Good Practice Guide Appendices Appendix 3

FAQs for Primary Care Clusters

What are primary care clusters?

Primary care clusters (clusters) are a mechanism to enable collaboration between Health Boards and their partners at a local level. Health Boards are statutorily responsible for the health of their population. This involves assessing the health and wellbeing needs of their populations and then planning and securing services to meet those needs.

Health Boards' partners include those people whose job it is provide health services or services which impact on people's health and wellbeing. This includes people who work in the NHS and also people who provide local authority services and those who work for or volunteer through the voluntary sector.

Why would service providers want to collaborate through a cluster?

The incentive to collaborate is the ability to take decisions which make better use of available funding, workforce and other resources. These decisions will help ensure manageable workloads and better access and care for local people who experience local services

Why is planning care locally so important?

In its review of evidence, published in July 2014, Public Health Wales NHS Trust said there is an emerging and strong consensus in the UK literature that planning and provision of primary care should be done at a small population level. The Kings Fund proposes an optimum size of 25,000 to 100,000 populations.

Drawing in all available clinical, non-clinical, workforce, financial and other resources, those of the NHS and also those of local authorities i.e. social services, housing, education, environment, transport, leisure and those of the third and independent sectors, and determining their use at a cluster level to provide local health services, creates better opportunities for addressing duplication, inefficiency, sustainability and gaps.

How much service planning and organisation could be done by clusters?

As much or as little as clusters feel comfortable with. A **cluster maturity matrix** is included in the appendices for illustrative purposes.

Are there any resources to help clusters develop?

Health Board Directors of Primary Care, Community and Mental Health are pulling together a range of work and learning to date to create a set of governance arrangements. These will be designed carefully to support each cluster on its own individual journey of development. These governance arrangements will be ready for use by June 2018.

In addition, Primary Care One is a repository of good practice and learning.

Can individual clusters collaborate?

Yes. This could happen in a variety of ways for a variety of reasons. It will depend on what makes sense locally.

How are cluster level population needs assessments used?

This very locally sensitive assessment of need at cluster level will then inform a cluster level 3 year plan to improve health and meet assessed needs.

Cluster level population needs assessments also feed in to formal statutory needs assessment such as the one for care and support required under the Social Services and Wellbeing (Wales) Act and the wellbeing needs assessment required under the Wellbeing of Future Generations (Wales) Act. These population needs assessments underpin health boards 3 year IMTPs, area plans produced by regional partnership boards and wellbeing plans produced by Public Services Boards.

Can clusters produce and implement plan?

Yes. We want clusters to use their locally sensitive population needs assessments to inform 3 year rolling plans for the use of all available clinical and non-clinical services, workforce, funding and other resources in order to meet assessed population need.

How many clusters are there?

Health Boards have created a total of 64 clusters across Wales. This could change if it makes sense to merge clusters or clusters may simply work with neighbouring clusters where this makes sense.

Are the national primary care contractual frameworks being used to support cluster working?

The annual changes to the national GP contract have been used for several years to encourage GP practices to collaborate with each other at cluster level to share outcomes in a small number of clinical areas such as cancer and polypharmacy.

In 2017-18, cluster working has been introduced explicitly in to the community pharmacy national contract.

Cluster working does not currently feature in the national dental contract or in the contracting arrangements for optometry services.

Is there any national work in support of cluster working?
Yes. Health Board Directors of Primary Care, Community and Mental Health commission an annual programme of support for clusters from the Public Health Wales hosted primary care hub.

A key tool is the Primary Care One website which acts a repository of learning and good practice to inform cluster plans. The hub also organises national, regional events for clusters to share learning. It has facilitated 2 cohorts of cluster leads through the Confident leaders Programme.

What can clusters procure for themselves?
See separate FAQ guide being developed.

Can clusters also plan access close to home to more specialist care?
Yes. As well as planning and delivering more primary care services to meet local need, primary care clusters will also play a significant role in planning the transfer of services and resources out of hospitals and into their local communities for the benefit of their local populations.

Collaboration across what are integrated Health Boards through primary care clusters creates better opportunities to take an innovative approach to designing local health services. Innovation is about generating new funding models, new service models and workforce roles, new ways of contracting and new partnerships with communities between professionals, services and sectors. Innovation also includes new technology, products and services, and working with universities and industry to accelerate innovation and to support economic growth in Wales. It is about making the best use of facilities to promote professionals working together.

How can clusters improve care for people at risk of or living with chronic conditions?
Demographic and lifestyle changes are driving an increase in chronic conditions and the need for long-term care or management of illness. This is shifting and blurring the boundary of traditional concepts of healthcare and between health and social care, requiring much more effective working between different professionals and services, including social services. It also includes the individual's own network of support from friends and family. Most formal services are still planned and secured by the NHS and local authorities, often contracted from primary care providers and

the third sector. Sharing information and integrating the planning and delivery of health and social care services by different organisations across these historic boundaries is an area where improvement and efficiency will come from innovations like joint service contracting, pooled budgets, and new integrated delivery structures.

People will increasingly want to use home diagnostic equipment and to share data from digital devices. They will increasingly use their health record online and other sources of information, advice and assistance to make informed choices about their own care, using high-quality reliable information and advice in formats that meet their needs. They will also look for informed guidance from professionals on using new technology. Continuous monitoring in areas like mental health, cardiovascular disease, diabetes and respiratory disease will transform the way conditions are managed, reconfiguring services to enable earlier diagnosis, more emphasis on prevention, and more independence for patients.

What can clusters mean for contracted services?

In some parts of Wales, as in other parts of the UK, the GP independent contractor model is under pressure with newly-trained doctors seemingly reluctant to buy into a practice partnership. The age profile for both GPs and practice nurses is increasing; there are more part-time professionals working in general practice and there are challenges in recruiting, particularly in rural and deprived areas.

While the General Medical Services contract model, which is negotiated nationally, for contracting services from independent GPs, who usually come together in partnerships to form a GP practice, will remain the principal model in Wales, Health Boards, through their cluster collaboration, will consider the use of other options. These options include contracting care at a cluster level as well as at individual GP practice level, employing GPs directly themselves and using the alternative provider medical services contract model to secure services from GPs not set up as a traditional practice partnership. To be sustainable now and in the future, some practices will need to consider merging with another one, or establishing federations. As well as using a range of contracting options, we want Health Boards to agree flexible career structures and portfolio roles to meet local needs.

To support the coordination of care, Health Boards with their partners through the clusters should consider and develop joint contracting arrangements with multiple service providers, including other primary care contractor services like community pharmacy, dentistry and optometry and local authorities and the third and independent sectors. The current model of enhanced general

practice service specifications can be effective in focusing care on vulnerable groups, can be further developed to support this.

This more flexible and innovative approach to contracting will help change the flow and use of resources and how services are delivered, benefitting service users and providers and will enable Health Boards to be more strategic in their direction of resources to areas of need.