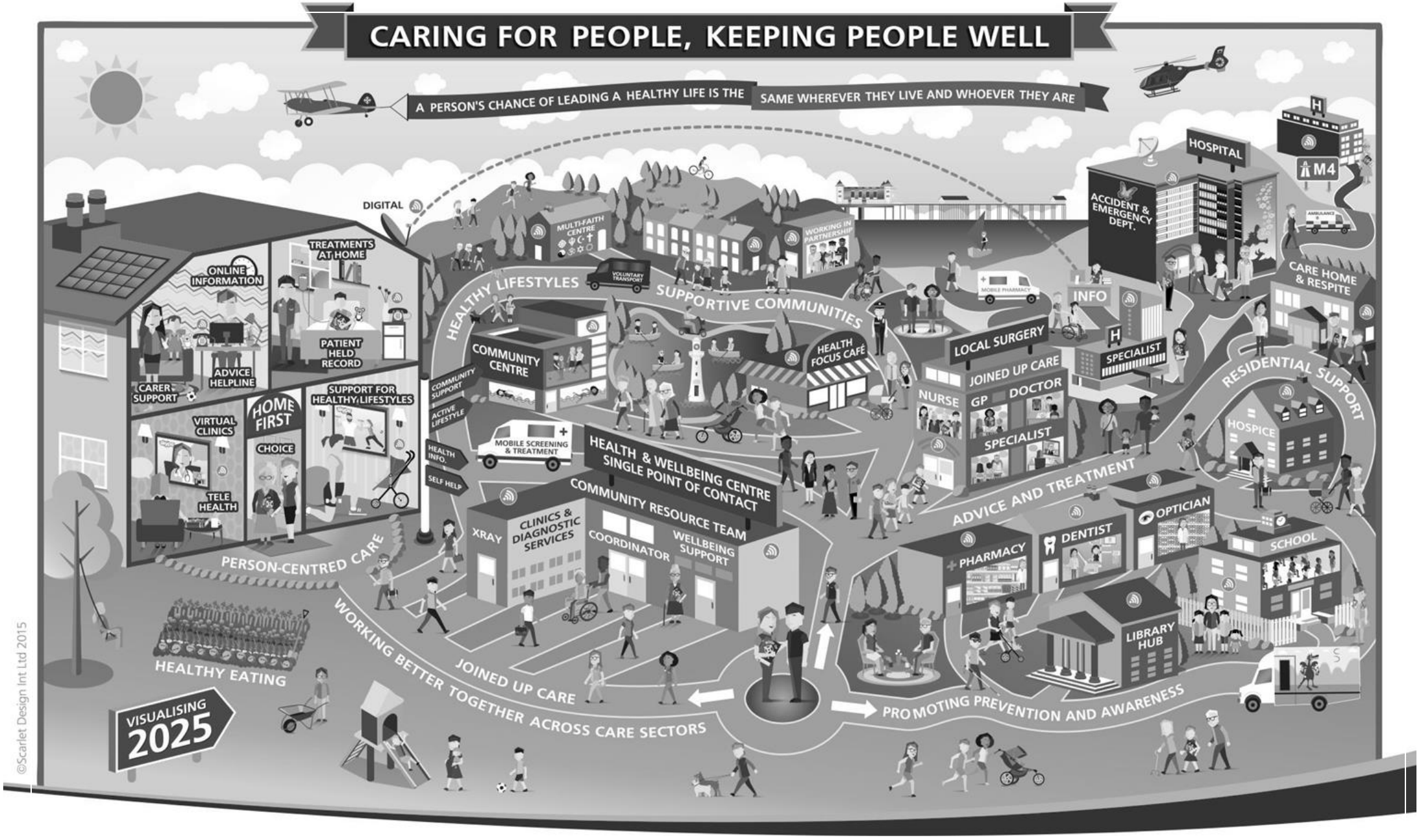


INTEGRATED MEDIUM TERM PLAN 2019-22
PCIC CLINICAL BOARD

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

INDEX

INTRODUCTION

A1. BACKGROUND

The Primary, Community and Intermediate Care (PCIC) Clinical Board includes a wide range of services that sit outside hospital settings. The Clinical Board delivers health and wellbeing services in patients' homes, in the community and from a range of other facilities. The approach is to plan and deliver care to the population of Cardiff and the Vale of Glamorgan via the cluster network, with exceptions related to very specific populations such as the health service provision to HMP Cardiff.

The UHB delivers health and wellbeing services in patients' homes, pharmacies and optometrists in the community and from a range of other facilities.

Key Drivers

A number of key drivers have been identified and incorporated into this document, as part of the PCIC IMTP planning process, notably:

- A Healthier Wales – Our Plan for Health and Social Care
- Strategic Programme for Primary Care – November 2018
- The oral health and dental services response to A Healthier Wales: our plan for Health and Social Care
- The Transformational Model for Primary and Community Care in Wales and progress pacesetter projects
- Well-being of Future Generations (Wales) Act 2015
- Cardiff and Vale Shaping Our Future Wellbeing Strategy, and applying the home first principles wherever it is appropriate to do so.
- Transformation – driving change through planned care, unscheduled care, and locality working.
- The Cardiff and Vale Integrated Health and Social Care Partnership's purpose is to manage and develop services to secure better joint working between local health boards, local authorities and the third sector, and to ensure effective services, care and support are provided that best meet the needs of the local population. The Partnership's current priorities can be found here.
- GMS Sustainability
- Cluster development, Cluster Plans 2017-2020 are available online, and are informed by cluster needs assessment

- Cardiff Local Development Plan 2006-2026 (Adopted Plan, 2016) and associated Planning for Health and Wellbeing Supplementary Planning Guidance (2017), Vale of Glamorgan Local Development Plan 2011-2026 (Adopted Plan, 2017), Cardiff and the Vale of Glamorgan Population Needs Assessment (2017)

This is not an exhaustive list, but references the most significant drivers for PCIC that impact upon multiple services and upon which local priorities are aligned.

Key Achievements

Improving Access

- Continued evolution of the Primary Care Nurses for Older People Model.
- Improvement grants secured for Lansdowne Surgery and Pontprennau Medical Centre to support LDP growth in the area.
- Increased capacity of the Hospice at Home service (in collaboration with Marie Curie), increasing the numbers of individuals supported wishing to die at home.

Pilot Schemes/Projects

- Project within Cardiff West Cluster looking at improving purchasing costs of common items across the practices.
- Roll-out of Care Home Integrated Support Team.
- Roll-out of Electronic Patient Record in the Department of Sexual Health.
- Development of CAVGP to support GP recruitment and promote primary care innovation and successes.
- 1 week placements offered to five pre-registration pharmacists in 2018/19 to offer them exposure to primary care.
- Commissioning of the Common Ailments Service in 95 community pharmacies across Cardiff and Vale.

Evidence-Based Interventions / Service Changes

- Ongoing effective engagement of clusters to develop the vision for future service provision in order to meet projected LDP growth, particularly in North and West Cardiff.
- Cardiff and Vale GP Practice boundary change exercise carried out to review existing practices and agree amended boundaries, supporting service sustainability in meeting the needs of the local population within Cardiff and Vale.

- Analysis of the role of the cluster pharmacists within practices in the Central Vale Cluster, with the data produced being used to influence other service development, such as mental health care practitioners.

Integration / Collaboration

- Integrated working - Department of Sexual Health, Medicines Management, Clusters, and Secondary Care, standardising contraception prescribing between primary and secondary care.
- Establishment of the Active Healthcare Operational Group within HMP Cardiff, which has multidisciplinary engagement.
- Working with the All Wales Levels of Care lead from Welsh Government in developing the District Nursing Principles (Nurse Staffing Act) and undertaking a quality audit in South and East Cardiff as part of the ongoing All Wales work.
- Cluster engagement in Cardiff West to standardise administrative and pharmacist work, with a future plan to look at centralising these services to cover the whole cluster.
- End of life education provided to the Urgent Primary Care Out of Hours team (OOHs) by the Palliative Medicine consultants and the Macmillan GP, through collaboration with Macmillan, City Hospice and Marie Curie Hospice.

MDT Working

- Development of the MDT working in General Practice, focused on mental health and MSK services.
- Expansion of MDT working within OOHs, including triage nurses and paramedics, advanced clinical nurse and paramedic practitioners, minor illness nurses and paramedics, and dental nurses.
- Increased use of administrative staff within clinical teams, such as District Nursing.

Patient Experience and Engagement

- Increased discussions within the Cardiff East Cluster on advanced care planning.
- Patient Experience working group established within the North and West Locality, with representation from all teams, exploring the ways in which the patient experience is captured and how the information is then acted upon.
- A UK research project on the viability of family administration of medication at home for palliative patients is currently underway in Cardiff, linking with the Marie Curie Research Centre. This will provide patient and family focused information about preferences and opportunities to improve end of life care at home, enabling timely pain relief.

Exemplars

- Bevan Innovation Exemplar 2019 for the co-ordinated, needs-assessed approach taken regarding medicines management support for recently discharged patients within Cardiff West Cluster.
- Bevan Innovation Exemplar 2019 for the evaluation of an Innovative Patient Participation Group in the co-production and design of primary care services.
- Bevan Health Technology Exemplar 2019 for the use of smart ECG monitors in the development of the independent prescriber pharmacist role to improve the early detection of atrial fibrillation in the North Cardiff Cluster.
- Bevan Innovation Exemplar 2018 for the development of a cluster-based GP recruitment and retention toolkit.
- Cardiff and Vale OOHs templates and policies have been adapted throughout Wales, including: escalation protocols, capacity and demand planning, home visiting protocols, and the way in which shift fill rates are reported into Welsh Government.
- Improvement in National Prescribing Indicators, with a focus on pain and antibacterials in 2018/19. Best or 2nd best for all indicators across Wales.
- Leading on Agored accredited education for Primary Care employed HCSW on behalf of All Wales and WEDS.

