Annex 2

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

GP Fellowship Scheme

Primary and Community Services Delivery Unit

Abertawe Bro Morgannwg Health Board

About the GP Fellowship Scheme

- Are you a committed, enthusiastic GP interested in a secure, well paid and stimulating post, but not quite ready for that partnership role?
- Do you want to spend a period of time gaining experience and confidence, to feel you are genuinely respected as an essential member of the wider team before committing long term?
- Are you particular about wanting to balance family and personal life and other interests with hard work?

Then why don't you apply to become part of our innovative GP Fellowship Scheme? Joining the Scheme will give you the opportunity to do all these; working flexible sessions in General Practice, experiencing different models of care while gaining invaluable skills and confidence.

We are looking to appoint 7 or more GPs, who will each work regular sessions in a local GP practice (or practices) receiving independent mentoring, guidance and support from named GP partners, ABMU Health Board managers and established salaried GPs within the Neath Port Talbot GP cluster Networks .

What can we offer?

Abertawe Bro Morgannwg University Health Board can offer:

- Competitive Salary (a flexible package depending on experience): £55,965 - £84,453 p.a. pro rata
- Flexible hours (part-time, full-time, job-share and sessional contracts)
- Welsh pool risk (indemnity) included in the package
- Substantial financial incentives from the GP Cluster Networks for 1-2 year commitments
- Placements can be short or medium term
- Potential for academic and research opportunities linked to Swansea University
- Potential to develop special interests
- Personal and professional development opportunities
- Contract with favourable terms and conditions including paid annual leave, study leave, sickness absence in line with NHS Agenda for change.

If you would like more information about the scheme, please visit www. ..... Or contact:

Hilary Dover
Director Primary and Community Services,
Block A,
Neath Port Talbot Hospital
Baglan Way,
SA12 7BX
[redacted]

Dr Mark Goodwin
Afan Cluster Network Lead GP (NPT Primary Care Executive Group),
Afan Valley Group Practice
Waun Avenue, Port Talbot
SA13 3DP
[redacted]

Participating GP Cluster Practices

Afan GP Cluster

The Cluster comprises 9 GP practices spanning urban and rural areas. 6 of the 9 cluster practices are participating in the GP Fellowship Scheme

Cwmafan Health Centre Practices

Cwmafan Health Centre houses two very well established GP practices. Cwmafan is a large village and community in the Afan valley in Wales, and is within the Neath Port Talbot County Borough Council area.

Cwmafan Health Centre (Dr Basir)

Cwmafan Health Centre, Y Ganolfan Iechyd, Penllyn Estate, Cwmafan, Port Talbot, SA12 9PY.

Contacts:
Partner: Dr Roya Basir - [redacted]
Practice Manager: Linda Davies - [redacted]

Telephone No: [redacted]
List size: 3370

Number of GP sessions required: 6 sessions per week

We are a small, friendly, well organised GMS practice in a semi rural setting with a pleasant village atmosphere. We are 1 mile from M4 junction and have excellent transport links to Swansea (10 miles) and Cardiff (30 miles). We occupy a Health Authority purpose built building and have a high score for

- Patient Satisfaction
- QoF
- Child Immunisations and
- Flu Vaccines

We use INPS (Vision) Clinical System.

Cwmafan Health Centre (Dr Penney)

Cwmafan Health Centre, Y Ganolfan Iechyd, Penllyn Estate, Cwmafan, Port Talbot, SA12 9PY.

Contacts:
Partner: Dr Richard Penney – [redacted]
Practice Manager: Amanda Penney – [redacted]

Telephone No: [redacted]
List size: 2242

***Number of GP sessions required*:** 40 sessions per annum (holiday cover)

Dr Penney's Practice at Cwmavon Health Centre is a suburban/rural practice with a registered practice population of 2242 patients. The GP partner works with 2 part time practice nurses, a part time practice

manager and 3 part time receptionists.

We are a small practice and endeavour to combine up to date evidence based health care with personal knowledge and continuity of care. Dr Penney has had 21 years of experience of working in this practice and consequently we know many of the patients and families very well.

We have seen many changes in the way primary care operates and have adapted to these changes.

Port Talbot Resource Centre Practices

Port Talbot Resource Centre is one of the largest of its kind in the UK and is one of the first projects in Wales to achieve integration between primary and community NHS services. 4 GP practices (King's Surgery, Fairfield medical Centre, Rosedale medical Centre and Riverside Surgery) are located at the centre. The centre also has a community pharmacy (Lloyds Pharmacy), a Dental Teaching Unit and a wide range of ABMU community and therapy services. Integrated health and social care teams are also housed at the site. The centre is frequented by voluntary sector organisations which provide advice and information sessions to patients.

Two of the 4 GP practices are participating in the GP Fellowship Scheme

Riverside Surgery

Ground Floor, Port Talbot Resource Centre, Moor Road, Port Talbot, SA12 7BJ

Contacts:
Partner: Dr Ian Coombs – [redacted]
Practice Manager: Rachel Griffiths – [redacted]

Telephone No: [redacted]
List size: 9200
Training Practice

Number of Partners: 5 (2 full time, 2 part time); 1 part time salaried GP

***Number of GP sessions required*:** 8 sessions per week

Riverside Surgery is an urban training practice situated in the state of the arts Port Talbot Resource Centre. Partner interests include, diabetes, contraception, female health, safeguarding of children and respiratory disease. Our practice nurses have qualifications in cardiovascular and respiratory medicine.

Relationships between the partners and the other members of the staff team are excellent. Our practice team consists of 16 experienced, motivated staff and our staff turnover is low. Community nurses, health visitors and social services are also located in the resource centre making for positive relationships and ease of communication.

Fairfield Medical Centre

1st Floor, Port Talbot Resource Centre, Moor Rd, Port Talbot SA12 7BJ

Contacts:
Partner: Dr Jeffrey Hocking – [redacted]
Practice Manager: Clare Boland – [redacted]
Telephone No: [redacted]
List size: 9000
Number of Partners: 3 GPs

Number of GP sessions required: 16 sessions per week

Fairfield Medical Centre is in brand new, well equipped premises, with an experienced and supportive administrative team and clinical team made up of nurses, paramedics, HCSW's and a sessional pharmacist.

We are flexible on how you want to run your clinics, whether it's straight appointments, just triage or a mixture of both. We love our IT and are constantly reviewing and updating how we evolve our systems to make us as efficient as possible.

We are located right next to the M4, in a purpose built resource centre where primary; secondary and community services are brought together under one roof.
Some of the services here are MCAS, Physiotherapy, Audiology, Dental, there is even a free legal clinic.

The practice has excellent facilities for both staff and patients, including a gym on site.

Mount Surgery

Margam Rd, Port Talbot SA13 2BN

Contacts:
Partner: Dr Viola Magdon [redacted]
Dr Shanthi Jambulingam
[redacted]
Practice Manager: Julie Tobin [redacted]
Business Manager: Paul Carmichael [redacted]

Telephone No: [redacted]
List size: 10,574

Number of Partners: 5

Training practice

Number of GP sessions required: 6 sessions per week

Mount Surgery is an urban GP practice with 5 GPs who have special interests in minor surgery, diabetes and respiratory disease. The practice has a good skills mix employing 2 practice nurses and 1 Health Care Support worker who run chronic disease clinics, smear clinics, treatment room duties etc.

As a training practice, Mount Surgery takes on Students from Swansea University, providing community based learning including and physicians assistants.

The practice serves the population of Port Talbot, South Wales. Our practice area covers approximately the SA12 & SA13 postcode areas of Port Talbot,

Margam, Taibach, Goytre, Sandfields and Aberavon.

Our practice population of 10500+ patients are able to access general medical services from our highly trained and professional medical staff. Our practice is:

- A high QoF achiever
- Paper-light
- Uses Vision
- Has excellent nursing and admin support and exceptional staff retention

We occupy a modern, purpose built premises. We also have a full complement of ABMU Health Board employed health visitors available from the surgery.

Cymmer Health Centre

Station Road, Cymmer, Neath Port Talbot, SA13 3EF

Contacts:
Partner: Dr Jeremy Drury (salaried GP) [redacted]
Practice Manager: Zara Sheppard [redacted]

Telephone No: [redacted]
List size: 2517

Number of Partners: 1 salaried GP & 1 long term locum

Number of GP sessions required: 60 sessions per annum (holiday cover)

Cymmer Health Centre is a health board run practice situated in the Afan Valley. We serve a rural community and have a close working relationship with other practices in area.

We have a very friendly, enthusiastic and professional team which includes 2 GP's, a practice nurse and a health care support worker and of course let us not forget the admin staff who keep the practice ticking over.

We are also in the fortunate position of having the health visitors and district nursing teams based in the same building which allows us the opportunity to work very closely and efficiently with these valuable members of the service.

Neath GP Cluster

Neath GP Cluster is made up of 8 GP practices covering a total GP population of about 55,000 patients. The practices cater to the health needs of a largely urban population.

1 GP practice in the Neath cluster is participating in the scheme.

Victoria Gardens Surgery

Victoria Gardens, Neath, SA11 1HW

Contacts
Partner: Dr Catherine Bowen [redacted]
Practice Manager: Mrs Andrea Edwards [redacted]

Telephone Nos: [redacted]
Fax: [redacted]
List size: 8200
Training practice: (2 GP trainers)

Number of GP sessions required: Up to 8 sessions per week

Victoria Gardens Surgery is well established stable practice with a a good skill mix and low turnover of nursing and clerical staff. As a practice we are friendly, supportive, forward thinking, enthusiastic and we aspire to improve services for patients and welcome new ideas. With affordable local property, we can offer an excellent work/life balance and standard of living.

The practice GPs have a diverse range of interests including joint injections, minor surgery, contraceptive services such as coil, Implanon fitting, Depoprovera etc.

The practice is situated in Neath town centre, close to local amenities, with easy access to the M4, direct train to London, just 40 minutes from Cardiff, close to the beaches of the Gower Peninsula and Brecon Beacons National Park.

