IMTP 2020/21 – 2022/23 APPENDICES

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Appendix 1: PTHB Annual Plan 2020 - 2021

Core Well-being Objective 1 — **FOCUS ON WELLBEING**

PRIORITIES
- Wider Determinants of Health
- Health improvement & Disease Prevention
- Supporting Communities and Carers

Core Well-being Objective 2 — **EARY HELP AND SUPPORT**

PRIORITIES
- Primary and Community Care
- Cluster Working
- Connecting Communities

Core Well-being Objective 3 — **TACKLING THE BIG FOUR**

PRIORITIES
- Mental Health
- Cancer
- Respiratory Conditions
- Circulatory Disease

Core Well-being Objective 4 — **ENABLE JOINED UP CARE**

PRIORITIES
- North Powys Well-being Programme
- Unscheduled Care and Out of Hours
- Planned Care
- Specialised Care
- Quality and Citizen Experience

Enabling Well-being Objective 1 — **DEVELOP WORKFORCE FUTURES**

PRIORITIES
- Designing, Planning and Attracting Workforce
- Leading the Workforce
- Engagement and Well-being
- Education, Training and Development
- Partnership and Citizenship

Enabling Well-being Objective 2 — **PROMOTE INNOVATIVE ENVIRONMENTS**

PRIORITIES
- Research Development and Innovation
- Capital Programme and Estates
- Facilities

Enabling Well-being Objective 3 — **PUT DIGITAL FIRST**

PRIORITIES
- Digital Care
- Digital Access
- Digital Infrastructure & Intelligence

Enabling Well-being Objective 4 — **TRANSFORMING IN PARTNERSHIP**

PRIORITIES
- Good Governance
- Financial Management
- Partnership, Planning, Performance and Commissioning

Appendix 1: PTHB Annual Plan 2020 - 2021

Organisational Priority			Ref.	Organisational Delivery Objective	Lead
Well-being Objective		Wider Determinants of Health	1.1	Implement the Powys Wellbeing Plan as a partner of the Public Service Board	DPH
		Health Improvement and Disease Prevention	1.2	Implement the health improvement and disease prevention programme Including Healthy Schools, Healthy Weights, vaccinations, social equity in screening approach, smoking cessation, physical activity, Sexual Health Improvement Plan	DPH
		Supporting Communities and Carers	1.3	Deliver Community and Carers Support as per RPB Plan Including making every contact count (MECC), work with the third sector on Community Connectors, Info Engine and Dewis, accessible information, advice for wellbeing and signposting for those most vulnerable	DoN
		Primary and Community Care	2.1	Implement the transformation programme for primary and community care Including general practice, dental services, eye care and medicines management	DPCCCMH
		Cluster Working	2.2	Deliver Cluster IMTPs (Integrated Mediurm Term Plans) Including the Transformation Fund implementation if successful	DPCCCMH
		Connecting Communities	2.3	Delivery of Start Well, Live Well and Age Well Programmes - Neighbourhood Nursing model, volunteering, ACES, Dementia and DOLS - Maternity, First 1000 Days and Healthy child, Infant and Paediatric Workstreams	DoN & DCCPCMH
		Mental Health	3.1	Deliver Mental Health Services Programme Including Adult Serivce Model, improvement plan, psychological therapies, Maternal and Infant Health, Integration and CAMHS	DPCCCMH
		Cancer	3.2	Implement the Powys Cancer Transformation Programme Clinical Change Programme for Cancer - Whole System Value Based Approach	MD
		Respiratory Conditions	3.3	Deliver the Breathe Well Programme Clinical Change Programme for Respiratory Conditions - Whole System Value Based Approach	MD
		Circulatory Disease	3.4	Implement the Powys Circulatory Conditions Programme Clinical Change Programme for Circulatory Conditions - Whole System Value Based Approach	DPH

Appendix 1: PTHB Annual Plan 2020 - 2021

Organisational Priority			Ref.	Organisational Delivery Objective	Lead
Well-being Objective		North Powys Well-being Programme	4.1	Deliver the North Powys Well-being Programme (Phase 2) and the Powys Model of Care	DPP
		Unscheduled Care and Out of Hours	4.2	Deliver the Powys Unscheduled Care Programme	DPCCCMH
				Deliver the Out of Hours model	DPCCCMH
		Planned Care	4.3	Deliver the Planned Care Programme	DPCCCMH
		Specialised Care	4.5	Deliver the WHSSC Integrated Commissioning Plan (PTHB contribution)	DPP
		Quality and Citizen Experience	4.6	Deliver the Annual Quality Work Programme Including the implementation of the Clinical Quality Framework and Improvement Actions	DoN
		Designing, planning and attracting the workforce	5.1	Implement the Powys Workforce Futures Strategic Framework (Theme 1) Including the Organisational Change Process Phase 2, Brand Powys, Succession Planning	DWOD
		Leading the workforce	5.2	Implement the Powys Workforce Futures Strategic Framework (Theme 2) Including Cultural Development, Managers Programme, Assistant and Deputy Directors Programme	DWOD
		Engagement and well-being	5.3	Implement the Powys Workforce Futures Strategic Framework (Theme 3) Including staff engagement, well-being initiatives and support	DWOD
		Education, training and development	5.4	Implement the Powys Workforce Futures Strategic Framework (Theme 4) Including training, Higher Education and Talent Management	DoN
		Partnership and citizenship	5.5	Implement the Powys Workforce Futures Strategic Framework (Theme 5) Including volunteering, work experience, Rural Acedmy Business Case and young people	DWOD

Appendix 1: PTHB Annual Plan 2020 - 2021

Organisational Priority		Ref.	Organisational Delivery Objective	Lead
Well-being Objective	 Research, Development and Innovation	6.1	Implement Innovation and Improvement Framework Deliver the Innovation and Improvement Hub	MD
	Capital, Programme and Estates	6.2	Deliver the Capital and Estates Programme Including long term estates strategy, capital developments, environmental sustainability, property and asset maintenance and investment, ISO14001	DPP
	Facilities	6.3	Deliver Facilities modernisation programme Including waste and recycling; catering, and transport	DWOD
	 Digital Care	7.1	Develop and implement a Digital Strategic Framework Including telehealth and telecare	DoF
	Digital Access	7.2	Implement the systems to improve digital access ICT National Programme implementation	DoF
	Digital Infrastructure and Intelligence	7.3	Improve ICT infrastructure and business intelligence Including business intelligence capability and systems	DoF
	 Good Governance	8.1	Deliver Annual Governance programme Board and Committee Governance, Board Assurance Framework, Information Governance	BS
	Financial Management	8.2	Deliver the Financial Strategy in line with Efficiency Framework Including approval of balanced IMTP 2019-2022 and delivery of financial balance	DoF
	Partnership. Planning, Performance and Commissioning	8.3	Deliver key partnership plans Including management of strategic change programmes, Regional Partnership Board, Mid Wales Joint Committee, Regional Planning Fora	DPP
		8.4	Deliver continuous planning, performance and commissioning Delivery of the Improving Performance Framework; Strategic Planning and Commissioning	DPP

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: CANCER

Local Priorities for 2020/21	Measures
• Implementation of Cancer Transformation Programme: Analysis of population need, evidence and opportunities; Programme Plan • Implementation of the Improving Cancer Journey (ICJ) including Governance Framework, pathway development and engagement, focusing on the experience of the cancer pathway and treatment • Continued implementation of the Single Cancer Pathway building on successful tracking development in 2019/20 and rapid diagnosis via JAG accredited theatre in Brecon for endoscopy procedures; further strengthening of early diagnosis with SCP bid for Joint consultants; ensuring appropriate access to MRI and CT scanning with timely receipt of reports and onward referral including pathways for urgent assessment working with acute providers • Ensure appropriate access to MRI & CT scanning with timely receipt of reports to ensure timely onward referral • Training and development including Macmillan Framework to support clinical leadership development; GP Practice cancer champions; GP oncology and palliative care education programme • Improve information provision, accessibility and awareness including work with third sector partners, neighbourhood schemes and community connectors and workplace communication mechanisms • Continued use of Commissioning Assurance Framework to robustly manage performance of directly provided and commissioned services and increasing use of commissioning intelligence to inform Cancer transformation programme • See End of Life Plan in Appendix for palliative care programme • My life , My Wishes launched, Adopt and Spread supported by Bevan Commission See Focus on Well-being section for cross reference to health improvement programmes and campaigns including smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation, promotion of healthy lifestyles; targeted and co-ordinated screening campaigns Also refer to the End of Life Delivery Plan in the Appendix for information on palliative and end of life care.	• Cancer access targets • Hospital activity data • Population needs • Screening uptake • Training activity • Measures relating to health inequalities (Powys Well-being Assessment)

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 – 2022 / 23
• Cancer Transformation Programme Plan agreed • ICJ Launch and Programme Plan sign off • Complete Good Practice / Evidence Review • Continue robust management of SCP measure in PTHB, adoption of optimal pathways where appropriate • Monitor SCP scheme for theatre nurses funded by WG	• Full needs assessment including review of existing services and pathways • Engagement on pathway experience • Continue robust management of SCP measure in PTHB, adoption of optimal pathways where appropriate • Monitor SCP scheme for theatre nurses funded by WG	• Continue engagement phase • Further milestones to be defined in Q1 and Q2 following analysis / plan development and sign off – will include resource plan and training needs plan • Continue robust management of SCP measure in PTHB, adoption of optimal pathways where appropriate • Monitor SCP scheme for theatre nurses funded by WG	• Further milestones to be detailed post Q1 and Q2 dependent on findings of analysis – will include Final Powys Model of Care for cancer; feasibility of options as appropriate Continue robust management of SCP measure in PTHB, adoption of optimal pathways where appropriate • Monitor SCP scheme for theatre nurses funded by WG	• Implement further phases of Cancer Transformation Programme (detailed work to be conducted in Phase 1 to identify longer term programme actions and milestones)

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: STROKE

Local Priorities for 2020/21-23	Measures
The Circulatory Programme noted in the Big Four Section of the IMTP will encompass the Stroke Delivery Plan, key actions for 2020/2021 noted below (a full Stroke Delivery Plan is overseen by the Powys Stroke Delivery Group): • Improve detection and management of atrial fibrillation and hypertension in primary care • Improve prevention and diagnostics for stroke with liaison and training across primary and community services • Early intervention and access to acute stroke care • Timely access to rehabilitation close to home with development of Powys pathways and services • Continue to develop staff and multidisciplinary working on stroke rehabilitation wards and in the community; review of staffing and team working on wards which admit people who have had a Stroke • Improve patient's experience of care from hospital to home, focusing on the transition of care and support by developing new stroke nurse role and working more flexibly across hospital and community settings • Implement and respond to patient experience findings and outcome measures; improve service user engagement in service improvement • Improve flow of patients through acute and inpatient rehabilitation units by improving community rehabilitation; • Workforce planning and modelling to address patient flow throughout the pathway • Increase intensity of therapy provided in the community • Improve communication and coordination of care to demonstrate continual improvement against 6 month review rates • Support the development of a stroke research network in Wales and identify further opportunities for engaging in research • Engage in plans for thrombectomy care in liaison with WHSSC • Continue to participate in strategic programmes where service planning for stroke is taking place at a national level and in neighbouring Health Boards in England and Wales including HDUHB Transforming Clinical Services, ARCH Programme, Herefordshire and Worcestershire Stroke Programme Board, ABUHB Clinical Futures • Update information available on website for stroke survivors including clear pathways for services and support within the county and specialist services out of county	• Stroke treatment measures • SSNAP Data • Hospital / clinic/ therapy activity • Primary Care Activity • Programme Plans • Study results • Workforce measures • PROMs • PREMs • Patient experience survey

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 – 2022/23
Paper developed to review MDT working, role of blended support workers and nursing HCSWs Support Early Discharge development work (ongoing)	Continue to improve effectiveness and quality of inpatient rehabilitation for stroke survivors as reported to WG	Stroke nurse in post - improved completion of 6 month reviews for stroke survivors	Service User Forums in place to support service co-production	Further phases of Circulatory Programme to be detailed following work in 2020/2021 on Phase 1 Continue to support clinicians undertaking the Stroke Clinical Leadership Programme Implementation of early supports discharge service as part of community neuro service across Powys

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: DIABETES

The national diabetes implementation group decides its priority areas annually but three key strands are likely to be consistent: meeting national standards in primary and inpatient care; supporting people to manage their conditions through structured education programmes; and creating more integrated primary and specialist provision

Local Priorities for 2020/21	Measures
The Circulatory Programme will encompass the Diabetes Delivery Plan, key actions for 2020/2021: • Delivery and evaluation of structured education programmes to support self care • Adopt the Referral Pathway for Children with Suspected Diabetes • Achieve improvement against 8 essential care processes (adults) • Participate in peer review of type 1 diabetes services • Promote the uptake of Diabetes Enhanced Services in primary care • Review outcomes of the community pharmacy campaigns to inform future programme and run campaigns with pharmacies / Diabetes UK Cymru • Create more integrated primary and specialist provision as part of the wider Circulatory Programme of work	• Public Health Outcome Framework • Hospital / primary care / clinic activity and attendance • Emergency admissions for key indicative clinical presentations • Insulin pump rates • Compliance with key care processes Education activity

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 – 2022/23
• Deliver Type 2 Living with Diabetes Patient Education • Annual Protected Learning Time Workshops	• Review Paediatric to Adult services • Annual review of 8 Care Processes with GP practice engagement	• Complete Type 1 Diabetes peer review • Targeted campaigns to support Flu Plan	• Annual review of Diabetes Plan – in context of Circulatory Programme	• Further phases of Circulatory Programme to be detailed following work in 2020/2021 on Phase 1

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: HEART DISEASE

Powys has cardiovascular chronic disease prevalence and health needs similar to other areas of Wales but has no specialist cardiology services within the Health Board.
Patients therefore have to travel large distances to different locations for specialist investigations and review and it has been identified in the 2013-16 Powys Heart Delivery Plan that Powys patients seek treatment for heart related conditions later than in other parts of Wales.
The vision of the Heart Conditions Delivery Plan is for a fully integrated primary, community, secondary and specialist pathway of care, designed around the needs of the patient, to provide the support for ongoing care.

Local Priorities for 2020-23	Measures
The Circulatory Programme will encompass the Heart Conditions Delivery Plan, key actions for 2020/2021: • Reduce smoking prevalence through the Tobacco Control Action Plan • Improve detection & management of atrial fibrillation (primary care) • Provide opportunities for physical activity and improving diet working with partner agencies as part of *Healthy Weight: Healthy Wales* • Agree the model for community cardiology as part of the wider programme of work on Circulatory conditions • Continue to embed heart failure PROMS data collection in Powys • Explore funding opportunities for research and pilot studies • Participate in the national cardiac rehabilitation audit • Working as part of the National Implementation Group, participate in the delivery of the National Delivery Plan and all Wales pathways to improve access, treatment times and outcomes • Making Every Contact Count promoted extensively to support staff to effectively raise the issue of smoking with patients. Information about signposting to local support services is included in the training	• • Public health outcome framework • Hospital activity • Primary and community care activity • Patient experience • PROMS • Programme measures

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 – 2022/23
• Delivery of heart failure PROMS data collection • Continuation of key interventions as noted above (ongoing) • Further specific milestones to be determined as part of the scoping phase of the Circulatory Programme	• As per Q1 – ongoing actions; further specific milestones to be determined during Phase 1 of Circulatory programme	• As per Q1 – ongoing actions; further specific milestones to be determined during Phase 1 of Circulatory programme	• As per Q1 – ongoing actions; further specific milestones to be determined during Phase 1 of Circulatory programme	• Further phases of Circulatory Programme to be detailed following work in 2020/2021 on Phase 1

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: RESPIRATORY

Organisational Priorities for 2020/21-23	Measures
• Implement phase 2 of the Powys Breathe Well Programme: • Complete the programme impact assessment • Complete the risk mitigation of the proposals • Respiratory model for Powys will be completed by March 2020 and the Phase 2 plan finalised for implementation in 2020-23 • Service specification developed and approved, with preferred option(s) identified and agreed. • A workforce model will be developed with the model of care and service specification work. • Implications for LTAs and SLAs identified. • Deliver and evaluate pilot Respiratory Response Team pilot project with WAST. • Work with RHIG (Respiratory Health Implementation Group) to strengthen asthma plans for children & young people; physiology and sleep services.	• Hospital / primary care / clinic activity • Referrals for pulmonary rehab • Smoking cessation • COPD related measures • Oxygen variation

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21	2021/22 - 2022/23
• Implement Phase 2 (value, workforce, informatics) • Service specification approved • WAST pilot project implemented • Progress workforce model including physiology and sleep services	• Phase 2 • Centenary • Progress workforce model including joint appointments • Transition of LTAs & SLAs negotiated • WAST pilot evaluated • Winter plan	• Phase 2 • Children & young people's asthma plans strengthened • Winter plan implementation • Review workshop • Patient Forums • Phase 3 development & embed in next IMTP	• Phase 2 completion • Children & young people's asthma plans strengthened • Winter plan implementation • Strengthened intelligence and performance reporting	• Implementation of Phase 3 of Breathe Well Programme (detailed programme actions and milestones to be determined by work carried out in Phase 2).

