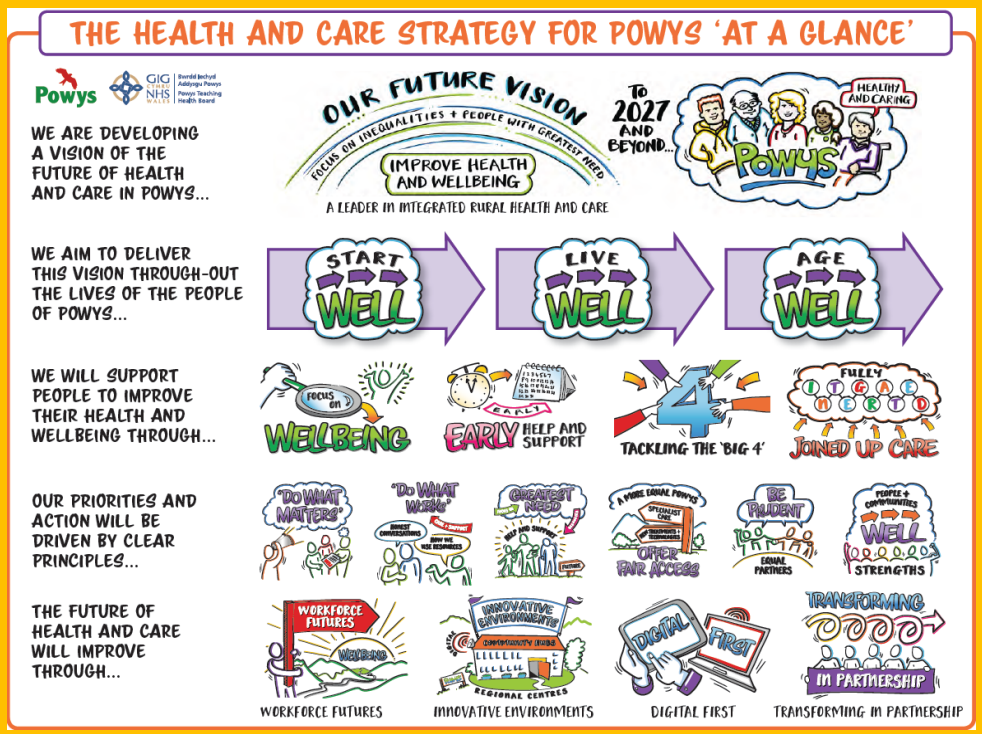
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Primary Care
Integrated Medium Term Plan
South Powys Cluster
2020 – 2023