The practice:

- Is Family friendly, offering flexible start/finish times within core GMS hours
- A Training practice with 2 GP trainer
- Is a High QOF achiever offering a range of enhanced services
- Occupies a purpose built surgery with low overheads
- Uses a Paper Light Vision system, with DocMan

Waterside Medical Practice

Brunel Way, Briton Ferry, Neath SA11 2FP
Contacts:
Partner: Dr Paul Williams [redacted]
Practice Manager: Katie Harris [redacted]

Telephone No: [redacted]
List size: 5720

Number of Partners: 3

Number of GP sessions required: 4 sessions per week

Waterside Medical Practice has an innovative, positive, forward thinking ethos and are continually adapting to the changing needs in Primary Care. We operate a triage system and have a flexible approach to work hours at the practice and have a remote access environment to allow extra flexibility. We strive towards achieving the optimum work life balance and are always willing to trial new ways of working.

We moved to new purpose built premises in November 2015 and have excellent consulting rooms and admin rooms at the practice.

Vision clinical system and paper light surgery using docman

High QOF achievers and offer a wide variety of enhanced services along with nurse led chronic disease management.

We have a diverse workforce including minor illness specialists, pharmacists and musculoskeletal practitioners and are always looking for alternative skills to improve the practice team. We have an excellent admin team of 10 and HCA and practice nurse who are great support to the practice team.

We have district nurses and health visitors based at the practice and there are midwife led clinics.

Waterside is part of a group of practices and has the option of rotating around the other two practices in the area of Neath, Briton Ferry and Port Talbot.

Upper Valleys GP Cluster

Upper Valleys GP Cluster consists of 4 GP practices which look after about 30,000 registered patients. 2 out of the 4 practices are participating in the GP Fellowship Scheme.

Dulais Valley Primary Care Centre

Dulais Road, Neath SA10 9EY

Contacts:

Partner: Dr Rebecca Jones

[redacted]

Practice Manager: Simon Boden-Tebbutt [redacted]

[redacted]

Telephone No: [redacted]

List size: 6040

Number of Partners: 2

Number of GP sessions required: 6 sessions per week

The Practice is semi rural where all patients and families are known to the clinical staff. A full feel for the area and community can be seen in the film "Pride".

We have an innovative and open to change approach. Our aim is to provide a service that furthers the well being and long term sustainability of the community in which we live and work. We strive to achieve wellness through health and related services.

A full GP led triage system is operated. There is a friendly supportive clinical team of Advanced Nurse Practitioner, Practice Nurses, HCA and Pharmacist.

We operate in a modern purpose built premises (2008) with excellent facilities.

High QOF achievers and we have district nurses and health visitors based at the practice. There are clinics for ante natal, podiatry, diabetic retinopathy screening, physiotherapy and aneurism screening.

We offer a wide variety of enhanced services along with nurse led chronic disease clinics.

- Well established and stable administration team.
- Close links and working relationship with the local community.
- Vision clinical system and paper light surgery using docman.
- Opportunities to develop new skills.

Pontardawe Health Centre

Alloy Industrial Estate, Pontardawe, Swansea SA8 4JU

Contacts:
Partner: Pat Wong [redacted]
Practice Manager: Steffan Gimblett [redacted]

Telephone No: [redacted]
List size: 12,000

Number of Partners: 3

Number of GP sessions required: 8 sessions per week

Pontardawe Primary Care Centre is located in a semi rural village on the outskirts of Swansea, but only 10 minutes from the M4. We serve a population of 12,000 patients from our purpose built modern primary care centre which also houses the district nursing team, health visitors and flying start teams, paediatric dentist, the national exercise referral team and counselling services to name but a few.

The experienced clinical team which also includes two nurse practitioners and will shortly be complimented by a prescribing pharmacist operates a hybrid triage appointment system. A signposting triage protocol has been developed to allocate patients to the most appropriate clinician / service based on their symptoms, be it GP appointment or a telephone triage call, pre booked nurse practitioner appointment, or referral to the local pharmacist for minor ailment clinic.

We aim to provide a seamless service to our patients which in turn ensures they are allocated to the most appropriate service, allowing our clinicians to consult with patients who should be seen in primary care.

We have a fully functional treatment room team running chronic disease clinics to include pre diabetes care and diabetic annual review clinics.

We also run minor surgery and joint injection clinics from our newly refurbished minor ops suite. We also accept referrals from other practices. We are active in most other Enhanced Services and hope to surpass this year's prescribing targets with the introduction of the prescribing pharmacist to ensure income levels are sustained and healthy.

Our GP team gets together every lunch time after morning surgery which is a great opportunity for the clinical team to interact with each other. We are a friendly and inclusive practice and the recruitment of an additional doctor to the team would allow us the flexibility to work towards our aim of becoming a training practice."

Annex 3

SALARIED GENERAL PRACTITIONER: PRACTICE SUPPORT TEAM

Abertawe Bro Morgannwg University Health Board

Primary Care and Community Services Deliver Unit

Job Description

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Advertisement for NHS Jobs

We are seeking applicants for an exciting full or part time opportunity to join an innovative, progressive team, as a GP in our multi-professional support team. Abertawe Bro-Morgannwg University Local Health Board is establishing a Primary Care Support Team and is looking for enthusiastic qualified GPs to join the team, to work alongside a practice nurse and business manager. We are looking for a variety of posts e.g. salaried, sessional and can be flexible to work around your requirements. We are especially looking for GPs who are committed to developing new ways of working and introducing new roles/skills into the traditional model of GMS.

Our team, which will be led by a Clinical Director for Sustainability is being put together to support the sustainability agenda and provide fast, practical improvement to independent contractor practices and the LHB's own managed practice to help reduce pressures and release efficiencies within in-hours general medical services. As well as direct clinical care the work of team members may involve leading on specific aspects of service improvement and development, education and research. This is an exciting opportunity to enjoy the benefits of a salaried post whilst working in local practices to deliver high quality primary care. Applicants must be fully registered with the GMC and hold a License to Practice. Applicants must also be on the GMC GP Register and have gained entry on the Welsh GP Performers List before taking up their post.

If you are a committed and enthusiastic GP who is looking for an exciting role within an evolving and innovative team, and if you are interested in progressing your career and contributing to the development of innovative models of rural healthcare in South-West Wales then we would be delighted to hear from you.

Those wishing to discuss the post informally in the first instance, or visit the department are encouraged to contact:

Hilary Dover
Director, Primary and Community Services Delivery Unit
Block A
Neath Port Talbot Hospital
Baglan Way
Baglan
SA12 7BX

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Background

We are seeking applicants for an exciting full or part time opportunity to join an innovative, progressive team, as a GP in our multi-professional support team. Abertawe Bro-Morgannwg University Local Health Board is establishing a Primary Care Support Team and is looking for enthusiastic qualified GPs to join the team. We are looking for a variety of posts e.g. salaried, sessional and can be flexible to work around your requirements. We are especially looking for GPs who are committed to developing new ways of working and introducing new roles/skills into the traditional model of GMS.

We are a University Health Board responsible for improving health and delivering integrated healthcare for over 500,000 people. With a turnover of over £1.2 billion and employing 16,500 staff, Abertawe Bro Morgannwg University Health Board provides tertiary, acute, intermediate, mental health, learning disabilities, community and primary care services to people in Swansea, Bridgend, Neath Port Talbot and beyond. Our Welsh Centre for Burns and Plastic Surgery is also responsible for patients in Southern England. As a University Health Board, we work in close partnership with Swansea University and other Welsh universities with a strong research and development, and training agenda. We are highly ambitious for the communities we serve and the people we employ, with exciting plans for the future.

We have clear values about how we do business which underpin everything we do – *caring* for each other; working *together* and always *improving*.

We have redesigned how we manage our Health Board to ensure that we achieve these ambitions and plans. Consequently we are looking for bold and inspirational individuals to fill GP roles in the Primary Care and Community Services Unit to help us fulfil our vision to provide quality, timely and robust primary care services for our local population. The Primary Care and Community Services Delivery Unit comprises of approximately 1400 staff with a budget of circa £300m, as well as holding a GMS contract with 73 general practices across the Health Board geographical area, and managing one practice directly.

Our team, which will be led by a Clinical Director for Sustainability is being put together to support the sustainability agenda and provide fast, practical improvement to independent contractor practices and the LHB's own managed practice to help reduce pressures and release efficiencies within in-hours general medical services. As well as direct clinical care the work of team members may involve leading on specific aspects of service improvement and development, education and research. This is an exciting opportunity to enjoy the benefits of a salaried post whilst working in local practices to deliver high quality primary care. Applicants must be fully registered with the GMC and hold a License to Practice. Applicants must also be on the GMC GP Register and have gained entry on the Welsh GP Performers List before taking up their post.

Working alongside other health professionals, the GP role will be part of a skilled team that provides targeted clinical intervention and management support to GP independent contractors in times of crisis or facing a range of sustainability issues, working with the practice in order to identify key areas of development that need to

be met in order to put the Practice on a sustainable footing with independent status. This will require collaborating with the practice team and undertaking an assessment of the practice management arrangements; developing and agreeing an improvement plan and working with the practice team to assist and support in taking this forward. This will also include assuming clinical responsibilities. The team may also support practices with business, finance and human relations management responsibilities. The period of direct clinical support is intended to be short term and transformational.

If you are a committed and enthusiastic GP who is looking for an exciting role within an evolving and innovative team, and if you are interested in progressing your career and contributing to the development of innovative models of rural healthcare in South-West Wales then we would be delighted to hear from you.

