Strategic Programme for Primary Care
Strategic Programme for Primary Care Fund 2022 (SPPC Fund)

Section 1 – Overview

Health Board	**Betsi Cadwaladr UHB**
SPPC Fund allocation	**£840,000.00**
Number of projects to be funded	3

Section 2 – Projects to be funded

Project 1

SPPC Fund alignment 2022	ACD Programme	~~Obesity~~	~~Other~~
Project title	**Embedding and Maturing Accelerated Clusters across North Wales**		
Budget for this project			

Description	Full Yr Cost (£)	Funding Required*
3 WTE Planning Officers (Band 8a)	£200,988	**£184,239** *(11-month effect)*
3 WTE Project Managers (Band 6)	£146,415	**£134,213** *(11-month effect)*
3 WTE Administration/ business support (Band 3)	£80,082	**£73,408** *(11-month effect)*
Non-pay costs (IT, travel etc.)	£15,000	**£15,000**
Capacity Building & Development Fund: Development of primary care contractor leads; PCPG OD work; and delivery arm progression	£187,564	£187,564
TOTAL (£):	£630,049	**£594,424**

| Short project description | It is recognised that partners will require additional support and resources to help them move forward with the ACD agenda, and implement Pan Cluster Planning Groups, and ensure the appropriate governance, leadership and systems are in place to provide a platform for integrated place-based working.

It is anticipated that there will be 6 PCPGs across North Wales, and that they will be coterminous with Local Authority/ County boundaries. The proposal seeks to recruit additional posts, as outlined above. Appointments will work on a health community footprint, and therefore will each post holder will work across two PCPGs.

Whilst recruited by the Health Board, these posts shall work for, and be accountable to the partnership. As such, they shall be as much a resource for local authorities/ social care, as they are for primary care and the Health Board. Senior |
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	Planning support will be provided through existing resources within the Health Board's Corporate Planning Team.
	These additional roles, working in partnership with existing teams and professionals across the partnership, will lead on the development and implementation of the PCPGs as well as support the transition from cluster working, to integrated place-based working. As such they will support partners to: ▪ develop an integrated partnership approach ▪ analyse and determine population need and spend, ▪ develop, commission and deliver services to meet population need. It is proposed that a 'Capacity Building & Development Fund' will be established, with funding allocated per PCPG in order to: ▪ Support the involvement of other primary care contractor leads, including optometry, dentistry and pharmacy. This will ensure the required programme pace. ▪ Support Operational Delivery and training, inducing facilitated sessions, aimed at support the development of PCPGs ▪ Explore and develop a joint understanding of alternative models of integrated delivery, including CICs; as well as consolidating progress and learning to date across a number of clusters.
Key objectives of this project	The key objectives of this project are to: ▪ Secure membership to the Groups and implement the agreed Terms of Reference ▪ Fund capacity for primary care contractor leads in order to support their involvement in the initiative ▪ Ensure that the needs of people and place are captured, understood and translated into high-level Pan-Cluster Plans, and integrated into the wider partnership plans, including the PSB well-being plan, Health Board's IMTP, and Local Authority Commissioning Plans. ▪ Ensure Pan-Cluster Planning Groups deliver against the requirements of the SPPC ▪ Ensure all projects and initiatives are delivered on time and within budget ▪ Support system leaders involved in Pan-Cluster Planning groups to work through the place-based roadmap and associated toolkits ▪ Support system leaders in the operational delivery of place-based budgets within their respective areas/ localities ▪ Support senior managers and directors to promote systems trust within localities/ clusters ▪ Consolidating progress and learning to date across a number of clusters, explore and develop a joint understanding of alternative delivery models for integrated delivery.
Start date	1st April 2022	Expected End date	31st March 2023
How will you monitor and evaluate this project?	The implementation of 'Pan Cluster Planning Groups' will be monitored through BCUHB's Executive Board, as well as through the Regional Partnership Board structure, with Quarterly progress reports submitted to both. This will allow