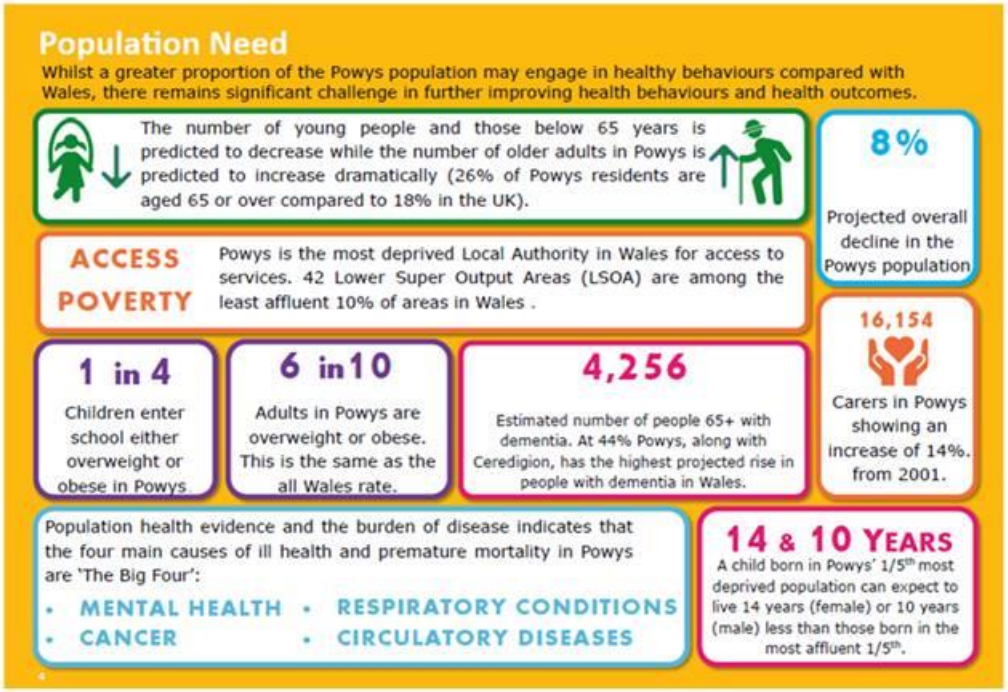
1. Executive Cluster Chair

- The South Powys Cluster has matured greatly since its inauguration in 2012. It developed from a close collaboration between the 4 GPs practices in the locality which dates back to 1995. The practices have been developing innovative ideas since that period with the goal of providing for the health and well-being needs of their patients as close to their homes as possible.
- This desire to provide as much care as possible in Primary Care has seen the development of the community resource teams and the Virtual Ward, which has shown a reduction in Emergency Admissions since 2012 when it started. It has resulted in a revolution in multidisciplinary working with integration between GP, community staff based in practices, Social Workers and Third Sector.
- Primary Care has moved from reacting to illness to seeking out those patients most at risk of admission and putting in place care packages to keep them in their own homes.
- The South Cluster has local access to 3 Community Hospitals in the area and have been trying to repatriate appropriate Secondary Care activity to these hospitals both for outpatients and day case. We also use the beds for rehabilitation and step up care. We also have access to limited diagnostics and plan to improve the range of diagnostics available using more point of care and digital telehealth solutions. We will also develop community outreach clinics using GPswSI to provide outpatient services for diabetes, cardiology and dermatology.
- The South Powys Cluster has been instrumental in piloting the New Model of Primary Care in Wales. We have seen triage developed in all practices for patients requesting a same day appointment (unscheduled care) and have also seen the piloting of remote triage where patients in one practice are triaged by nurses from a different practice but using the full clinical record as all 4 practices use the same clinical system. We have also piloted triage for patients requesting a routine appointment. These interventions have been independently evaluated and shown that 60% of requests to see a GP with a problem could be dealt with by another professional within the primary care team, Quality is improved with all GPs moving to 15 minute appointments and Access improved by the wait for a routine GP appointment reducing from 3 weeks to less than 72 hours. We plan to roll this pilot out to the other practices in the cluster in the next 3 years.
- We have introduced Pharmacists and technicians into each practice. They have transformed the quality and accuracy of prescribing, have reduced workload on GPs and made considerable verified savings. In the next 3 years we intend on developing their clinical role more to help with tackling the big four. They will provide clinics themselves in diabetes, respiratory, heart failure and pain management.
- We have developed a musculoskeletal service in each practice that can see patients with acute problems after they have been triaged, thus preventing an unnecessary GP appointment and providing a better clinical outcome for the patient, with more timely access to treatment. The service is limited at present but once we have collected more clinical outcome data we plan to expand the service.
- As you can see we have achieved a lot and plan to develop more. We want to transform primary care to become more multidisciplinary to include a wide range of professionals in the Primary Care team so that patients can have access to the correct person for their needs and to relieve pressure on GPs. This maintains Sustainability and improves Access for patients. It will allow us to attract new doctors and become a training faculty for the future.
- This year, Cluster IMTPs have been developed and priorities identified which ensure that the Cluster Plans deliver against the National Primary Care Model and its milestones. We will integrate Health and Social care to improve the patient pathway between Primary and Secondary Care, both to prevent admission as well as speed up discharge from hospital in a safe fashion. We intend to build on our successes so far in involving the third sector, by expansion in community connectors and social prescribing.

- We plan to develop more intermediate care to reduce reliance on Secondary Care. This will include more diagnostics and the use of Specialist GPs and Nurses to tackle the big four. We will improve the efficiency of our community hospitals with more outpatient and appropriate day case activity.
- We will see more cluster wide solutions in areas where there is clinical need, such as Women's Health and Minor Surgery and build on the collaboration that we have developed over the years.
- South Powys has transformed Primary Care and has made itself sustainable and improved the quality of primary care for its patients. We have created expectations for both NHS staff and patients that will require funding in the future for the developments that we have achieved and have planned.

Douglas Paton (Cluster Lead, Senior Partner and Lead GP Crickhowell Practice)

Plan on a page



Overview of the Cluster

Powys is made up of 3 Clusters – North, Mid and South. All 3 Powys clusters have multi-disciplinary and multi organisational membership including Health Board, County Council, Third Sector, Dentistry and Optometry. The South Cluster meets on a monthly basis, chaired by Lead GP from Crickhowell GP Practice and is managed by the Executive Director of Primary Care, Community & Mental Health Services.

Powys has made a distinction, since 2015 between clusters, as planning mechanisms that span organisations, services and professions. Also there are GP networks as groups of general medical practitioners. This allows GP Practice issues and wider cluster planning issues to be discussed separately, but with one informed by the other.

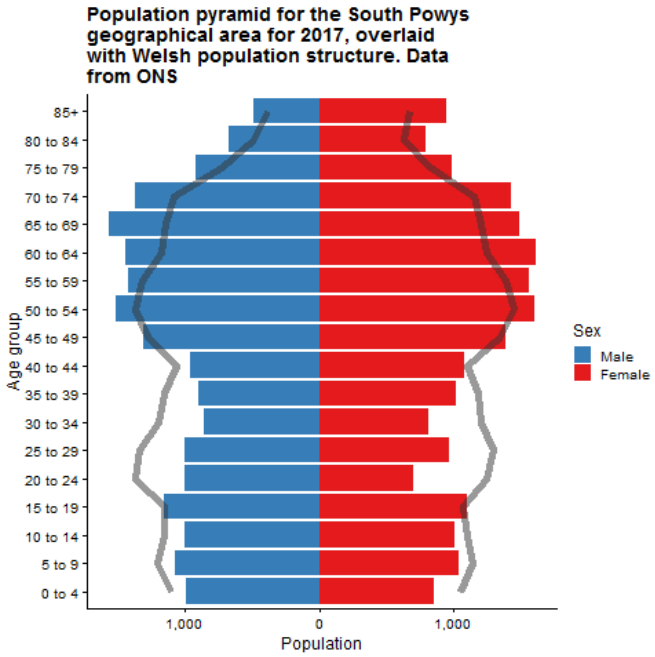
The other key component to the Powys model is delivery of services based around individual GP practices through an integrated Community Resource Team that includes practice, Health Board, County Council and Third Sector representatives.