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: NEUROLOGICAL CONDITIONS

Local Priorities for 2020/21-23	Measures
• Whole system approach including assessment of population need; programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy active lifestyles • Implement a co-productive approach to raising awareness of neurological conditions through continuing to work with Third Sector partners and local patient groups to raise awareness • Implement a co-productive approach to service development through using patient stories to evaluate and inform service developments and developing a service user forum to support the Steering Group • Developing clear pathways and models of care based on best practice and research evidence by working with specialist services in England and Wales to refine and improve patient pathways in line with national guidance • Raise the profile of the support and rehabilitation available in Powys to service users and professionals working in and out of Powys • Reduce unplanned admissions through better coordination of care in the community • Develop further capacity to provide appropriate intensity and level of therapy in the community through use of blended therapy assistants and telehealth • Enhance links with the Third Sector to maximise opportunities to support self-management • Ensure training programmes are in place for all levels of staff working with people with these conditions to improve access to emotional support • Support the development of clinical leadership skills in the field of stroke and neurological rehabilitation • Implement use of PREM and PROM in service evaluation and development • Powys subgroup of the National Steering group will pilot the Cerebral Palsy register using WCCIS and host the first stakeholder participatory events organised by part time research physiotherapist and Lead Paediatric Physiotherapist	• CNS engagement with awareness raising event across Powys • Service User Forum in place • Evidence based service specifications in place for commissioned services • PADRs • 2 clinicians on the Stroke leadership Programme • Reduced admission, greater uptake of services • Number of neuro cafés in place • National PREM and PROM tested locally and rolled out

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 – 2022 / 23
• Clinical Leadership workshop for B7 stroke and neurological Conditions Clinical Leads	• Pilot PROM and PREM as part of national project • Additional Neuro café's up and running in mid locality	• 2 PTHB Community Neuro Service Clinical Leads on the Stroke Clinical Leadership Development Programme • New Specialist MS pathway in place in south locality	• Roll out PREM and PROM for community neuro clinics • Service User Forum to be operational	• Annual review and priority setting to be carried out in 2020/2021 • Anticipated that a further two neuro cafes will be operational across Powys

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: END OF LIFE

Local Priorities for 2020/21-23	Measures
Supporting Living and Dying Well • Roll out the Powys My Life My Wishes to support advance care planning. • Ensure training is available for clinical teams to enable the use of My Life My Wishes and facilitate conversations about advance care planning • Work with Byw Nawr to raise public awareness about the importance of advance care planning and being more open about death, dying and bereavement. **Detecting and Identifying Patients Early** • Through the Macmillan GP End of Life facilitators ensure that primary care are able to identify patients early, maintain palliative care registers and have regular MDTs to support Advance Care Planning. • Through Macmillan Lead Nurses for End of Life Care Planning deliver the 6 steps programme in Powys care homes which will provide education and receive the support necessary to ensure the provision of good end of life care. **Delivering Fast, Effective Care** • Ensure that infants, children and young people approaching end of life have access to specialist paediatric palliative care team • Agree a model of End of Life care and scope current access to care provision for patients at end of life who wish to be cared for at home to ensure that there are accessible, equitable, quality services available to provide care to patients at end of life. **Reducing the distress of terminal illness for patients and their families** • Ensure transition arrangements are in place from child to adult palliative care services • Continue to provide support and guidance for clinical teams on the care decisions guidance, anticipatory prescribing and just in case boxes. • Scope the feasibility of supporting lay carers to administer sub cutaneous injections • Scope the provision and feasibility of providing intravenous bisphosphonates for malignant hypercalcaemia in community hospitals • Scope the current bereavement information and support in place for people who die in Powys **Education** • Deliver the 6 steps education programme to all Powys care homes • Develop a fundamentals in palliative care study day which will be available to all clinical staff • Deliver the palliative care module in Powys bi annually	• Staff feel they have the skills and knowledge to support advance care planning. • A programme of public events to support Byw Nawr will be in place • Appropriate Palliative care registers are in place and patients are reviewed through MDTs • Increase in the number of people with an Advance Care Plan • Appropriate care is available for people who wish to be cared for at home • Reduced inappropriate admissions at end of life from care homes. • The degree module and fundamentals study day will be delivered.

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21	2021/22	2022/23
Delivery of annual training programme/ events/ education/ care home support; My Life MY Wishes launch Q1 Education to support ACP Q1				Review / annual planning process	

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: LIVER DISEASE

Areas of focus in the national plan include lifestyle risks and variation in outcomes, reducing average length of time spent in hospital, reducing emergency admissions, reducing alcohol related admissions and reducing the increasing incidence of liver cancer. There is also a need to progress actions to improve outcomes in relation to lifestyle factors including obesity and alcohol.

Local Priorities for 2020/21-23	Measures
Focus on Wellbeing: • Whole system approach including assessment of population need; programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy active lifestyles **Early Help and Support:** • Improve awareness and understanding of liver disease within primary and community care and with partners to help detect early liver disease and make appropriate referrals • Ensure appropriate primary care management of those with liver disease including uptake of appropriate vaccinations • Further development of opportunistic assessment of alcohol in different settings and secondary care responses **Joined Up Care:** • Delivery of the Health and Care strategy model of care which has a focus on prevention based outcomes, lifestyle factors and reduction of the burden of the disease, which will support work to tackle liver disease, provide care closer to home and reduce admissions • Commissioning plans to ensure onward pathways are clear, specialist services are available and access to diagnostic testing and treatments are in place • Strengthen clinical leadership and review of services and pathways • Work with Third Sector substance misuse services to implement strategies in order to continue to reduce risk behaviour and substance misuse as part of the implementation of the Substance Misuse Strategy • Taking forward the implementation of WHC 048 2017 "Attaining the WHO targets for eliminating hepatitis (B and C) as a significant threat to public health • Improve the provision of assessment and testing of those at highest risk of liver disease	• Proportion of population who are obese • Promotion of healthy lifestyle factors • Proportion of adults self-reporting drinking more than recommended guidelines • Reduction in alcohol related admission rates • Rates of new diagnosis or cirrhosis • Liver disease mortality figures • Rate of hospital admission for liver disease

Key Milestones

2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21	2021/22	2022/23
• Strengthen clinical leadership and review	• Ongoing oversight with strengthened clinical input to review services and pathways, aligned to Powys model of care			Review and confirm in annual planning	

Appendix 2: Summary Plans (National Delivery Plan Areas)

SUMMARY PLAN: CRITICALLY ILL

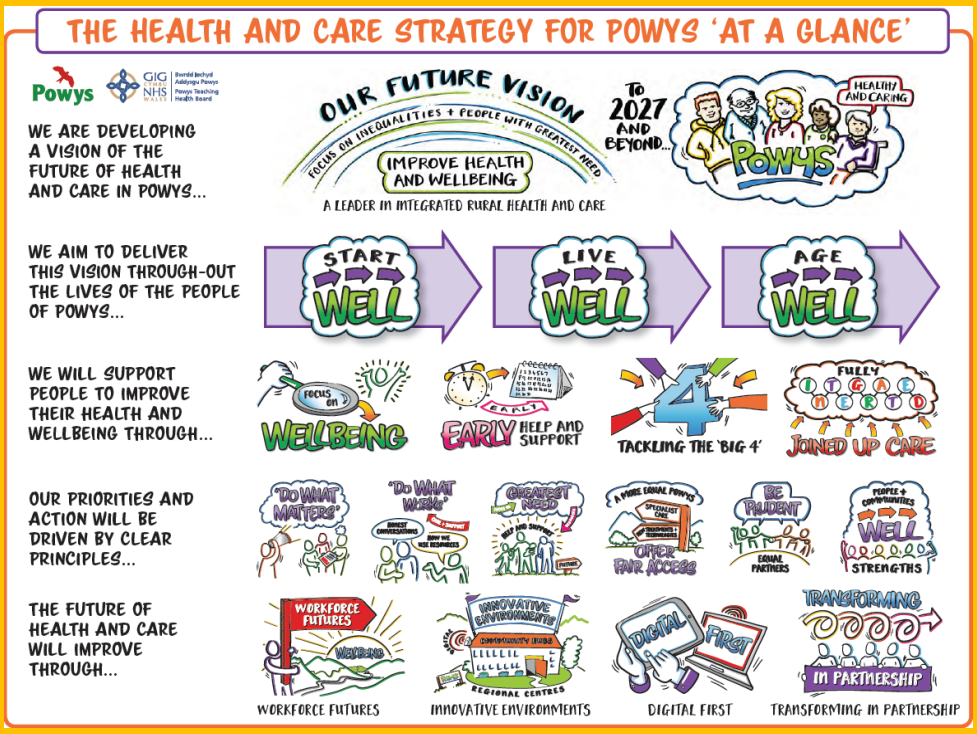
PTHB commissions critical care services from relevant NHS provider organisations through its Long Term Agreements (LTA) in both England and Wales. The Welsh Health Specialised Services Committee (WHSSC) is delegated to commission specialised services for the population of Wales. This includes paediatric intensive care and the critical care episodes which form part of a specialised admission for adults.

Local Priorities for 2020/21-23	Measures

Focus on Wellbeing/ Early Help and Support:
• PTHB has a role in relation to minimizing avoidable critical illness and admissions and the PTHB Health and Care Strategy promotes a way of working that improves the management of conditions and diseases through joined up support and care co-ordination, which is known to help prevent avoidable exacerbations and admissions.
 	
Joined Up Care
• A Key local priority is the interface between secondary and tertiary service with regard to intensive care for adults, managed though the WHSSC Integrated Commissioning Plan and interface with Powys
• Work is underway in Wales with the overall aim of developing a national model of care for those who are critically ill. The review is considering ways of working which could improve capacity and the impact of changing flows of some services e.g. vascular, out of hospital cardiac arrests and major trauma. PTHB is seeking to ensure that cross-border reconfiguration issues and patient flows are taken into account, e.g. Changes to the configuration of vascular services in England.
• Delivering Appropriate Effective Ward Based Care – PTHB has a role as a commissioner in relation to critical care providers to ensure:
  • Patients be cared for in the correct facility with highly qualified specialists
  • Patients and carers are as involved in their care as they feel appropriate
  • Patients receive care that is clinically effective
  • Effective Critical Care Provision and Utilisation - Welsh Health Boards caring for patients from Powys are expected to be compliant with the standards set out in the critical care delivery plan for Wales. English providers are also provided with links to the Welsh condition specific plans to ensure the compatibility of essential requirements.
• To respond to finding of the National Care Survey in Critical Care as appropriate.
• A key local priority for Powys is to work with the WHSSC to ensure there is clarity about the interface between secondary and tertiary service commissioning with regard to intensive care for adults. Through the WHSSC Integrated Commissioning Plan and the interface group with Powys, PTHB is seeking more detailed information about Welsh residents receiving services in **Timely Discharge from Critical Care**
• Patients have timely access to (where appropriate for their condition and needs) and discharge from critical care
• Procure and Commission the Clinical Information System for Wales
• (Psychiatric Intensive Care is covered through the arrangements for mental health services.)
	• National Outcomes
	• Commissioning Assurance Framework

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

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



APPENDIX 3: PTHB Cluster IMTPs

1. Executive Cluster Chair

The Integrated Medium Term plan for the North Powys Cluster offers the opportunity to align the Cluster plans with a common format and common goals with Powys Teaching Health Board. The 8 IMTP objectives provide a structure through which Clusters can develop the priorities for their own populations whilst seeking means to provide outcomes that will improve the health of the population and provide the most appropriate and deliverable interventions when necessary with the focus on providing these closer to, or indeed in, the patient's home.

To ensure that these interventions are deliverable, then we need to identify the pathways and the workforce needed. There are ongoing sustainability issues in several practices within the Cluster and these practices have already looked at ways of addressing these with assistance from PTHB. The use of a different clinician mix, such as Unscheduled Care Practitioners and Physicians Associates and the development of triage has been integral in allowing practices to deliver services. There is an issue with recruiting General Practitioners into some areas of Powys and this is mirrored with other clinicians and this is a priority for the North Powys Cluster. Year One priorities include the establishment of stronger links with surrounding universities to encourage nursing students to come to North Powys at undergraduate level to experience rural Primary Care and also to develop a programme where the North Powys practices working in conjunction with PTHB and universities can provide "in-house" development and mentorship of existing and new staff with shared resources. The recruitment of General Practitioners has also been prioritised with work needing to be done to identify the reasons behind the reluctance of doctors to work in certain areas of the county. There is also a desire to provide placements for Foundation Grade Doctors so that they can experience the diversity of rural General Practice and the many benefits that it brings.

The development of both general and condition specific pathways has its base in identifying population need and developing resources to best meet this need. Some of this work can be done at Cluster level in conjunction with PTHB whilst other work needs to be part of the engagement of Cluster with the North Powys Health and Wellbeing Programme. The work of the latter requires not only local "buy in" but also that of our Secondary Care providers and this can be facilitated through the Mid Wales Joint Committee. The intention is to provide as much care as possible closer to the patient and there have been workshops to explore the "art of the possible". The use of digital technologies will be integral in providing this care both with remote consultations with clinicians but also with self-care and monitoring through apps such as Florence.

The Cluster has identified two local pathways needs that need to be a Year One Priority. These are the delivery of an in-county Sexual Health service and the development of an early recognition and intervention service for young people with Mental Health symptoms.

The objectives encapsulated within the IMTP of the four streams of both Core Well-being and Enabling Well-being are at the centre of the objectives of the North Powys Cluster. The cluster plan will also deliver against the milestones in the national primary care model. There is a recognition that needs differ across the Cluster, there are areas of significant deprivation and other areas where disease prevalence is higher than the Powys average. It is only through working collaboratively as an individual Cluster, with the other two Cluster in Powys, with Powys Teaching Health Board and with external providers that we can achieve the best outcomes for the Cluster population.

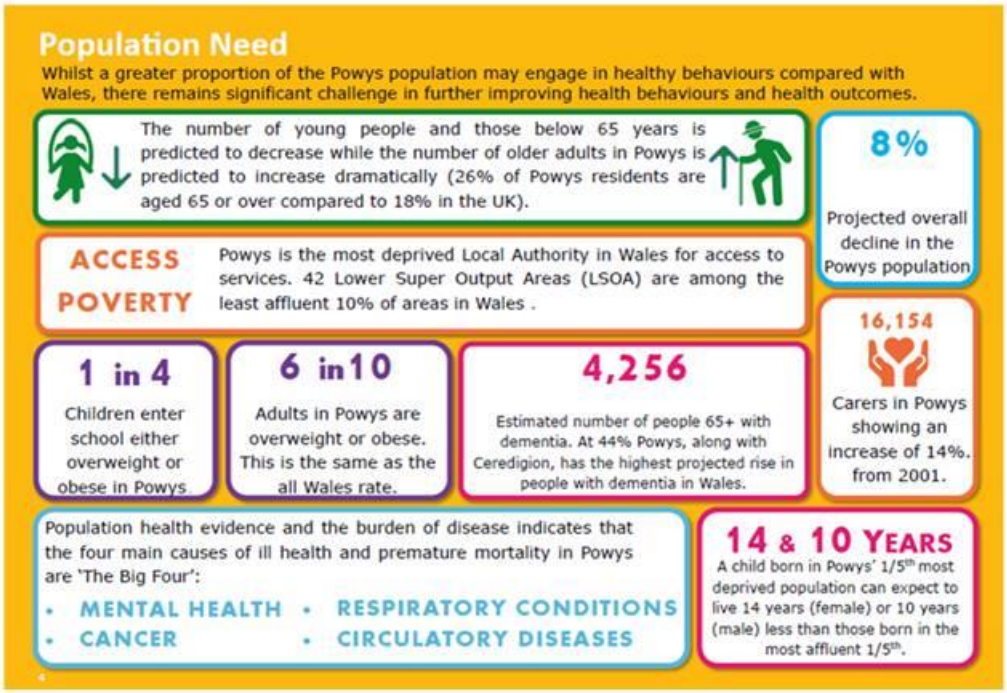
The 8 IMTP objectives are shown below:

Dr Andy Raynsford

North Powys Cluster chair

October 2019

2. Introduction to the 2020 – 23 Plan / Cluster



APPENDIX 3: PTHB Cluster IMTPs

All 3 Powys clusters have or aspire to multi-disciplinary and multi organisational membership including Health Board, County Council, Third Sector, Dentistry and Optometry. The North Cluster meets on a bi monthly basis.

Powys has made a distinction between clusters, as planning mechanisms that span organisations, services and professions, and GP networks as groups of general medical practitioners. This allows GP Practice issues and wider 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.

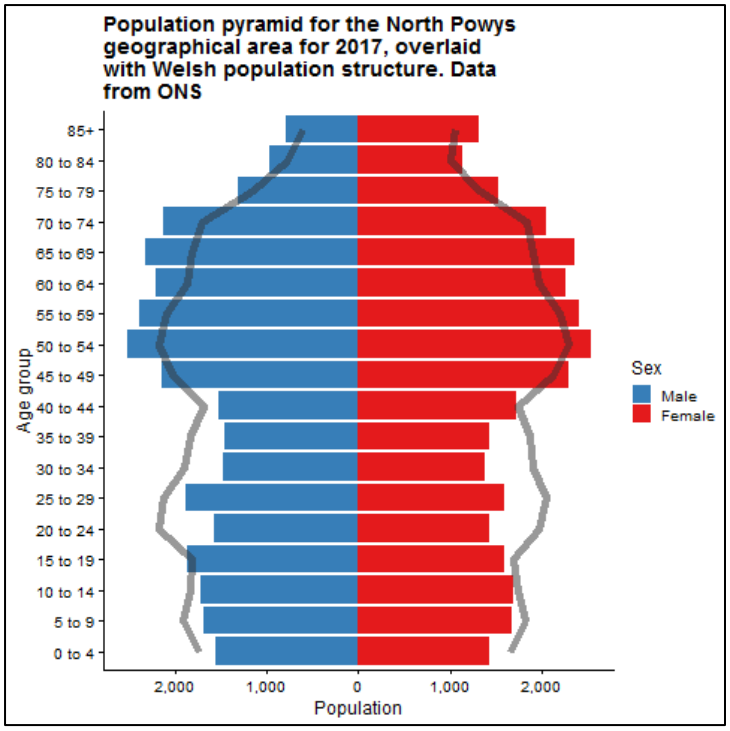
North Powys Primary Care Cluster is made up of 7 GP Practices - Llanidloes, Newtown, Dyfi Valley, Montgomery, Welshpool, Llanfair Caereinion and Llanfyllin, with a combined list size of approximately 64,000 patients.
There are also 8 Pharmacists, 7 Optometry Practices, 9 Dental Practices and 3 Community Dental Services in the north Cluster.

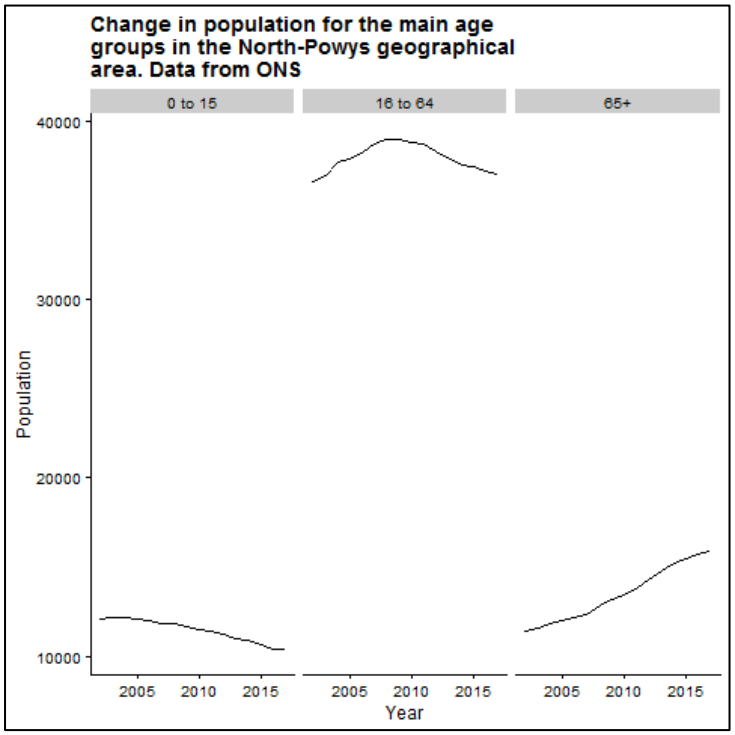
The cluster group formed in 2012. Initial collaborative working was good and the Cluster worked well with the Health Board to develop solutions and pathways for challenges facing the health economy.

The local difficulties with practice sustainability has impacted heavily on the ability of practices to devote sufficient impetus to take collaborative projects forward but have had to concentrate on maintaining their own viability.

The North Powys Cluster area has many challenges with rural communities, some areas of high deprivation and an ageing population. There are transport challenges with long distances to the nearest District General Hospitals of Bronglais and Shrewsbury & Telford Hospital. Recruitment continues to be a challenge across the cluster with Locum availability remaining very limited.