ABMU Local Health Board can offer:

- Competitive Salary (depending on experience): £55,965 - £84,453
- Flexible hours (part-time, full-time, job-share and sessional contracts)
- Crown Medical indemnity cover included in package
- Placements can be short or medium term (up to 6 months)
- Potential for academic and research opportunities
- Potential to develop special interests
- Personal and professional development opportunities
- Contract with favourable terms and conditions
- No out of hours commitment

Those wishing to discuss the post informally in the first instance, or visit the department are encouraged to contact:

Hilary Dover
Director, Primary and Community Services Delivery Unit
Block A
Neath Port Talbot Hospital
Baglan Way
Baglan
SA12 7BX

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SUMMARY JOB DESCRIPTION

Salaried GP

JOB DETAILS

Job Title: Salaried General Practitioner (Primary Care Support Team)

Grade: Medical and Dental

Salary Scale: £55,965 - £84,453 (depending on experience)

Contract: Permanent

Hours of Work: Full-time/Part-time/Sessions are negotiable

Department: Primary & Community Services Delivery Unit

Base: Block A, Neath Port Talbot Hospital (under review)

ACCOUNTABILITY

Accountable to: Managerially accountable to Head of GMS and Clusters

Professionally accountable to Primary & Community Services Delivery Unit Medical Director

JOB PURPOSE

- To take a senior role in a Multi-disciplinary team that delivers care to patients registered with individual general practices across ABM and the LHB's managed practice to ensure the sustainability of general medical services in the area though the delivery of patient-centred, safe, effective primary healthcare services

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- To provide direct clinical input to meet patient demand and expectation through new ways of working. Support will initially be focussed on supporting practices that are experiencing difficult periods of recruitment and sustainability

- To provide capacity for practices working their way through current and future pressures to consider their business model, providing a diagnostic element where areas for improvement can be identified and understood to enable the practice to build capacity and improve resilience

DUTIES AND RESPONSIBILITIES

- Provision of direct clinical care in GP practices receiving input from the Primary Care Support Team. There may also be a requirement for participation in specific aspects of practice management and patient related administration

- Respond to medical problems presented by patients, by means of history taking, examination, investigation where appropriate, diagnosis, treatment and referral as needed

- To keep accurate and legible records of all patient contacts and contribute to electronic data recording and audit as directed by the service

- To keep up to date with current and forthcoming National Service Frameworks and NICE guidance and their impact on primary care services

- To ensure that care is delivered using evidence based practice by developing and maintaining your level of expertise, knowledge and skills by keeping up to date with CPD and appraisal requirements. The Health Board will facilitate this process by providing designated time and study leave in line with the Health Board Policy

- To undertake on-call duties as part of the practice on-call rota, where agreed. This may include requesting that patients present at the surgery, telephone consultations, house visits and triage

- To support the practice in the implementation and achievement of the GMS contract; QOF and Cluster Network Development Domain

- To attend and contribute to regular Primary Health Care Team administration and clinical meetings whether formal and informal. This may involve adjustments to workload to allow attendance

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- To contribute to the clinical governance agenda ABMU Local Health Board and to fully participate in the reporting of incidents to the DATIX / Clinical Governance Manager and the National Patient Safety Agency

- To collaborate with the practice team, using experience and professional expertise to contribute to a review of practice clinical systems; staff skill mix and processes and provide robust professional advice to the practice team on the opportunities to implement changes that release capacity and improve efficiency in a robust business model going forward

- To provide any data relating to their own work for the Clinical Lead to produce written and verbal reports to be produced on the activity of the team

- To attend and contribute to LHB/Primary Care Support Unit meetings and training events whether formal or informal. This may involve adjustments to workload to allow attendance.

- To facilitate the Health Board in being assured of clinical governance arrangements in general practice.

COMPETENCE

You are responsible for limiting your actions to those that you feel competent to undertake. If you have any doubts about your competence during the course of your duties you should immediately speak to your Medical Director.

REGISTERED HEALTH PROFESSIONAL

All employees of the Health Board who are required to register with a professional body, to enable them to practice within their profession, are required to comply with their code of conduct and requirements of their professional registration.

SUPERVISION

Where the appropriate professional organisation details a requirement in relation to supervision, it is the responsibility of the post holder to ensure compliance with this requirement. If you are in any doubt about the existence of such a requirement speak to the Medical director.

RISK MANAGEMENT

It is a standard element of the role and responsibility of all staff of the Health Board that they fulfil a proactive role towards the management of risk in all of their actions. This entails the risk assessment of all situations, the taking of appropriate actions and reporting of all incidents, near misses and hazards*.*

RECORDS MANAGEMENT

As an employee of the Health Board, you are legally responsible for all records that you gather, create or use as part of your work within the Organisation (including

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patient health, financial, personal and administrative), whether paper based or on computer. All such records are considered public records, and you have a legal duty of confidence to service users (even after an employee has left the UHB). You should consult your manager if you have any doubt as to the correct management of records with which you work.

HEALTH & SAFETY REQUIREMENT

All employees of the Health Board have a statutory duty of care for their own personal safety and that of others who may be affected by their acts or omissions. Employees are required to co-operate with management to enable the Health Board to meet its own legal duties and to report any hazardous situations or defective equipment.

FLEXIBILITY STATEMENT

The content of this Job Description represents an outline of the post only and is therefore not a precise catalogue of duties and responsibilities. The Job Description is therefore intended to be flexible and is subject to review and amendment in the light of changing circumstances, following consultation with the post holder.

CONFIDENTIALITY

All Health Board employees are required to maintain the confidentiality of members of the public and members of staff in accordance with ABMU policies.

ABM University Health Board is a non-smoking environment.

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PERSON SPECIFICATION

The person specification should set out the qualifications, experience, skills, knowledge, personal attributes, interests, and other requirements, which a post holder requires to perform the job to a satisfactory level.

	ESSENTIAL **The qualities without which a post holder could not be appointed**	**DESIRABLE** **Extra qualities which can be used to choose between candidates who meet all the essential criteria**	**METHOD OF ASSESSMENT**
QUALIFICATIONS	➢ Full GMC Registration with a licence to practise and entry on the GMC GP Register ➢ Certificate of Completion of Training (CCT) in General Practice / Certificate Confirming Eligibility for General Practice Registration (CEGPR), or equivalent ➢ Included on a Medical Performers List or eligible ➢ Evidence of continuous professional development	➢ Academic excellence (prizes, merits, distinctions etc.) ➢ MRCGP	Application Form. Certificates & Registration check
EXPERIENCE	➢ Experience in general practice ➢ Competent in the provision of general medical service ➢ Safe and effective written and verbal communication skills, including the use of telephone consultation ➢ Knowledge and participation in CPD ➢ Evidence of leadership and people management	➢ Experience of working in alternative models of delivery ➢ Experience of working in a collaborative manne ➢ Experience of using electronic clinical patient records ➢ Experience with local NHS services	Application Form Interview References
SKILLS	➢ Proven ability to handle a busy and varied primary care caseload and respond flexibly to workload fluctuations ➢ Ability to take independent clinical decisions when necessary and to seek advice from senior doctors as	➢ Audit ➢ Research interests relevant to specialty ➢ Teaching / Training experience ➢ Facilitation skills	Application Form Interview References

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	appropriate ➢ Commitment to team approach and multi-disciplinary working ➢ Effective counselling and communication skills ➢ Understanding of clinical risk management and clinical governance ➢ Commitment to participating in and understanding of the management process ➢ Good IT proficiency ➢ Ability to develop and sustain relationships with a wide range of individuals and within groups ➢ Ability to work across organisations to deliver a common objective ➢ Ability to draft letters, reports and protocols in a timely manner		
KNOWLEDGE	➢ Detailed knowledge of the General Medical Services contract ➢ Understanding of GMS regulations ➢ Aware of local issues and their impact on the health needs of the LHB ➢ Knowledge of the management and structure of the NHS	➢ Knowledge of risk management	Application Form Interview References
PERSONAL ATTRIBUTES (Demonstrable)	➢ Flexible approach ➢ Ability to cope with stressful situations and undertake responsibility	➢ Ability to speak Welsh ➢ Motivational Skills	Application Form Interview References

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	➢ Excellent interpersonal skills and team-working skills ➢ Ability to work with a multi-disciplinary team ➢ Motivated and efficient ➢ Commitment to learn from best practice		
OTHER	➢ Satisfactory Immigration Status ➢ Satisfactory Health Clearance ➢ Satisfactory Enhanced Disclosure Check ➢ Ability to fulfil the duties of the post, including on-call commitments and travel to meet requirements of the post		Application Form Interview

Date Prepared: 28th July 2016 **Prepared by:** Sarah Griffiths Primary Care Manager

Date Reviewed: **Reviewed by:**

Agreed by: **Employee** **Agreed by:** **Manager**

Date Agreed:

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Annex 4

Healthy Homes Project – Occupational Therapy in General Practice

1.0 Introduction

Bridgend County Care is currently piloting a dedicated Casework and OT Service linked to Primary Care Services.

The aim of the project is to provide a dedicated OT and Casework Service linked to surgeries based in the West Network to reach older frail people aged 75 and/or who have long term/complex health conditions and fall within one or more of the following categories:

- Are socially inactive and/or isolated
- Are known fallers (taken possibly from the Practice's Falls Register)
- Have recently been discharged from hospital and have complex health needs
- Suffer a sensory impairment
- Patients recently discharged and identified "at risk" of accidental injury in the home **and** where existing provision cannot meet the required response time and/or need
- Have suffered previous accidental injury and have been admitted to A&E and as a result require safety modifications to eliminate further risk.
- Suffer with Dementia
- Live in poor or inappropriate housing (i.e. damp, mould, cold, require adaptations etc.)
- Require home safety measures and/or mid-level adaptations in order that they can continue to live independently at home

The Project was launched at the beginning of May 2016 and the demand has been significant. From the period May 2016 to the end of September 2016 121 referrals were received and 95% from Portway Surgery.

2.0 Strategic Context

The historical pattern of investment and delivery of healthcare services in Wales has focused largely on illness and hospital care rather than primary care and the prevention of ill health.

The Welsh Government's *Plan for Primary Care Services in Wales advocates the need to develop a more social model of health, which promotes physical, mental and social wellbeing that draws all relevant organisations, services, carers and people to ensure the root causes of ill health are addressed*. The overall principles underpinning this Plan include:

- prevention and early intervention
- prudent health care
- Active involvement of the public and patients and their carers in decisions about their care and wellbeing
- Planning services at a community level of 25,000-100,000
- Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill health, reduce dependency and effectively treat illness

Over the next four years there will be a change of focus with health boards moving their resources towards primary care, supported by hospitals and other services.