Demonstrating the Impact of Achievements

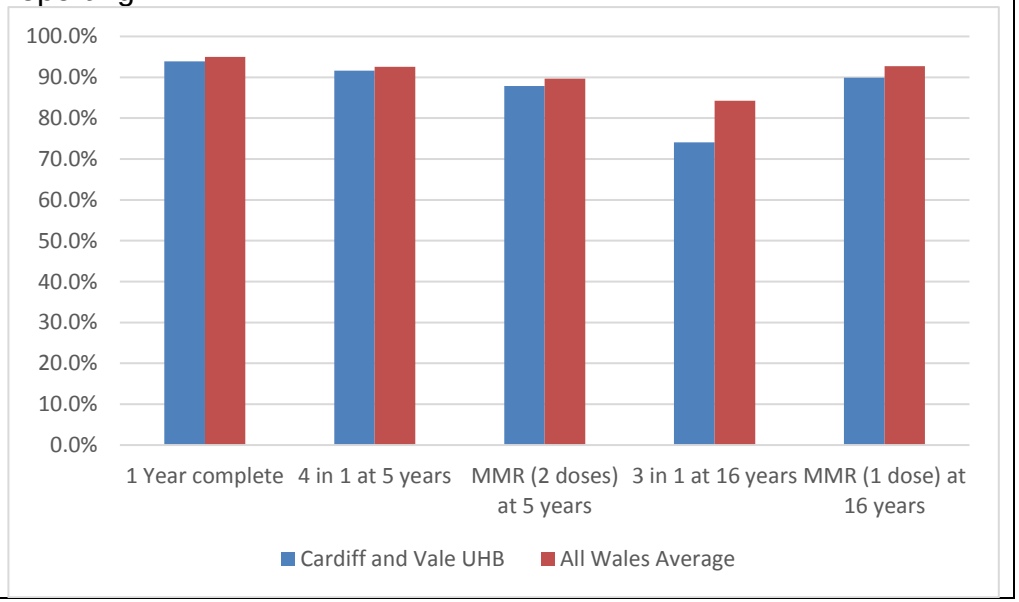
- Appointment system in the Department of Sexual Health was changed to a walk-in system, which has reduced the DNA rate from 9% to 1.6%, resulting in a saving of £60,000 per annum. This change has also enabled the service to see an additional 1,050 patients.
- Working collaboratively with the All Wales Healthcare Acquired Infection Reduction Group, PCIC has achieved a 24% reduction in E-Coli incidence between March and September 2018 and developed plans for reducing C-Diff and MSSA Bacteraemia.
- The process for supporting the nursing rota in HMP Cardiff was changed in June 2018, and early indications are that this change has resulted in an overall reduction in overtime payments of 20%.
- The GPST has engaged with at-risk GP practices, enabling them to manage their risks and continue to provide services to their practice populations, including 4 practices who submitted formal applications for sustainability support and were managed via improvement plans.
- Review of existing enhanced services in community pharmacies to increase delivery and performance. This resulted in: an increase in the number of pharmacies offer Level 3 smoking cessation support; an increase in the availability of flu vaccinations via community pharmacies; and simplification of the Emergency Medicine Service through OOHs.

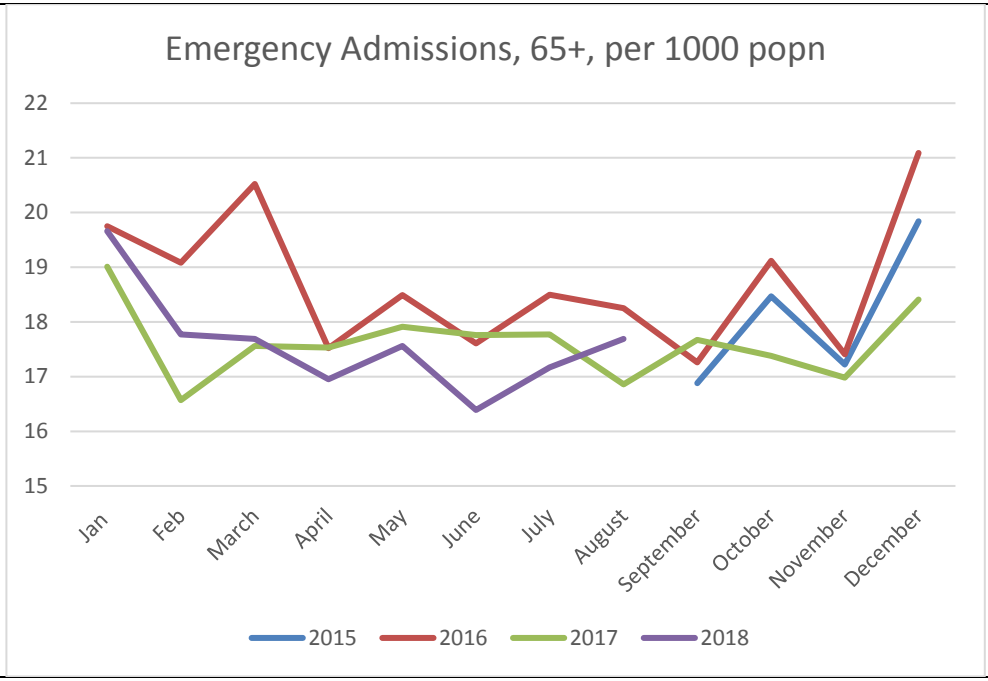
- Over 100 PCIC staff were trained in Making Every Contact Count in 2017/18. MECC training continues to be offered to PCIC staff (including a new nationally developed e-learning package), most notably piloting level 2 MECC with practice nurses; a session which covers aspects of motivational interviewing to support brief intervention to address health harming behaviours.
- Each of the nine clusters have engaged with the Public Health team, who have supported the implementation of prioritised public health actions at a local level, including identification of population needs and to development of actions and interventions. Examples of work include increasing referrals to smoking cessation support, increasing immunisation uptake, increasing bowel screening uptake, providing information on sexual health services, supporting the development of a social prescribing approach and delivering Making Every Contact Count training.
- Development and introduction of Collaborative Community Falls Clinics to educate patients on avoiding falls, responding to falls, and recovering from falls. These sessions are planned to help support patients in the community and reduce the need for hospital admissions.
- Continued evolution of the Social Prescribing Model across Cardiff and Vale. This enables patients to access non-medical care through Third Sector, Local Authority and other partner agencies, such as mental health support networks, mindfulness groups, and weight management groups etc.
- Cluster working in the Western Vale with community and secondary care partners to make Western Vale a Dementia Friendly Community, thus enabling patients and their families to feel better supported in their local communities and able to continue living longer at home.

A2. CLINICAL BOARD PERFORMANCE OVERVIEW

2.1 High level outcomes

Key Performance Indicator	Clinical Board Performance	Peer Benchmark	Planned Action – High Level Description
Immunisation Rates – the immunisation uptake rates for both *seasonal flu* and childhood immunisation. Target 75%	The end of season uptake 2017/18 for Cardiff and Vale for over 65 year olds was 71.0%, which was an increase on the previous year's figure of 69.0%. The end of the season uptake for Cardiff and Vale for at risk groups was 49.0%, an increase from the previous year's figure of 48.3%	On an all Wales level CAV UHB was ranked 1/7 for over 65 immunisation in 2017/18, retaining the same placement as 2016/17. CAV UHB was ranked 3/7 for the immunisation of at risk groups in 2017/18, retaining the same placement as 2016/17.	Cardiff and Vale UHB Immunisation Plan developed for 2018/19 and many key actions will roll over into 2019/20
Pre-school **Childhood Immunisation.** Target 95%	See graph	See graph	We have been working to reduce inequalities in immunisation uptake in partnership with the Public Health team, by targeting support to GP practices with low uptake, and clusters in more deprived areas of Cardiff and Vale. This has included working with community leaders in some ethnic minority groups with lower uptake. The Public Health team have also fully implemented a quarterly data cleansing and

			performance cycle in primary care, consisting of quarterly practice- and cluster profiles of key immunisation uptake; a transparent system for identifying and engaging with practices with outlying uptake each quarter, working with those practices to implement evidence-based interventions; and targeted data cleansing in advance of COVER reporting. 

Emergency admissions in the over 65's per 1000 population.	Generally EMAs for over 65s have remained below the rate for the previous year throughout 2018/19 to date, although the level of admissions did climb towards the end of Summer 2018.		

2.2 High level clinical and service efficiency

<table>
<tr><th>Key Performance Indicator</th><th>Clinical Board Performance</th><th>Peer Benchmark</th><th>Planned Action – High Level Description</th></tr>
<tr><td>Average number of full team CRT patients accepted by CRTs per week</td><td>Fluctuations in demand and levels of cancellations have affected performance, and these are being explored, particularly in regards to the VCRS.</td><td>Baseline position – 33 per week.

WG Primary Care Investment Target – 40 per week (27 Cardiff CRT, 13 Vale CRS)</td><td>- Work with wards to reduce the number of cancellations and increase appropriate referrals to the service.
- Work with Local Authority partners to ensure resilience within the domiciliary care market.