The South Cluster has a high level of maturity, with collaborative working very well embedded and partner participation consistent. It is comprised of the following:

- 4 GP practices – population 45,580:
  - Brecon and Sennybridge
  - Ystradgynlais
  - Hay and Talgarth
  - Crickhowell

There are also 8 Pharmacists, 6 Optometry Practices, 8 Dental Practices and 2 Community Dental Services in the south Cluster.

The population of the cluster is displayed below:



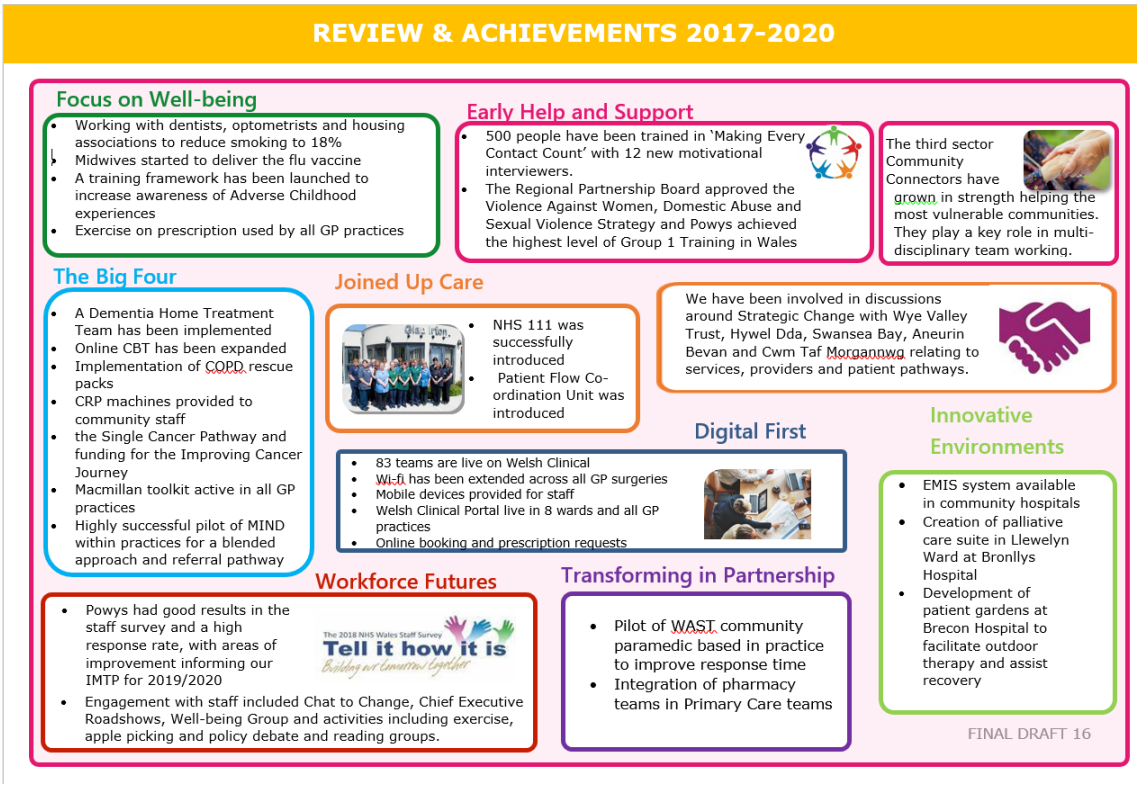
There are 3 community hospitals within the South Powys Cluster

	Brecon War Memorial Hospital	**Bronllys Hospital**	**Ystradgynlais Community Hospital**
A&E / MIU	Yes – 24 hours, 7 days a week	No	Yes – M-F, 9-5
Wards	• Y Bannau Ward – medical - 15 beds • Epynt Ward – rehabilitation – 15 beds • Crug Ward – Older Adult Mental Health Unit – 10 beds	• Llewellyn Ward – General – 15 beds – GP led • Mental Health Inpatient Unit	• Adelina Patti Ward – medical – 20 beds • Tawe Ward – Mental Health inpatient ward – 8 beds • Day Hospital
2 x laminar flow Operating Theatres	• Diagnostic and Treatment Centre • Orthopaedic • Ophthalmology • Occularplasty • Podiatric surgery • Maxillofacial • Gynaecology • General surgery • Urology • Oral surgery • **Endoscopy** sessions:- Gastroscopy • Sigmoidoscopy • Colonoscopy • Cystoscopy • Bowel Screening Wales • Pre-Anaesthetic sessions • Biometric sessions • Colposcopy		

	• Children's Centre – community Paediatric services • Community Dentistry • Specialist Nurses • Child & Adolescent Mental Health Service (CAMHS) • **Birth Centre** – Midwife led		• Mental Health • Midwifery • Specialist Nurses • District Nursing • Health Visiting & School Nursing • Community Dentistry • Podiatry
Outpatients	• Orthopaedic – upper and lower limb • Ophthalmology • Occularplasty • Podiatric Surgery • Maxillofacial • Gynaecology • General • Rheumatology • Medical benefits • Vascular • Continence • Dietician • Nerve conduction studies • Diabetic Eye screening • Genetics • Cardiology • Physiotherapy • Occupational Therapy • Speech & Language Therapy – Adults & Children • Podiatry • Audiology • X-Ray	• Podiatry • Falls Programme • Physiotherapy • Occupational Therapy • Pain & Fatigue Management Centre • Occupational Health • Learning Disability – community service only • Psychology	• Respiratory • Cardiology • Physiotherapy • Dietetics • X-ray
Clinics	• Stroke clinic • Pacemaker follow-up clinic • Diabetic clinic • Genetic clinic • Ear, Nose & Throat clinic • Nurse led Pessary clinic • Nurse led Ear Care clinic • Stop Smoking clinic	• Dietetics • Parkinson's • Bladder and bowel specialist nurse • Respiratory • Dietetics • Chiropody • Diabetic retinopathy • Aortic aneurysm screening	
Third Sector	• League of Friends	• League of Friends	• League of Friends • Red Cross • Tenovus • Powys Carers Service