The Primary Care Project provides a vehicle for embedding a housing-related service in a primary care setting and delivers practical solutions in order to achieve change to the home environment thus carrying out preventative measures to avoid accidental injury and falls that can lead to hospital admission and/or long term care.

3.0 The Service

The Project undertakes a comprehensive home visiting service that will include:

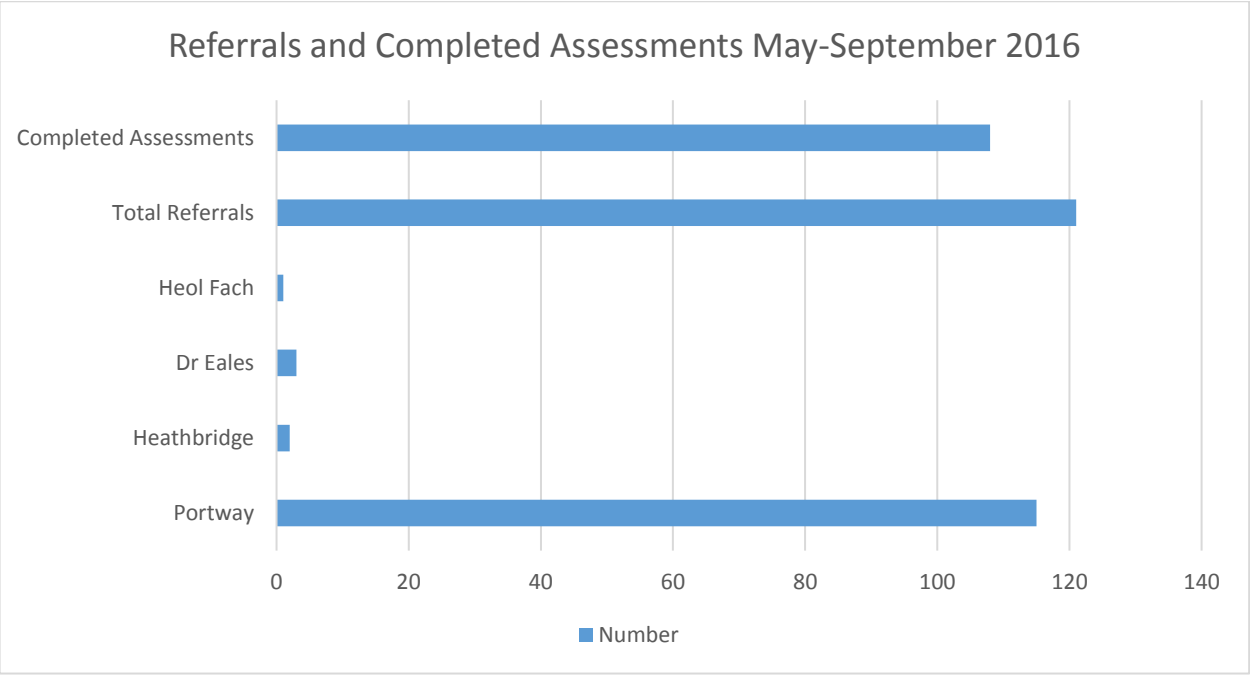
- A Financial Assessment that would ensure welfare benefits maximisation as well as eligibility to a range of statutory housing grants and charitable funding.
- Falls Risk Assessment (FRAT)
- A "Healthy Homes Check" to ensure the condition of the property is not prejudicial to the health of the occupant(s). This would include identification of such factors as damp problems, lack of adequate heating, poor insulation and general disrepair that can often lead to poor health as well as access to a range of grants that can fund the necessary work (i.e. boiler scheme)
- Environmental risk assessments in and around the vicinity of the home to identify potential hazards. This would include a Home Fire Safety Check.
- A comprehensive in-house Occupational Therapist Assessment that helps to avoid waiting times and instigate access to necessary major and mid-level adaptations in a timely manner
- A Trusted Assessor's Assessment that will include a "prescription" for minor aids and adaptations and interventions that help to prevent falls, accidental injury, social isolation and fear of crime (i.e. Hand rails, grab rails, WC seats, Telecare, door chains etc.).
- Advice and assistance regarding moving to alternative housing (i.e. sheltered housing etc.).

In addition the Project also promotes the work undertaken by the Falls Co-ordinator and offers support to patients identified at risk of falling and/or those already placed on Falls Registers. With additional capacity the Project will also be able to provide advice and information to older people attending Flu Clinics.

4.0 Outcomes May -September 2016

Number of Referrals 121

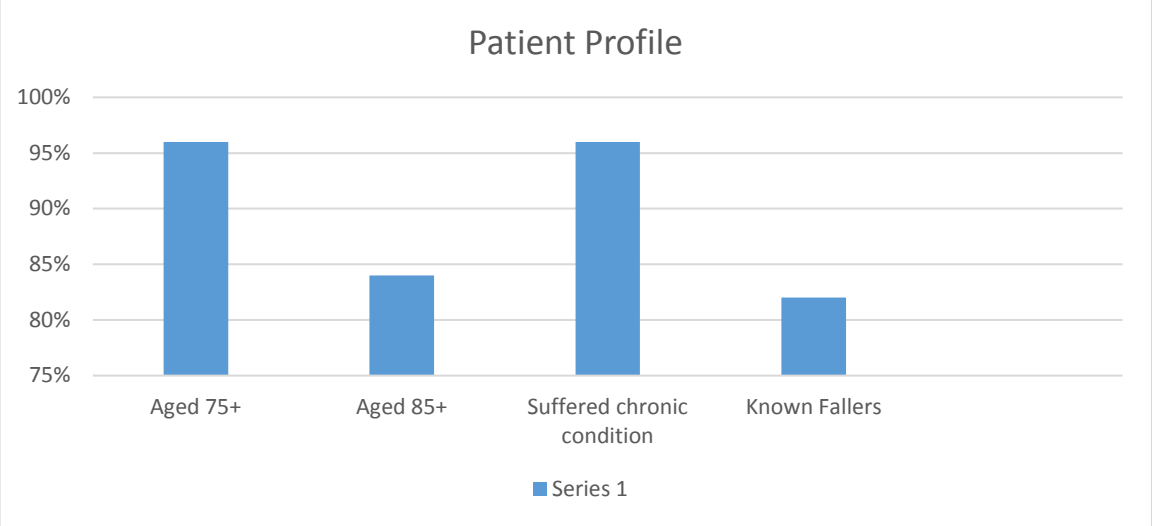
Referral Source



As indicated the majority of referrals (95 %) have been referred via Portway Surgery.

So far 108 of these cases have received a full home assessment from the Agency Caseworker and 79% of patients have received more than one visit. 40 cases have involved the Occupational Therapist for follow-up assessments where more complex home adaptations were required.

4.1 Patient Profile



4.2 Completed works to date

Funding Source	Number of Interventions	Value
Rapid Response Adaptations Programme	7	£ 2,450.00
Healthy Home Assistance	13	£ 4,277.00
Bridgend Bathing Grant Scheme	1	£ 4,000.00
Bridgend Stairlift Grant Scheme	1	£ 1,500.00
Telecare Installations	9	£ 6,750.00
Comfort Safety & Security	1	£ 1,000.00
Home Fire Safety Checks	11	£ 137.50
Attendance Allowance Approved	30	£ 44,369.00
Intermediate Care Grant	9	£14,000
Total	82	£78,483.50

4.3 Work in Progress

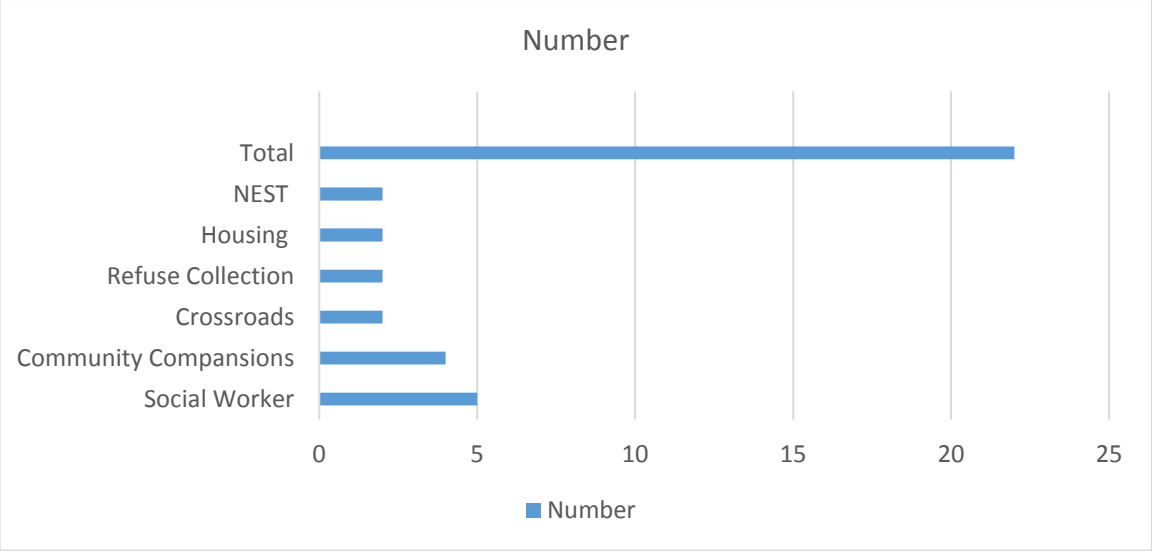
Funding Source	Number of Interventions	Value
Benefits Applications to be submitted	10	£42,640
Benefits Applications to be completed	7	£29,848
Disabled Facilities Grants	2	£20,000
Intermediate Care Grants	8	£15,000
Heating	3	£12,000
Total	30	£119,488

Other Developments

Since the Project commenced the Welsh Government has made available £50,000 to the end of March for heating grants "Boilers on Prescription". Three areas in Wales have been chosen to target this scheme (Gwynedd, RCT and Bridgend's "Primary care Project.

The Agency secured £50,000 capital funding from Western Bay specifically for the project to deliver mid-level adaptations based on prevention/early intervention.