CRT data up to October 2017:

<table>
<tr><td>Full Team</td><td colspan="4">Cardiff</td></tr>
<tr><td>Period</td><td>Discharge</td><td>Community</td><td>Total</td><td>Target</td></tr>
<tr><td>Weeks 1-4</td><td>19.3</td><td>8.8</td><td>28.0</td><td>27</td></tr>
<tr><td>Weeks 5-9</td><td>17.2</td><td>8.2</td><td>25.4</td><td>27</td></tr>
<tr><td>Weeks 10-13</td><td>19.3</td><td>8.3</td><td>27.5</td><td>27</td></tr>
<tr><td>Weeks 14-17</td><td>19.5</td><td>7.3</td><td>26.8</td><td>27</td></tr>
<tr><td>Weeks 18-22</td><td>19.2</td><td>6.4</td><td>25.6</td><td>27</td></tr>
<tr><td>Weeks 23-26</td><td>19.0</td><td>5.8</td><td>24.8</td><td>27</td></tr>
<tr><td>Shortfall</td><td>19</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
</table>

Full Team	Vale			
Period	Discharge	Community	Total	Target
Weeks 1-4	7.3	3.8	11.0	13
Weeks 5-9	6.8	2.6	9.4	13
Weeks 10-13	7.8	1.8	9.5	13
Weeks 14-17	8.0	2.3	10.3	13
Weeks 18-22	8.0	1.6	9.6	13
Weeks 23-26	3.8	1.8	5.5	13
Shortfall	**98**			

District Nursing Quality Indicators – compliance with care plans and risk assessment

The District Nursing teams have tended to meet their targets, and work is ongoing regarding risk assessments.

Levels of sickness and vacancies within some teams have impacted on compliance against targets.

District Nursing Compliance Report
Caseload as at 05/09/2018

			These figures only include patients on the caseload with at least 2 Face to Face casenotes											
			Target = 100%		Target = 85-90%		Target = 75-80%		Target = 0-10%		Target = 80-90%		Target = 80-90%	
	Clients on Caseload	Open Referrals	Clients with Category of Care		Clients with Careplans		Careplan Updated in the Last 12 Weeks *		Number Seen Twice or More Without Careplan		Clients with Risk Assessment		Risk Assessment Updated in the Last 12 Weeks	
Cardiff N, W and SW	**1433**	**1461**	**1406**	**98%**	**1002**	**91%**	**753**	**75%**	**105**	**9%**	**970**	**81%**	**785**	**71%**
ELY TEAM	257	259	248	96%	194	95%	149	77%	10	5%	191	82%	156	76%
NORTH CARDIFF TEAM	380	381	375	99%	291	94%	241	83%	19	6%	295	89%	262	85%
RADYR TEAM	208	208	202	97%	135	91%	98	73%	13	9%	134	78%	105	71%
RIVERSIDE TEAM	345	360	338	98%	192	81%	137	71%	46	19%	160	78%	124	52%
WHITCHURCH TEAM	253	253	253	100%	193	90%	131	68%	21	10%	191	75%	143	67%
Cardiff S, E and City	**1290**	**1292**	**1235**	**96%**	**916**	**89%**	**648**	**71%**	**111**	**11%**	**915**	**80%**	**736**	**72%**
BUTETOWN TEAM	170	170	163	96%	146	98%	93	64%	3	2%	145	80%	116	78%
PENTWYN TEAM	244	244	235	96%	184	93%	153	83%	13	7%	180	91%	164	83%
ROATH TEAM	231	231	221	96%	169	93%	111	66%	13	7%	169	75%	126	69%
RUMNEY TEAM	433	434	405	94%	251	78%	156	62%	69	22%	253	73%	185	58%
SPLOTT TEAM	213	213	212	100%	166	93%	135	81%	13	7%	168	86%	145	81%
Vale of Glamorgan	**1144**	**1163**	**1088**	**95%**	**827**	**91%**	**572**	**69%**	**85**	**9%**	**806**	**78%**	**627**	**69%**
BARRY TEAM 1	290	290	286	99%	208	88%	168	81%	29	12%	211	83%	175	74%
BARRY TEAM 2	249	249	249	100%	190	96%	147	77%	8	4%	173	84%	145	73%
PENARTH TEAM	375	384	325	87%	255	88%	155	61%	36	12%	259	76%	197	68%
WESTERN VALE TEAM	230	240	228	99%	174	94%	102	59%	12	6%	163	67%	110	59%

* **Careplan Updated in the Last 12 Weeks** - these figures include only patients whose Category of Care is Curative, Maintenance, or CHC / Terminal

Compliance with the Urgent Primary Care Out of Hours Wales Quality Monitoring Standards	Generally performance within OOHs has improved over the last 12 months due to the introduction of new roles and processes. However, September 2018 saw a dip in compliance against the indicators, due to a significant increase in patient contacts during a period when the service is staffed at Summer demand levels.	All Wales Comparison	

Cardiff and Vale of Glamorgan Out of Hours Monthly Data Report

** Please note the percentages are rounded to the nearest whole number.

	Demonstrates that a standard has been achieved
	Demonstrates that a standard is within 10% of being achieved
	Demonstrates that a standard has **not** been achieved
	Demonstrates volumes only

			Total Contacts=8515				Total Contacts= 8297				Total Contacts= 9010			
			Total Clinical Contacts Recorded on Adastra = 7295				Total Clinical Contacts Recorded on Adastra = 7052				Total Clinical Contacts Recorded on Adastra = 7703			
			Jul-18				Aug-18				Sep-18			
Standard	**Description**	**Target**	Total	Result	Score		Total	Result	Score		Total	Result	Score	
Telephone Services														
Telephone Calls	Number of calls answered within set timeframes	95% ans. in 60 seconds	7460	6764	91%		7194	6526	91%		7745	7027	91%	
		100% ans. in 120 seconds	7460	7051	95%		7194	6798	94%		7745	7391	95%	
Abandoned Calls	Number of callers who abandon their attempt after 60 secs.	No more than 5%	7460	113	2%		7194	464	6%		7745	132	2%	
Handling	% of calls recording the correct patient demographic information	100% Correct	7460	7460	100%		7194	7194	100%		7745	7745	100%	
Telephone Triage Services														
Urgent Triage	Number of urgent calls, logged & returned within set timeframes	98% triaged within 20 minutes	2008	1687	84%		1862	1529	82%		2281	1928	85%	
	Longest time to triage an urgent call	Longest time		667				575				754		
	Average of the 10 longest times to triage an urgent call	Average time		445				332				274		
Routine Triage	Number of routine calls, logged & returned within set timeframes	98% triaged within 60 minutes	3566	3150	88%		3492	3021	87%		3723	3306	89%	
	Longest time to triage a routine call	Longest time		912				1327				771		
	Average of the 10 longest times to triage a routine call	Average time		824				741				443		
Immediate Life Threatening (ILT) Conditions														
Referral	Number of life threatening conditions identified	100% within 3 minutes	143	143	100%		104	104	100%		183	183	100%	
Home Visiting														
Home Visits	The number and percentage of home visits	No target	7295	496	7%		7052	440	6%		7703	536	7%	
HV P1 (Emergency)	The number of face to face contacts within one hour	75% seen within one hour	12	9	75%		5	5	100%		15	10	67%	
	The number of face to face contacts within two hours	100% seen within two hours	12	11	92%		5	5	100%		15	14	93%	
HV P2 (Urgent)	The number of face to face contacts within two hours	98% seen within two hours	172	137	80%		147	111	76%		192	154	80%	
HV P6 (Less Urgent)	The number of face to face contacts within six hours	98% seen within six hours	312	274	88%		288	230	80%		329	223	68%	
Primary Care Centre Appointments														
PCC	The number and percentage of PCC attendances	No target	7295	2295	31%		7052	2165	31%		7703	2514	33%	
PCC P1 (Emergency)	The number of face to face contacts within one hour	75% seen within one hour	20	18	90%		14	11	79%		30	20	67%	
	The number of face to face contacts within two hours	100% seen within two hours	20	20	100%		14	14	100%		30	30	100%	
PCC P2 (Urgent)	The number of face to face contacts within two hours	98% seen within two hours	212	185	87%		204	186	91%		262	226	86%	
PCC P6 (Less Urgent)	The number of face to face contacts within six hours	98% seen within six hours	2063	2042	99%		1947	1922	99%		2222	2193	99%	
Transmissions														
Transmissions	The number of reports sent to GP Practice by OOH	100% by 9am	8169	8169	100%		7594	7594	100%		8393	8393	100%	
Other Data														
Outcomes	The number of calls ending in telephone advice	No target	7295	1989	27%		7052	1767	25%		7703	2042	27%	
	The number of calls advised to contact their GP within 24hrs.	No target	7295	894	12%		7052	844	12%		7703	934	12%	
Referrals OUT	The number of referrals to the Emergency Department	No target	7295	518	7%		7052	465	7%		7703	539	7%	
	The number of referrals to WAST	No target	7295	236	3%		7052	168	2%		7703	226	3%	
	The number of referrals for direct admission	No target	7295	253	3%		7052	289	4%		7703	277	4%	
Referrals IN	The number of referrals from the Emergency Department	No target	7295	35	0.5%		7052	47	0.7%		7703	43	0.6%	
	The number of referrals from WAST	No target	7295	168	2%		7052	128	2%		7703	139	2%	
Rota	Shift fill rate (reported in hours)	100% of shifts filled	4173	3696	89%		4214	3520	84%		4363	3899	89%	
Complaints/Incidents														
Complaints	Total number of complaints received & number upheld	No target		2				5				1		
Compliments	Total number of compliments received	Volume only		2				2				3		
Significant Events	Total number of significant events recorded	Volume only		0				0				0		
Serious Incidents	Total number of serious incidents recognised	Volume only		0				0				0		

WG Primary Care Investment Outcomes	The primary care investment schemes have remained amber or green throughout 2018/19.		