	issues to be escalated and barriers unblocked, where necessary. The effectiveness of 'Pan Cluster Planning Groups' will be monitored through the development of effective integrated cluster/ locality plans, and the effectiveness of those plans in meeting the needs of local people and communities.
	Work to develop and mature Accelerated Clusters, including the completion of the place-based roadmap will be achieved by the Pan-Cluster Planning Group, with progress fed-up in to the relevant Area Integrated Services Boards. Contained within the roadmap is an evaluation framework template, which is designed to help partners monitor the success (or otherwise) of the place-based partnership, and will be used to support reporting up through the relevant governance channels.
Describe how this project differs to what is already in place locally or what has been tested elsewhere?	This project responds to the requirement to develop a new governance system for the strategic management of Cluster/ locality planning; as such it is a new project for the region, which will require careful management to ensure it delivers.
	The project builds upon, and will support the further implementation of place-based integrated models of care and support, developed as part of the North Wales Community Services Transformation programme. The work also builds upon the existing pan-organisational relationships that have developed and matured over the past 5-10 years, and formalise them and the vision they are seeking to achieve, into signed Partnership Agreements, Pooled Budget Arrangements, and Risk-Share Agreements. The toolkit is new to partners and aims to strengthen place-based partnerships and the pooling of budgets at place, and so will require support to ensure they are developed and implemented appropriately.

Project 2

SPPC Fund alignment 2022	ACD Programme	~~Obesity~~	~~Other~~
Project title	**Developing a (digital) systems approach to population health management**		
Budget for this project			

Description	Full Yr Cost (£)	Funding Required*
1 WTE Data Scientists (Band 8a)	£66,966	**£61,386** *(11 month effect)*
1 WTE Project/ Business Lead (Band 8b)	£80,638	**£73,918** *(11 month effect)*
Non Pay costs (IT, travel etc)	£3,300	**£3,300**
TOTAL (£):	**£150,904**	**£138,604**

Short project description	Population health management involves using analytics to better understand the specific needs of parts of the population. Whilst there is a plethora of Needs Assessments undertaken and used by partners, these are often unconnected, and often lack sufficient data at a community/ cluster-level in order to properly inform place-based resource allocation, commissioning, and service development.
	This proposal seeks to work with partners across primary care, community health, social care and public health, to agree the types of population data that is needed to support effective Cluster planning. Where that data is nor currently being collected, or is not collected within the appropriate timescales, mechanisms will be developed to support its collection.
	Once the range of metrics have been agreed upon, and mechanisms put in place to collect/ collate the data, an integrated Needs Assessment Data Dashboard will be developed to allow partners to 'pull-off' and analyse relevant data, with ease.
	Finally, this integrated data dashboard, when developed, will be able to be used by Pan-Cluster Planning groups to update and refresh cluster/ locality pen profiles.
Key objectives of this project	The key objectives of this project are to: ▪ Design and develop an integrated locality/ cluster strategic needs assessment dashboard, to support ongoing Cluster planning ▪ Agree how this function will be embedded within core delivery ▪ Agree a series of outcomes focused metrics to measure and evaluate performance ▪ Enable partners to track changes and trends in population need and use this information to help measure the impact of service changes.

Start date	1st April 2022	Expected End date	31st March 2023

How will you monitor and evaluate this project?	Progress will be monitored on an on-going basis through the Health Board's Corporate planning team, with regular reports fed-into Clusters and Area Integrated Service Boards.
	Milestones and key deliverables will be agreed at the commencement of the project, which the Project/ Business Lead, shall be responsible for maintaining.

	Quarterly reports will also be fed-into the Health Board's Executive Board in order to ensure the appropriate corporate oversight is maintained.
Describe how this project differs to what is already in place locally or what has been tested elsewhere?	This project builds on the development of locality needs assessments, undertaken as part of the Community Services Transformation Programme, and will serve to strengthen this approach, and allow for the collection and systematisation of locality/ cluster data. The proposed approach draws on the successful Joint Strategic Needs Assessments undertaken in England, and in particular the planning dashboards used by partners to track trends in population need (see Cheshire West example)