4.4 Signposting Activities



10 clients also received advice only at the point of assessment: 4 of these were referred to the Hospital to Home Service and 5 were referred to MBS

4.5 Typical Case Studies

Mrs X is 81, lives alone and suffers with a number of long term health problems. She has severe arthritis and problems with her balance. Our Caseworker carried out an assessment and identified a number of problems she was experiencing in her home. She also carried out a full welfare benefits check and identified that she was not receiving Attendance Allowance.

Within 6 days of completing the assessment our Home Safety Officer installed grab rails in the bathroom and outside in the garden, a stair rail and rails leading to her front door. The Caseworker also carried out another visit to complete an Attendance Allowance Application.

Mrs X is delighted with the work. She feels she can manage better at home and feels safer. She feels more confident and is no longer frightened of falling. She is delighted with the Attendance Allowance which means she is £82 a week better off. She feels she can "leave the heating on longer" and "no longer worries about the bills".

Mr Y is in his mid-eighties and has severe mobility problems. He has a chronic heart condition as well as other long term health issues. He has fallen on a number of occasions at home and the last fall left him with a fractured wrist. Our Caseworker carried out a home visit and identified he was encountering difficulties getting in and out of the bath as well as negotiating the stairs.

She arranged for the Project's Occupational Therapist to visit who carried out a full assessment and recommendations were put forward for Mr Y to have stairlift installed via the Bridgend Bathing Grant Scheme and a level access shower via the Intermediate Care Fund. In addition she also arranged for the installation of Telecare as well as a rail leading to the front door, chair raisers and a bed lever.

Our Caseworker also returned and completed an Attendance Allowance Claim and application for Council Tax Benefit. She also applied for a Comfort, Safety and Security Grant to replace two of his windows that were rotten and making his home draughty and cold.

Mr Y is “absolutely thrilled”, the adaptations have “made such a difference to his life”, his home is warmer and the additional income means he can get the help he needed to support his independence at home.

5.0 Added Value for Patients

- The delivery of home adaptations complemented by welfare benefit increases, digital & financial inclusion support, Telecare & assistive technology, a wider *Healthy Home* Assessment together with the professional supervision of building work
- Ability to link into benevolent and private funding
- Reliable alternative to rogue traders and ‘cowboy builders’
- Trusted brand with good understanding of safeguarding issues
- Places the individual at the centre and promotes independence
- Improves home safety, addressing housing risks and preventing potential housing-related health issues
- Delivers a service based on early Intervention & prevention
- Improved level of independence
- Ensures frail older people have housing-related support and a positive environment in which to live with improved level of independence
- Provides a risk-based approach to home safety, thus lowering the risk of admission to hospital due to falls and accidents in the home
- Can support frail people who have been recently been discharged from hospital
- Addresses the wider issues of housing disrepair, low income, fuel poverty, falls prevention, etc.
- Provides accessible information to older people as early as possible.
- Maximises independence and wellbeing
- Seeks to address low income by maximising opportunities to increase income through welfare benefits maximisation

6.0 Targeted Outcomes for Primary Care Services

This Project aims to achieve greater collaboration between primary care and community based services that seeks to:

- Allow health practitioners to devote more time to patients with high level and complex health needs
- Demonstrate new ways of working through effective collaboration
- Reduce waiting times for necessary adaptations thus helping to reduce the risk of accidents and falls in the home and possible admission to hospital/long term care
- Improve clinical planning for GP’s and other health professionals within primary care by freeing up time to focus on clinical assessment and patients with complex health needs
- Give Health professionals additional ‘tools’ to do their job
- Offer a model based on early intervention, prevention and prudent health care
- Maximise resources within the community to focus on the specific health, housing and social care needs of those in greatest need
- Place the individual at the centre and promotes independence
- Coordinate services around people in meeting their individual needs
- *Reflect the Welsh Governments Plan for Primary Care Services in Wales* of bringing together and fostering collaboration and coproduction at a local community level
- Complement the Social Services and Wellbeing (Wales) Act 2014 that places duties on statutory bodies to work together with the public to promote wellbeing and give people a greater voice and control over their care.

In doing so this will help to achieve significant savings for health and social care services in relation to:

- Falls and accidents
- Hospital Admissions and readmissions

- Ambulance savings
- Social care costs (managed care)
- Residential and long term nursing care
- Potential to reduce OT Waiting Lists and duplication

7.0 Capacity

The Project is operated on the basis of two part time officers, a Caseworker and Occupational Therapist.

The project started initially at Portway with the Caseworker attending weekly meetings to promote the service. This allowed the Project to develop excellent relationships with staff based at Portway and this can be reflected in the high number of referrals received to date.

The Agency's Falls Co-ordinator also met with Practice Mangers in other surgeries to promote the service and left referral packs

The Project so far has received only a few referrals from the other Practices operating in the cluster. This mainly due to capacity issues that has meant that the promotional work carried out at Portway Surgery has not been extended to the other practices within the cluster.

It is also important to note that the Caseworker and Occupational Therapist will provide more than one visit and the service requires follow up visits as required.

8.0 Estimated Cost of Project

Staff & Operating Costs	**Part time**
EXPENDITURE	
Caseworker (x 2.5 days)	£ 12,500.00
Occupational Therapist (x 2.5 days)	£ 15,000.00
Administrator (PT)	£ 7,890.00
NI & Pensions	£ 5,308.00
Travel & Phone	£ 1,500.00
Temporary Staff Costs	£ 1,000.00
Office Costs	£ 400.00
Total	£ 43,598.00

Referrals

Part time
Investment
£43,598.00
Referrals
250
Investment per patient
£174

Annex 5

Ty Elis Counselling Service

SERVICE LEVEL AGREEMENT REVIEW

ABMU HEALTH BOARD

November 1, 2016

Produced by: Anna Tippett

Ty Elis Counselling Service

1. Purpose

This review is being undertaken in line with the requirements outlined in the Service Level Agreement. Clause 3.3 states that the commissioner shall undertake a review on a six month or annual basis as deemed necessary.

2. Background

The Service Level Agreement was established between Ty Elis and ABMU Health Board in December 2015 in order to provide one to one counselling services for adults in the North cluster area.

The funding has been provided for a structured therapeutic counselling intervention to relieve persons who are emotionally distressed, to improve coping strategies and resilience.

i. Quantitative Data

Referral rates, by GP practices for March – August 2016

	List Size	Mar	Apr	May	June	July	Aug	TOTAL
New Street Surgery	4431	3	3	1	2	1	1	**11**
Bron Y Garn Surgery	5860	2	2	3	4	1	1	**13**
Cwm Garw surgery	7616	3	2	4	0	1	2	**12**
Llynfi Surgery	9528	7	6	1	7	5	8	**34**
Nantymoel Surgery	3046	2	4	4	1	2	2	**15**
Ogmore Vale Surgery	4338	1	1	1	1	1	2	**7**
Tynycoed Surgery	10016	5	1	1	13	4	11	**35**
Woodlands	6527	6	4	5	4	6	4	**29**

Attendance Rates for March – August 2016

	No of sessions			Attendance rates		
	No. Sessions Att	No. Sessions Unatt	Total Sessions	No. Sessions Att	No. Sessions Unatt	Total Sessions
Mar-16	99	31	130	76%	24%	100%
Apr-16	91	35	126	72%	28%	100%
May-16	90	43	133	68%	32%	100%
Jun-16	123	48	171	72%	28%	100%
Jul-16	114	34	148	77%	23%	100%
Aug-16	118	48	166	71%	29%	100%
	635	239	874	73%	27%	100%

Level of Support Provided

The tables below show the number of clients who have received 0-7, 8-10, 11-16 and 16+ weeks of counselling between March – August 2016.

		No of sessions			Attendance rates		
Weeks	No of clients	No. Sessions Att	No. Sessions Unatt	Total Sessions	No. Sessions Att	No. Sessions Unatt	Total Sessions
0-7	140	185	85	270	67%	33%	100%
8-10	15	110	30	140	79%	21%	100%
11-16	15	132	63	195	68%	32%	100%
16+	12	208	61	269	77%	22%	100%
	182	635	239	874	73%	27%	100%

ii. Qualitative

Sample of Warwick Edinburgh Mental Wellbeing Scale results

The effectiveness of the counselling service has been assessed using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). WEMWBS has been developed to enable the monitoring of mental wellbeing in the general polualtion. It is a 14 item scale with 5 response categories summed to provide a single score ranging from 14-70 (see appendix 1)

The table below identifies a proportion of clients who have completed the WEMWBS at both their first and last counselling sessions and the movement between their scores. Any positive movement represents an increase in mental welleing personally assessed by the client.

Client ID	Number of sessions attended	Warwick Edinburgh Movement in score
16037	15	9
16200	6	6
15264	3	22
15114	12	6
15223	3	35
15236	12	22
15252	3	40
15341	16	9
16017	10	-9
16120	10	3
16135	7	28
16138	4	19
16153	10	15
16155	5	33
15227	7	7

Informal Feedback from clients

Tŷ Elis - Client Feedback from January 2016

January 2016 – "I have found Tŷ Elis has helped me regain control over my life. Tŷ Elis has given me the mental tool that I can use in every day life."

January 2016 – "I started counselling due to many factors of my life that I found difficult and hard to deal with. Today I leave counselling with a new look on life John particularly has been a great help in understanding and putting things into words and scenarios that I can understand. I would welcome this to everyone – great help great people"

3/2/16 "Counselling at Tŷ Elis was definitely a worthwhile experience and has helped me think about myself and the way I go about things. I've taken away a few key ideas which are useful to me and how I think about my actions. The Counsellor was very attentive and would always make me think about why I said certain things and the reasoning behind it, he would always help me articulate my words."

"Just a little note to say you may be interested to know I have enrolled at Bridgend College for a year so all your hard work has not been ignored and hopefully it will help me further"

April 2016 – "Thank you to Tŷ Elis for all your help, thanks for everything"

July 2016 – "To all at Tŷ Elis thank you for a life changing experience, keep it going"

Thank you card from an Associate Counsellor (Nadia) thanking Ann and the SV group, "it's been a pleasure working with all of you, wish you all the best"

19 October 2016 – Feedback on Facebook from an Outreach Client "I would like to say a big thanks for the help I've had, a big thank you to my Counsellor (name taken out) for all her help. Many thanks.