3. Key Achievements from Previous Cluster Plans

The South Cluster has worked since 2012 to develop a primary care model that integrates primary/community care to provide better access for patients to high quality primary care services and to provide sustainability of these services by promoting new ways of working. An example of Cluster achievements is displayed below:



In addition to the above, we have already implemented the following:

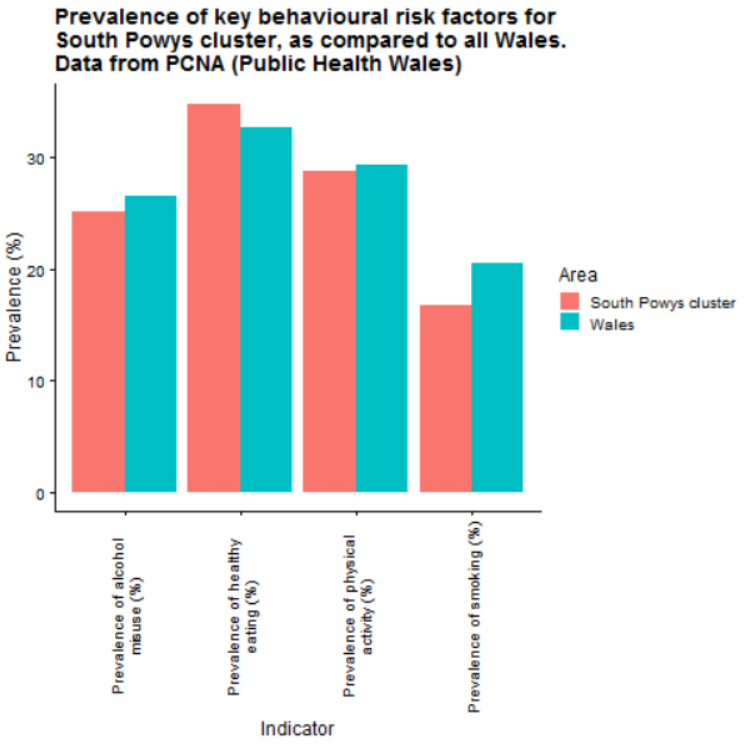
- Virtual Wards and Community Resource Teams
- Introduction of telephone triage and remote working across all practices
- Signposting to the most appropriate service for the presenting need by both receptionists and clinicians
- GP with Special Interest delivering Dermatology service for the Cluster
- Introduction of Health Board Silver Cloud online CBT system to support practices and community mental health services
- Clinician triage for both planned and unscheduled care
- New members of the primary care team – pharmacists, pharmacy technicians, ANPs, physiotherapists
- Introduction of cluster based Pharmacist team to support GP practices and community services using Pacesetter funding
- Use of Skype for medication review meetings cluster wide
- Near patient testing
- Optometrists – signposting of patients to service
- Practice based muscular skeletal physiotherapists
- Cluster wide enhanced services including minor surgery
- Increased involvement of Third Sector – Red Cross, PURSH [Powys Urgent Response Service at Home], Macmillan, Credu
- Introduction of 3rd Sector Community Connectors, attached to each practice to support statutory service providers, through partnership with PAVO
- Recording of all calls within the practice for training and monitoring purposes
- Remote ways of working for pharmacy and triage
- Standardised template used by GPs for easy clinical outcome evaluation
- Photos held on medical records to monitor healing rates with dermatology

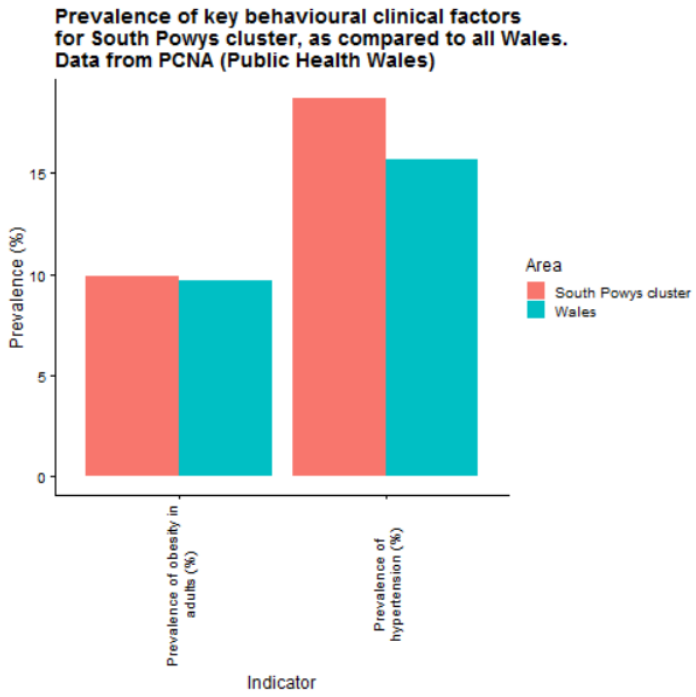
- EMIS system within the hospitals
- My Health Online
- Online booking for appointments and prescriptions
- Active monitoring for mild to moderate mental health problems
- Introduction of 3rd Sector MIND practitioners to support GP Practices and Community Mental Health Services using ICF funding
- Social prescribing by MIND
- Development of Community Interest group for the GP network – Red Kite – since 2015

The Cluster have implemented a large part of the All Wales Primary Care model.