Project Name	WG PC Investment	Performance (evidence of delivery against WG DA outcomes)	Overall Status
1. CRT Expansion	£2.393m	Struggling to consistently meet the overall weekly target of an average of 40 full team pts accepted across the Cardiff CRT and VCRS.	CRT Expansion
2. Cluster Investment	1.414m	Invested across the nine clusters.	Cluster investment
3. PC Workforce Investment	£504k	GP Support Team actively working with fragile practices. OD Manager left the UHB in June 18 leaving a gap in cluster governande support.	PC Workforce Investment
4. Phlebotomy/District Nursing	£400k	Circa 90% of DN bloods now being undertaken by B3 phlebotomists.	Phlebotomy/District Nursing
5. Well-being Co-ordinators	£273k	Good outcomesd, but issue with data sharing not yet resolved.	Wellbeing Co-ordinators
6. Falls Pacesetter (new for 2018/19)	£200k	Implement lessons learnt from Canterbury and provide the community element of the falls pathway developed.	Falls Pacesetter
7. Prescribing Pain Clinic Pacesetter (new for 2018/19)	£170k	Pharmacist IP-led chronic non-malignant pain medication review clinic in GP Practice.	Pain Clinic Pacesetter
8. Social Prescribing Pacesetter (new for 2018/19)	£167k	To develop a model of social prescribing across Cardiff and Vale UHB	Social Prescribing Pacesetter
9. Community Diabetes	£90k	The project is split between DSN and dietetics investment. Showing good outcomes.	Community Diabetes
10. Prescribing IMTP	£70k	A range of prescribing quality improvement projects.	Prescribing
11. Family Planning	£52k	Linked to the DOSH modernisation programme of work.	Family Planning
12. Eye Care	£26k	Post cataract pathway and glaucoma pathway. Struggling to get ahereance and expected numbers through on the past cataract follow up pathway.	Eye Care
13. Pulmonary Rehab	£17k	Good patient experience and patient outcomes evidenced.	Pulmonary Rehab

2.3 High level cost indicators

Key Performance Indicator	Clinical Board Performance	Peer Benchmark	Planned Action – high level description
District Nursing benchmarking	Cardiff and Vale UHB benchmarked at 2.7WTE	The average establishment for District Nursing across Wales was 2.8WTE per 1000 population over the age of 65. Cardiff and Vale benchmarked at 2.7WTE. If the establishment was uplifted to the average across Wales this would be equivalent to approximately an additional 7.5WTE. WAO 2014	Phlebotomists added to the team during 2016/17 as part of the WG Primary Care Investment Administrators added to the team during 2017/18.
Urgent Primary Care Out of Hours benchmarking	Cardiff and Vale UHB OOHs expenditure per 1,000 population = £7.77 Cardiff and Vale UHB OOHs cost per contact = £34.63 Cardiff and Vale UHB OOHs expenditure as % of total GMS expenditure 2015/16 = 5.5%	Lowest in Wales against these three indicators. Wales OOHs expenditure per 1,000 population = £10.84 Wales OOHs cost per contact = £52.74 Wales OOHs expenditure as % of total GMS expenditure 2015/16 = 6.9%	Continued introduction of other HCPs into OOHs service, providing a robust service through informed use of skill-mix.
Medicines Management indicators		Cardiff and Vale is either 1st or 2nd on all National Prescribing Indicators across Wales.	Continued work with general practice and secondary care specialities. Continue to progress quality improvement projects

A3. Risks and Opportunities

The PCIC Clinical Board key risks to the delivery of the PCIC IMTP include:

- Significant population growth
- Continuing Healthcare (CHC) growth pressures
- GMS Sustainability concerns
- Resource and capacity to drive transformation and improvement including cluster development
- Lack of engagement and input from partners and other Clinical Boards
- Estates issues associated with some of our primary and community based facilities
- Financial resource constraints – managing nil growth
- IM&T infrastructure compatibility issues
- Public expectation and acceptance of new models of care
- Recruitment and retention

A4.SUMMARY OF KEY PRIORITIES FOR 2019-22

The Clinical Board priorities for 2019/20 can be considered within three broad categories:

- **Sustainable Primary, Community and Intermediate Care**
    - GMS sustainability will remain a priority, providing proactive support to GMS. GMS sustainability metrics will also be presented to the UHB Board from 2019/20.
    - Addressing primary care estates issues
    - Roll out Mental Health and MSK to support the sustainability of general practice
    - Cluster development
    - Proactive planning to manage the impact of the LDP in Cardiff and the Vale of Glamorgan. Work to ensure the sustainability of Urgent Primary Care OOHs service will continue, including ongoing review of the skill mix within the team and the way in which the service is delivered based on the capacity and demand management analysis undertaken. Develop the CRTs and other community services in order to ensure that the community provision is resilient enough to demands.

- Reviewing services for vulnerable people (homeless, prison, and asylum seekers) in partnership with Local Authority and Third Sector partners.

- **Transformation and Service Improvement**
  - Deliver the Transforming Primary Care Model and learn and share lessons from the pacesetter projects (falls, pain clinics, and social prescribing).
  - Deliver against A Healthier Wales strategy including the quadruple aim and ten design principles via the transformation funded projects allocated to Cardiff and Vale.
  - Implement Shaping Our Future Wellbeing in the Community programme, ensuring seamless care can be delivered with wider partners. The development of Health and Wellbeing Hubs and Wellbeing Centres will continue, supporting the home first principle and delivery of care outside of hospital settings.
  - Development of services in primary care from secondary care.
  - Continue to focus on workforce planning and cluster development, ensuring transformation and resilience in primary and community settings.
  - Support dental contract reform through the Dental Services Fit for Future Generations work and an increased focus on prevention.
  - Work collaboratively with partners and other Clinical Boards to develop and take forward pathways.
  - Have systems to evaluate the outcome of change and improvement.
- **Sustained Service Delivery / Core Business**
  - Continue to support hospital discharges and prevent the need for hospital admissions (through the work of the Cardiff CRT and Vale CRS).
  - Prepare for the full implementation of the District Nursing principles.
  - To proactively plan for service delivery over winter, provide assurance to Welsh Government on specific deliverables over the Winter period, and ensure robust business continuity plans are developed going forward.
  - Continue to review models and ways of working to drive improvement, ensure efficiency and effectiveness, and will seek to develop bespoke performance metrics for primary care in order that delivery can be measured and monitored appropriately.
  - Continue to strive for continuous improvement, and a variety of quality/safety/performance measurements will be used to monitor this including the phase 2A national primary care quality and delivery measures.
  - Have systems to ensure continuity of care between in and out of hours.

PCIC will continue to work with partners across the UHB and externally in order to ensure services most appropriately meet the needs of the local population. Our work will continue to be informed by local and national strategies such as Cardiff and Vale UHB's Shaping Our Future Wellbeing Strategy and A Healthier Wales – Our Plan for Health and Social Care. The workstreams emerging from the Strategic Programme for Primary Care – November 2018 (prevention and wellbeing; 24/7 model; data and digital technology; workforce and organisational development; communication and engagement; and transformation and the vision for clusters) are reflected in the priorities for PCIC. We will continue to explore joint working and pathway development in order to ensure people access the most appropriate service at the right time and that there are no unnecessary delays in a patient's pathway due to transfers of care between teams/Clinical Boards/wider partners. The Clinical Board will also seek to continue to deliver to the financial requirements.

Summary of measures to quantify the impact of the key priorities for 2019-22

Priority Area	Indicator	Measure and quantifying
Improving access to primary care services	• % of GP practices open during core hours*. • % of GP practices appointments at least 2 nights per week**. • % adults accessing NHS Primary Dental Care. % children accessing NHS Primary Dental Care. • Increase in the number of patients accessing the common ailment scheme.	Improvement target from: 88% (2017) to 100%. Improvement target from: 95% (2017) to 100%. Improvement target from: sustain the same % population coverage (due to population growth) from the current (2016/17) 51.43% for adults and 65.06% for children. Monitoring CAS monthly activity numbers.

GMS Sustainability – Providing resilient and sustainable primary care services	• Number of GP appointments freed up as a result of activity being seen by MSK and MH workers. • Decrease the number of fragile practices.	22,000 MSK appointments, 63,000 MH appointments offered across Cardiff and Vale practices by 2020/21. No contract terminations, no directly managed practices, increase in the number of practice mergers supported by the UHB.
Cluster Development – increased cluster maturity	• Increase in maturity of the nine Cardiff and Vale clusters***	Increase from the baseline position of Level 1 by quarter 4 2019/20.
Primary Care transformation	**Eye care** • Increase in the overall number of Optometry clinics and appointment slots across the pathways identified (Glaucoma, medical retina (including wet AMD), and diabetic retinopathy ensuring patients are seen within agreed clinical timescales. **Falls pacesetter** • Increase in number of patients attending community falls clinics**.**	Increase in the overall number of Optometry clinics and appointment slots. Creating secondary care capacity to support delivery of RTT targets. Community falls clinics activity increase and improved patient outcomes for those attending.
USC indicators	• Reduction in emergency admissions for over 65s by locality compared to the same period the previous year.	Year on year reduction. Quarterly reduction by locality.

	• Reduction on admissions to hospital from Nursing Homes. • CRT accept 40 full team patients on average each week. • OOHs improvement in urgent triage and PCC P1 face to face targets.	An average of 13 full team patients accepted in the Vale CRS each week, and an average of 27 full team patients accepted in Cardiff CRT each week. Increase in average % of urgent patients triaged within 20 minutes. Increase in average % of patients seen within one hour for a face to face appointment.