October 2016 –Message on Facebook from Gillian H "These are my thoughts of what Ty Elis represents for many … (I am a lighthouse, rather than a lifeboat, I do not rescue, but instead help others to find their own way to shore, guiding them by my example)

We have now put in place a client satisfaction survey which is anonymous and voluntary. Forms returned on 31 October 2016 and 1 November 2016 have rated us the highest score of (5) for Administration, Facilities and location and Counselling sessions.

1 November 2016 comment on feedback form "Excellent service, my counselling has brought me back to my old self, it done me the world of good, my Counsellor was excellent"

3. Reflections on the service

Llynfi Surgery

- Llynfi Surgery are satisfied with the service

Nantymoel Surgery

- As part of the North network we have found the funding of sessions to be beneficial for patients and it has reduced waiting times. A service for under 18s would be wonderful if available.
- The service has been very useful. However, lately we have found that the waiting times are increasing and patients are representing

Tynycoed Surgery

- Hosting wise in Tynycoed we have not seen any issues, it runs smoothly, the counsellors are all very pleasant and accommodating they don't make waves or create difficulties, so from that perspective a good experience with minimal impact on the practice. (Practice Manager feedback)
- Seems to be working ok form my point of view I just ask them to go to the desk . (GP feedback)
- Good access, Patients seem to find it very helpful. (GP Feedback)

Ty Elis

- Counsellors and their clinical supervisers confirm that they are finding a wide range of issues some very challenging, long term issues for clients and other clients only need 1-2 sessions. As a result we are averaging 7 sessions per client. Clients receive the appropriate length of counselling they need.
- As a charity we are providing a unique service in quality and outcome that is excellent value for money where clinical supervision and management is provided on a voluntary basis and some other costs are covered by other fund raising activities. This service is available only if underwritten if not the service would disappear.
- Where consent is given by the client for us to contact their GP especially for longer term clients, Counsellors are working with their GP to put sustainable support services in place for those clients who may present with a number of issues which have been discovered during the counselling sessions.
- Limiting sessions for longer term clients will reduce the value of those sessions and may result in a revolving door with the client representing later and so not reducing the waiting list just that they received counselling in short bursts over a longer time. As a new service we feel that it may be we are seeing a higher

proportion of longer term clients at the moment but that this will reduce as our service meets client's needs sooner. We are monitoring this and will report to GP's on this.

- Counsellors are working well with GPs and Practice Managers and this increase in trust is resulting in an increase in client referrals from all GP practices.
- The initial start up period where we had no waiting list we found clients were not ready for counselling when we contacted them within 2-3 weeks for a session and they decided to wait to see if they wanted to come. We have always found that some waiting time is beneficial for individuals and are then ready to work at improving their mental wellbeing with our counsellors. Managing client expectation that they will have a short wait is what prevents them representing to GPs before they receive counselling. We inform GP's of the current wait time in our reports but will highlight this further.
- Counsellors are enjoying working in the Tynycoed practice and have felt very welcome by the practice staff.
- We are able to quickly increase the number of sessions offered each quarter if required and funding is available to assist in reducing the waiting list.
- We have developed robust reporting processes and can provide GP's with the client service information requested quickly at each month/quarter end. We have rectified any issues raised regarding 2 specific clients very quickly in that period and improved our internal recording as a result.

4. Conclusion

Information from this review shows that patients from each of the GP practices in the North cluster are accessing the Ty Elis Counselling service with higher numbers of patients presenting from Llynfi, Tynycoed and Woodlands surgery. This may be due to the fact that two of these practices have a large patient list size and the counselling service is based at the Tynycoed surgery which may increase GP/Patient awareness of the service.

Data shows that non attendance rates for the counselling service are high (between 23 and 32% of available sessions each month). Ty Elis use a range of methods to tackle this issue, including text messaging for those clients that provide consent as well as advising clients at their first appointment that they will be unable to continue accessing the service if they fail to attend on more than two occasions. It is also important to note

that clients accessing counselling may be experiencing challenging/difficult times in their lives and this may affect their ability to attend booked sessions.

The data shows that clients accessing over 10 weeks of counselling account for 53% of the total number of sessions provided during the six month period. These clients (27 out of 182) represent 14% of all clients seen within the 6 month period.

Ty Elis has advised that those clients accessing more than 16 sessions will be known to the GP and consent has been obtained to continue counselling. It is anticipated that attendance at the couselling service prevents/reduces repeat attendance at the GP surgery. Counsellors are regularly challenged by their supervisor about clients who require high levels of counselling sessions and Ty Elis is keen to ensure that clients do not become dependent on the service.

The qualitative data provided suggests that clients showed improvements in their mental wellbeing following the intervention and informal feedback via cards/notes and online suggests that clients are very satisfied with the service. A formal client satisfaction survey was not used by Ty Elis during the review period, however a survey has now been developed (see appendix 2) and will be used in future.

Recommendations/future actions

- Ty Elis to implement the client satisfaction survey to assist in the monitoring of the service and ensure compliance with the SLA
- Ty Elis to provide regular updates on the current waiting time for counselling services to ensure that GPs are able to manage patient expectations when they signpost to the service.
- The cluster may wish to review the referral criteria and consider who they wish to been seen by the service? Is this an early intervention/prevention service or a service for patients with more complex/high needs?
- The cluster may wish to consider capping the number of sessions available to patients or whether it is more appropriate to allow Ty Elis to provide services based on identified need.

- In order to fully assess the service, a review should be undertaken in March 2017 in order to reflect on 12 months of available data.
- The cluster may wish to consider investing slippage funding in order to reduce the current waiting list.

Appendix 1

Below are some statements about feelings and thoughts.

Please tick (√) the box that best describes your experience of each over the **last 2 weeks**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

© WEMWBS

Warwick-Edinburgh Mental Well-being Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved.

Appendix 2

Tŷ Elis (Porthcawl Counselling Service)

Client Satisfaction Survey

We are continually looking to improve our service. If you are able we would welcome any feedback which we can use to improve our service for you and others who may need counselling.

If possible please could you answer the following 3 questions and rate the service received by you between 1 being very bad and 5 being very good.

Question	1 Very bad	2 Bad	3 Satisfactory	4 Good	5 Very good
1 Administration How do you rate your initial registration contact with Tŷ Elis?	☐	☐	☐	☐	☐
2 Facilities and location How do you rate the premises and facilities? Location attended – **please tick one below** **Victoria Av, Porthcawl** ☐ **Tynycoed surgery** ☐ **Hartshorn House, Maesteg** ☐	☐	☐	☐	☐	☐
3 Counselling sessions How do you rate the one to one counselling service provided?	☐	☐	☐	☐	☐
Please put any other comments regarding our service, staff or whether we have been able to assist you that you would like to add below.					

Your feedback is taken very seriously and may be used as part of any funding bids Tŷ Elis makes to maintain or develop our service to individuals. We will not use your name unless you provide it to us on this form and by doing so consent to your name being provided to current and potential funders of our service.

Annex 6

JOB DESCRIPTION

CLUSTER NETWORK LEAD

Accountable to:	**Area Clinical Director**
Responsible to:	**Area Clinical Director**
Responsible for:	**Leading the work of ……..…. cluster network**
Hours:	**One session per week - job share possible**
Remuneration	**£10,000 per annum plus £5,000 responsibility allowance**

.

1 JOB PURPOSE

1.1 To provide senior clinical leadership to …….. cluster network.

1.2 To provide leadership and direction for the cluster network to remodel care pathways to achieve better outcomes for patients and service users.

1.3 To ensure smooth operation of the …….. cluster network, chairing multi-disciplinary network Board meetings to successfully undertake an annual planning cycle, identifying innovative programmes of work and overseeing their successful implementation.

1.4 To support the development and delivery of effective clinical governance systems for cluster networks in line with ABMU frameworks and policies.

1.5 In liaison with the Unit Business and Finance partner to ensure stewardship of the cluster resources.

2 KEY RELATIONSHIPS

- Unit Medical Director
- Director, Primary & Community Services
- Unit Nurse Director
- Area Clinical Directors
- Heads of Primary Care
- Head of Nursing
- Unit Dental Director
- Unit Ophthalmic Advisor
- Cluster Development Managers
- Other Cluster Network Leads
- General Practitioners

2.1 Members of cluster network Boards including Pharmacists, Dental and Ophthalmic professionals, Third Sector, Public Health, Medicines Management, Local Authority and Health Board colleagues

3 MAIN DUTIES

3.1 Accountable to the Area Clinical Director, the cluster network Lead will be required to work closely with the Primary & Community Services Unit and the Unity Medical Director to drive an accelerated programme of cluster network development providing clinical leadership within the context of the Health Board and Welsh Government strategic plans.

3.2 Work closely with cluster network members and the Primary & Community Services Unit to develop and implement an innovative cluster network plan that incorporates national and Health Board strategic aims with a focus on improved population health and high quality health care.

3.3 To contribute to service re-design across the spectrum of health and care services.

3.4 Chair meetings of the Cluster Network Board and ensure it works within its terms of reference and Quality and Outcomes Framework.

3.5 Represent the cluster network at relevant Health Board and partners' events and meetings.

3.6 Ensure effective communication is maintained within the Community Network Board and that all members communicate cluster network business to and from their respective teams.

3.7 In conjunction with other cluster network members, encourage patient and carer engagement in the cluster network programme.

3.8 Set the tone and style of Cluster Network Board discussions to facilitate effective decision making and constructive debate.

3.9 Set the agenda for Cluster Network Board meetings in liaison with the Primary & Community Services Unit.

3.10 Work closely with the Head of Primary Care and the Unit Finance and Business team to develop a cluster network financial plan.

3.11 Maintain a constructive and open relationship with the Director of Primary & Community Services, Unit Medical Director and Unit Nurse Director and the Management Team.