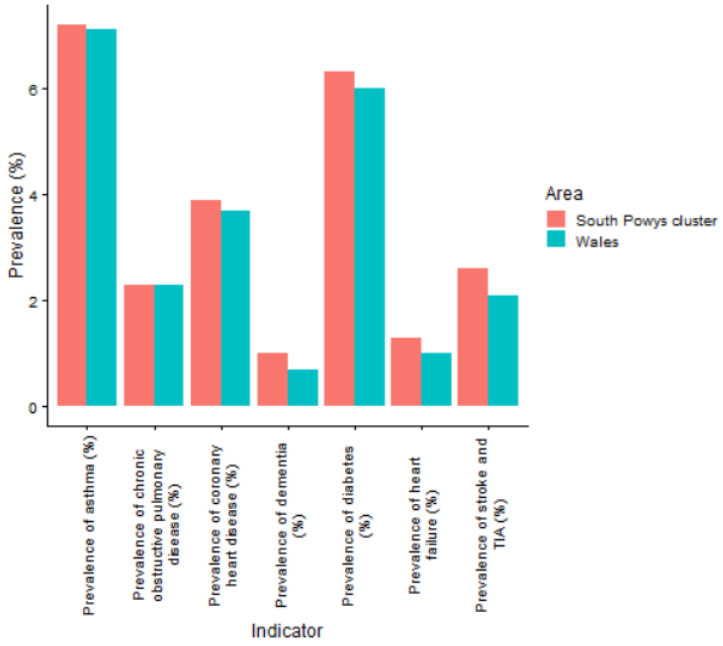
4. Cluster Population Area Health and well-Being Needs Assessment

The charts below demonstrate the information relating to the Cluster health and wellbeing assessment as provided by PTHB Public Health directorate.

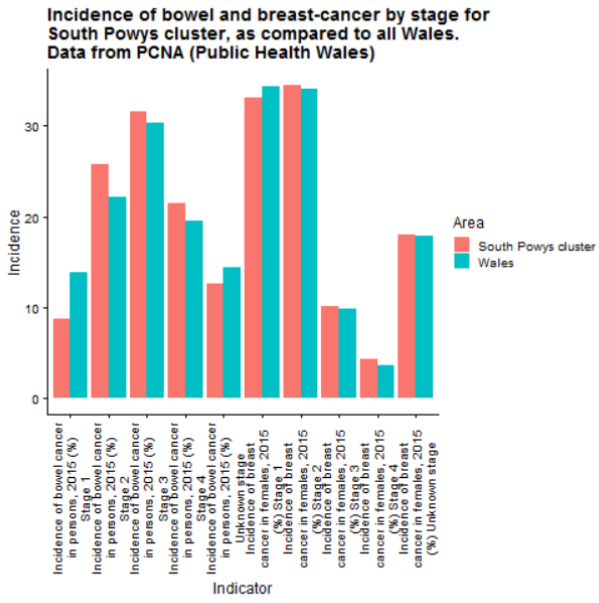




Prevalence of key long-term conditions for South Powys cluster, as compared to all Wales. Data from PCNA (Public Health Wales)



Incidence of bowel and breast-cancer by stage for South Powys cluster, as compared to all Wales. Data from PCNA (Public Health Wales)



5. Cluster Workforce Profile

Full technical detail and analysis has been completed and will be submitted to WG separately in line with the IMTP.

6. Financial Profile

- Further work is required to develop the governance and assurance frameworks required to clarify accountability arrangements
- Appropriate level representation from all partner organisations is a priority going forward
- Limited capacity with partner organisations to plan and manage change
- Organisational change and consistency of involvement
- Converting short team funded developments into long term funded service changes
- More direct influence into Executive Team

Communication and engagement mechanism

The main channel for these communications will be via the following:

- Health Focus groups
- Patient condition groups

8. Planned Cluster Actions and Intended Measurable Outputs and Outcomes 2020-23

The following have been identified as elements that the South Cluster wish to deliver over the next few years. In addition to the items listed, the following have been identified as priorities for the Cluster for 2020-21:

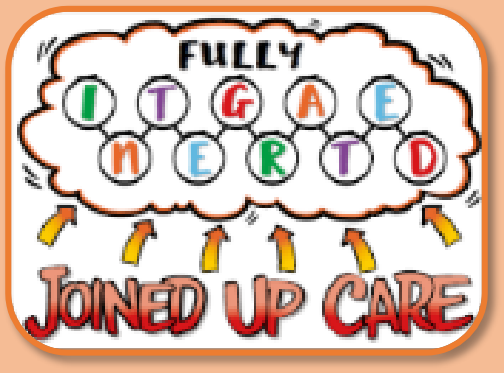
- GPwERs Cardiology, Dermatology – Business plan, funding source and identification/recruitment of GPwERS Phase 1 – Integration of service phase 2 and plan to roll out to cluster phase 3
- Pain Management – Business plan and funding sources explored to introduce a primary care pain management support tech that will focus on medication reduction and early stage intervention
- LARC IUCD – SLA and set up of cluster solution IUCD/LARC clinics based in Ystradgynlais and Brecon hospitals
- Physiotherapy – Agreement on SLA, continuation and increase of in-house Physiotherapy sessions plus further integration with TRIAGE services
- Roll out of Primary Care Transformation through Telephone first, Physiotherapy, OT, Pharmacist, Community and third sector services – Maximising the capacity of Telephone first. Integration of services, pathways and patient education to increase service knowledge and access

The Cluster milestones and actions aligned to the PTHB IMTP objectives are shown below. The priorities for 2020-21 also include the outputs and outcomes that are to be achieved. It is important to note that work will progress on a number of the actions in 2020-21 not just the priorities.