*****% GP practices open during daily core hours or within one hour of the daily core hours Monday to Friday

** % GP practices offering appointments between 5pm & 6:30pm at least 2 nights per week

*** comparing to the 208/19 baseline position, established in December 2018

B. KEY DELIVERY PRIORITIES 2019-22

B.1 POPULATION HEALTH IMPROVEMENTS

The identification and collation of information on population health needs is being realigned to meet the requirements of the Social Services and Wellbeing (Wales) Act 2014 and the wellbeing assessment required by the Well-being of Future Generations (Wales) Act 2015. This will ensure consistency of information and priorities for action provided to local policy makers and operational services leads, as well as avoiding unnecessary duplication of effort.

5.1 Addressing Health Inequalities

ACTIONS TO REDUCE HEALTH INEQUALITIES		
ACTION	OUTCOME	MEASURE
Enhancing the Cluster Model within Cardiff and Vale: • Review governance arrangements, support and resourcing. • Deliver cluster OD programme.	• Increased cluster maturity	• Cluster maturity matrix
Responses to LDP Growth: • Continue to engage clusters and services in the development of local service plans to ensure delivering of the Shaping Our Future Wellbeing strategy can be achieved in the context of LDP growth	• GMS provision available to all Cardiff and Vale residents. • Local infrastructure and services are sufficient to meet increased demand.	• All residents in CAV have access to a GP, and there is equitable access to other appropriate services for residents across CAV. • Progress against Primary Care Estates Strategy
Development of Wellbeing Hubs and Centres: • Support the development of Health and Wellbeing Hubs and Centres, including engaging with other	• Local infrastructure and services are sufficient to meet increased demand.	• Hubs and Centres delivered on time

ACTIONS TO REDUCE HEALTH INEQUALITIES		
ACTION	OUTCOME	MEASURE
Clinical Boards and wider partners to design complementing services.		
Develop Primary Care Estates Strategy • Plan/progress primary care estates developments.	• Local infrastructure and services are sufficient to meet increased demand.	• Strategy document developed
Vulnerable Groups: • Reviewing services for vulnerable people (homelessness, prison, asylum seekers) in partnership with Local Authority and Third Sector partners	• Agree and implement LES for the CHAP. • Develop workforce plan for vulnerable groups. • Develop Mental Health pathway for HM Prison.	• Number of patients referred from CHAP onto General practice. • Mental Health pathway being used.
Review provision of healthcare services in HM Prison Cardiff: • Developing pathway agreement with Mental Health Clinical Board for men accessing mental health services • Creation of a standard pathway for men with substance misuse issues to ensure equivalence for the men in custody • Protecting health wing cells from general prison operational capacity • Increased GP availability outside of core hours.	• Improved access to required healthcare services. • Improved management of detox for men with substance abuse problems • Protected capacity in health wing to ensure patients can access services and be treated in an appropriate environment • Dedicated GP time to tackle particular issues, such as substance misuse	• Time to access services • Level of supported detox provision • Level of maintenance prescribing for patients with substance misuse issues • Benchmarking against other prison facilities • Capacity and usage level of health cells, and correlation with time to access health services • Number of GP sessions, uptake, and effect on overall prison population health.
Department of Sexual Health : • Develop in-house microscopy • Assess CAV DOSH position in relate to the All Wales Vision for	• More effective testing and reporting • Testing service more responsive to service needs/demands	• Number of tests undertaken in-house. • Time between sample being taken and result received.

ACTIONS TO REDUCE HEALTH INEQUALITIES		
ACTION	OUTCOME	MEASURE
Sexual Health and develop a workforce plan in response.	• Workforce plan will support capacity and demand management and support recruitment and retention of staff with required skills	• Workforce plan developed, agreed and maintained. • Appropriate staffing levels within service dependent on service requirements identified.
Medicines Management – Locality/Cluster Priorities • Work with clusters/localities to identify local medicines priorities • Engage with cluster pharmacists to support medicines management quality improvement • Identify prescribing data to support local priorities • Improve prescribing involvement and support within primary care clusters	• Increased engagement with clusters • Support targeted needs of local population	• Level of engagement with individual clusters received via Locality Manager and Community Director • Prescribing representation at cluster meetings/events
Access to General Medical Services during Core Hours • Develop access standards and key performance indicators	• Improvement in GMS and Primary Care access performance indicators • Improved patient access to appropriate care • Reduction in patients utilising urgent care services (OOHs, EU) inappropriately	• Access to GMS services during core hours and 2 nights per week.
Implement and Monitor GMS Contract Revisions for 2019/20 • Implement process to support robust monitoring of contract.	• Ensure compliance with GMS contract • Standardised approach to processes • Patient access to provision covered under enhanced services	• Practice Assurance Visits • Clear processes developed and documented. • Audit schedule of enhanced services
Develop the Social Prescribing Model in Cardiff and Vale	• Consistent approach to social prescribing in Cardiff and Vale	• Social prescribing networks established in each cluster.

ACTIONS TO REDUCE HEALTH INEQUALITIES		
ACTION	OUTCOME	MEASURE
• Through the Social Prescribing pacesetter work and transformation project develop working in partnership with Compassionate Communities) a social prescribing approach across Cardiff and Vale	• Learn from the Compassionate Communities work, testing outcomes in the SW Cardiff cluster.	

5.2 Prevention Priority Deliverables

The key Public Health Actions for the UHB are described here: Cardiff and Vale Local Public Health Plan. The Primary Care Cluster Plans also contain detailed actions related to specific Public Health actions which have been identified as highly relevant to the local population, and can be found here . Patient self-care and getting the right messaging to the population of Cardiff and Vale will be an ongoing priority working with collages within the Health Board. PCIC will work closely with the Public Health team to continue to roll out Making Every Contact Count, and work with other Clinical Boards and partners to deliver the following priorities:

ACTION	OUTCOME	MEASURE
Pacesetter Collaborative Community Falls Clinics • Continue to develop and review the collaborative community falls clinics as a mechanism for educating the public about falls risks and actions to reduce the likelihood of a fall occurring	• Increased provision of service within the community working to prevent falls • Increased confidence levels within older people population group • Less need to access GP services post-fall • Less need to access unscheduled care services post-fall	• Number of patients attending community falls clinics • Patient confidence level scores pre and post falls clinics
Childhood Immunisations • Increase uptake of childhood immunisations across Cardiff and Vale	• Improved childhood health • Increase in “herd immunity” and protection for those who are immuno-compromised / immuno-suppressed	• Increase in reported vaccination levels

ACTION	OUTCOME	MEASURE
	• Increased public understanding of the benefits of vaccines	
Influenza Vaccinations • Increase uptake of the vaccine among 65 years old and over, and among under 65s in risk groups.	• Improved population health • Increase in “herd immunity” and protection for those who are immuno-compromised / immuno-suppressed • Increased public understanding of the benefits of vaccines • Reduced impact on urgent unscheduled care systems (GPs, OOHs, EU), particularly over the Winter period	• Increase in reported vaccination levels

B.2 PLANNED CARE

In identifying and responding to the planned care demand and delivering the Welsh Government performance requirements the clinical board does not lead or deliver on many planned care services, although primary care services cover both planned and unscheduled care. However, it is an important contributor to the delivery of care, and in particular has a key role in pathway redesign. These include:

- Optometry
- Oral surgery
- Ensure GP engagement in the roll-out of Healthcare Pathways

There are also specific services delivered by PCIC:

- Acute Response Team (premises based care)
- Community Resource Team (planned facilitated discharge)
- Wound healing

There are some key enablers within PCIC's remit which have a critical impact on the delivery of planned care by the UHB, including:

- GMS sustainability
- Primary care capability to respond to LDP growth

6.1 Detailed 2019/20 Actions

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
Chronic Condition Management – Diabetes • Development of a joint diabetes approach between Medicine and PCIC Clinical Boards –learning from the establishment of the cluster-based Diabetes Nurses and Invest to Save initiatives.	• Improved management of chronic condition which is increasing in the local population.	

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
Chronic Condition Management - COPD • Development and pilot of the value based healthcare approach to COPD to improve diagnostic certainty of patients on COPD registers. • Integrated working opportunities with Medicine Clinical Board	• Ensure correct COPD diagnostic practice in order to better manage patients with the condition. • Reduce GP attendances and need for hospital admissions • Optimise therapies and ensure patients treated as clinically appropriate	• Number of patients reviewed using the new diagnostic model, and correlation with number of patients on the COPD register • Clinical outcomes – prescribing, hospital attendances etc…
Continuing Health Care – Support Resource • Review commissioning arrangements for CHC/FNC, capacity and contract monitoring	• Manage patient and family expectations • Enabling constructive decision making and sustainable care planning • Support performance management and improvement	• Compliance to meeting KPIs relating to FNC/CHC reviews.
Optometry Joint Working with Surgery Clinical Board • Develop Locality-based Optometry Diagnostic Treatment Centres to focus on glaucoma services, AMD (including injections), and eye casualty service. • Embedding the use of electronic referrals across all optometry practices in CAV	• Patients seen closer to home according to prudent healthcare principles • Reduction in demand on the UHW site • Improved access to services in the community • Increased utilisation of enhanced skill mix of community optometrists • Improved content and appropriateness of referrals into secondary care • Increased joint working between primary and secondary care	• Number of patients able to access specific services in a community setting
Primary Care Dental Service Development • Ensure the successful implementation of the Dental contract reform programme • Deliver oral surgery in primary care settings	• Increased access to dental services in the community for local population • Patients seen closer to home • Reduction in waiting list times for Surgery Clinical Board	• Number of practices in the dental contract reform programme • Waiting list times within secondary care