Project 3

SPPC Fund alignment 2022	ACD Programme	Obesity	Other
Project title	**Development of a digital program to enable virtual group pathways for people living with Type 2 diabetes who are able to use weight loss as a treatment for their diabetes**		
Budget for this project	**Total: £106,972** ***Costs*** Estimated tender requirement for this proposal is £15,000 To staff the pathways to underpin and deliver the work: Diabetes Specialist Dietitian - 0.4wte Band 6: £18,790 Nurse Consultant 0.1wte Band 8C: £8,679 Diabetes Specialist Nurse/Nurse Practitioner 0.4 band 7: £22,283 Dietetic Assistant - 1wte band 3/4: £30,674 Admin - 0.5wte band 2: £11,546 Total staffing: 91,972		
Short project description	There is no Very Low Calorie Diet (VLCD) service offer within the obesity pathway in BCUHB for people with Type 2 diabetes mellitus (T2DM) of a long duration. Many people with diabetes would be disadvantaged by being unable to access supported interventions because they have had their T2DM for longer than 6 years which meets typical existing programs, and / or if they prefer remote delivery of services. Building upon the experience in Primary Care diabetes practice over the last 12 months, using a supported 'virtual' VLCD for ANY person with Type 2 diabetes of ANY duration, we have illustrated how this intervention has significant benefit: it is more inclusive, and offers a real opportunity to enable substantial health benefits for more of our population. Specifically: the local study comprising 25 patients completed the 8-week program and had data available at 6-months. Comparing baseline to 6-month data there was a mean reduction in HbA1c of 11.1mmol/mol (68.6 vs. 57.5mmol/mol, $p<0.05$), **resulting from a reduction in**		

	weight of 11.5kg (105.0 vs. 93.5kg, p<0.05), a reduction in BMI of 4.1kg/m2 (36.5 vs. 32.4kg/m2, p<0.05) and a reduction in monthly drug costs of £40.01 (£60.65 vs. £20.64, p<0.005). As noted, the local pilot showed that alongside significant reductions in body weight and HbA1C, there was an average medication cost saving of £40 per month per person. Once developed alongside our existing pathway developments, it is anticipated that in time, the proposed program would facilitate the delivery of a minimum 60 patients per week (~2500 per year). This equates to a short-term cost saving of £100k for just a single month of medication reduction: recurrent and greater savings are inevitable. We use this SPPC opportunity with the aim of securing investment to support the development and operation of an on-line learning space that enables ease of access, and optimal teaching support, plus facilities for people with diabetes who wish to lose weight using VLCD (initially, plus further development thereafter) to improve their long term health outcomes.
Key objectives of this project	1. Appoint via tender a third-party company to develop and maintain a digital program which: - Provides an on-line, easily accessible learning space (such as WordPress website / Canvas, Moodle / Blackboard) - Enables a mix of delivery methods and resources to be used on demand - Track who is accessing the training and completing assessments - Be scaled up and spread once the program has been developed and quality assured - And comes with technical support 2. Appoint staff to facilitate development, pilot delivery and evaluation. 3. Evaluate outcomes

Start date	April 2022	Expected End date	March 2023
How will you monitor and evaluate this project?	The goals of this program are to demonstrate: - That using digital innovation, an on-line training space can facilitate the delivery of VLCD in the primary care setting, and that it: - Can be integrated into the existing Type 2 diabetes pathway for North Wales - Can enable the successful weight loss treatment for Type 2 diabetes regardless of the duration of the condition. - Can be facilitated by non-specialist practitioners with clinical oversight for dietetic review and prescribing changes using a validated de-prescribing algorithm built in to the space - Can be cost effective compared to other traditional pharmaceutical approaches - Can further demonstrate value based healthcare for people to access BEFORE they require referral to specialist services, and:		

	- Can enhance the primary care service offer for planned diabetes care. Investing in this opportunity for people who have lived with Type 2 diabetes for a long time and / or struggle to access learning opportunities. Measures and reporting pre- and post-implementation will include use of validated tools: 1) Full dietetic assessment at baseline 2) HbA1c, Weight, Blood Pressure, Lipid Profile 3) Drug history 4) Measures of well-being / Acceptability of the virtual format & content
Describe how this project differs to what is already in place locally or what has been tested elsewhere?	There are no virtual platforms to offer this approach to support weight management as treatment for people living with Type 2 Diabetes. This will be a new, high value innovation to help improve access for these individuals with a long-standing diagnosis, with the potential for considerable, far-reaching health and quality of life outcomes. There are work-streams in place to offer VLCD in 3 National projects, but access is restricted to a duration of diabetes of 6 years or less. As noted above, local projects (in both a high risk hospital-based diabetes service with face to face support, and via a general practice setting using a virtual approach) have seen successful outcomes that indicate any person with a long duration of diabetes OR with complex diabetes, can benefit from supported weight loss through VLCD as an effective treatment. In addition, we saw a good level of engagement with the virtual approach to offer the VLCD in the small Primary Care VLCCD program.