Core Well-being Objective 1	Focus On Well-being	
	Priorities	• Explore options to increase access to Community home support / reablement
		• Strengthen links with Virtual Ward to reduce emergency admissions
		• Develop common approach with community pharmacists to increase access to common ailments service
		• Develop integration with Specialist Nurses to support people with long term conditions (Respiratory, Diabetes, Cardiology)
		• Enhance Direct access to community pharmacists, opticians and dentists for patients "Choose Well"
		• Further integration of Community connectors attached to each practice
		• Increased public awareness through increased public health campaigns
		• Population profile to understand prevalence and ensure services provision meets demand
		• Confirm opioid reduction pathway in cluster

Core Well-being Objective 2	Early Help And Support	
	Priorities	• Improving pathways to Mental Health support • Improved access to diagnostics – POCT, MRI, CT • Advanced care plans for COPD patients to reduce hospital admissions • AF project continues in all practices "Stop a Stroke" initiative • Making Every Contact Count opportunities used where appropriate (MECC) • Development of telephone first and remote telephone referral pathways to improve access to appropriate care

Core Well-being Objective 3	Tackling The Big Four	
	Priorities	• Improve pathways to Mental Health services – define interventions for tier 0/1 patients. • Emotional support and resilience to young people: Establish a service to promote early help and support to young people experiencing emotional distress, yet do not require specialist Mental Health services from CAMHS. • Continue the roll out of the blended counselling and C-CBT service (Silver cloud) • Cancer – local pathways • Macmillan toolkit and support for end of life care • Care plan in place for all high risk respiratory patients • Improved integration with Specialist Nurses • Development of GPwERs Cardiology and "one stop shop"

Core Well-being Objective 4	Joined Up Care	
	Priorities	• Telephone first – rollout of a total and remote triage system. • Integrated CRTs and virtual wards to reduce emergency admissions. • New roles integrated for the Welsh Primary Care model – physios, pharmacists, ANPs. • Increased links with Community Connectors and discharge planning. • Develop proposals for global enhanced services for the Clusters • GPs with extended role development • Working with community pharmacists to develop chronic condition clinics • Repatriation of secondary care services that can be delivered closer to home – dermatology, vasectomy, pain management, IUCD • Continuation of Pharmacy SLA

Enabling Well-being Objective 1	Workforce Futures	
	PRIORITIES	• Development of new roles to support Wales Primary Care model • Joint Primary Care and Health Board training • Targeted development of GPwSIs to respond to population need and key pathways • Increased training of GPs, medical students, nurses, pharmacists • Regular sessions at Cluster level to disseminate and share learning across Powys

Enabling Well-being Objective 2	Innovative Environments	
	Priorities	• Development of scope and model for community well-being hubs in each dependent on health economy • Development of early pregnancy assessment unit and Women's Health Clinics

Enabling Well-being Objective 3	Digital First	
	PRIORITIES	• Further development of telehealth and telecare with links to consultants and secondary care settings • Maximise use of Cluster templates and integrated GP systems • Increased use of Skype appointments • Promotion of apps and electronic services to support systems, services and patient self care • Improved operability between systems to improve access to data when required • Develop remote working within the Wales Primary Care model • Tablet devices for GP home visits

Enabling Well-being Objective 4	Transforming In Partnership	
	PRIORITIES	• Continued development of cluster relationship with extended community care • Joint management of staff and services • Health focus and patient groups • Contribute to the robust management and response to strategic change programmes around the South Powys borders including Aneurin Bevan Clinical Futures, Hereford and Worcestershire Sustainability and Transformation Partnership proposals e.g. Stroke Programme, Major Trauma and Thoracic Surgery pathways • Development of community pharmacy teams to improve working relationships and improve patient care • Development of community hospitals for enhanced minor illness provision

9.

9. Strategic Alignment and Interdependencies with the Health Board, IMTP, Area Plan and Transformation Plan/Bids and the National Strategic Programme for Primary Care

The ambition for the people of Powys remains high. It is the second year of the shared Health and Care Strategy launched back in 2017 which set out the vision for a 'Healthy, Caring Powys'. This long term strategy for health and care forms the Local Area Plan and is itself a component of the very long term, inter-generational Powys Wellbeing Plan.
The Health and Care Strategy is based on extensive local engagement as well as taking into account national well-being goals, five ways of working and the sustainable development principle. The quadruple aim and design principles have been applied in the supporting priorities and actions.
PTHB are determined to be leaders in Wales in primary and community care and to continue to strengthen their role as an effective commissioner on behalf of the population of Powys. There is a very complex system of pathways across multiple health and care providers in England and Wales, as well as PTHB being a direct provider of healthcare. PTHB are a key partner with the local authority and third sector.