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
• Develop and embed pathways for dementia, oncology and congenital heart disease patients. • Establish contracts in primary and community dental care services following established Managed Clinical Network pathways regarding conscious sedation for children and adults. • Facilitate the transfer of Community Dental Services into PCIC from the Dental Clinical Board and strengthen the links between CDS and the Primary Care Community Dentist provision.	• Increased joint working between primary and secondary care • Improved access for patients, such as pre-treatment dental care for oncology patients and MDT pathways for patients with dementia. • Reduction in numbers of patients requiring general anaesthesia for dental treatment	• Movement of funding from Dental Clinical Board to PCIC to support contracts • Numbers of patients with dementia requiring access to secondary care dental treatment • Reduction in referrals into secondary care for General Anaesthesia
Vale Locality Integration of Nurse Assessor Team and Long Term Care Social Service	• Reduction in duplication (such as joint visits to care homes) • Improved communication and understanding of roles and responsibilities	• Establishment of integrated team, with an integrated referral process
GMS Financial Support Packages to address sustainability concerns • Continuation of the financial support package assisting merging GP practices to merge • Continuation of financial support for practices absorbing patients from closed practices	• Support successful merging of practices • Enable all patients of closed Cardiff and Vale practices to register with a GP practice • Support practices to absorb list growth as a result of other practices closing • Practices supported to develop/upgrade their systems in order to respond to list growth	• Number of practices supported to successfully merge • Number of patients from closed practices absorbed in practice populations elsewhere in CAV • Stability of service provision within those practices affected by significant list growth

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
Roll out Mental Health and MSK to support the sustainability of GMS • Linking with the Mental Health Clinical Board to establish a cluster-based Mental Health support service with direct booking from GP reception • Linking with CD&T Clinical Board to establish a cluster-based Physiotherapy diagnosis and treatment service with direct booking from GP reception	• Patients experiencing mild to moderate mental health issues able to directly access specialist services • Patients experiencing MSK issues able to directly access specialist physiotherapy services • Improved patient pathway • Improved patient experience • Lower demand on GPs for mental health support • Lower demand on GPs for MSK support • Increased cross-Clinical Board working	• Number of patients directly accessing the support of a Primary Care Mental Health Practitioner • Level of mental health related workload for GPs • Number of patients directly accessing the support of a physiotherapist • Level of MSK related workload for GPs
District Nursing priorities • Preparation for full implementation of the District Nursing principles • Continue to review requirements for DN Night Visiting Service	• Supporting patients remaining in their own homes	• Adherence to DN principles
Delivering for Older People • Complete review of the CRT • Develop and implement the Team Around the Individual with Dementia model within the community • Extend the Care Home Integrated Support Team • Develop and implement Discharge to Assess Domiciliary (Get Me Home +) • Progress work in conjunction with Lightfoot and Canterbury on falls and frailty, linking with Medicine Clinical Board on pathways • Develop Cardiff CRT and Vale CRS including	• Consistent model of PCNOP across Localities • Reduced length of stay for patients who need to be admitted to hospital • Reduced call outs to WAST / OOHs / Practices from care homes • More people supported to die in their preferred place of residence • Improved joint working between PCIC and Medicine Clinical Board	• Numbers of older people admitted to hospital • Length of stay for people who are admitted • Levels of call outs to care homes • Number of people supported to die in preferred place. • Patient length of stay within MEAU

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
pilot and review MEAU pathway • Develop falls management in the community pathway, with input from WAST	• Less need to admit patients for social care or observations to Assessment Unit or Ward • Lower levels of falls within the community Less need to convey patients to hospital post-fall	• Number of referrals into VCRS from MEAU • Levels of admissions to hospital following a fall • Number of WAST conveyances to hospital for patients with falls CRT response times for patients referred with falls
Primary Care Premises • Develop Primary Care Estates Strategy - making fit for purpose, including new models of ownership	• Updating existing estate / developing new estate in line with organisational priorities to ensure sustainability of services. • Make best use of assets and resources • Ensuring sufficient GMS capacity to respond to LDP growth	• Progression of premises plans against set timescales. • Production of Primary Care estates strategy

6.2 High level 2019/20 and 2020/21 Actions

As previously referenced, the high level Clinical Board's planned care actions for 2019-2022 would include:

- LDP and Estates (GMS), but also widening to include other PCIC services.
- Pathway development.
- Areas not previously resourced but which have actions outstanding.
- Quantifying the shift of resource from secondary care to primary and community care services/settings

B.3 UNPLANNED CARE

In identifying and responding to the unplanned care demand and need to deliver the Welsh Government performance requirements, it is important to note that the Clinical Board is a key contributor to the delivery of care, and in particular has a key role in pathway redesign.

Pathway redesign includes:

- CRT/ECAS/Day Hospital remodelling
- MEAU pathway

There are specific services delivered by PCIC which are key to unplanned care:

- Palliative Care
- Urgent Primary Care Out of Hours (OOHs)
- Care Home Integrated Support Team
- DN HCSW framework
- Joint Equipment Store
- Customer Contact Centre
- Night District Nursing Service
- Western Vale District Nursing Services
- Discharge to Assess Units
- Cluster Frailty Nurses
- CRT support with patient flow
- IRIS

There are some key enablers which have a critical impact on the delivery of unplanned care by the UHB:

- GMS Sustainability
- Primary Care capability to respond to LDP growth

7.1 Detailed 2019/20 Actions

The details of the clinical board's priority unplanned care actions for 2019/20

ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
Urgent Primary Care Out of Hours (OOHs) : • Build upon the MDT working arrangements, workforce planning, and education pathway work. • Continue to develop an MDT approach by introducing Mental Health Nurses, Nursing Assistants, and other HCP roles into the service.	• Full MDT working arrangements in place. • Service is more robust and better able to respond to pressures on the service, leading to a more sustainable provision. • Improved staff retention rates. • Patients see the right person, first time.	• Shift fill rate (by speciality/professional group)
End of Life Care Service Improvement: • Improved clinical pathways and processes for patients receiving end of life care.	• Improved planning around EOL care hospice beds; • Ensure bed numbers meet demand • Increased access for heart failure patients • Reduced need to admit patients receiving s/c diuretic • Family better prepared to support care needs – improved understanding of equipment, family feel better supported in delivering care at home	• Number of hospice beds per population • Number of patients with heart failure admitted for diuretics • Length of hospital stay data for patients accessing palliative care services • Numbers of patients achieving preferred place of care and death
Develop Community Pharmacy Services to support care in the community: • Roll out of enhanced services, common ailments service	• Care provided by community pharmacy rather than GP practice where appropriate	• Numbers of patients accessing common ailments scheme

ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
• Promotion of community pharmacy services to GPs to increase utilisation, promote awareness and inclusion of wider pharmacy roles – Cluster, Employed, UCRS Tech etc., work to increase signposting to services such as smoking cessation by GPs and other partners.	• Integration of community pharmacy within clusters	• Data related to provision of enhanced services

7.2 High level 2020/21 and 2021/22 Actions

As previously referenced, the high level Clinical Board's unplanned care actions for 2019-2022 would include:

- LDP and Estates (GMS) but also widening to include other PCIC services
- Pathway development
- Areas not previously resourced but which have actions outstanding
- Quantifying the shift of resource from secondary care to primary and community care services/settings

B.4 QUALITY, SAFETY AND IMPROVEMENT

It is inevitable that there will be emerging risks to both patient safety and quality across the whole system of healthcare provision, and the UHB will need to anticipate and respond to these. This will form an important focus for quality and safety initiatives over the next three years. The PCIC Clinical Board QSE priorities for 2019/22 are outlined below:

8.1 Detailed 2019/20 Actions

ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2019/20		
ACTION	OUTCOME	MEASURE
AIM 1 - GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
Continue to review all business unit Q,S&E structures to ensure optimum assurance. Monitor and review the PCIC Q,S&E dashboard in line with the workstation clinical Dashboard	• Improve reporting arrangements to the PCIC Q,S&E Committee. • Assurance on Q,S&E measures provided to the Clinical Board.	• In Place by Q1 2019/20
AIM 2 – SAFE CARE		
Infection Prevention and Control: • Continue to review existing processes to ensure optimum AMR to reduce the incidents of HCAIs (C'Diff, MSSA, MRSA, E.coli inflections) in line with the All Wales collaborative strategy. Sepsis: • Continue to raise the profile of sepsis 6 (six actions) throughout PCIC Clinical Board services and independent contractor services with the support of PHW/1000Lives Plus	• Ensure the Clinical Board is taking corrective action to minimise HCAI incidence. • Increase awareness of sepsis and the importance of monitoring observations through NEWS / PRAILS initiatives.	• Monitor monthly Performance indicators and share learning through existing networks • No adverse incidents / early identification of patient deterioration

ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2019/20		
ACTION	OUTCOME	MEASURE
Point of Care testing: • Continue to ensure robust systems and processes are in place to monitor the use of point of care systems testing across the Clinical Board. Continue to review medication safety/quality: • Promotion of National Prescribing Indicators • Appropriate promotion of safety notices • Liaison with other health care professions/sectors	• Ensure compliance with UHB/Welsh Government policy and existing legislation • Safety of medication prescribing and administering	• Improvement against NPIs – continued high performance • Decrease in variation between GP practices
AIM 3 – EFFECTIVE CARE		
Regular record keeping and Medicines audits undertaken by PCIC services. Continue to revise clinical audit plan and monitor effectiveness and outcomes for improvement. Implement the District Nursing Principles into practice and work with the All Wales group	• Regular audits reported to PCIC Q,S&E Committee and action plans developed. • Regular monitoring of clinical audits undertaken and associated action plans through PCIC Q,S&E. • To deliver effective and safe patient care within the community	• Undertake audits and develop action plans. • Attend working groups
AIM 4 – DIGNIFIED CARE		
Implement and continually review the End of Life Delivery Plan	• Monitor the numbers of patients cared for at home (PPD) • Monitor the increased demand for SPC and patient outcome measures • Increase number of ACPs undertaken	• Number of patients cared for at home (Monthly SDG / Provider KPI's • Quarterly SLA meetings and KPI reviews

ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2019/20		
ACTION	OUTCOME	MEASURE
		• Number of ACPs in place in the community.
AIM 5 – TIMELY CARE		
Improve access and patient experience to Urgent Primary Care OOHs Improve the sustainability of GMS and Dental contractors	• Reduction of WG breaches against the targets • Improved sustainability and access to GMS/Dental services	• Patient surveys • Access indicators
AIM 6 – INDIVIDUAL CARE		
Continue to develop and implement PCIC patient experience framework	• Continue to improve planning and structure for gaining feedback from patients / service users to help shape future service planning arrangements	• Patient experience reports to PCIC Q,S&E Committee • Attendance at UHB Patient feedback group

8.2 High level 2020/21 and 2021/22 Actions

The high level clinical board's Quality, Safety and Improvement actions for 2020/22 include:

ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2020/21 – 2021/22		
ACTION	**OUTCOME**	**MEASURE**
Continue to provide robust assurance to the Clinical Board management team and Executive Board through effective Quality, Safety and Patient Experience systems and processes	• Deliver safe, effective, timely care to the population of Cardiff and Vale through delegated services	• Monitor of agreed WG targets and KPI's through monthly clinical board meetings

8.3 Patient Experience Framework

8.3.1 Detailed 2019/20 Actions

The clinical board's priority Patient Experience Framework actions for 2019/20 include:

ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2019/20		
ACTION	OUTCOME	MEASURE
AIM 1 – REAL TIME		
Provision of questionnaires in clinical settings	• Clear opportunity for service users to comment on their experience • Early opportunity for UHB to respond to matters about which patients and service users are unhappy	• Planned periodic patient feedback questionnaires with data analysis throughout the 12 month financial year cycle.
Provision of "Happy or Not" machines in clinical areas	• Clear opportunity for service users to comment on their experience • Enables people with language or literacy challenges to respond	• Periodic reports can be provided to provide overall sense of patient satisfaction at the provider site throughout the 12 month financial year cycle.
Use of social media to encourage timely response to health and care experiences	• Clear opportunity for service users to comment on their experience • Encourage responses from broader spectrum of health population	• Numbers of patient comments received and themes identified
AIM 2 – RETROSPECTIVE		
Gathering of patient stories – positive and negative experiences to be recorded	• Enables patient/service user to provide in-depth detail regarding their patient journey	• Analysis of concerns and compliment feedback through QS&E committee Bi monthly

ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2019/20		
ACTION	OUTCOME	MEASURE
		• Patient stories presented to QS&E forums on a bi monthly basis
Extract all possible learning from reports from regulatory bodies such as CHC, HIW, CIW	• Obtaining of an objective view of risks and benefits of current service provision.	• Action plan developed in response to improvement requirements with agreed timescales.
AIM 3 – PROACTIVE/REACTIVE		
Active performance management of clinicians on Performers Lists	• Ensures patients experience safe care • Supports safeguarding	• Number of clinicians whose performance is managed • Numbers of clinicians added to or removed from Performers Lists • Numbers of reviews undertaken by PMCAT, NCAS, GMC, GDC
Active monitoring of tier 1 targets (HCAI) encouraging Primary Care providers to carry out RCAs of healthcare acquired infection	• Reduces patient liability to acquire infection in the community • Reduces likelihood of admission to hospital • Reduces likely length of stay in hospital	• Monthly monitoring of numbers of key HCAI's /infections
Active monitoring of Pressure Ulcer incidents	• Reduces patient liability to acquire infection in the community • Reduces likelihood of admission to hospital • Reduces likely length of stay in hospital	• Monthly monitoring of numbers of pressure ulcers (SI and Safeguarding reporting)

ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2019/20		
ACTION	OUTCOME	MEASURE
Implementation of patient held records	• Patients more involved with own care • Patients have transferrable information to share with a variety of health care professionals	• Number of patients using self-held care notes
Ensure appropriate provision of advocacy, particularly working towards dementia friendly services and environments	• Improves patient experience of care • Addresses the needs of individuals whatever their identity or background • Upholds human rights	• Number of occasions when advocates are utilised • Patient responses to questionnaires and other types of feedback mechanisms
Ensure services meet the needs of patients with learning difficulties and/or disabilities by providing information in accessible formats and ensuring compliance with appropriate frameworks, such as the Welsh Government Framework of Action 2017-2020 for people who are deaf or living with hearing loss.	• Patients are able to access services appropriately • Healthcare professionals are aware of the individual needs of patients and respond appropriately to ensure high quality and safe person-centred care.	• Patient responses to questionnaires and other feedback mechanisms
Ensure meeting of Welsh Language Standards within PCIC-delivered services, and promote Welsh Language provision to partners, including Primary Care contractors, Local Authorities and Third Sector organisations.	• Supports diversity and inclusiveness • Improves patient experience of care • Demonstrates UHB commitment to safe care of patients • Upholds human rights	• Number of occasions when advocates are utilised • Number of occasions when interpreters are required • Patient responses to questionnaires

ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2019/20		
ACTION	OUTCOME	MEASURE
Develop patient engagement and information materials in a wider range of formats	• Ensures that activities are inclusive and accessible	• Patient responses to all types of feedback through varied solutions i.e. Questionnaires
AIM 4 – BALANCING		
Management of clinical incidents reported on Datix	• Enables thorough investigation of matters reported • Enables theming of reports which leads improvement works • Enables improvement of seamless care between primary and secondary care	• Audits of incidents will demonstrate where improvement works have been successful • Monitoring of the timely processing of the incidents as per the agreed WG guidance
Roll out of eDatix to primary care contractors. Reliant on corporate support and resource.	• Better management of primary care incidents and sharing of information.	• Number of incidents entered onto eDatix by primary care contractors.
Undertake RCAs of significant incidents	• Enables improvement in patient experience by preventing similar incidents in future.	• Numbers and themes of serious incidents reported. • Numbers of RCA investigations undertaken in a rolling 12 months 01/04/18-31/03/19

8.3.2 High level 2020/21 and 2021/22 Actions

The high level clinical board's Patient Experience actions for 2020/22

ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2020/21 – 2021/22		
ACTION	OUTCOME	MEASURE
Develop, use and monitor consultation and communication plans to ensure meaningful public and stakeholder engagement in future development of primary care plans. Ensure other Clinical Boards are involved in engagement opportunities.	• Ensure wider engagement of population affected by changes in PCIC services • Ensure service change is driven by population need • Increase awareness of rationale behind service changes	• Plan to be developed within 2018/19 financial year, and implementation carried through into 2019/20

C. RESOURCING & ENABLING FRAMEWORKS

C9. CAPITAL INFRASTUCTURE

The following capital schemes are key enablers to support our clinical board priorities:

9.1 In Development

Scheme	Benefit	Current Status	Delivery Timescale
Shaping our Future Wellbeing in the Community Delivery of a network of community facilities, based on a Locality and cluster model, to support the implementation of the SOFW strategy.	• Delivery of care closer to home • Improve partnership working • Delivering care in fit for purpose premises • Enhanced cluster and inter-practice working • Support people living safely at home, tackling social isolation, promoting ill health prevention. • Rationalise use of community facilities and improve integration with partners from local authority and third sector	Programme Business Case submitted to WG and approved September 2018	2018/19 onwards
Health and Wellbeing Hubs and Centres	• Implementation of the Shaping Our Future Wellbeing strategy • Improving access to services and delivering closer to people's homes • New and innovative responses to population health and wellbeing through new pathways and service delivery models	Maelfa – Open 2021 Park View – Open 2022 Penarth – Open 2021	£8m £16-20m £6m
Managing LDP Growth Population growth in Cardiff and the Vale of Glamorgan is significant with an additional circa 49,000 homes being developed over the next ten years.	• Additional capacity to address LDP growth • Patients accessing care appropriately therefore preventing patients inappropriately accessing the unscheduled care system	Individual PODs developed for: Fairwater, St David's and	Ongoing until LDP completed

Scheme	Benefit	Current Status	Delivery Timescale
	• Patients able to access a wide range of GMS services on a practice level • Increased opportunities to maximise integration and whole systems working at a primary care level	Lansdowne. Business Cases submitted and moving forward.	
Primary Care Estates Strategy Develop an overarching Primary Care estates strategy. Deliver a high quality primary care estate which is fit for purpose and supports the redesign of services.	• Clear long term strategy for primary care estate in Cardiff and Vale to drive priorities with regard to capital development work.	Some scoping work started	2019/20
Primary Care Discretionary Payments	The following have been agreed - St David's Medical Centre - Roath House Surgery - Brynderwen and Minster(Branch) - Court Road - Llandaff Surgery - Danescourt - Western Vale Family Practice (St Athan site)		

9.2 Community and Primary Care Estate

Scheme	Benefit	Delivery Timescale
See LDP/Estates Programme POD, GMS sustainability POD and Cluster working POD One of the enablers to free up space within practice premises that are already subject to rent reimbursement as part of their GMS floor space is the utilisation of records storage by supporting the "Scan and Store" initiative to house records off site, enabling internal reconfiguration to provide more space for staff and patient care. Major or Minor Improvement Grants enable practices to make the best use of their existing practice space, enabling them to become more resilient with patient list size growth in having the space to house more clinical staff, thus assisting in the pressure of population growth as a result of the LDP. Minor improvement grants also enable practices to enhance their existing premises to ensure that they meet standards for patients. In converting and utilising existing space there is minimum impact on the overall budget to support rent reimbursement. Converting internal space to allow the practice to grow and develop provides sustainable service provision for existing patients as well as allowing the practice to grow its patient list. Outcomes that matter to people : Supporting Improvement Grants to ensure that practices are fit for purpose and are accessible for patients; providing care locally within the community.	1. Make best use of primary care estate. 2. Delivery of care closer to home. 3. Improve partnership working. 4. Delivering care in fit for purpose premises.	2019-2022

C10 INFORMATICS & IT

The 2019/20 priority informatics and IT deliverables for the clinical board focus on maximising the use of new and existing systems, and developing new ways of working supported by technologies such as the use of mobile technologies and e-health systems.

