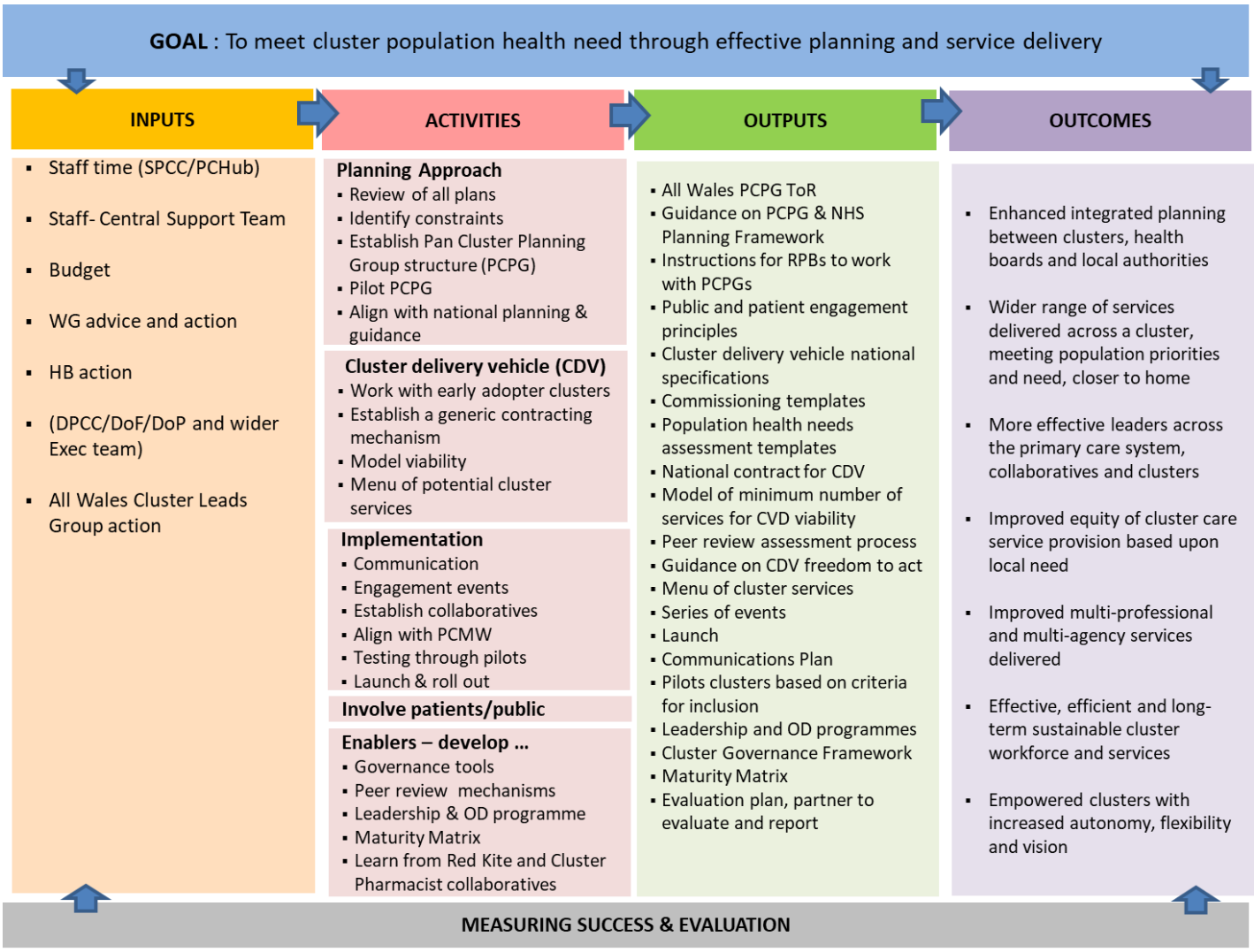
2.1.3 Anticipated ACD implementation benefits

The overarching aim of ACD is to meet cluster population health need through effective and robust planning and service delivery. Benefits have been articulated for key stakeholders as follows:

For people/ communities	• Needs recognized and advocated for • Better access to new services, delivered rapidly • Services delivered closer to home • Less of a postcode lottery within a county area
For local service providers	• Clarity over what is to be delivered by practice • Flexibility to be part of cluster delivery • Commitment to local collaborations between ICs • Less unnecessary bureaucracy
For clusters (planning)	• Significantly enhanced profile with multi-agency partners • Ability to influence key partners • Access to mainstream resourcing and its deployment • Localising a raft of national/ health board priorities (National Clinical Framework) • Pushing enhanced quality provision with teeth • Clarity of purpose
For clusters (delivery)	• Clarity of services to be delivered and purpose • Light-touch scrutiny from health boards • Autonomy to deliver against service commissioned • Ability to draw key local players in together • Financial clarity and flexibility over multiple years • Outcomes driven • Real focus on harnessing and involving local resources
For planning at a local authority level	• Clear involvement of multi-professional cluster leads • Ability to have a local/ county suite of priorities • Focus on what matters most to population • Ability to have a consistent approach/ set of services
For health boards/ regional partnership boards	• Clusters become mainstream and key patient advocates • Ability to have full sight of impact of resource decisions • Set overarching principles and see flow to and from cluster level • Improved quality of health and well-being assessments

2.1.4 ACD logic model

A logic model has been developed for the ACD programme as a whole (not for each outcome individually).



For more information on ACD, see the **ACD Toolkit**.

2.2 Framework for Accelerated Cluster Development

Maturity levels have not been identified for indicating progress towards attainment of ACD outcomes.

ACD outcome 1: Enhanced integrated planning between clusters, health boards & local authorities

Criteria for determining success of local implementation

- New mechanisms mandating integrated planning mean PCPG access to collective intelligence on local needs and solutions to meet them
- Planning will be more effective and efficient via utilisation of pooled planning resources
- Planning will feel less onerous for PCPGs with pooled planning resources
- Shifting planning responsibilities away from clusters frees them to focus on delivery of quality care

ACD outcome 2: Wider range of services delivered across a cluster, meeting population priorities and need, closer to home

Criteria for determining success of local implementation

- Economies of scale on PCPG footprints strengthen the business case for expanded provision of health and well-being services closer to home
- Decision making around priorities will reflect a broader consensus on what services or actions will have the greatest impact on local health status
- Clusters are enabled to offer more choices around local services to people at or near to home, without having to directly commission or provide them
- Clusters retain influence (through community engagement and professional collaboratives) over the description of local needs and thus still inform priorities for service redesign to meet them

ACD outcome 3: More effective leaders across the primary care system, collaboratives and clusters

Criteria for determining success of local implementation

- Clearly-defined roles and responsibilities will be underpinned by a bespoke leadership development programme and authority to act
- Well-informed system leaders with the autonomy to act will be supported by a cast of experts inputting diverse local knowledge, skills and experience
- Cluster leads will no longer have to grapple with the competing demands of planning and delivery, free to refocus on what matters most—delivering high quality care

ACD outcome 4: Improved equity of cluster care service provision based upon local need

Criteria for determining success of local implementation

- PCPGs are required to demonstrate consideration of the equity impacts of commissioning arrangements, ensuring services deliver both universal improvements in access and outcomes, and make progressive adjustments for those with greater needs, by design
- Clusters can have confidence that needs-informed PCPG-commissioned services are configured to redress health inequities, supporting the multi-professional team to concentrate on getting the right care, to the right people, at the right time

ACD outcome 5: Improved multi-professional & multi-agency services delivered

Criteria for determining success of local implementation

- PCPG footprints allow for cost-effective provision of diverse multi-professional/ multi-agency services, offering people more choice and clinicians broader therapeutic options
- Closer working across professions and agencies will allow clusters to meet holistic care needs, while simultaneously enriching the work environment via diversification of perspective and expertise

ACD outcome 6: Effective, efficient and long term sustainable cluster workforce and services

Criteria for determining success of local implementation

- Differentiation of planning and delivery responsibilities allows all roles to fully engage in what only they do best, in keeping with prudent healthcare principles and improving skilled workforce retention
- Differentiation of planning and delivery responsibilities allows all roles to fully engage in what only they do best, enhancing job satisfaction and enthusiasm for making changes that deliver what matters most to staff, patients, people and communities

ACD outcome 7: Empowered clusters with increased autonomy, flexibility and vision

Criteria for determining success of local implementation

- PCPGs will determine shared priorities with greater implementation consistency across the locality for maximal population impact, while simultaneously avoiding barriers to clusters making pragmatic adaptions to flex them for better fit to hyper-local circumstances
- With accountability for planning transferred to PCPGs, clusters are empowered to decide how plans are best implemented in the local context, making bespoke tweaks to ensure consistency with the local vision for meeting neighbourhood care needs