The population of the cluster is displayed below:





There are four community hospitals within the North Powys Cluster:

	Llanidloes War Memorial Hospital	**Bro Ddyfi Community Hospital**	**Montgomery County Infirmary (Newtown Hospital)**	**Victoria Memorial Hospital, Welshpool**

Address	Eastgate Street, Llanidloes, Powys, SY18 6HF	Heol Maengwyn, Machynlleth, Powys, SY20 8AD	Llanfair Road, Newtown, Powys, SY16 2DW	Victoria Memorial Hospital, Salop Road, Welshpool, Powys, SY21 7DU
A&E / MIU	No	No	No	Yes
Wards	**Graham Davies Ward** (Medical & Rehabilitation ward) **Palliative Suite** **Maternity Unit**	**Twymyn Ward** (Medical & Rehabilitation ward including bariatric beds)	**Brynheulog Ward** (Medical & Rehabilitation ward) **Stroke Rehabilitation Ward** **Maternity Unit**	**Maldwyn Ward** (Medical & Rehabilitation ward) **Palliative Suite** **Maternity Unit**
Therapies	Dietetics Occupational Therapy Orthoptics Orthotics Physiotherapy Podiatry Psychology Speech & Language	Dietetics Occupational Therapy Physiotherapy Podiatry Psychology Speech & Language	Dietetics Occupational Therapy Orthoptics Orthotics Physiotherapy Podiatry Psychology Speech & Language	Dietetics Occupational Therapy Orthoptics Physiotherapy Podiatry Psychology Speech & Language
Consultant Outpatient Clinics	General Medicine General Surgery Gynaecology Oncology Ophthalmology Orthopaedic Orthoptics Paediatrics	Cardiology Diabetes General Medicine General Surgery Gynaecology Oncology Ophthalmology Orthopaedic Paediatrics	ADHD Cardiology Colorectal Colposcopy Diabetes Diagnostic ENT Gastroenterology General Medicine General Surgery Gynaecology Orthopaedic Paediatrics Parkinson's Rheumatology	ENT General Medicine Gynaecology Orthopaedic Paediatrics
Specialist Nurse Clinics	Diabetes Continence Parkinson's Respiratory	Diabetes Continence Parkinson's Respiratory	Diabetes Continence Parkinson's Respiratory	Diabetes Continence Parkinson's Respiratory
Other Outpatient Services	Diabetes Eye Screening Wales	Diabetes Eye Screening Wales X ray Dept.	Diabetes Eye Screening Wales X ray Dept.	Diabetes Eye Screening Wales British Pregnancy Advisory Service X ray Dept. Renal Unit

3. Key Achievements from Previous Cluster Plans

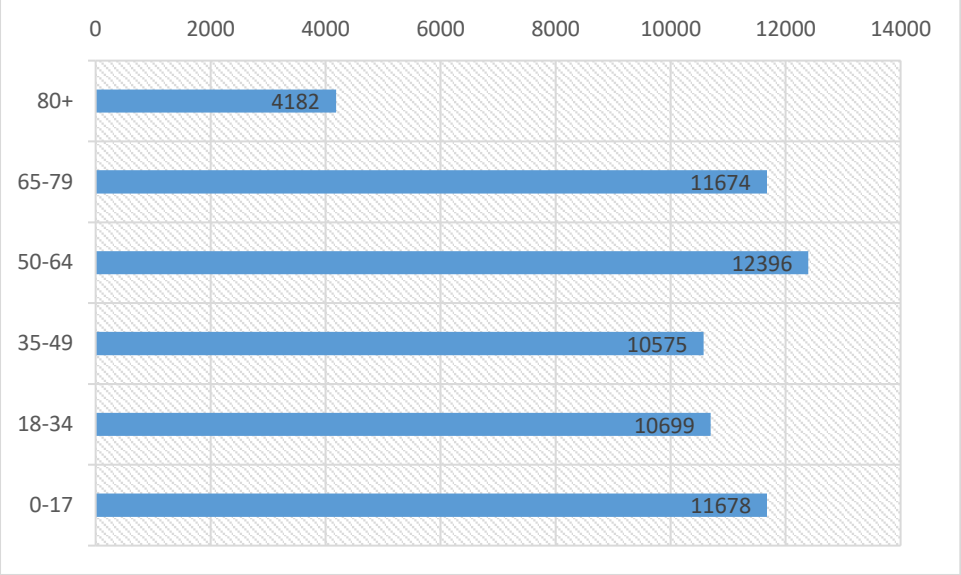
- Introduction of Physician Associates to support GPs
- Introduction of local Dermatology Outpatient Services
- Looking at alternative disciplines i.e. Urgent Care Practitioners (UCPs)
- Introduction of local British Pregnancy Advisory Services
- Introduction of telephone triage in some practices

- Introduction of Health Board Silver Cloud online CBT system to support GP Practices and Community Mental Health services.
- Introduction of 3rd sector community connectors, attached to each practice to support statutory service providers.
- Strong body looking at bringing patient services back into the locality i.e. repatriation of mental health service.

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

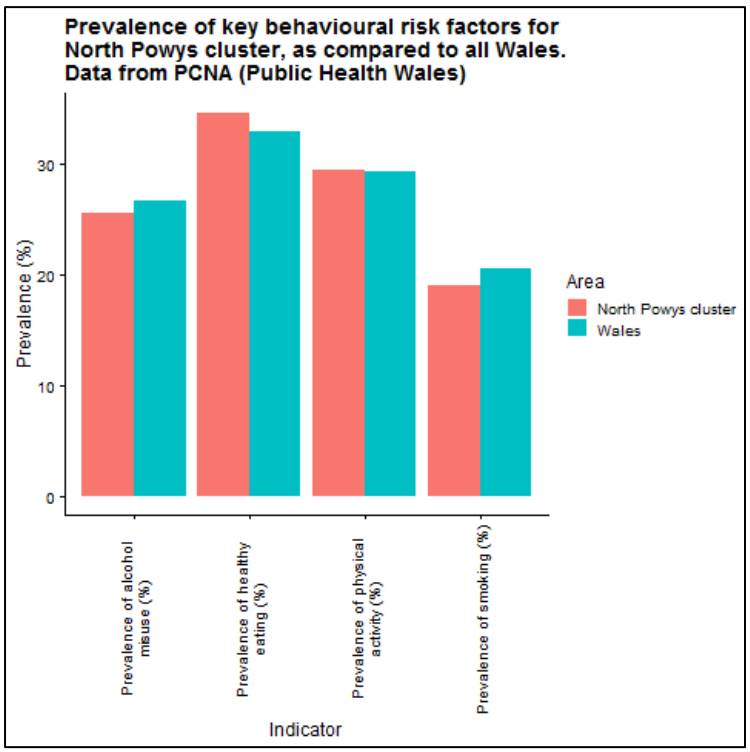
The population of North Powys is currently 63271, the main centres of population include Newtown (11319), Welshpool (6668), Llanidloes (2804) and Machynlleth (2213). The rest of the population are widely dispersed in smaller centres, hamlets and across many rural properties.

The age bandings spread is reasonably even across the North Powys area:

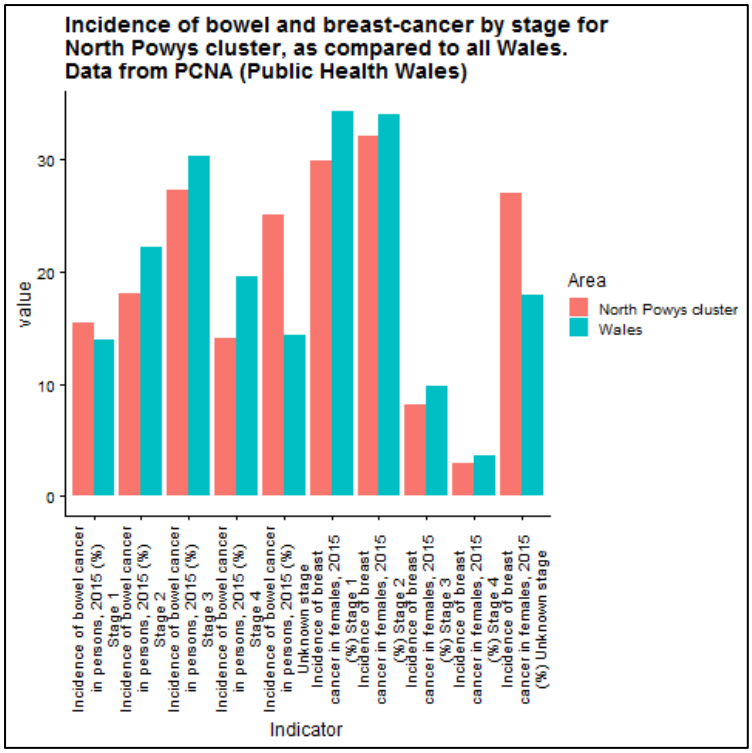


The tables below compare the prevalemce rates of the north Powys cluster as compared to the all Wales averge in the following areas:

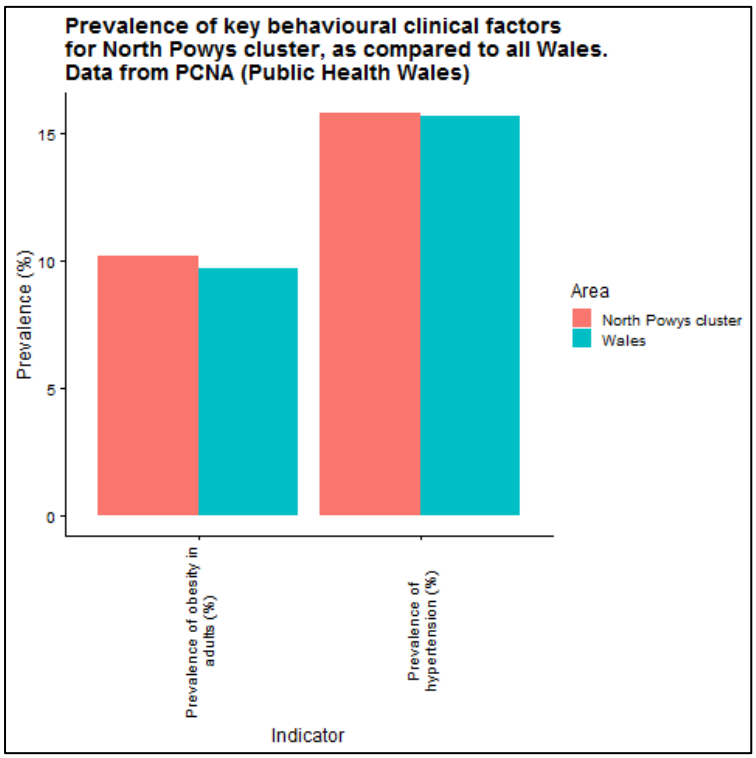
- Prevalence of key behavioural risk factors
- Incidence of bowel and breast cancer
- Prevalence of key behavioural clinical factors
- Prevalence of key long term conditions



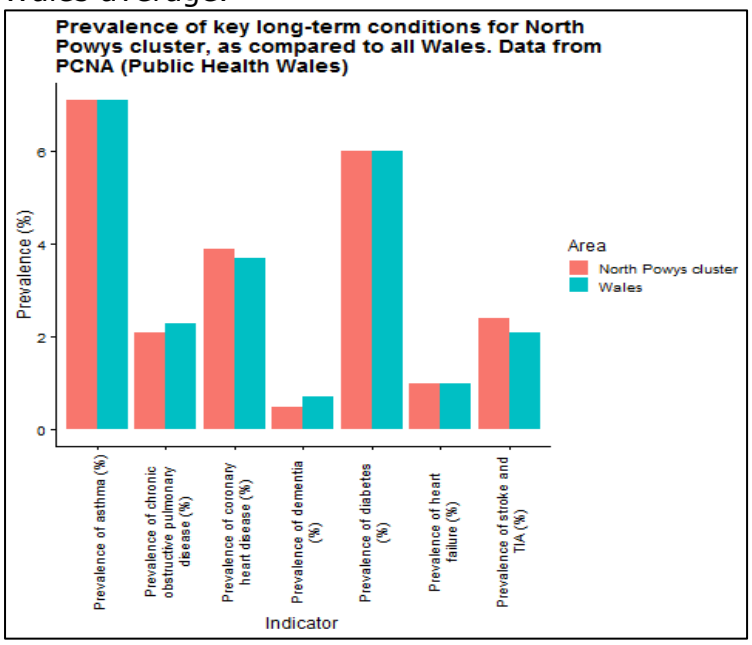
Prevalence of alcohol misuse and smoking in north Powys is below the all Wales average. Physical activity is comparable to the all Wales average and healthy eating is above average.



Incidence of stage 1 and unknown stage of bowel cancer are above the all Wales average. Incidence of stages 2, 3 and 4 are below. Incidence of stage 1,2,3,4 breast cancer are below average, unknown stage is above the Welsh average.

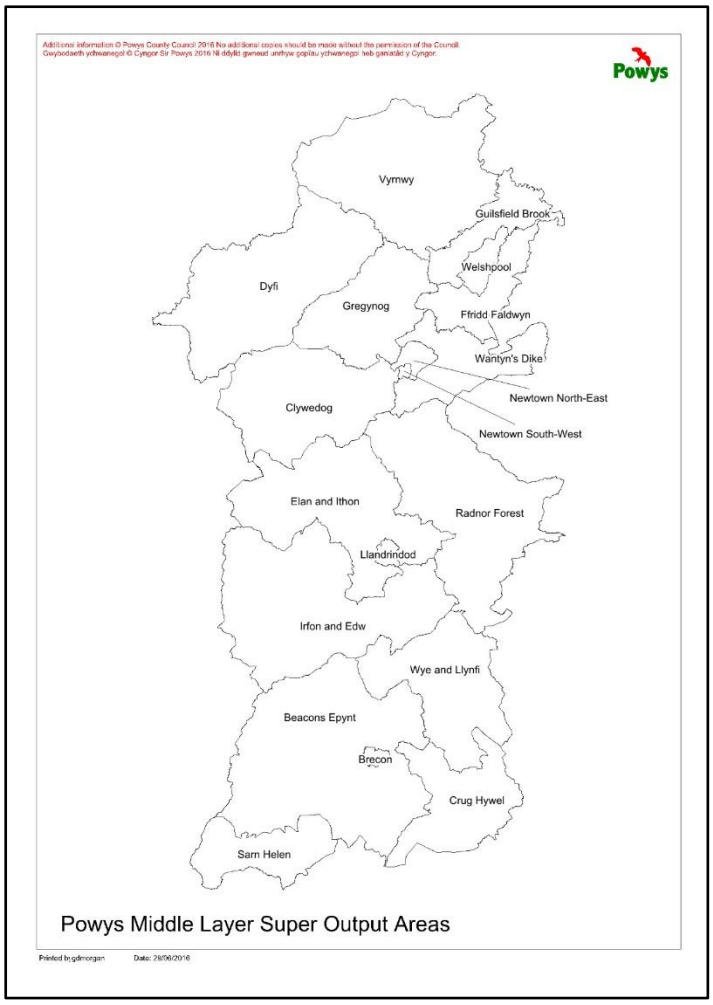


Prevalence of obesity and hypertension in North Powys are both slightly above the all Wales average.



Prevalence of coronary heart disease and stroke / TIA are above the Welsh average. Asthma, diabetes and heart failure equate to the all Wales average. Prevalence of COPD and dementia are below average

North Powys can be broken down into ten 'localities' (Middle Layer Super Output Areas as defined by the Office of National Statistics) as shown in the map below:



The key findings from the North Powys needs assessments carried out by Powys County Council in 2019 are that:

Tackling the Big 4:

- Hospital admissions for respiratory diseases is highest in Welshpool
- Respiratory inpatient admissions are highest in Welshpool and Newtown
- Respiratory mortality for under 75's is above average in Newtown North East
- Hospital admissions for cardio-vascular disease is above average for Welshpool, Dyfi and Newtown North East
- Circulatory disease inpatient admissions is high in 5 out of 10 North Powys localities
- Circulatory disease outpatient admissions are above average in 6 of the 10 North Powys localities
- Cancer mortality is above average in Newtown South West, Dyfi, Welshpool and surrounding area of Fridd Faldwyn
- Percentage of patients with hypertension is above average in Machynlleth and Llanfair Caereinon GP practices
- Percentage of patients with coronary heart disease is above average in Montgomery GP practice area
- Patients with above average COPD rates are found in the Dyfi Valley Practice area
- Above average number of patients with Diabetes are found in the Dyfi Valley practice area.

Focus on Well-being

- Newtown South West has the most indicators of below average rates for well-being focused measures
- General fertility rate is mostly lower in more rural areas of North Powys
- A higher average of children are living in poverty in Newtown South West and Welshpool
- The estimated number of people living with dementia has a higher average in the very north of Powys, Vrynwy locality
- The lowest levels of home ownership for North Powys are in Newtown and Welshpool
- People in Newtown South West have a higher average for those struggling to keep up with bills
- Newtown South West has the highest average unemployment and in general unemployment is rising steeply in Powys
- The lowest level of satisfaction with the local area is Newtown South West
- Lowest average levels of two parent households are in Newtown South West
- Children on the child protection register average rates are high in Newtown and Welshpool
- Vaccination rates at age 4 are lowest in the Wantyns Dike ward
- Premature births have a higher average rate in Newtown South West and Welshpool
- Low birth weights are higher in Newtown and Guilsfield Brook, north of Welshpool
- There are more pressure points for older people's accommodation in the Llanfair Caereinion area

Joined up care

- There are more indicators below average for joined up care in Newtown South West and the Dyfi areas
- The number of unpaid carers on average is higher in Welshpool and Newtown South West
- Hip fractures and more prevalent in Newtown South West and Clywedog localities
- Satisfaction with GP's is lower in Newtown, Welshpool and Dyfi localities
- The rate of people receiving domiciliary care is higher in Newtown South West and Dyfi localities
- The rate of time spent on domiciliary care clients is on average higher in Wantyns Dyke and Dyfi localities
- There is a greater need for sheltered housing in the very North of Powys, Vrynwy locality.

5. Cluster Workforce Profile and 6. Financial Profile

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

7. Gaps to Address and Cluster Priorities for 2020-23 – Key Work Streams and Enablers

- Involvement in the planning of the Health & Wellbeing Hub in Newtown; a project, which will hopefully allow for the provision of services for patients closer to home. This will also help patients seek advice and help from the 3rd sector and Powys County Council to attempt to decrease unnecessary GP appointments.

- Appropriate level representation from all partner organisations is a priority going forward and will be in line with the PTHB across all three Clusters.
- Expansion of the Pharmacy Team to support sustainability in line with Transformation bid.
- Expansion of the Triage system
- Develop a system for the development and mentoring of members of the multi-disciplinary teams both within Cluster practices and in conjunction with Glyndwr University.