3.12 Support the design of an educational programme for cluster network based Protected Learning Time.

3.13 Ensure deputising arrangements, if required, are met from within the existing clinical members of the cluster network.

3.14 Ensure the principles of effective governance, prudent health care and the ABM values : *caring for each other, working together and always improving* underpin cluster network work plans and programmes.

4 GENERAL RESPONSIBILITIES

4.1 Health and Safety

It is the duty of each employee to exercise reasonable care to safeguard their own health and wellbeing and that of others who may be affected by their acts or omissions.

4.2 Corporate Governance

All employees are required to comply with corporate governance and standing financial instructions.

4.3 Equality

The Health Board will take all practicable steps to ensure that staff are recruited, managed, developed, promoted and rewarded on merit and that equal opportunities are given to all staff. Each employee is responsible for their own professional and personal behaviour and there is a requirement for all staff to conduct themselves in a manner which does not cause offence to another person.

4.4 Counter Fraud

The post holder will be expected to comply with the Health Board's counter fraud strategy.

4.5 Confidentiality

As an NHS employee, I am aware that I have a common law "duty of confidence" to patients. This continues after I have left NHS employment and after the death of a patient. I agree to abide by my legal responsibilities with

regard to the maintenance of confidentiality and to abide by the organisation's policies and procedures relating to all aspects of information governance.

4.6 **Compliance**

All employees must comply with the requirements of the Health Board's strategies, policies and procedures, for example, Records Management.

The purpose should remain constant but the duties and responsibilities may vary over time within the overall role and level of the post.

5 TERMS AND CONDITIONS

5.1 Sufficient time will be allocated for the performance of the role, to be negotiated upon appointment.

5.2 A management supplement will be paid in addition to the salary of the post holder's substantive/main employment.

5.3 The appointment will be for a fixed term of two years, renewable by mutual agreement.

Last reviewed: 1st November 2016

Annex 7

Pacesetter Programme Report - September 2016

Interim evaluation

Introduction

The Pacesetter Programme, which aims to promote and evaluate innovation across Primary Care in Wales, has been running for over 18 months and many projects are demonstrating early benefits and outcomes. The Pacesetter event held on 21 September 2016 enabled the Directors of Primary Care and Mental Health (DPCMHs) of Health Boards to assess progress against the agreed aims of each project and determine the next steps for the Programme as a whole.

There was general agreement amongst the Directors that the Programme has been effective in bringing together Primary Care colleagues from around Wales to share the learning and develop a future vision for Primary Care. Components of the emerging model are undergoing assessment through the Pacesetter Programme, each project testing a different aspect of the whole system model.

In addition to the Pacesetter projects, a range of other Primary Care initiatives is on going in Health Boards across Wales, supported by different Welsh Government funding streams. Directors are clear that the outcomes of these developments must also be incorporated into the evidence base for future Primary Care services. We are mindful that the Pacesetter projects are primarily focused on GP working and that there are other opportunities for transformational change through integrated working and collaboration with Local Authorities, Third Sector and Public Health Wales.

This paper aims to provide an overview of the key messages and actions that emerged from the recent Pacesetter event. Details of individual projects can be accessed on the Public Health Wales events resources page at:
https://www.eventsforce.net/nliah/frontend/reg/tOtherPage.csp?pageID=288259&efsel_menu=4218&eventID=885&eventID=885

1. Sustainability of Primary Care

The fragility of many practices across Wales has a range of underlying causes, including increasing volume and complexity of practice workload, difficulties in staff recruitment and the challenges faced (particularly by smaller practices) in practice management, planning and networking. Compounding these problems is the reluctance by some practices to request support, often those most likely to benefit.

1.1 Support and Development Teams / Units

Support and Development Teams or Units work with vulnerable practices to find effective solutions for sustainability and resilience, tailored to meet their individual requirements. They also offer opportunities to test out new workforce models and different ways of working.

Key messages

- To be effective, Support Teams need dedicated project management, enthusiasm and drive, plus the ability to manage expectations. Clinical leadership is vital for engagement of colleagues, to lead redesign and educate teams in the benefits of new ways of working, innovative technologies, etc.

- Risks for Support Teams/Units include destabilising other practices through resource movement within an area, in effect 'robbing Peter to pay Paul'. Practices can become dependent on Support Teams and there is a need to balance support given with the responsibilities of practices. A clearly defined agreement with practices at outset on source of payments, accountabilities, etc. will mitigate these risks.

- Seeking patient feedback is important to understand the practical changes required to improve access, address unmet need and counter health inequalities. Incentivising improved patient access through Enhanced Services has proved successful with practices, setting out clear terms and conditions within an SLA.

- Obtaining detailed statistics on GP retirement and practice sustainability helps the evaluation of sustainability in each area. Assessment of risk for every practice will inform forward planning. Sustainability dashboards provide a status report to assist workforce planning and include: the contractual status of practices, analyses of GP demographics and retirement plans, and identification of avoidable appointments (categorised).

- Triage and MDT working promote sustainability across Primary Care, with extended teams better able to cope with the practice workload. The model promotes recruitment as involved practitioners report higher morale and motivation throughout their working day.

- Clustering helps sustainability, bringing practices together to build resilience and improved economies of scale. Cluster models include the federation, collaboration, co-operatives and 'cluster plus'. *Need definitions for these.* 'Buddying' is a new focus for the future and Health Board support for practice mergers assists in future-proofing patient services.

- Standardised outcome measures for sustainability would assist in providing a national view of Primary Care innovation across Wales. Data could include evidence of improved quality and volume of patient care; new services delivered; different ways of working; new work roles created; strengthened relationships with Primary Care contractors.

1.2 Understanding Capacity and Demand

Understanding capacity and demand within practices and clusters helps to facilitate system and process change and should underpin all local service and workforce planning.

Key messages

- Analyses of local capacity and demand link population needs with new service developments, helping to build capacity in identified areas. Joined up work on capacity and demand across the primary / secondary care interface will facilitate whole system change.

- Simple technologies can assist with demand and patient feedback gives powerful information on effectiveness, e.g. self-service machines at front door. There is potential for clinical triage systems to switch on with demand surges, maximising efficiencies of the triage workforce.

- Candid conversations with the public on the challenges of sustainability for small practices can increase awareness and understanding of underlying issues and give opportunities to engage local populations in proposed solutions.

1.3 Recruitment and Retention

There is an urgent need to find new workforce roles and alternative models that do not simply move existing resources around the healthcare system. In areas where it is harder to recruit, a collaborative approach across adjacent Health Boards can help to maximise peer support and resources.

Key messages

- 'New workforce blood' can be attracted into an area through offering a menu of new roles for GPs, tailoring clinical and academic interests to the posts and providing support through CPD time, education and opportunities for additional qualifications.

- Support Units can facilitate recruitment and act as a 'landing pad' to give new GPs an opportunity to work in the area without committing to a practice

Actions for Primary Care Sustainability

1. Proactive recruitment drive to attract new GPs into Wales through conference stands across the UK, social media, etc.
2. Disseminate the resources developed for Access QI: a) model / tools for capacity and demand analyses; b) accreditation system; c) validated patient satisfaction survey
3. Share the work on sustainability dashboards and consider a national approach to capturing this information across Wales
4. Consider a set of standardised outcome measures for sustainability to provide a national view of innovation across Wales
5. Share the Enhanced Service specifications and SLAs for Primary Care buddying roles and practice mergers
6. Explore technologies available to help practices address patient demand
7. Disseminate standardised care bundles and pathways developed for ambulatory care sensitive conditions
8. Develop an All Wales model for Support and Development Teams/Units, sharing the collaborative learning that is emerging from the Pacesetter Programme
9. Explore the opportunities for Academic Fellows in Primary Care
10. Hold public meetings with the local population to explain difficulties in sustainability of small practices and engage them in potential solutions

2. IT Systems, Data and Evaluation

The development of robust IT systems for automated data capture on a cluster basis are essential to implementing the new model for Primary Care in Wales. Pacesetter teams have worked hard to find methodologies that capture outcome measures, including qualitative data such as evidence of practice collaboration, staff engagement and professional motivation.

Key messages

- Complex service developments across practices and clusters require significant lead-in time for IT developments. Cluster-based IT, with shared clinical and appointment systems such as Vision 360, are essential to facilitate joint working across practices.
- We need to capture more patient-focussed outcome measures that demonstrate the benefits of services in reducing patient harm and prevent clinical deterioration through earlier intervention
- Identifying the benefits of one particular service change within a complex system can be difficult, so some Pacesetter teams have recorded an assessment of the impact of their interventions at the point of patient contact.
- Working with data at cluster level allows for effective practice comparisons and benchmarking. Services requiring patient self-referral should be implemented through GP systems to ensure data on the service can be captured
- Teams involved in transformational redesign need the support of data analysts due to the complexity of primary care systems and the expertise needed to evaluate the emerging data.
- Use of peer review systems is useful to educate and change behaviours.

Actions to develop IT Systems for Data and Evaluation

1. Escalate the need to capture Primary Care data in an automated way through a national approach to IT solutions. Share READ codes for service redesign across Wales.
2. Share the learning from use of Vision 360 across practices in a cluster-based model. There is potential for an All Wales approach, using V360 across wider providers. IT systems for in- and out-of-hours need to be joined up.
3. Share the learning from commissioning a software developer to link EMIS / Vision systems and the templates developed for clinical pathways.
4. Use dashboards at cluster level for effective practice comparisons and benchmarking.
5. Develop a national set of outcome measures for pharmacy services to assist evaluation and comparison.
6. Explore the potential to capture data on alternative patient pathways through the Local Authority and Third Sector.

3. New Primary Care Models and Innovation

Pacesetter teams have put forward a vision for Primary Care in Wales based on a prudent approach to healthcare, with the GP practice at the heart of service provision. Strong, stable general practice built around an enhanced MDT workforce, with clusters offering the mechanism for practices to work together, has great potential to increase efficiencies and deliver new patient-centred care in the community. Whole system change will promote and support earlier interventions, self-care and lifestyle changes.