PTHB have submitted a bid to the Welsh Government Transformation Fund seeking funding to be able to implement the Powys Primary Care Transformation Programme. This will be delivered through clusters in line with the principles and components of the Primary Care Model for Wales. This model aims to deliver the following objectives:

- Improved access to urgent and unplanned care
- Improved proactive care for those with more complex needs
- Improved routine and preventative care
- Improved business efficiency and sustainability within practices
- Delivery of safe effective care as close to home as possible

The scope of this proposal aims to transform primary and community care provision in Powys. Through an accelerated programme, a whole system Cluster based health and care service planning and delivery model will be created. This will:

- Improve the health and wellbeing outcomes for the Powys population, by designing services that specifically meet the needs of that population
- Improve access to care by providing more primary and community services, delivered locally, in order to prevent avoidable acute care demand
- Improve general practice sustainability by creating additional clinical capacity within Practices and additional potential income streams

Improve efficiency by ensuring that all resources available within the health and care system are deployed in a coordinated manner, across professions and sectors in order to deliver agreed outcomes.

Partners across primary, community health, and social care will work together to further develop Clusters and the planning of health and well-being services to respond to local need. Clusters bring together services around a local community, to improve health and wellbeing, quality and efficiency of care and integration. Innovative care pathways will be designed and trialled, reviewing and refreshing approaches to interventions such as Virtual Wards and Care Co-ordination. This will link this to the design of planned and urgent care, working with partners in secondary, specialist and ambulance services, so that services can be more easily accessed and appropriately utilised. Rural Regional Centres and Community Hubs will be at the heart of a joined up approach to primary, community, unscheduled and social care.

This will be achieved as part of a service transformation where the focus will be on health, wellbeing and prevention using home based care and self-management, local health and social care services to reduce the need for hospital based care and treatment.

The aim is to make it as easy as possible for patients, clients, stakeholders and staff to interact with the Health Board, Council and its partners through innovative service delivery and better use of technological and information assets.

The Cluster will work to further rollout and upscale existing telehealth/ telecare and assistive technology solutions as well as seeking funding over the next three years to develop new solutions. Specifically this will include My Health on Line, the Florence texting service, the SilverCloud online CBT programme and the My COPD and neurological apps that enable people to increase their involvement in the management of their treatment, conditions. The wider use of Skype and remote consultations within the Cluster will enable further development of handheld apps for self-management of health conditions.

Strategic Context

'A Healthier Wales: Our Plan for Health and Social Care' was published by Welsh Government in 2018, setting out a shared ambition to bring health and care services together into a seamless whole system approach, designed and delivered around the needs and preferences of individuals, with a much greater emphasis on health and well-being. It describes a community based model of health and social care, with a stronger public health approach and transformation of key areas including primary, planned and urgent care.
There is a focus on transformation and innovation to meet the needs of the Welsh population. A Healthier Wales describes a shift from large general hospitals to regional and local centres.

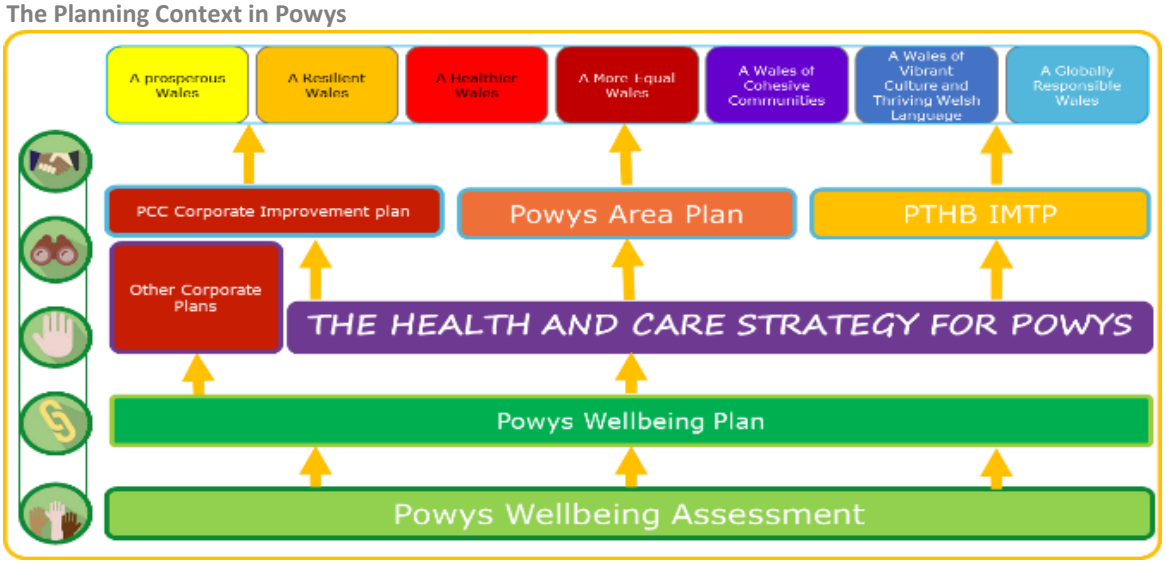
<u>Well-being of Future Generations Act</u>

Five Ways of Working: Long Term Vision

A Healthy Caring Powys sets out our long term vision. Key to this is the evidence of the well-being assessment which, in addition to setting out the current picture of well-being in Powys, explores the long term impact if the current focus and approach remains the same.

The health board has made a commitment to fully align organisational delivery and performance improvement to the long term vision. The overleaf diagram outlines the planning context and the way in which plans and planning requirements fit together to support the delivery of the national well-being goals.