Communication and engagement mechanism

- Health Focus groups
- Patient condition group

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

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	• Analyse population profile to understand prevalence and ensure service provision meets demand
		• All communities to become Dementia Friendly through conjunction with 'Dementia Matters' development officers, Powys Dementia Network and PAVO.
		• Increase public awareness through public health campaigns coordinated by PTHB, PHW
		• Increase capacity of community home support / reablement.
		• Further integration of community connectors attached to each practice
		• Analysis of frailty register to identify all patients aged 65 and over who may be living with moderate or severe frailty
		• Review Dementia registers to understand prevalence

APPENDIX 3: PTHB Cluster IMTPs

Core Well-being Objective 2	Provide Early Help And Support	
	Priorities	• Increase direct access to community pharmacists to deliver common ailments service. • Provide further opportunities for independent prescribers by offering DMP (Designated Medical Practitioner) role in each practice • Improve access to diagnostics as part of the north Powys Regional Rural Centre developments • Promotion Of Healthy Living And De Medicalisation Of Wellbeing • Develop and implement local sexual health services / pathway

Core Well-being Objective 3	Tackle The Big Four	
	Priorities	• Review mental health pathway for young people and improve access to early help and support • Feasibility study to develop a Crisis House / Sanctuary Provision in North Powys • Increase use of Florence to support self management of chronic conditions • Develop a system of putting Care Plans in place for all high risk individuals • Implement the use of MacMillan Primary Care Cancer toolkit

Core Well-being Objective 4	Enable Joined Up Care	
	Priorities	• Clinical led practice triage in place in all practices • Pilot Mental Health Practitioner triage in Newtown and Llanfyllin areas • Further develop integrated community resource teams and Virtual Wards to reduce admissions • Repatriation of secondary care services that can be delivered locally • Clarify discharge lines between district general hospitals and practices

APPENDIX 3: PTHB Cluster IMTPs

Enabling Well- Objective 1	Develop Workforce Futures	
	Priorities	• Develop cluster level designated training programme for clinical staff including rotations
		• Improve primary care & PTHB links with University of Glyndwr
		• Provide mentorship for newly qualified independent prescribers
		• Identify factors that make recruiting GPs into some areas of Powys challenging and develop strategies to increase recruitment

Enabling Well-being Objective 2	Promote Innovative Environments	
	Priorities	• Develop Community Wellbeing Hubs across cluster to provide services closer to home
		• Develop North Powys Rural Regional Centre including provision of healthcare normally provided out of county

Enabling Well-being Objective 3	Put Digital First	
	Priorities	• Work towards providing digital acute discharge records from all secondary care providers to all practices
		• Promote the use of apps to support patient access to information advice and self care
		• Develop telehealth and telecare
		• Establish Point of Care Testing across cluster

APPENDIX 3: PTHB Cluster IMTPs

Enabling Well-being Objective 4	**Transforming In Partnership**	
	Priorities	• Work closely with Mid Wales Joint Committee for Health and Care to develop local services across cluster
		• Contribute and respond to the Future Fit Programme of services provided at the Royal Shrewsbury Hospital, Shrewsbury and the Princess Royal Hospital, Telford
		• Continue to develop cluster relationship with extended community care and voluntary sector

APPENDIX 3: PTHB Cluster IMTPs

Milestone / Action	Output	Outcome
Further integration of community connectors attached to each practice	• Presentation at Cluster • Promote community connector role in General Practices and to the wider public / communities	• Development of robust service
Review Dementia registers to understand prevalence	• Dementia registers up to date and accurate • Liaison with Mental Health services to ensure prompt assessments	• Care & support meets patient needs
Develop and implement local sexual health services / pathway	• Cluster and PTHB to review existing services and develop pathway	• Implementation of pathway / services which are accessible to patients & delivered closer to home
Review mental health pathway for young people and improve access to early help and support	• Project plan developed and new model tested	• Early help service established
Increase use of Florence to support self management of chronic conditions	• Identify which conditions to support • Identify patients in each practice • PLT delivered for practice nurses	• Plan in place to roll out use of Florence across cluster
Clinical led practice triage in place in all practices	• Ensure all practices are developing same day and routine triage • Explore options for cluster wide remote triage from single source (for those practices interested)	• Same day triage in all practices
Improve primary care & PTHB links with University of Glyndwr	• Develop quality placements • Offer placement opportunities for student nurses in all practices • Explore options for post qualified placements	• Increase number of nurses recruited
Identify factors that make recruiting GPs into some areas of Powys challenging & develop strategies to increase recruitment	• Develop placement programme for FY1 and FY2 doctors & medical students • Develop links with deaneries & universities	• Initiate a number of placements / opportunities • Have an understanding why recruitment has not previously been successful and develop strategies accordingly

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.

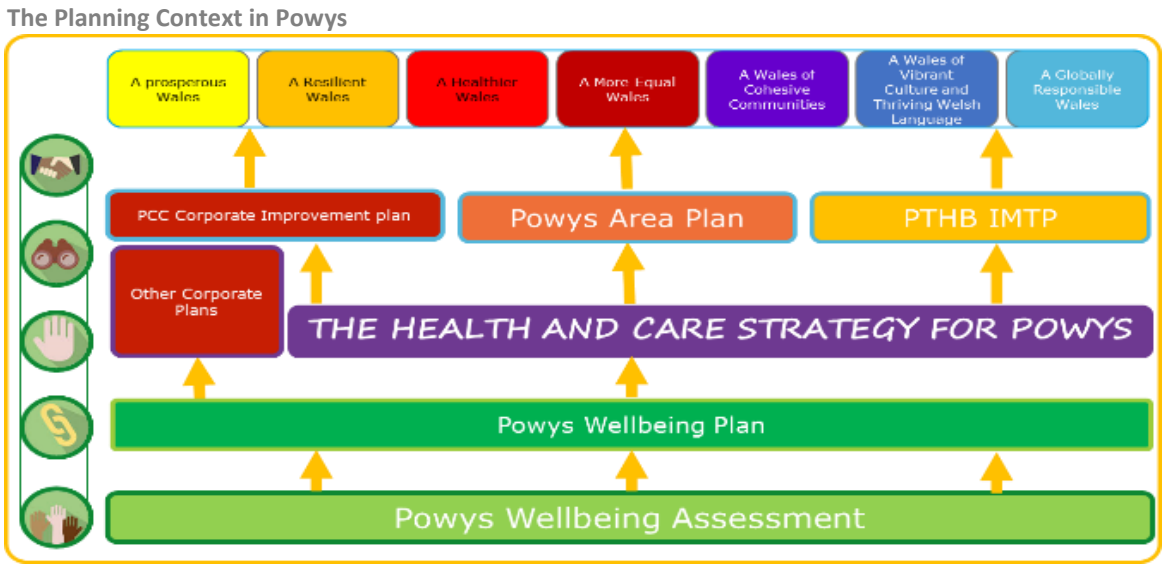
Well-being of Future Generations Act

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.

APPENDIX 3: PTHB Cluster IMTPs

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.



Five Ways of Working: Prevention

The Health and Care Strategy and the Powys Teaching Health Board 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

APPENDIX 3: PTHB Cluster IMTPs

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 sector.

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

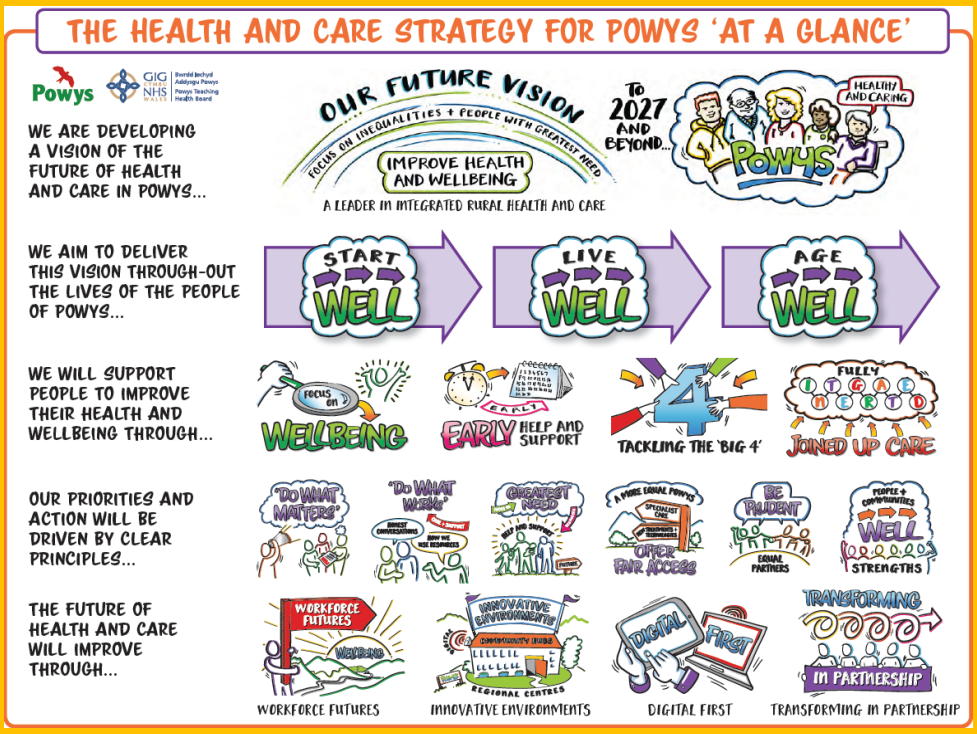
Ensure there is continuous and effective communication, involvement and engagement with the population of Mid Wales, staff and partners.

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

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



1. Executive Summary – Cluster Chair

The Mid Powys PC cluster has developed steadily over the last 4 years, evolving from a GP Practice focussed Forum, into a group of primary and community care professionals from throughout the Mid Powys communities, that we hope will extend further in the next 12 months, to fully represent all services, and our population. We currently meet on a quarterly basis.

Our priorities have historically centred on supporting the sustainability of the GP Practices; identifying gaps in the services for patients, and seeking solutions in partnership with the health board and other health professionals, to ensure accessibility and equitable provision to Mid Powys citizens.

The annual Cluster fund allocation has enabled us to test out new approaches to service, (such as online GP consultations) and pump prime innovations that transform the way we deliver primary care in Mid Powys. Our Cluster Pharmacy Team is a prime example of this. The Team has proved it possible and advantageous for Practices to share resources across the Clusters five Practices; releasing pressure on GPs and other health professionals, and enhancing patient care. The fund has also supported practices to continue to provide online training and support for administration staff, pay for equipment for patient waiting rooms, and other smaller projects. The Cluster fund has also supported Practices to purchase Jayex Boards; which not only act as a 'calling in' system for patients, but which the Cluster use to deliver health promotion information and Public Health messages to our patients, in a collective approach.

Over the past 12 months we have secured good links with the third sector, and our Community Pharmacists in the Mid. 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.

Ambition for the future includes extending the membership of the Cluster to that of Optometrists, patient groups, and to encourage fuller involvement from our Local Authority partners. We will also endeavour to stabilise and build on our connection with the Health Board, and secure further help and support from key partners such as Public Health Wales and Welsh Ambulance Services. Plans include

- To develop the Trusted Assessors working in collaboration with our social care partners – training for those that are deemed capable of fulfilling this role in our hospitals
- Our Respiratory patient pathway in primary care – specifically delivery of Spirometry. GP Practices seek an increase in Specialist Nurse capacity in the Mid that could address this issue **or** financial support to deliver this diagnostic service 'in house'

Address recruitment and retention issues in the Cluster – specifically the need for Practice Nurses in two of the 5 Practices currently (but acknowledging this is a resource in all Practices that can fluctuate in availability, with vacancies arising across the Cluster). The intention is to recruit a full time nurse or two part time nurses to work in two Practices, funded by Cluster Funding, and supported in their training by neighbouring Practices if mentorship/clinical supervision is required. Training needs will take into account the needs of the Cluster as a whole e.g.; if there is a need for implant/coil device fitting, the nurse role will address this, and we will look to support Practices with this service etc. The health board will take on the role of employer.

- Support training needs of Practice and Cluster based staff, utilising the Cluster Fund. Specifically ensure a refreshed delivery of training to Reception Staff on Active Signposting.

- Work with our health board partners to review the functionality of the Virtual Wards and assessing effectiveness.

2. Introduction To The 2020 – 23 Plan / Cluster

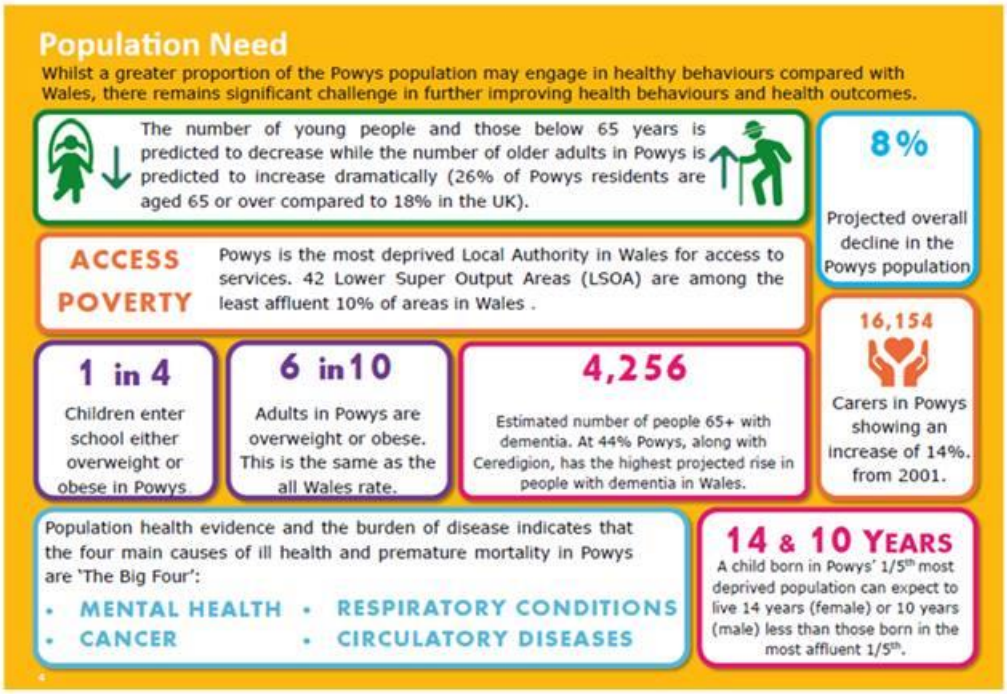
- Establishment of an Advanced Nurse Practitioner role for the Virtual Wards in the Mid Cluster – to carry our frailty assessments, home visits, and advanced nursing procedures for the patients admitted to the wards. Job description to follow – via the Neighbourhood Nursing Project.
- Prioritise the above schemes, and allocate work streams to achieve over a three year period.
- Diagnostics and near patient testing.
- Health Champion role- Cluster wide health supporting role – with information on areas such as Cancer Screening, Carer Support, Dementia friendly communities and direct support, My Life My Wishes, etc. No duplication with the CC role, but a focus on health promotion.
- QAIF requirements – As required by the new GMS contract 2019-20. All practices engaging in cluster working to address identified and agreed Quality Improvement initiatives also a commitment to attend 5 GP Network meetings annually.
- The digital offer and how this can support self management; Florence texting, MyHealthOnline, COPD app, SilverCloud online CBT, Invest in Your Health Skype sessions.
- Establishment of Social Worker/s working alongside GP Practices or 'in house'. They will have full involvement in the CRTs, and Community Hospital beds, address social needs of the population at pace with demand, avoiding long delays in obtaining assistance at home, long hospital stays, and linking with our third sector partners.

The 8 IMTP objectives are shown below:

Fleur Thompson

Mid Cluster Lead
October 2019

Overview of the Cluster



All 3 Powys clusters have multi-disciplinary and multi organisational membership including Health Board, County Council, Third Sector, Dentistry, Optometry and Community Pharmacy. The Mid Cluster meets on a quarterly basis.

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

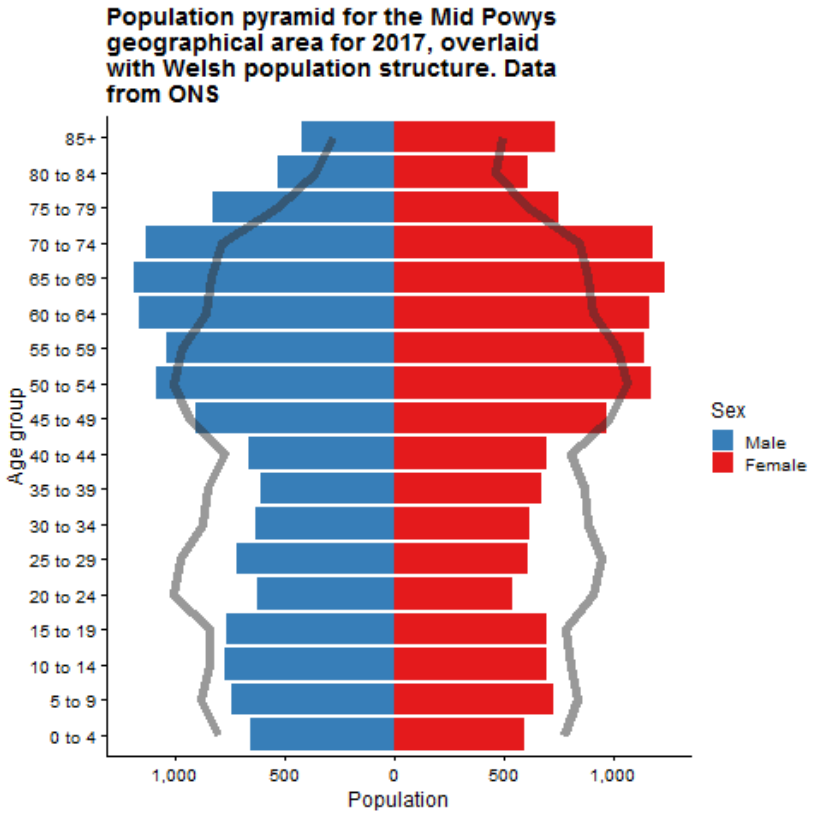
The other key component to the Powys model is delivery of services based around individual GP practices through an integrated Community Resource Team that includes practice, Health Board, County Council and Third Sector representatives.

The Mid Powys Cluster is made up of 5 GP Practices;

Builth, Knighton, Llandrindod Wells, Prestiegne and Rhayader with a combined list size of approximately 29,500 patients.

There are also 7 Pharmacists, 4 Optometry Practices and 5 Dental Practices in the mid Cluster.

The population of the cluster is displayed below:



The Mid Cluster has a medium level of maturity, with collaborative working evident but not consistently embedded.