Key messages

- There is evidence of mixed maturity of clusters across Health Boards, with those that thrive demonstrating a wider involvement of partners such as the Third Sector, pharmacy, Public Health and Social Services. Much activity in general practice can be delivered in different ways through other agencies, professional groups or by the smart use of technology.
- A range of triage / call-handling models is emerging to suit different clusters and patient populations, aiming to facilitate MDT working and maximise GP capacity. Allowing different models to evolve, whilst ensuring standardised outcomes and governance frameworks, appears to be effective and there is potential for remote triage systems to be delivered by GPs working from home. Some areas are working towards a 'total triage' model across a cluster and links with the future 111 service - designed with a centralised triage / information centre and supported by a strong MDT hub.
- Linking Secondary Care services into the Primary Care team is hugely beneficial to patient-centred care. Specialist nurses are well placed to bridge primary/secondary care within clusters, bringing expertise and promoting close links between specialist teams and the community.
- Complex patients are best managed by mature shared care, combining skills across the primary / secondary interface and establishing integrated mechanisms for managing high-risk patients. Examples of success include the Vanguard sites in England, where GPs are incorporated into complex care teams. However, there are concerns around the risks of adding more complex care to the existing workload of GPs without first developing an enhanced MDT to appropriately manage the everyday workload of the practice. For change to be successful, it is important to have accessible resources in the right place at the appropriate time.

- High quality practice management is critical to successful practice innovation, establishing new models and promoting the change agenda. The role of practice manager needs recognition and development through training, motivation and support.

- The benefits of the Federation model over less formal cluster arrangements include both development of a stronger infrastructure that brings commitment to cluster working and new ways of working. In establishing the Federation model, 'form must follow function' to ensure the right contractual and financial arrangements are implemented to deliver the agreed outcomes.

- The GMS and Pharmacy contracts are too rigid and constrained at present, and professionals find contractual arrangements do not support innovative working within clusters. Revised contracts are needed to support larger teams to flex and deliver care differently.

- Superannuation and indemnity issues for GPs are reported to cause significant barriers to new ways of working. Work has been done in other UK countries to understand the issues and find solutions that give medico-legal protection, whilst allowing for greater flexibility and lower costs for individual practitioners.

- There are fundamental issues of trust around the potential for Primary Care to deliver wider services and for other professional groups to take on appropriate work currently provided by GPs. It takes time to plan, deliver and embed transformational changes, building confidence and ensuring the people with the right skills are in post.

Actions to establish new Models for Primary Care

1. Research the outcomes and learning from Federations established across the UK. Consider a Federation Handbook for Wales, based on the learning log and Federation Toolkit developed through the Pacesetter Programme.

2. Develop the principles and standards for a national triage model suitable for different populations and geographical areas of Wales.

3. Evaluate the wider Primary Care model through linking Triage, MDT working and integrated care in the community to assess the impact on patient outcomes and practice workload.

4. Advise a review of current contractual, superannuation and indemnity arrangements for GPs and pharmacists to promote greater flexibility and support for innovation / whole system change.

4. Multidisciplinary Team Working and Training

There are significant opportunities to manage the increasing demand on Primary Care services in new ways, ensuring patients see the right professional within a cluster team without unnecessary delays. The enhanced team can incorporate a wide range of professionals and skillsets, opening up potential for innovation and transformational change. Teams are already pushing the boundaries with roles for paramedics, Physicians Associates and Local Authority professionals, in addition to extended roles for nurse practitioners, pharmacists, physiotherapists, technicians, occupational therapists, counsellors and receptionists.

Key messages

- Giving GPs more time, space and resources is pivotal in remodelling services around patient need, integrating primary and secondary care services with the wider cluster team to offer holistic, patient-centred care.

- Assessment of the professional skills needed to cope with demand across the cluster is important, using careful analysis of patient demand and the skill mix required. Professionals need to be empowered and trained appropriately, with provision for CPD, clinical supervision and mentorship essential to supporting professionals to work in new ways. The cluster may

also prove to be a suitable training / CPD vehicle for extended roles for paramedics, nurse practitioners and pharmacists.

- A strong governance framework, with clear accountabilities and indemnity for all team members, is an essential foundation for new cluster models. Primary Care teams may prefer to keep the responsibilities for training, clinical supervision, appraisal and reporting arrangements within the corporate processes of Health Boards / WAST / Local Authorities, at least in the early stages of cluster development.

- The role of the practice manager for leadership and change management is key to the success of new organisational forms and innovation within clusters, as is recognition of the importance of their place in the Primary Care team.

- Collaborative arrangements with WAST, developing joint rotas and shared learning opportunities for advanced practitioners, are proving successful in clusters.

- Pharmacists can have a considerable impact on medicines management issues relating to patient empowerment, compliance, efficacy and safety when working as a core member of the Primary Care team. Optimising medication provides whole system benefits and improved quality of life for patients, in addition to financial savings.

- Physiotherapists with advanced skills (joint infections, prescribing, blood test interpretation) are leading successful MSK services within Primary Care, with significant reductions in GP appointments and secondary care referrals.

- There are considerable benefits to retaining the independent contractor status for GPs alongside other GP contractual arrangements. Autonomy promotes innovation, provides motivation and offers financial rewards to practitioners.

- Many practice premises are not currently fit for purpose for extended teams and cluster working. A review of Primary Care estates is overdue and critical if new models of Primary Care are to be implemented at pace.

Actions to Develop the Multidisciplinary Team

1. Develop frameworks for each new professional role within the Primary Care team including: scope, clinical competency/boundaries, indemnity, training/CPD plan and mentorship.

2. Define the workforce and skill set required for clinical triage

3. Extend training programmes for new professional roles to increase the workforce pool for clusters. Establish mentorship schemes to support professionals in new roles.

4. Explore the potential for specialist nurses working in secondary care to work within primary care / community, perhaps on a rotational basis across the interface.

5. Design a national model for pharmacy to develop both generic and specialist pharmacist roles within the Primary Care team, considering the potential to:
- Link community pharmacy services with cluster pharmacists
- Integrate pharmacy skills into all Care Home clinical teams
- Extend roles for pharmacy technicians
- Establish Pharmacy Domiciliary Care services for selected housebound patients

6. Advise on a review of physiotherapy training programmes to up-skill experienced physiotherapists and technicians in greater numbers for integration into the core cluster team.

7. Scope the current status of Primary Care estates to assess suitability for new ways of working, with space and facilities to support extended teams and cluster working.

8. Consider a national Leadership and Development programme for practice managers.

5. Culture and Behaviour change

Pacesetter teams recognise the importance of engaging and involving the public and professionals in service and pathway redesign. Changing culture and behaviours takes time, especially for older patients and professionals, with the greatest impact often coming from personal experience or hearing of the benefits from family and friends. Building flexibility into new models, with opportunities to let developments evolve gradually, is proving effective in the Pacesetter Programme.

Key messages

- It is essential to engage patients in service design and delivery to ensure that patient-centred care systems are developed across clusters. Holding open and transparent conversations with the public helps explain the potential for new models of Primary Care, building understanding and trust. Introducing patient choice into new service delivery models can be effective - behaviour change is often promoted once patients can see the benefits of initiatives.

- The use of wording and timing of messages can have a profound influence on patient behaviours and need to be understood before embarking on transformational change. Working with communities on the ground, through small groups or in schools, is an effective approach to raise awareness and change behaviours. Encouraging the public to have conversations with pharmacists about their medication raises awareness, reduces waste and improves compliance.

- Successful change within Primary Care teams depends on practices *wanting* to change. Working in close partnership with staff on the ground, Health Board teams can help to motivate, empower, support and lead teams through the process of change.

- GPs need faith in new systems and innovative ways of working to embrace change. A gradual introduction of innovations, feeding back with evidence of the benefits and safety of new ways of working, helps to build trust and promote engagement.

- GPs value audit data that provides evidence of an impact on clinical outcomes through changed professional practice and this can be an effective way to engage them in innovation. GPs also appreciate information on culture and behaviour changes. Dashboards can help to engage professionals and demonstrate the impact of service change. This is of particular relevance for GPs who delegate work to new healthcare professionals within the practice team.

Actions to Change Culture and Behaviour

1. Link with training programmes to inform practitioners of the factors influencing culture and promote the use of behaviour change methodologies by Primary Care teams across Wales.

2. Roll out *Your Medicines Your Health* as a national model across Wales, sharing the outcomes for each component of the campaign. Make links with the future Wellbeing Act to embed the principles of YMYH into the national curriculum for schools.

3. Promote the benefits of creative art in health and wider use of YMYH methodologies within schools

Conclusion

This paper is based on the presentations and subsequent discussions at the Pacesetter event on the 21 September 2016. It is intended to inform the debate on the future development of primary care and to identify the support needed by Primary Care teams across Wales.

Colleagues at the Pacesetter event highlighted the importance of a clear, agreed vision for Primary Care in Wales and the need for commitment on the journey towards a new Primary Care model.

The Pacesetter programme and outcomes of other Primary Care initiatives offer opportunities to explore the organisational forms that promote the collaboration and flexibility essential for sustainability and holistic patient care. There are significant opportunities for clusters to influence how Health Boards operate and lead the development of healthcare services across Wales

Recommendations

Directors are asked to comment and agree on the messages and actions this paper reports. in particular, they are asked to consider:

1. How workforce planning across Wales takes account of the implications of this new emergent model for primary care.

2. The benefit of a series of 'national frameworks' for Wales to support Primary Care teams wishing to adopt outcomes and learning from the pacesetter work. National frameworks could include:

- A practice workforce model
- A primary care pharmacy framework
- A primary care physiotherapy (treatment of musculoskeletal conditions) framework
- A primary care triage model
- A primary care support unit model

3. The Pacesetter Programme does not encapsulate all primary care innovation across Wales and it is recommended that future work on the emergent model should have a wider scope than projects falling under the Pacesetter umbrella. Promotion and support for self-care, integration, social prescribing and co-production are important areas for development and evaluation.

4. The importance of engaging with stakeholders to ensure that the model and recommendations emerging from the Pacesetter Programme are aligned with the views of Primary Care leaders and partners across Wales.

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