The Planning Context in Powys



Five Ways of Working: Prevention

The Health and Care Strategy and the IMTP encompass primary, secondary and tertiary prevention. Core objectives of the Health and Care Strategy include a focus on well-being and the provision of early help and support. The IMTP outlines specific actions which encompass reducing tobacco use, promoting a healthy diet and access to physical activity, empowering staff to have the confidence and competence to discuss healthy lifestyles with service users, and ensuring the population is protected from the threat of infectious diseases through immunisation programmes. It also includes a focus on early years and ensuring children are protected from adverse experiences from a young age, ensuring every child enters school ready to learn. Road traffic accidents are also highlighted, recognising the impact that this issue has in a rural area like Powys. More broadly, the Powys Well-being Plan sets out a vision for a Powys in 2040 in which there is a stable and thriving economy, a sustainable and productive environment; a population which is healthy, socially motivated and responsible, and people are connected to resilient communities and a vibrant culture. The steps to achieve the 2040 vision are published in the Well-being Plan.

Five Ways of Working: Integration

Powys County Council and PTHB are key partners in the Regional Partnership Board and the delivery of the Area Plan and 'A Healthy Caring Powys'.

Bwrdd Partneriaeth Ranbarthol Powys
Iechyd a Gofal Cymdeithasol
One Powys Yn Un
Powys Regional Partnership Board
Health and Social Care

Key to this is the triple integration approach of health and social care, mental and physical health and primary and community care.

Five Ways of Working: Collaboration

When launched in 2017 'A Healthy Caring Powys' was the first joint strategy between health and social care in Wales. It is reliant on collaboration between the health board, Powys County Council, the Third Sector, Universities, the public, patients and carers. The strategy ensures that efforts and resources are aligned to deliver improved outcomes for the Powys population.

Five Ways of Working: Involvement

The well-being objectives were developed from what the people of Powys said about their health and care – in service user surveys, complaints, compliments, engagement events, service user forums, conferences and specific health and care events.



10. Health Board Actions and Those of Other Cluster Partners to Support Cluster Working and Maturity

There are clear links and interdependencies between the PTHB IMTP and priorities, other cluster partners and the aims and milestones in this plan.

PTHB transformational programmes, notably the North Powys Well-being Programme, the Workforce Futures programme, the Primary and Community Care work, the plans for Digital First and the Breathe Well programme, form the PTHB response to a complex environment of change around the borders of Powys and across commissioned services.

The North Powys Well-being Programme is the first of the major programmes to secure investment in the form of Welsh Government Transformation funding. This includes the development of a model of care that is based on prevention and well-being first, with care closer to home, wrapped around the person and their community, not the services and organisations. It is an opportunity to work across traditional boundaries, including education, housing and the independent, community and voluntary

The Primary and Community Care element is building on a strong track record in Powys, with many of the elements of the National Primary Care Programme already in place and some significant innovations which are being rolled out in other areas of Wales after a successful starting point in Powys.

Tackling the Big Four is concerned with the clinical strategies in place for those conditions that have the most impact on the population of Powys. The Breathe Well programme is being taken forward as a key priority and significant progress has been made in 2019/2020 with robust plans to accelerate the work in this area for 2020/21.

Each of these in turn depends on the development of strategic frameworks for Digital First and Workforce Futures, to underpin the transformation ambitions. These enablers are key to ensuring that the transformation programmes are based on robust assumptions, forming a resilient and sustainable approach across both health and care.

In order to achieve the outcomes of 'digital first', Powys Teaching Health Board has three interconnected priorities:

- Digital Care: Telehealth and Telecare
- Digital Access: Implementation of the ICT National Programme
- Digital Infrastrucutre and Intelligence

It would almost be impossible to develop or rollout digital applications that address service needs unless the digital infrastructure is fit for purpose, secure and robust. It is the inter-dependency and balance between these components that have been considered when planning a holistic work programme.

Workforce Futures is a key enabler in the Health and Care Strategy and creating a 'Healthy, Caring Powys' between now and 2027. The successful delivery will include co-operation with PTHB partners including the commissioned services workforce. This will be more important as more services are repatriate to Powys. This will help establish joint posts not only across sectors, but also across health organisations. The Health Boards OD framework therefore focuses on structure, process, people and culture. The framework will support organisational alignment to meet the need of the Health & Care Strategy and the transformational change programme required. There are significant opportunities, but also challenges, including recruitment, retention, an ageing workforce and workforce fragility.

The Mid Wales Joint Committee for Health & Care was established to ensure there is a joined up approach to the planning and delivery of health and care services across Mid Wales. The Joint Committee's partner organisations will work together to address the current health and care needs of the Mid Wales population as well as the challenges for the future. There are 5 overarching aims:

Aim 1: Health, Wellbeing and Prevention

Improve the health and wellbeing of the Mid Wales population.

Aim 2: Care Closer to Home

Create a sustainable health and social care system for the population of Mid Wales which has greater focus on care closer to home.

Aim 3: Rural Health and Care Workforce

Create a flexible and sustainable rural health and care workforce for the delivery of high quality services which support the healthcare needs of rural communities across Mid Wales.

Aim 4: Hospital Based Care and Treatment

Create a sustainable and accessible Hospital Based Care and Treatment service for the population of Mid Wales with robust outreach services and clinical networks.

Aim 5: Communications, Involvement and Engagement

Ensure there is continuous and effective communication, involvement and engagement with the population of Mid Wales, staff and partners.

The Mid Wales Joint Committee has four subgroups to ensure that the work programme is achieved:

- Mid Wales Clinical Advisory Group
- Mid Wales Public and Patient Engagement and Involvement Forum
- Mid Wales Planning and Delivery Executive Group
- Rural Health and Care Wales Management Group