There are 2 community hospital and a health and social care centre in the Mid Cluster:

	Llandrindod Wells Hospital	**Knighton Community Hospital**	**Glan-Irfon Health & Social Care Centre**
Address	Llandrindod Wells County War Memorial Hospital, Temple Street, Llandrindod Wells, Powys, LD1 5HF	Ffrydd Road, Knighton, Powys, LD7 1DF	Glan-Irfon, Love Lane, Pendre, Builth Wells, Powys, LD2 3DG
A&E / MIU	Yes	No	No
Wards	Claerwwen Ward – Generic Clywedog Ward – Elderly Mental Health Elan Ward – Day Surgery Birthing Centre – Maternity X-Ray Occupational Therapy Physiotherapy	Panpwnton Ward Cottage View Residential Home Nantawelon – Community Psychiatric Nurses Occupational Therapy – Inpatient and Outpatient Service Birth Centre – Midwifery led Speech and Language Health Visitors Bumps and Babes sessions Dietetics – Inpatient & Outpatient sessions Palliative Care input	12 Integrated Care Beds
Theatres	*Theatre* Orthopaedic		

	Gynaecology Ophthalmology General Surgery Ear, Nose & Throat (ENT) Endoscopy Oral Surgery Urology		
Outpatients	Outpatients Orthopaedics General Surgery Elderly Mentally Ill (EMI) Orthodontic Oral Surgery Ophthalmology Visual Fields Occuloplasty Dermatology Gynaecology Obstetrics Paediatrics Ear. Nose & Throat Audiology Rheumatology Urology Continence Orthotics Orthoptics Surgical Appliance Pre-operative assessment Dietetics Child & Adolescent Mental Health Scheme (CAMHS) Podiatric Surgery Falls Assessment Clinic Procedures such as removal of sutures and dressings	*Outpatients* Child Psychology Old Age Psychiatry Memory Clinic Diabetic Retinopathy AAA screening Cardiac Nurse service Stoma Nurse service Parkinson's Nurse service Falls clinic Podiatry Lymphedema Clinic CMATS	
Clinics	Clinics Gait Retinopathy Speech & Language Podiatry Mental Adolescent Benefit Agency Paediatric Physiotherapy Child Psychology New Born Hearing		Treatment Room Leg Clinic Drop in Health Clinic Falls Clinic Health & Wellbeing Group Memory Antenatal Dietician Podiatry Cardiac Stroke Parkinson's Child and Adolescent mental health service Psychosexual Lymphedema Urodynamic Smoking Cessation Abdominal Aortic Aneurysm screening Diabetic eye screening Respiratory CMATS
Third Sector	League of Friends		

	Complimentary Therapy Red Cross Cancer Support & Macmillan Nurse Tenovus Powys Carers Service		

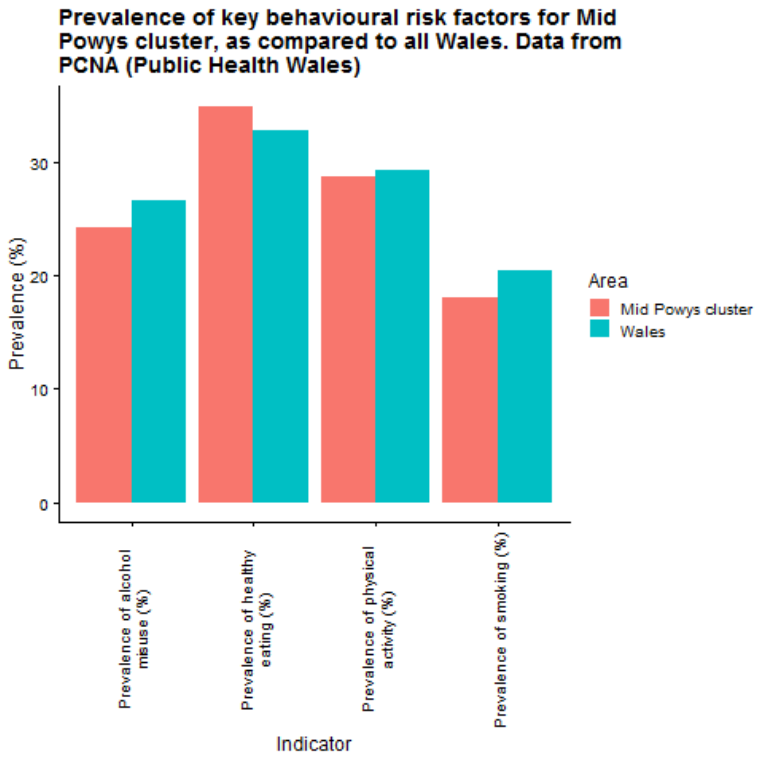
3. Key Achievements from Previous Cluster Plan

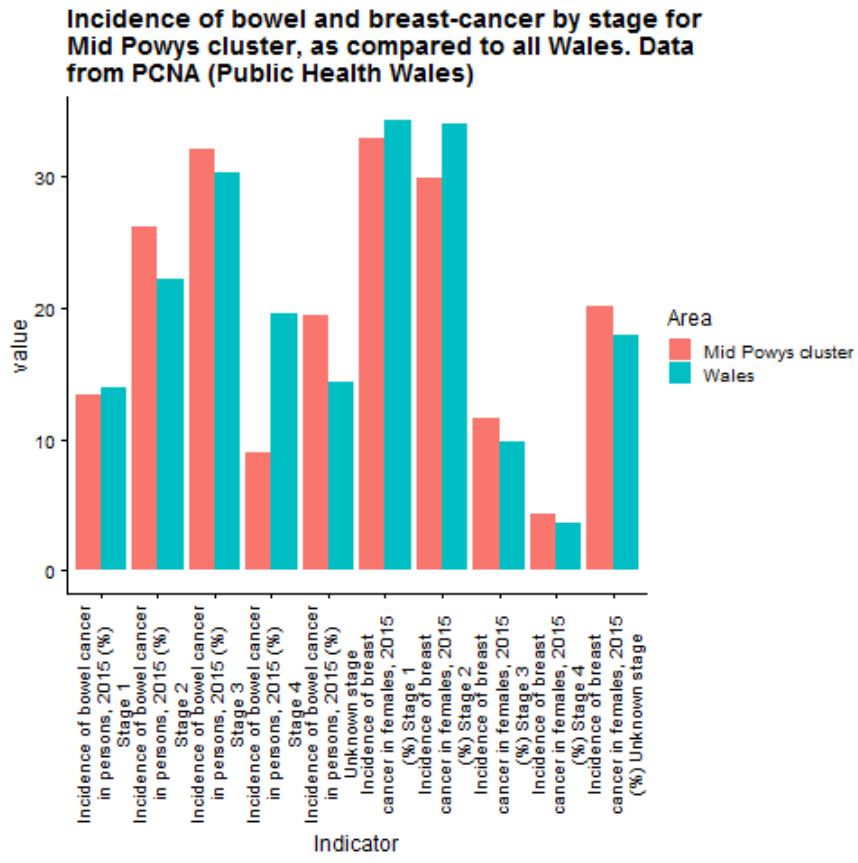
4. Cluster Population Area Health and Well-Being Needs Assessment

Examples of cluster developments include

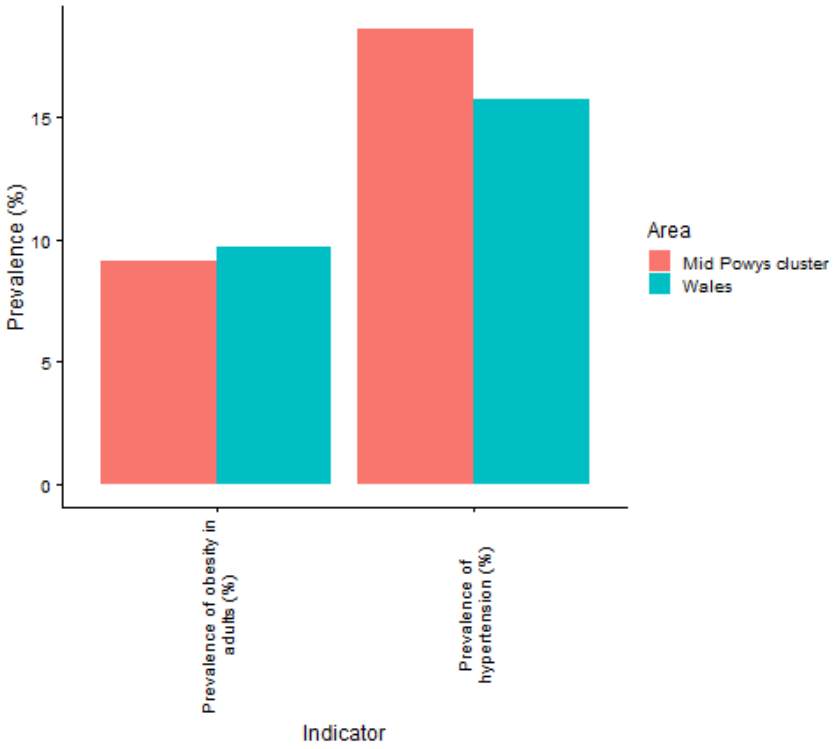
- Introductions of 3rd sector MIND Practitioners to support GP practices and community mental health services
- Introduction of health board Silver cloud on line CBT system to support GP Practices and community mental health services
- Introduction of 3rd sector community connectors, attached to each practice to support statutory service providers
- Introduction of Cluster Pharmacist Team to support GP practices and community services
- Evaluation of online GP consulting to improve GP Practice access
- Development of community Dentistry Services to replace independent contractor capacity
- Introduction of Physicians associates to support GPS
- Introduction of telephone triage in some practices
- Introduction of jayex Boards to all Practices, and ongoing support for software licencing.

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

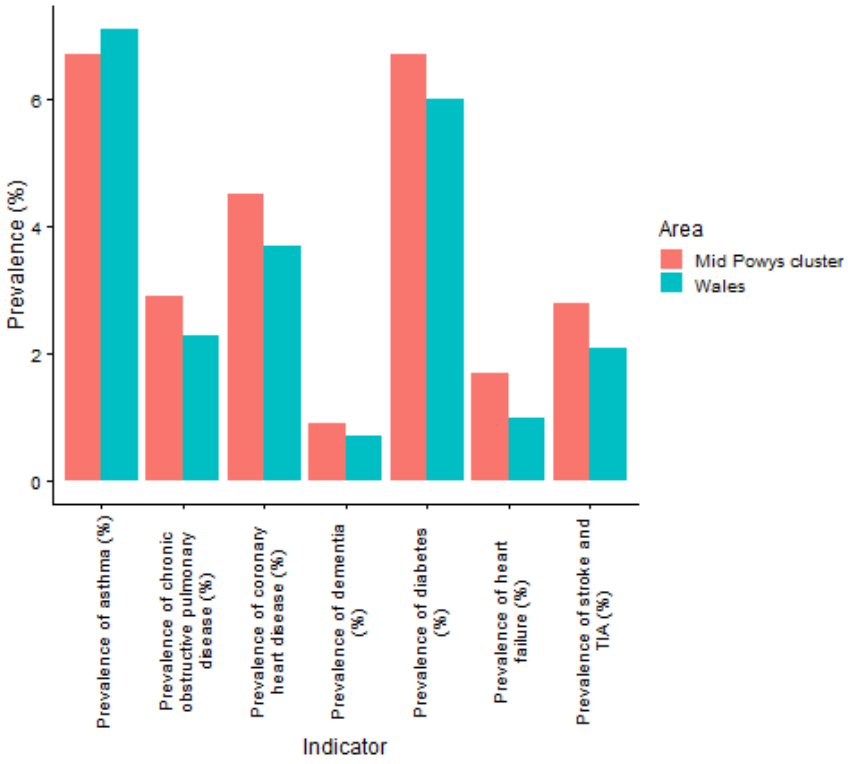




Prevalence of key behavioural clinical factors for Mid Powys cluster, as compared to all Wales. Data from PCNA (Public Health Wales)



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



5. Cluster Workforce Profile and 6. Financial Profile

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

7. Gaps to Address and Cluster Priorities for 2020-23 – Key Work Streams and Enablers

- 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
- Assessment of Virtual ward
- Respiratory
- Invest in your Health

Communication and engagement mechanism

- Health Focus groups
- Patient condition groups

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

The Cluster milestones and actions aligned to the 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	• Community Home Support/Reablement – Address the inequalities in community home support
		• Community Connectors – Maximise the benefits of Community Connectors across the cluster (Year 1) and carry out an evaluation of the service. (Year 2)
		• Cluster Health Champion – Scope and clarify Cluster Health Champion role in the Cluster communities.

APPENDIX 3: PTHB Cluster IMTPs

Core Well-being Objective 2	Early Help And Support	
	Priorities	• Increase direct access to and optimise use of community pharmacists to deliver common ailments service. • Invest In Your Health - Long Term Conditions – Continue to promote this service and increase uptake. Call for pre–diabetic focus/prevention focus in future courses. • Improved Access To Diagnostics –Practices to increase capability for point of care diagnostics and would like to explore the possibilities with the health board; to include CRP, ESR, D-Dimer testing.

Core Well-being Objective 3	Tackling The Big Four	
	Priorities	• Condition Specific Local Pathway Design – Respiratory pathway to reduce emergency admissions and to link in with the new breathe well programme. Assess effectiveness of the COPD rescue pack initiative, increase capacity of specialist nurse provision in the mid cluster, address Spirometry services – who provides this and how it is supported. • Increase use of Florence to support self management of chronic conditions • Emotional support and resilience to young people: Establish a service to provide 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 (Silvercloud) • Implement the use of MacMillan Primary Care Cancer toolkit

Core Well-being Objective 4	Joined Up Care	
	Priorities	• Develop cluster approach to provide GP support and collaboration across • Care Plans In Place For All High Risk Individuals and analysis of frailty register to identify all patients aged 65 and over who may be living with moderate or severe frailty • Review and evaluate delivery of Virtual Wards across cluster. • Develop role of cluster pharmacy team

APPENDIX 3: PTHB Cluster IMTPs

Enabling Well- Objective 1	**Workforce Futures**	
	Priorities	• Development of Cluster Practice Nurse role
		• Develop 'buddying up' peer support for practice nurses across Cluster

Enabling Well-being Objective 2	**Innovative Environments**	
	Priorities	• Development of scope and model for Community Wellbeing Hubs
		• Development of scope and model for Regional Rural Centres

Enabling Well-being Objective 3	Put Digital First	
	Priorities	• Development of Telehealth/Telecare/Telemedicine
		• Establish Point of Care Testing across cluster
		• Increase use of Skype Appointments

APPENDIX 3: PTHB Cluster IMTPs

Enabling Well-being Objective 4	**Transforming In Partnership**	
	Priorities	• Continued Development Of Community Care Cluster Relationship
		• Health Focus Groups/Patient Groups
		• Contribute and respond to service / pathway changes and developments in neighbouring district neighbouring hospitals
		• Review and update Cluster Terms of Reference

APPENDIX 3: PTHB Cluster IMTPs

Milestone / Action	Output	Outcome
Further integration of community connectors attached to each practice	• Presentation and quarterly reports at Cluster • Promote community connector role in General Practices and to the wider public / communities	• Development of robust service
Development of Cluster Health Champion role	• Scope and clarify Cluster Health Champion role in the Cluster communities.	• Cluster to decide if and how to implement Cluster Health Champion role
Redesign Respiratory pathways and services	• Link with the new Breathe Well programme. • Assess effectiveness of the COPD rescue pack initiative, • Increase capacity of specialist nurse provision in the mid cluster • Address Spirometry services	• Reduction in emergency admissions
Increase use of Florence to support self management of chronic conditions	• Identify which conditions to support • Establish which practices wish to participate • Identify patients in each practice • PLT delivered for practice nurses	• Plan in place to roll out use of Florence across cluster
Review mental health pathway for young people and improve access to early help and support	• Project plan developed and new model tested	• Early help service established
Develop cluster approach to provide GP support and collaboration across	• Identify model of providing remote GP support as part of business continuity plans, winter resilience planning & workforce issues.	• Continuity of services
Develop role of cluster pharmacy team	• Expand and develop consistent support to practices across cluster	• Improve outcomes, reduce harm and increase value from medicine use
Development of Cluster Practice Nurse role	• Appointment of cluster practice nurse through cluster funds • Establish role across cluster	• Collaborative support networks established between identified practices in need of this resource
Develop telehealth and telecare	• Dialogue between cluster / PTHB to explore options • Identify how technology will be utilised to develop telehealth	• Business case produced • Patients will receive remote consultations and assessments from clinicians

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

Our ambition for the people of Powys remains high. We are entering the second year of our 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 our Local Area Plan and is itself a component of our very long term, inter-generational Powys Wellbeing Plan.

We developed our Health and Care Strategy 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.
We are determined to be leaders in Wales in primary and community care and to continue to strengthen our role as an effective commissioner on behalf of the population of Powys. We have a very complex system of pathways across multiple health and care providers in England and Wales, as well as a role as a direct provider of healthcare. We are a key partner with the local authority and third sector.

We have submitted a bid to the 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, we will create and deploy a whole system Cluster based health and care service planning and delivery model. This will:

- Improve the health and wellbeing outcomes for our 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

We will work with partners across primary, community health, and social care in further development of Clusters and planning health and well-being services to respond to the local need. Clusters bring together services around a local community, to improve health and wellbeing, quality and efficiency of care and integration. Together we will design and trial innovative care pathways, reviewing and refreshing approaches to interventions such as Virtual Wards and Care Co-ordination. We 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.

Our 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. We will also scale up the wider use of Skype and remote consultations within the Cluster allowing 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.

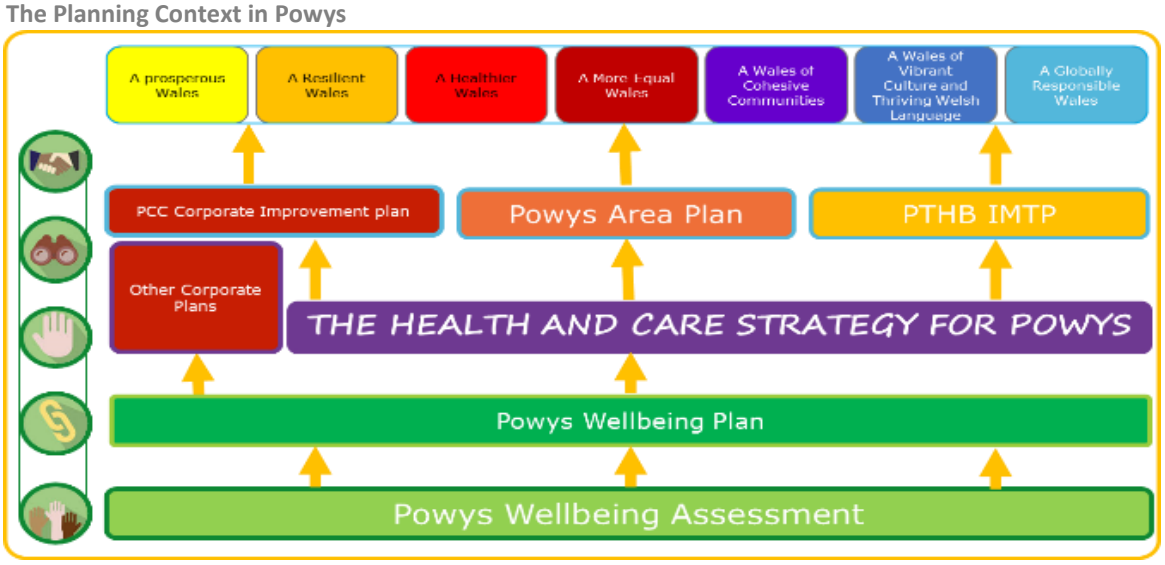
There is a focus on transformation and innovation to meet the needs of the Welsh population. A Healthier Wales describes a shift from large general hospitals to regional and local centres.

Well-being of Future Generations Act

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 sector.

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

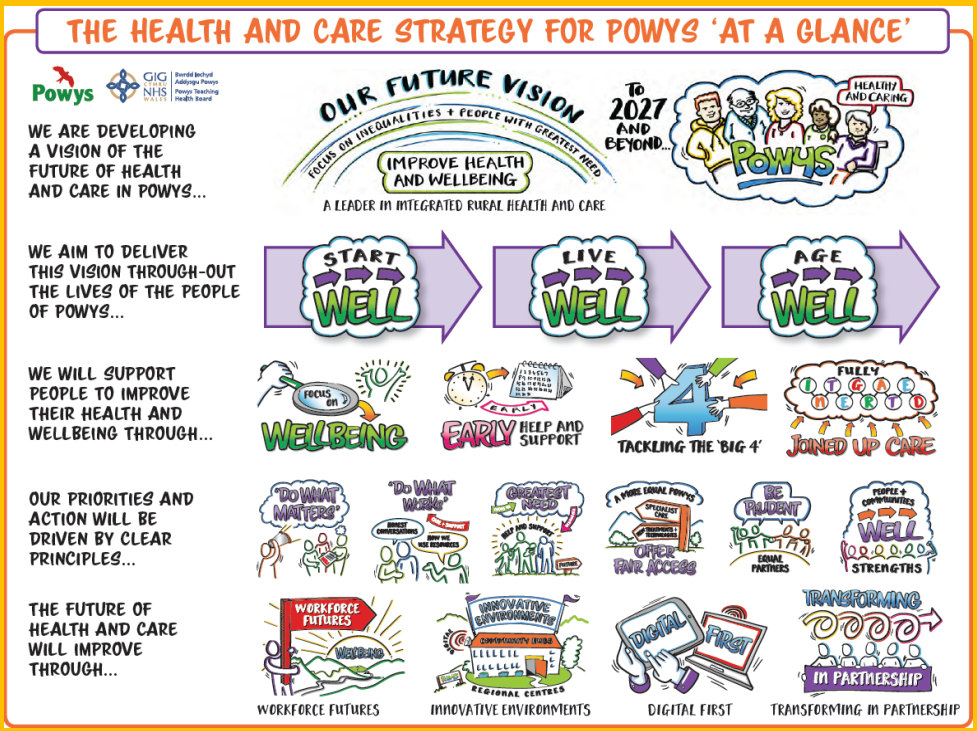
Ensure there is continuous and effective communication, involvement and engagement with the population of Mid Wales, staff and partners.

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

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



!. 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 it's 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

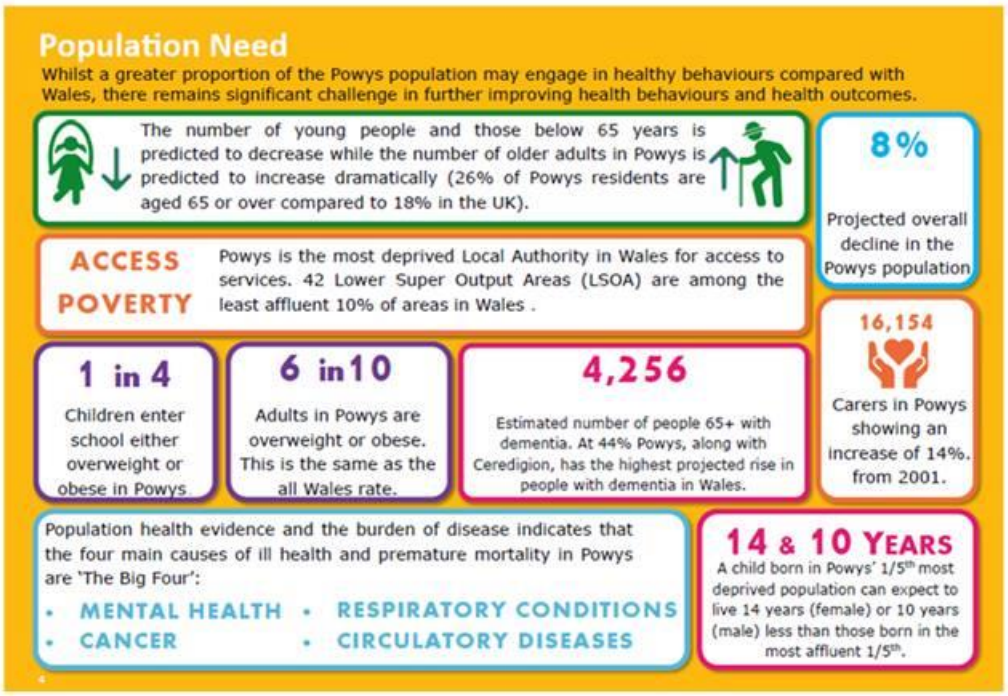
involving the third sector, by expansion in community connectors and social prescribing.

- 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

2. Introduction to the 2020 – 23 Plan / Cluster



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.

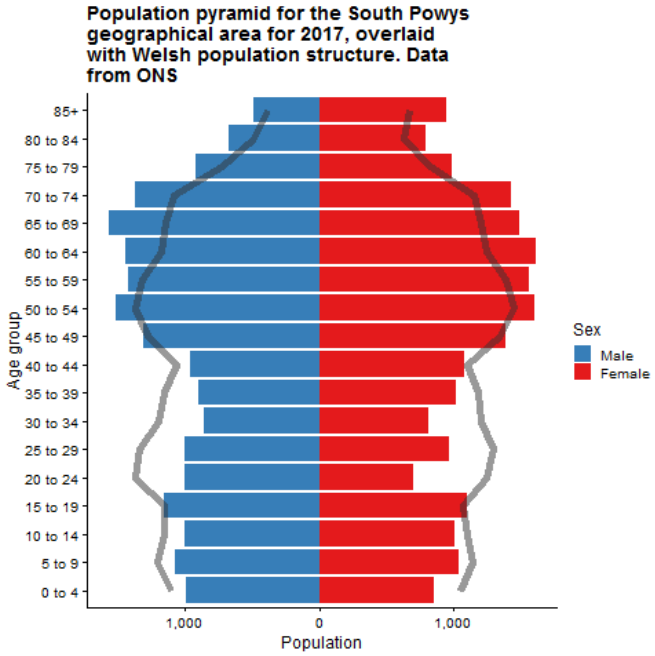
The other key component to the Powys model is delivery of services based around individual GP practices through an integrated Community Resource Team that includes practice, Health Board, County Council and Third Sector representatives.

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		

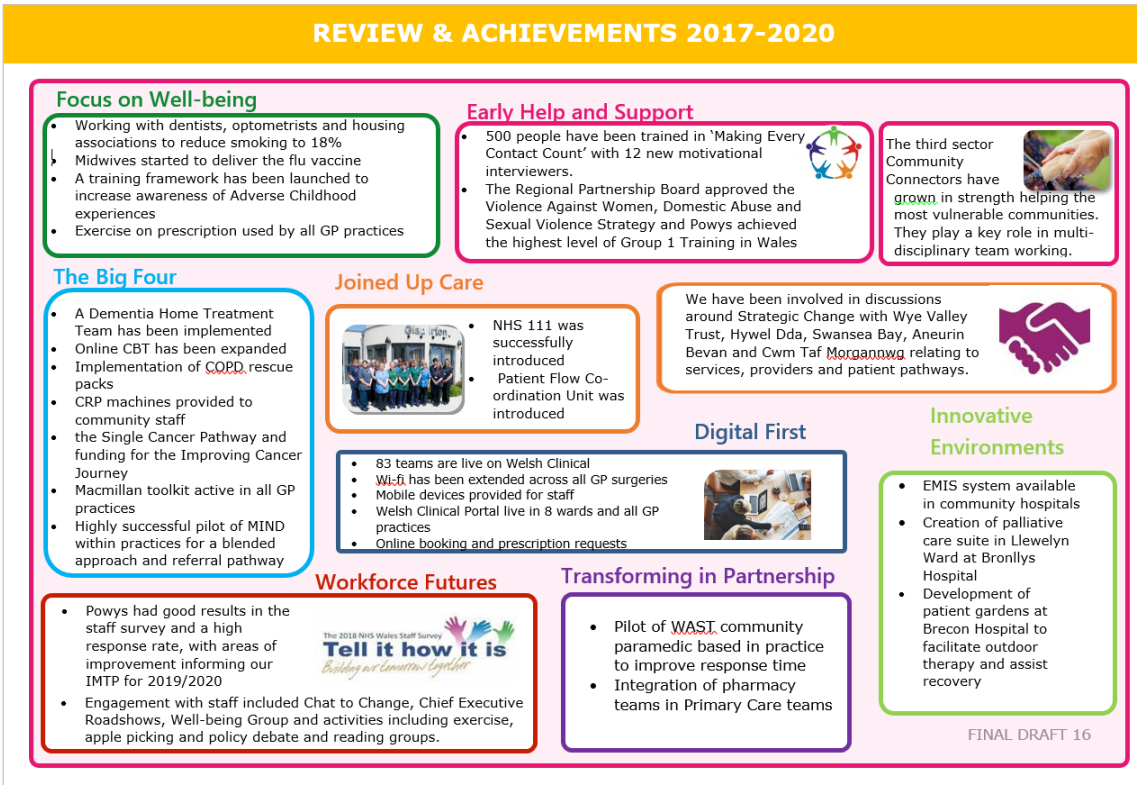
	• Urology • Oral surgery • **Endoscopy** sessions:- Gastroscopy • Sigmoidoscopy • Colonoscopy • Cystoscopy • Bowel Screening Wales • Pre-Anaesthetic sessions • Biometric sessions • Colposcopy		
	• Children's Centre – community Paediatric services • Community Dentistry • Specialist Nurses • Child & Adolescent 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	• Podiatry • Falls Programme • Physiotherapy • Occupational Therapy • Pain & Fatigue Management Centre • Occupational Health • Learning Disability – community service only • Psychology	• Respiratory • Cardiology • Physiotherapy • Dietetics • X-ray

	• Diabetic Eye screening • Genetics • Cardiology • Physiotherapy • Occupational Therapy • Speech & Language Therapy – Adults & Children • Podiatry • Audiology • 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:

APPENDIX 3: PTHB Cluster IMTPs



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

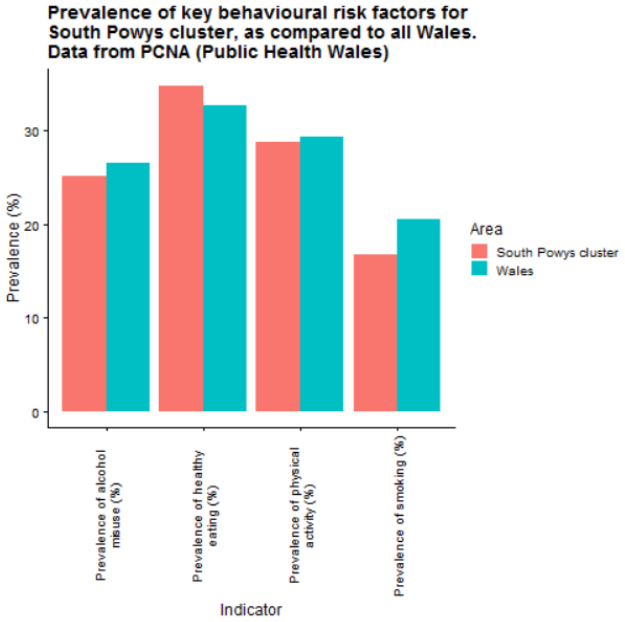
- Virtual Wards and Community Resource Teams
- Introduction of telephone triage and remote working across all practices
- Signposting to the most appropriate service for the presenting need by both receptionists and clinicians
- GP with Special Interest delivering Dermatology service for the Cluster
- 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

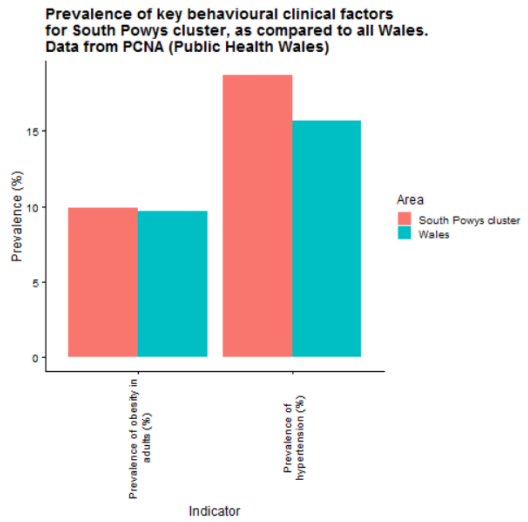
- Introduction of 3rd Sector MIND practitioners to support GP Practices and Community Mental Health Services using ICF funding
- Social prescribing by MIND
- Development of Community Interest group for the GP network – Red Kite – since 2015

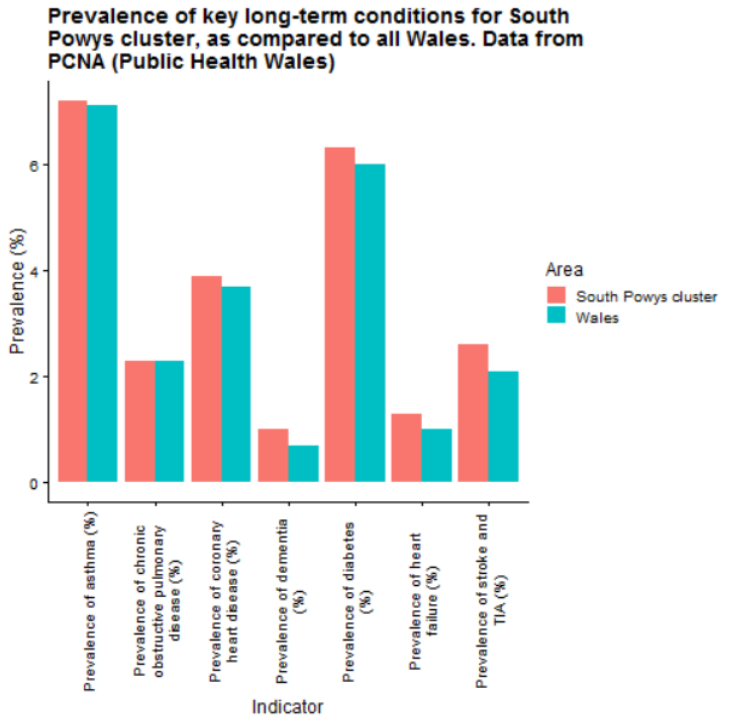
The Cluster have implemented a large part of the All Wales Primary Care model.

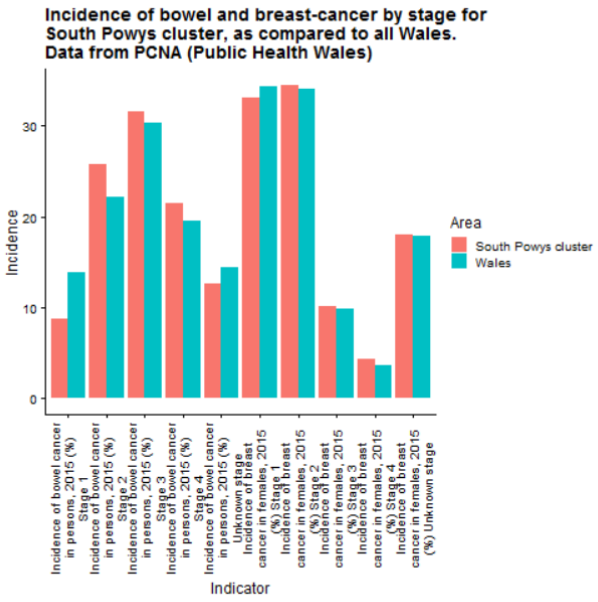
4. Cluster Population Area Health and Well-Being Needs Assessment

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









5. Cluster Workforce Profile and 6. Financial Profile

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

7. Gaps to Address and Cluster Priorities for 2020-23 – Key Work Streams and Enablers

- 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.

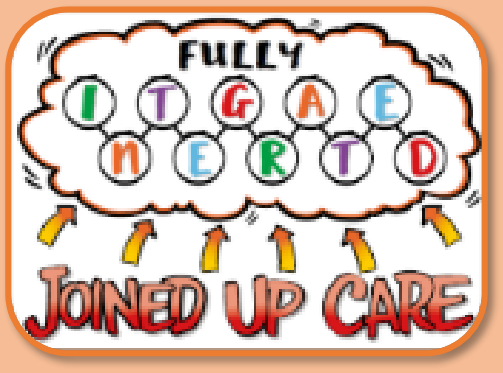
APPENDIX 3: PTHB Cluster IMTPs

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

APPENDIX 3: PTHB Cluster IMTPs

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. 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

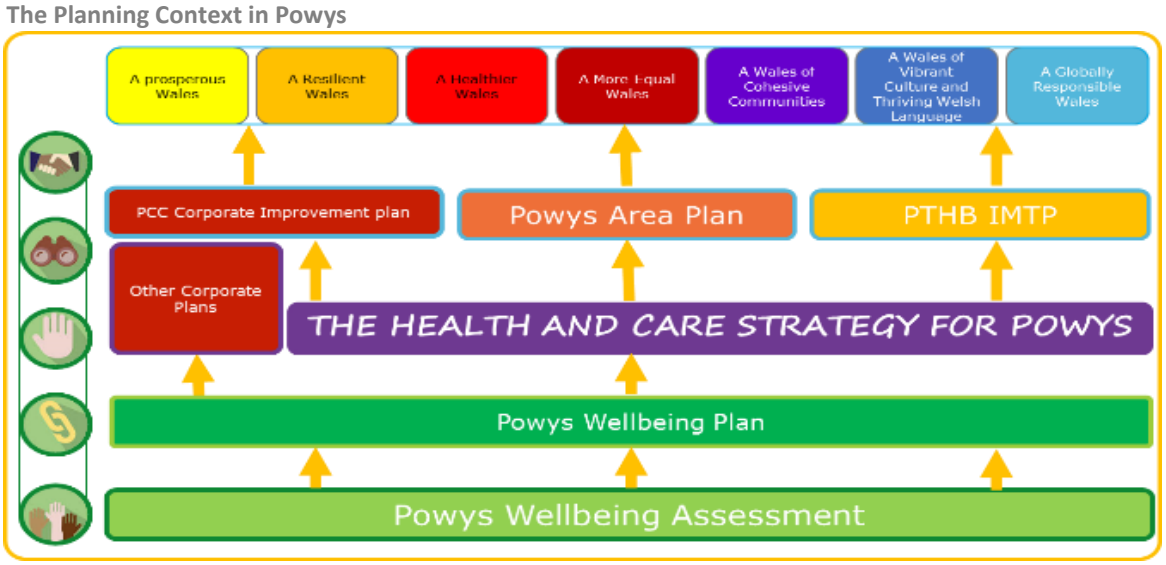
'A Healthier Wales: Our Plan for Health and Social Care' was published by Welsh Government in 2018, setting out a shared ambition to bring health and care services together into a seamless whole system approach, designed and delivered around the needs and preferences of individuals, with a much greater 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.

Well-being of Future Generations Act

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.



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.



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.

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

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

Appendix 4: Table of Long Term Agreements (LTAs)

English NHS Providers	LTA Value 18/19 £'000's	Commissioning Intentions 2020/21
Shrewsbury and Telford Hospitals NHS Trust	£25.3m	• Further strengthening of assurance in relation to the quality and safety of services • Participation in escalated arrangements in response to regulator action • Implementation of the outcome of the public consultation on Future Fit • Consider interface with the development of the integrated care system • PTHB actions to reduce emergency activity and admissions. • Ensure DToC and hospital flow arrangements are working smoothly • Ensure sustainable arrangements for neurology • Increase in-reach arrangements in line with Future Fit • Ensure coherent pathways for patients with diabetes
Wye Valley NHS Trust	£14m	• Continue work to reduce: Delayed Transfers of Care; Emergency Activity and admissions • Review impact of RTT initiatives • Consider the impact of the development of the Integrated Care System; and strategic change within the Herefordshire and Worcestershire STP area • Strengthen in-reach arrangements • Ensure robust shared care arrangements • For rheumatology (including supervision of a prescribing pharmacist) • Seek access for paediatric dental GAs • Seek interim provision of vasectomies whilst solutions are developed in the South and Mid Clusters • Move from block for best tariff
Robert Jones & Agnes Hunt Orthopaedic Hospital	£9.1m	• Seek to develop re-referral advice and support • Keep alternative orthopaedic pathway • Transfer spinal outreach contracting arrangements from WVT (not a change in location of delivery) • Ensure NICE compliant shared care arrangements in place for rheumatology
Gloucester NHS Foundation Trust	£1.5m	• Explore new ways of working including pre-referral advice and the modernisation of follow-up • Clarify in-reach immunology from Bristol (in liaison with WHSSC) • Assess impact of changes to specific tariffs • Confirm pathways for Barrett's oesphregus patients
Midlands Partnership	£1.1	• Ensure appropriate access to CAMHS
Worcester	£0.522m	• Review joint working in relation to stroke between Hereford and Worcestershire • Monitor mortality improvement plans
Wolverhampton	£0.193m	• Seek to maintain additional neurology support until sustainable services closer to home • Monitor mortality improvement plans

Appendix 4: Table of Long Term Agreements (LTAs)

Sandwell	£41k	• N/A
Shropshire Community Health Care NHS Trust	TBC	• Review expenditure on community services out of county and repatriate to Powys where possible • Prevent delayed transfer of care
Welsh NHS Providers		**Key Issues**
Aneurin Bevan UHB	£11.869M	• Work with ABUHB to develop the pathways needed ahead of the opening of The Grange University Hospital in March 2021 • Work collaboratively to strengthen commissioning assurance, focusing on maternity services • Strengthen assurance of maternity services • Seek interim provision of vasectomies whilst solutions are developed in the South and Mid Clusters
Swansea Bay UHB	£7.954M	• Work with Swansea Bay University Health Board to modernise clinical in-reach services to ensure sustainability
Hywel Dda UHB	£6.973M	• Seek further collaboration with Hywel Dda and BCUHB to develop services closer to home and address current gaps, including clinical in-reach services for diagnostics • Seek access for paediatric dental GAs
Betsi Cadwaladr UHB	£2.107M	• Seek further collaboration with Hywel Dda and Betsi Cadwaladr UHB to develop services closer to home and address current service gaps, including clinical in-reach services for diagnostics • Seek progress in relation to special measures
Cwm Taf Morgannwg UHB	£1.140M	• Work collaboratively to strengthen maternity assurance • Seek additional diagnostic support
Cardiff & Vale UHB	£1.314M	• Work with CVUHB on any changes to pathways arising from the South Wales Programme • Ensure provision of Powys specific incident information
Velindre	£1.051M	• Participate in collaborative commissioning arrangements to deliver the next phase of the Cancer Strategy • Consider radiotherapy business case

Appendix 5: Summary of Powys Well-Being Assessment

The following pages provide a summary of the Well-being and Population Needs Assessments which were originally undertaken in response to the development of the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014. The full analysis and list of sources can be found at https://en.powys.gov.uk/article/5794/Full-Well-being-assessment-analysis.

POWYS DEMOGRAPHICS

A Changing Population

The population in Powys is generally older in comparison to the rest of Wales.

The working age adult population is smaller in Powys compared to Wales.

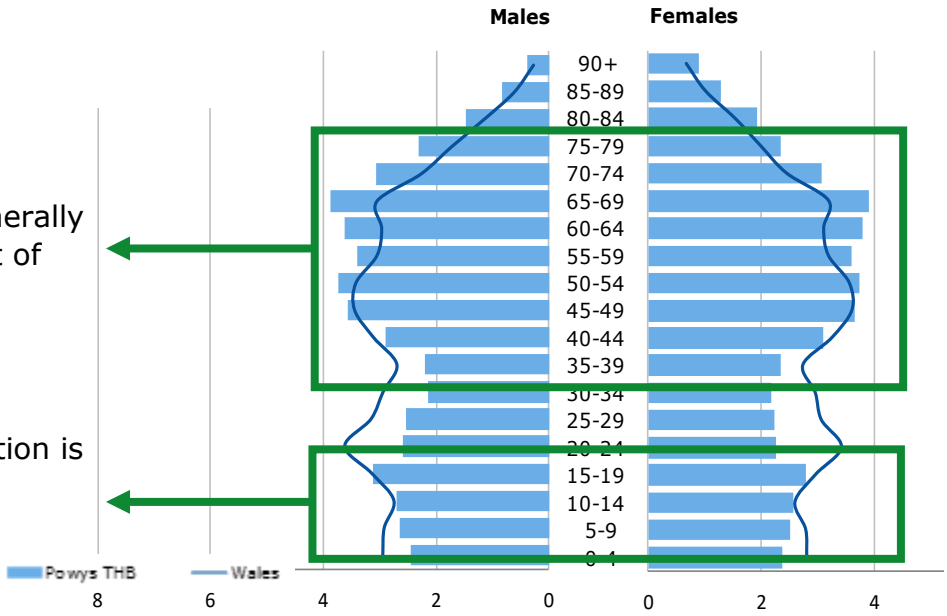


Diagram 19: Powys Population Pyramid

8% Projected overall decline in the Powys population by 2039.

15% Powys population aged 15 and under.

59% Powys population aged between 16 and 65.

26% Powys population aged 65 or over.

5,500 people migrated out of Powys in 2015

5,900 people migrated into Powys in 2015

The number of young people and those under 65 is predicted to decrease while the number of older adults in Powys is predicted to increase.

DETERMINANTS OF HEALTH

Economic Well-being and Poverty

Economic well-being is above the Welsh average but there is hidden poverty in Powys associated with rural communities.

On average, Powys residents earn consistently less than people in many other Welsh Local Authorities, ranking third lowest in Wales.

Unemployment rates are low but there is a high proportion of people in part time work and a low wage economy.

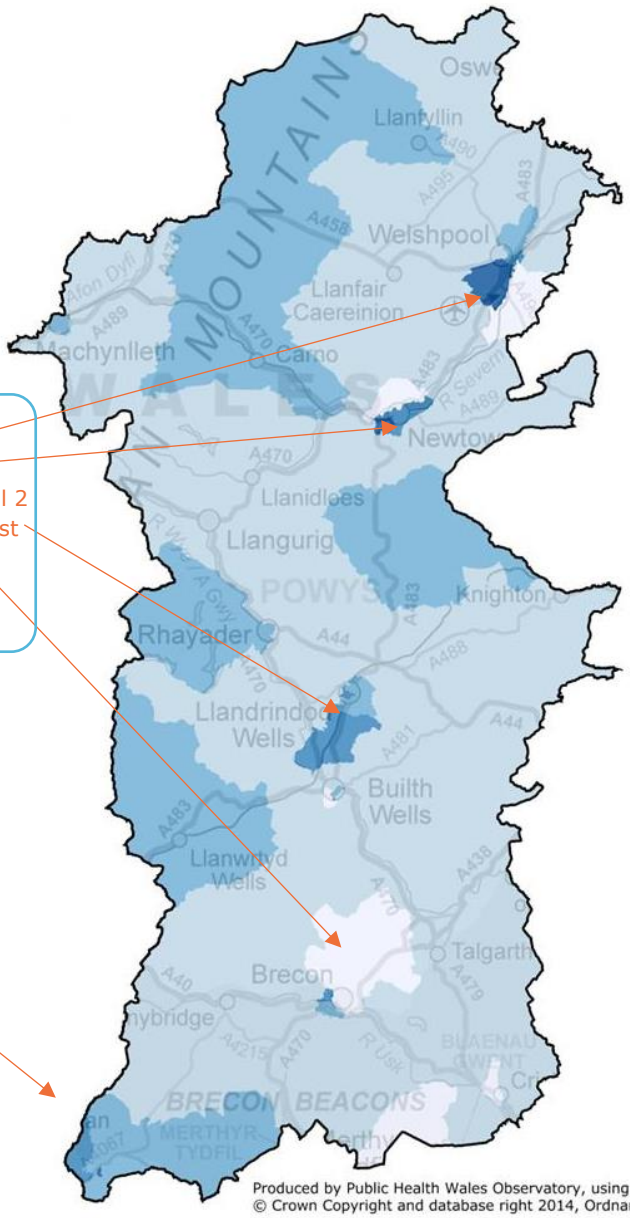
Five Local Authority Super Output Areas (LSOAs) in Powys are among the most deprived in Wales

- Welshpool Castle
- Newtown South and Newtown Central 2
- Llandrindod East/West
- Brecon St John 2

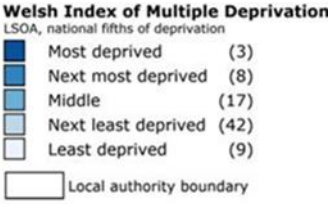
Five LSOAs in Powys as shown above are among the most deprived 30% in Wales while Ystradgynlais 1 is the most deprived area and is among the 10% most deprived LSOAs in Wales.

Powys has a disproportionately high number of small businesses, alongside a high proportion of self-employed workers. This needs to be seen in the context of 11.3% of men and 8.9% of women of working age in Powys having no formal qualifications.

Between 2004 and 2013, there was a reduction in the proportion of Year 11 leavers not in education, employment or training.



WIMD Map of Powys LSOAs



Community Well-being and Health Assets

83% Of Powys residents report that they feel they belong to their local area (Welsh average 76%).

Powys has a high prevalence of the assets required for resilient, self-reliant communities. This is almost universally the case, with good levels of provision relative to Wales, whether looking at people, community or structural assets. The only area where more attention may be required in some parts of Powys is in relation to education and training.

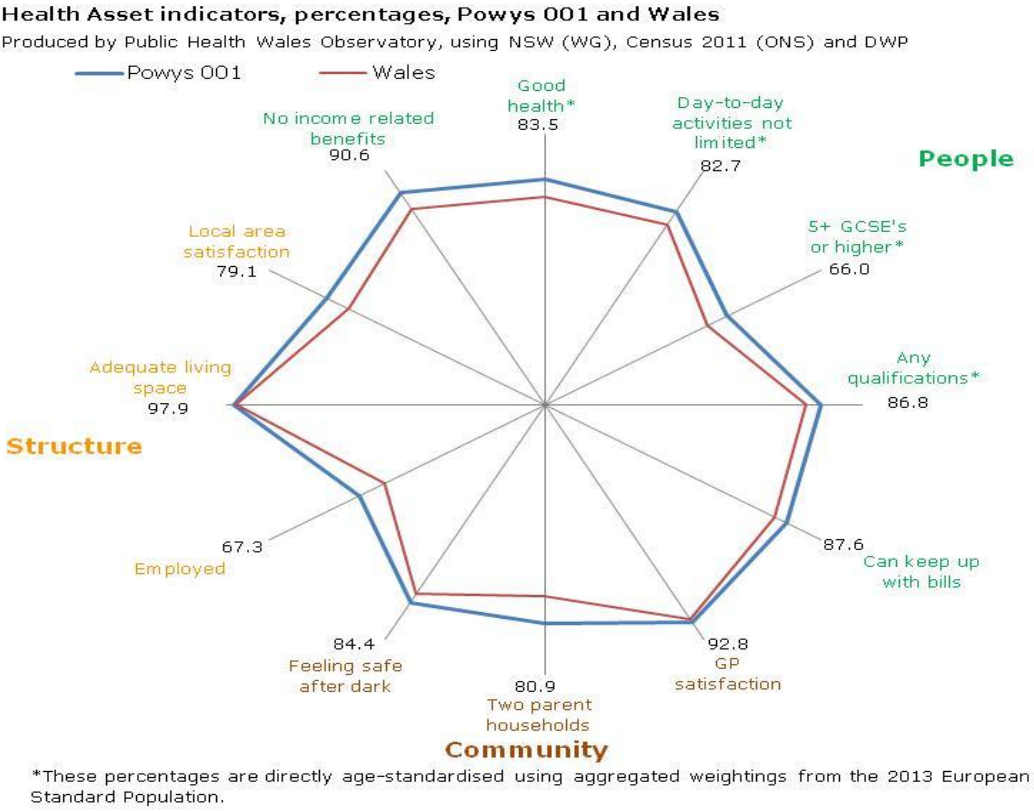


Diagram 21: Health Asset Indicators, Percentages Powys 2011

Public sector services in Powys include 98 schools, 17 branch libraries and 2 mobile libraries, 16 leisure centres, 9 hospitals, 1 Integrated Health and Care Centre, 18 fire stations and 14 police stations.

Powys is the second most expensive place to buy a house in Wales in relation to income rates (8.7 times the median annual gross pay for a full time job in Powys, 6.4 in Wales).

Housing quality in Powys is worse than across Wales, with 24 of the 75 Electoral Divisions among the worst 20% of areas for housing quality in the WIMD 2000.

A total of 859 people are supported by domiciliary care in Powys. As our elderly population increases, there will be more demand for suitable accommodation options.

LIFESTYLE AND HEALTH STATUS

Public Health Outcomes Framework

The Public Health Outcomes Framework[1] sets out a shared understanding of the health outcomes that are important to the people of Wales. The key messages and the position of Powys relative to the Wales average for each measure is shown below:

Powys is significantly better than the Wales average for nearly half the indicators published in the Public Health Outcomes Framework.
People in Powys live longer and spend more years in good health.

Adults eat more healthily and are more physically active in Powys.

The mortality rate from road traffic accidents is relatively high in the Powys population; however, there is some complexity in relation to this information.

Fewer people feel lonely and there is a greater sense of community in Powys.

Working age adults and older people are more satisfied with life.

Table 2: Public Health Outcomes Measures for Powys

Overarching Outcomes	
Outcome	**PTHB value**
Healthy life expectancy (females)	68.7yrs
Healthy life expectancy (males)	68.2yrs
Life expectancy (females)	83.5yrs
Life expectancy (males)	80.3yrs
Mental well-being among adults (average score on Warwick-Edinburgh Mental Well-being Scale)	52.3
Gap in healthy life expectancy at birth between the most and least deprived fifth (females)	14.4yrs
Gap in healthy life expectancy at birth between the most and least deprived fifth (males)	10.4yrs
Gap in life expectancy at birth between the most and least deprived fifth (females)	5.2yrs
Gap in life expectancy at birth between the most and least deprived fifth (males)	5.2yrs

Appendix 5: Summary of Well-Being Assessment

Living Conditions that Contribute to Health	
Outcome	**PTHB value**
People able to afford everyday goods and activities	87.91%
School leavers with skills & qualifications (level 2)	No data
Gap in employment rate for those with a long term health condition (i.e. difference in employment rate between general population and those with Long term health conditions)	13.1%
A sense of community	64.7%
People feeling lonely	13.1%
People who volunteer	37.5%
Quality of housing (% assessments free from cat 1 hazards)	51.7%
Quality of the air we breathe (average NO_2 concentration)	5.1µg/m^3*

Ways of Living that Improve Health	
Outcome	**PTHB value**
Adolescents drinking sugary drinks once a day or more	13.6%
Adolescents using alcohol	7.2%
Adolescents who smoke	2.7%
Adults drinking above guidelines	17.8%
Adults eating 5 a day	29.7%
Adults meeting physical activity guidelines	65.9%
Adults who smoke	18.4%
Physical activity in adolescents	16.8%
Breastfeeding at 10 days	51.5%
Smoking in pregnancy	11.2%
Teenage pregnancies	14.9 per1,000
Vaccination rates at age 4yrs	86.2%

Health throughout The Life Course	
Outcome	**PTHB value**
Low birth weight	4.7%
Adolescents of healthy weight	76.7%
Children age 5yrs of healthy weight	72.6%
Tooth decay among 5yr olds (average no. decayed, missing, filled teeth)	0.9
Life satisfaction among working age adults	85.6%
Working age adults free from limiting long term illness	75.3%
Working age adults in good health	79.3%
Working age adults of a healthy weight	44.7%
Hip fractures among older people	502.4 per 100,000
Life satisfaction among older people	87.8%
Older people free from limiting long term illness	50.8%
Older people in good health	60.9%
Deaths from injuries	41.9 per 100,000
Deaths from road traffic injuries	8.7 per 100,000
Premature deaths from key non-communicable diseases	261 per 100,000
Suicides	14.6 per 100,000

Source: Public Health Wales Observatory

Appendix 5: Summary of Well-Being Assessment

Key:

- Significantly better than the Wales average
- Not significantly different to the Wales average
- Significantly worse than the Wales average
- ★ Significance to Wales average not measured

MENTAL HEALTH NEEDS

Importance of Mental Well-being

Improving mental health is a critical issue for people of all ages and its impact is cross cutting, affecting life chances; learning, home life, employment, safety, physical health, independence and life expectancy.

11 Years	The average lost years to life for males with mental health problems. Women with mental health problems on average lose 6 years this is the biggest health inequality.
1in4	Number of people in the UK who will experience a mental health problem each year.
25%	GP consultations which are for people with mental health problems.

Depression and Anxiety

8%	Of the Powys population report being treated for depression or anxiety and it is one of the top three leading causes of disability.

One in four patients presenting to their GP live with depression with the average GP seeing at least one patient with depression during each surgery session. 80% of people identified as having depression, are managed entirely in a primary care setting. In the UK, 25% of older adults have depression requiring an intervention and over 40% of those in their 80s are affected by depression. This is significant given Powys' demography. It is also important to note that ddepression is the leading cause of suicides in England and Wales each year.

It has been estimated that between 10-15% of women suffer from post-natal depression. In Powys there are approximately 1000 births per year, which means around 100 women may suffer post-natal depression.

Dementia and Alzheimers

Dementia prevalence increases with age, roughly doubling every five years for people aged over 65 years. Dementia affects 20% of people over 80 years of age in the UK and one in 14 people over 65.

4,256	Estimated number of people in Powys aged over 65 with dementia. At 44% Powys, along with Ceredigion, has the highest projected rise in the number of people with dementia in Wales.

In Powys it is thought that only 39.6% of the projected number of people with dementia have a diagnosis.

Up to 70% of acute hospital beds are occupied by older people, approximately 40% of whom have dementia. However, patients who have dementia experience many more complications and stay longer in hospital than those without dementia. It is also estimated that 30% of people will die with dementia and many of these die in general hospital settings. The improvement in care for people with dementia in general hospitals is a component of the Powys Dementia Plan.

Link to Powys Dementia Plan

BURDEN OF DISEASE

The *Health and its determinants in Wales*[2] report provides an overview of the health and well-being of the population of Wales. It outlines the main areas of health need and presents the complex picture of health in Wales. Although information is shown on an all Wales basis, the picture it presents of disease and disability throughout the life course is equally likely to apply to Powys. Given the importance of maintaining health and well-being, it is useful to see the relative contribution made by different causes to ill health and disability across the life course. This is shown below using disability-adjusted life years as a measure of ill health.
Source: Public Health Wales

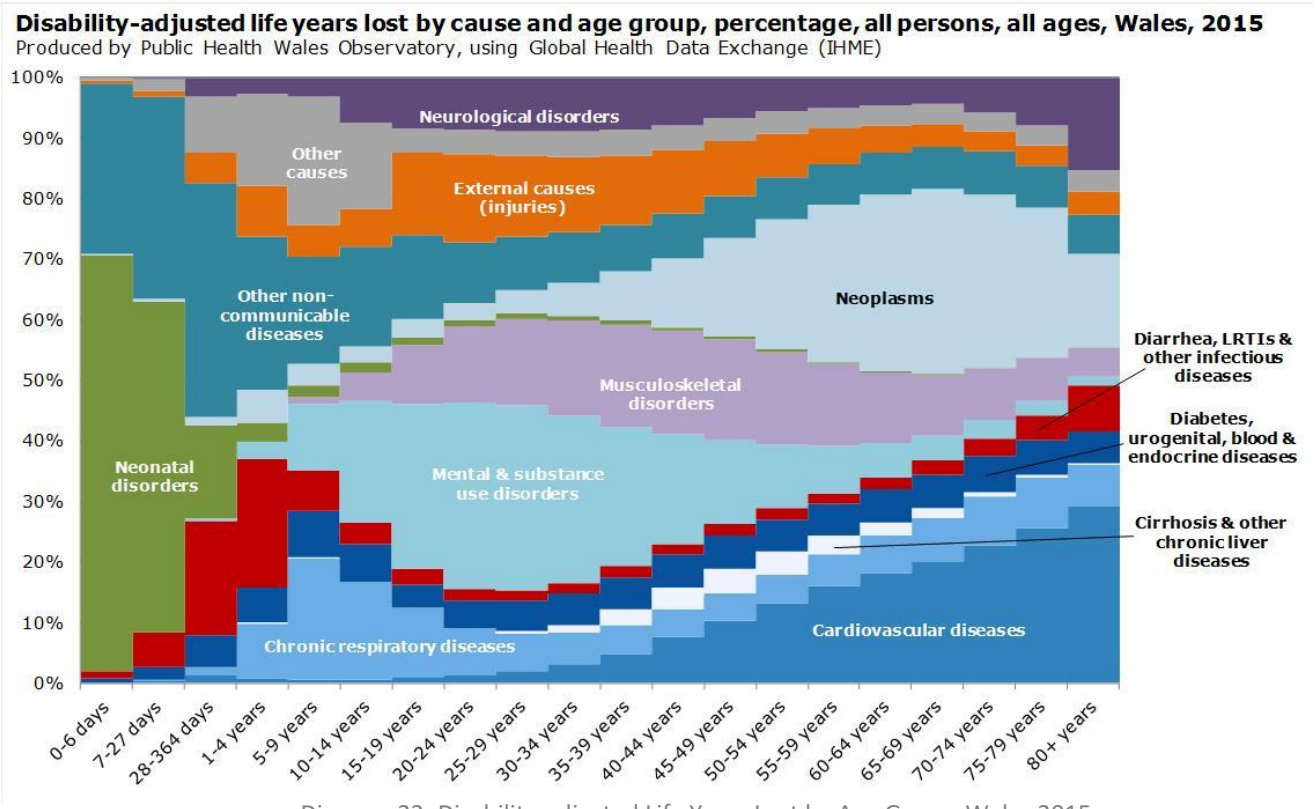


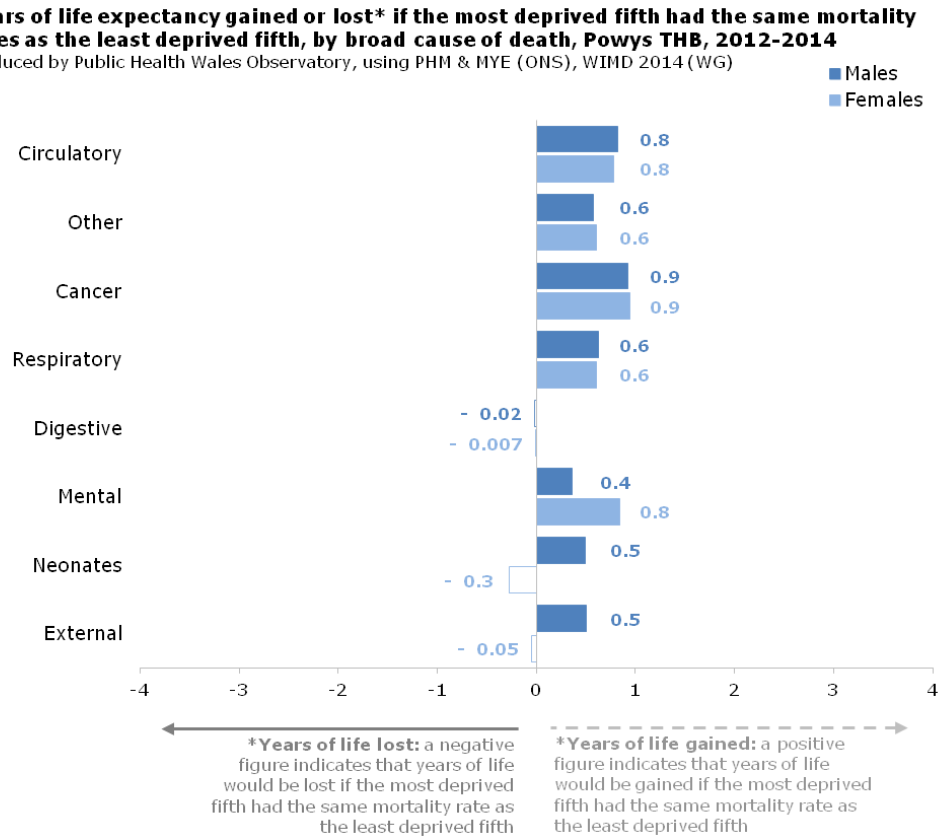
Diagram 22: Disability-adjusted Life Years Lost by Age Group, Wales 2015

This clearly illustrates the contribution made to ill health by different causes at different stages of the life course. Cancer (neoplasms), cardiovascular diseases, respiratory diseases, and mental health disorders all feature prominently from the early years onwards. *The Health and Care Strategy for Powys*[3] recognises the need to address these four causes, bringing them together under the heading "Tackling the Big 4".

Musculoskeletal disorders are also shown to be a significant cause of disability and ill health, especially in relation to working age adults. In the context of *The Health and Care Strategy for Powys*, the incidence of musculoskeletal disorders will be addressed through actions that fall within the "Focus on Well-being" (i.e. keeping adults healthy and active), and through "Early Help and Support" (i.e. ensuring prompt access to diagnosis and treatment). Musculoskeletal problems often arise in the workplace, and, as a significant employer, Powys Teaching Health Board will continue to prioritise the well-being of staff, taking a preventive approach and managing employee health rather than employee sickness. Actions to address the well-being of our staff are described elsewhere in the IMTP.

HEALTH INEQUALITIES

People who live in the most deprived parts of Powys live more years in poor health compared to people in the least deprived areas. A child born in the most deprived quintile can expect to live in good health for 14 years (female) or 10 years (male) less than in the most affluent. The graph shows the uneven distribution of the major causes of premature death in Powys:



A number of evidence-based high impact interventions have been shown to work in tackling health inequalities and reducing the life expectancy gap:

- Widespread, systematic adoption of increased prescribing of drugs to control blood pressure and cholesterol; increased smoking cessation services; increased anticoagulant therapy in atrial fibrillation; improved blood sugar control in diabetes.
- Targeted approaches to case finding to address late diagnosis, particularly in disadvantaged communities, in hypertension, Chronic Obstructive Pulmonary Disease (COPD), lung cancer, cardiovascular risk, diabetes and harmful drinking.
- Improving access to health care for vulnerable populations such as ensuring the homeless are able to register with a GP, and older people with cancer are given access to chemotherapy as determined by their functional status and not their age.
- Involving people and communities in designing services to meet health and care needs.
- Promoting the Making Every Contact Count initiative, which systematically puts prevention, protection and promotion of health and well-being into each contact.
- Investing in targeted and universal early years services and good maternal health for all.

- As an employer, reducing discrimination and nurturing and developing a workforce that is representative of the population it serves.

OTHER KEY FINDINGS

16,154 Carers in Powys, showing an increase of 14% from 2001.

576 The number of young carers known to Credu (the Powys organisation for carers) in 2016.

Carers

The increasing numbers of carers and young carers is of particular significance as unpaid carers, usually family members, contribute significantly to maintaining the well-being of individuals with complex needs due to long term physical or mental ill-health, disability or old age in the community. The health and well-being of carers is affected by their caring responsibilities, as many may experience ill health, poverty and problems accessing employment. In Powys, 65% of unpaid carers are over 50 and 39% are retired. Their health is typically below average, and some carers are now providing more than 50 hours of care each week.

Of those carers who took part in the citizen survey; 33% said they could do things which were important to them with 24% saying this applied only part of the time and 29% felt supported to continue in their caring role. People also said there are a lack of places to go for older people during the daytime and have stressed the importance of the existing day time services and the respite it provides to carers.

The number of young carers is increasing, with most providing up to 19 hours of care. Some young carers, due to their responsibilities, are missing out on school time. This can have an effect on their education and future prospects. Due to the increasing elderly population, more young people are finding themselves with caring responsibilities.

Violence Against Women, Domestic Abuse and Sexual Violence

In 2016, Powys has seen a 10% rise in the number of domestic violence incidents being reported, compared with 2015. In the north of Powys, BME (Black, Minority and Ethnic) and LGBT (Lesbian, Gay, Bisexual, Transgender) groups are also more likely to be affected. Many crimes are still not reported, and the number of incidents is expected to rise over the coming years. This rise continues an existing trend with an overall increase of 75% since 2010.

Vulnerable Children

The most common age group of vulnerable children is 10-15 years old, this makes it hard to find suitable foster parents as their needs are greater. More children are being placed on the child protection register, with neglect being the most common reason. The number of cases referred to the Youth Justice Service has fallen since 2010, along with the number of children in need. This is in the context of a statutory requirement for Powys County Council to improve children's services, following a review by CIW during 2017.

Children with Disabilities

Autistic spectrum disorders are the most common presentation of disability within children in Powys. In 2016, 155 open cases were referred to the team (a decrease of 13% since 2012). From caseloads, 52% of children with disabilities live in north Powys.

Appendix 6: Glossary of Terms and Acronyms

Glossary of Terms

Acronym	Full Description
ABUHB	Aneurin Bevan University Health Board
ACP	Advanced Care Planning
AMD	Age-related Macular Degeneration
ARCH	A Regional Collaboration for Health
ATMP	Advanced Therapeutic Medicinal Products
BC	Business Case
BCUHB	Betsi Cadwaladar University Health Board
BI	Business Intelligence
BMI	Body Mass Index
CAF	Commissioning Assurance Framework
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCTV	Closed Circuit Television
CHC	Community Health Council
CHKS	Clinical Health Knowledge System
CMHTs	Community Mental Health Teams
CNO	Chief Nursing Officer
COPD	Chronic Obstructive Pulmonary Disorder
CQUIN	Commissioning for Quality and innovation
CRT	Community Resource Teams
CTMUHB	Cwm Taff Morgannwg University Health Board
CTP	Care Trust Plus
CVI	Certificate of Visual Impairment
DAG	Delivery Assurance Group
DGH	District General Hospital
DNA	Did Not Attend
DoLS	Deprivation of Liberty Safeguards
EASC	Emergency Ambulance Services Committee
ECLO	Eye Care Liaison Officer
EDD	Estimated Discharge Date
EFPMS	Estates Facilities Performance management System
EMRTS	Emergency Medical Retrieval and Transport Services
EMS	Emergency Medical Services
ENT	Ear, Nose and Throat
e-PIMS	Electronic Property Information Mapping Service
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FBC	Full Business Case
FE's	Further Education
FGA	Future Generations Act
FNC	Funded Nursing Care
GDPR	General Data Protection Regulation

Appendix 6: Glossary of Terms and Acronyms

GDPs	General Dental Practitioners
GDS	General Dental Services
GI	Gastro Intestinal
GP	General Practitioners
GPTR	GP Test Requesting and Reporting
HCAI	Health Care Associated Infection
HCRW	Health and Care Research Wales
HCS	Health Courier Service
HCSW	Health Care Support Worker
HEIW	Health Education and Improvement Wales
HRG4+	Non funded English pricing system
ICF	Integrated Care Fund
ICP	Integrated Care Pathway
ICT	Information Communications Technology
IFOR	Information Focused Online Reporting
IFRS	Individual Funding Requests
IG	Information Governance
IM&T	Information Management and Technology
IMTP	Integrated Medium Term Plan
IP	Internet Protocol
IPR	Individual Performance Review
IQT	Improving Quality Together
IRIS	Innovation, Research, Improvement Service
IT	Information Technology
JAG	Joint Advisory Group
JET	Joint Executive Team
LD	Learning Disability
LoS	Length of Stay
LRF	Local Resilience Forums
LSOAs	Lower Super Output Areas
LSU	Low Support Unit
LTA	Long Term Agreement
MDT	Multi Disciplinary Team
MECC	Making Every Contact Count
MH	Mental Health
MMR	Measles Mumps and Rubella
MMR2	Measles Mumps and Rubella 2
MRSA	Methicillin Resistant Staphylococcus Aureus
MSc	Master of Science
MSSA	Methicillin Susceptible Staphylococcus Aureus
MTeD	Medical information and Electronic Discharge
MWJC	Mid Wales Joint Committee
NDP	National Delivery Plan
NEPTS	Non Emergency Patient Transport Services

Appendix 6: Glossary of Terms and Acronyms

NHS	National Health Service
NHSWSSPC	NHS Wales Shared Services Partnership
NWIS	NHS Wales Information Service
NWSSP	NHS Wales Shared Service Plan
OCP	Organisational Change Process
OD	Organisational Development
ODTCs	Optometric Diagnostic Treatment Centres
PACS	Primary and Acute Care System
PACS	Primary and Acute Care System
PADR	Personal Appraisal and Development Reviews
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PGD	Patient Group Directions
PhD	Doctor of Philosophy
PHLS	Public Health Laboratory Services
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
PSB	Public Service Board
PTHB	Powys Teaching Health Board
QI	Quality improvement
R&D	Research and Development
RPB	Regional Planning Board
RTT	Referral to Treatment
SARC	Sexual Assault Referral Centre
SaTH	Shrewsbury and Telford Hospitals
SIFT	Service Increment for Training
SLAs	Service Level Agreements
SSNAP	Sentinel Stroke National Audit Programme
STP	Sustainability and Transformation Partnership
THB	Teaching Health Board
UHB	University Health Board
UK	United Kingdom
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence
WAO	Wales Audit Office
WAST	Welsh Ambulance Services Trust
WCCG	Welsh Clinical Communications Gateway
WCCIS	Welsh Community Care Information System
WCP	Welsh Clinical Portal
WCRS	Welsh Care Records System
WGPR	Welsh Government Patient Record
WHC	Welsh Health Circular
WHSCC	Welsh Health Specialist Services Committee
WIAS	Welsh Imaging Archive Service
WPRS	Welsh Patient Referral Service
WVT	Wye Valley Trust

Appendix 7: Useful Links

Useful Links to Further Information

Powys and Mid Wales	
Powys Teaching Health Board	http://www.powysthb.wales.nhs.uk/ and separate hyperlinks to PTHB Annual Report; PTHB Annual Quality Plan; PTHB Health Inequalities Plan http://www.powysthb.wales.nhs.uk/board-meeting-29-january-2020 'PTHB Clinical Quality Framework' 'Annual Governance Programme'
Powys Regional Partnership Board Area Plan	https://en.powys.gov.uk/article/1741/Powys-Regional-Partnership-Board https://en.powys.gov.uk/media/617/Powys-Area-Planning-Board-Substance-Misuse-Commissioning-Strategy-2015--2020/pdf/Powys_APB_Commissioning_Strategy_2015-2020_en.pdf?m=1510656898427
Powys Regional Partnership Board Health & Care Strategy	http://www.powysthb.wales.nhs.uk/health-and-care-strategy
Powys Public Service Board Well-being Plan	https://en.powys.gov.uk/article/5789/Towards-2040---the-Powys-Well-being-Plan
Powys Well-being Assessment	https://en.powys.gov.uk/article/5794/Full-Well-being-assessment-analysis
Hearts and Minds: Together for Mental Health	http://www.powysthb.wales.nhs.uk/hearts-and-minds
Powys / Mid and West Wales Safeguarding Framework	http://www.powysthb.wales.nhs.uk/safeguarding http://cysur.wales/home/regional-policies-procedures/
Other Joint Plans and Commissioning Strategies:	https://en.powys.gov.uk/article/1742/Powys-RPB-Documents
- Powys Assistive Technology Strategy Joint Commissioning Strategy: Substance Misuse - Joint Commissioning Strategy: Learning Disabilities - Joint Commissioning Strategy: Domestic Abuse - Dementia Care Plan - Powys Ageing Well Plan - Joint Commissioning Strategy for Carers - Joint Commissioning Strategy and Plan for Older People	
Powys Community Health Council (CHC)	http://www.wales.nhs.uk/sitesplus/1144/home
Powys County Council	http://www.powys.gov.uk/
Powys Association of Voluntary Organisations (PAVO)	http://www.pavo.org.uk/home.html
Mid Wales Joint Committee	http://www.midwalescollaborative.wales.nhs.uk/
All Wales	
Rural Health and Care Wales	https://ruralhealthandcare.wales
Welsh Ambulance Services NHS Trust	http://www.was-tr.wales.nhs.uk/
Welsh Health Specialised Services Committee	http://www.whssc.wales.nhs.uk/home
Emergency Ambulance Services Committee	http://www.wales.nhs.uk/easc/about-us
Welsh Government	https://gov.wales/?lang=en
Health Education and Improvement Wales (HEIW)	https://heiw.nhs.wales/
Public Health Wales	http://www.publichealthwales.wales.nhs.uk/
NHS Wales Informatics Service (NWIS)	http://www.wales.nhs.uk/sitesplus/956/home
NHS Wales Shared Services Partnership (NWSSP)	http://www.nwssp.wales.nhs.uk/home