Scheme	Benefit	Delivery Timescale
Improve access to, and sharing of, primary and community care records and data: • Improve links between different IT systems across the UHB and partner agencies • Develop processes to cover Information Governance and GDPR requirements regarding the sharing of information to enable easier sharing of data with appropriate partners	• System users able to utilise records across systems, supporting better patient care, enabling seamless care, and improving efficiencies	2019/20 - 2021-22
Ensure systems are effective and fit for purpose for both current and future requirements: • Support roll-out of WCCIS • Review systems to explore opportunities to link information across IT systems • Work with UHB IT to 'future-proof' systems and ways of working	• Move towards whole system integration • Improve responsiveness to changes in ways of working and delivering services.	2019/20 - 2021-22
Make effective use of existing technology and digital solutions: • Promote use of telephone and web-based triage and consultations in primary care • Support the use of home working in relevant services, including OOHs	• Patients able to access primary care services using the most suitable method depending on need, allowing better demand/capacity management of face to face contacts.	2019/20 - 2021-22
Use technology to support workforce to provide more care closer to home: • Increase use of mobile devices within community services	• Less need for clinical staff to return to base to carry out specific functions, improving flexibility and efficiency	2019/20 - 2021-22

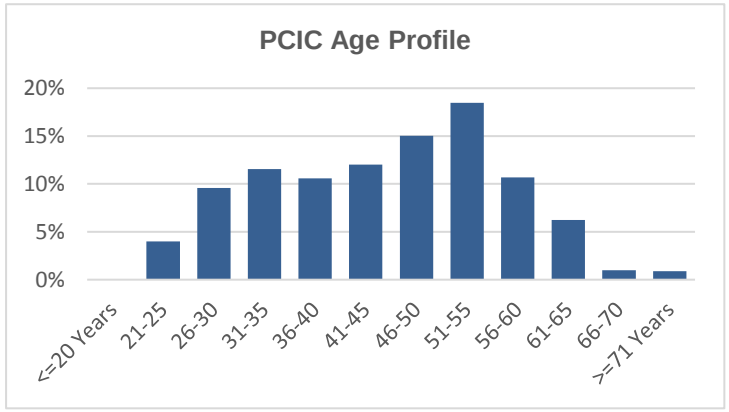
C12 WORKFORCE

Directly Employed Workforce

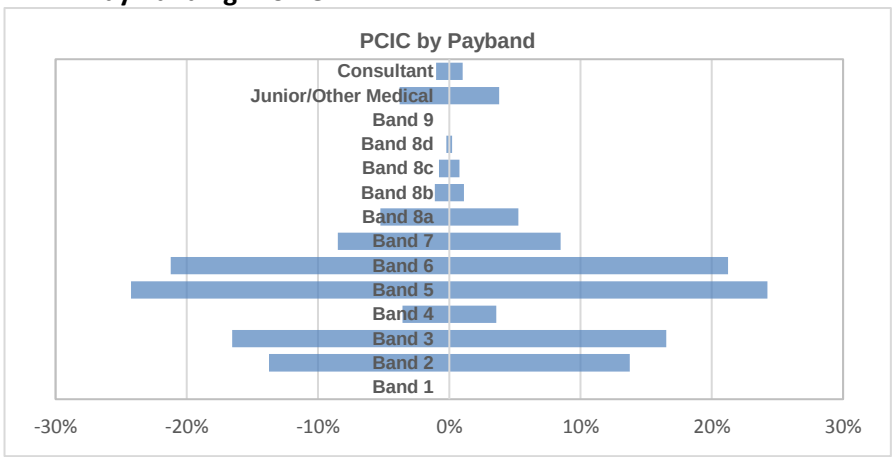
The PCIC Clinical Board has 899 (661.45 wte) directly employed staff (does not include the Primary Care independent contractor workforce, independent sector (nursing home) workforce and social care staff across our two Local Authorities, this is mentioned under Primary Care Workforce later in this section).

The following charts provide an overview of the UHB's current directly employed workforce profiles as at 30 September 2018.

Age Profile



Pay Banding Profile



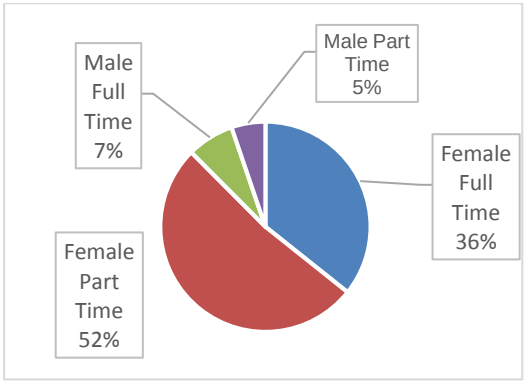
Age and Pay Banding Profile

The workforce is predominately aged between 31-50 years (49%) with 37% aged 50 years and over. There is only 14% of the workforce aged 21-30 years, with no one aged 20 or below. This presents a challenge to the clinical board in terms of future sustainability of services, retaining knowledge, skills and experience as well as growing future talent. There is also the challenge of the availability of skills to recruit to any turnover when some roles are already a shortage profession or some skills required for the future do not currently exist and need to be grown and nurtured.

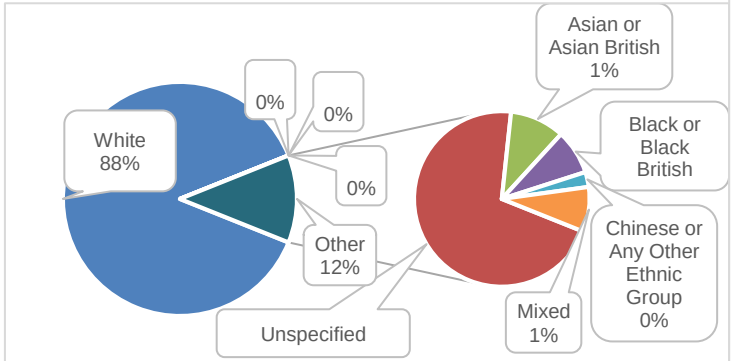
Challenges remain around recruitment and retention of the directly employed workforce which is a key priority 2019/20. The age profile of our nursing workforce in particular, as the largest staff group, could result in a loss of significant capacity, skills and expertise in the next 3-5 years. In 2018/19, PCIC Clinical Board was linked to the student streamlining process for Band 5 nurses to maintain recruitment levels. While recruitment has not currently been a challenge for district nursing, it has been for our more vulnerable services such as sexual health and HMP Cardiff in terms of the availability of specific skills set and expertise required to work in these environments.

Shape of the PCIC Workforce

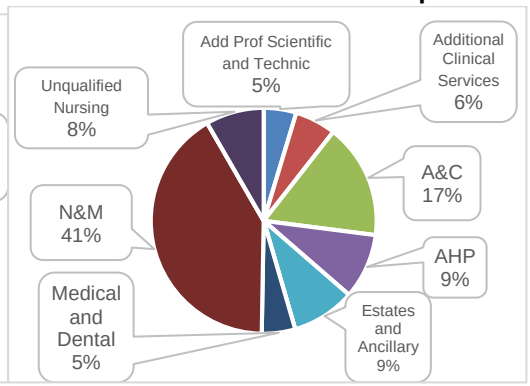
Gender



Ethnicity



Staff Group



The majority of the workforce is female (88%) with 52% working part time and 36% working full time, which is 1% change since the same time last year. Flexible and mobile working will remain crucial to retaining talent and a variety of communication tools are necessary to keep staff updated and engaged due to variation in working patterns, work settings and access to IT, and IT connectivity.

The majority of the workforce is white (88%) with 12% other, 9% not stated and 1% in both black and minority ethnic categories. This has remained static. The Single Equality Plan has a number of actions to continue review of our workforce in this regard to ensure it strives to reflect the local population where relevant e.g. in recruiting practices.

Most staff fall within the Agenda for Change Band 5 (24%) and Band 6 (21%), which is the same as last year (the outputs from the nursing workforce planning is outlined later in this section). There has been some growth in the Band 3s with the 16.54% now in post compared to 15.84%. There are no Band 1s in the Board. However, there will be a focus on apprenticeships to develop the Bands 1-4. Continued focus will be on the developing apprenticeships, further development of HCSWs, advanced practice and extended roles such as ANPs, APPs and Independent Prescribing and Physician Associates to feature in workforce plans to support workforce and service sustainability.

Recruitment and retention strategies are key to the sustainability of services alongside strategic workforce plans. Reducing vacancies and addressing voluntary resignation has been a challenged and some progress made. Turnover remained over 9% this year, which has increased since March 2018, and above the 6.34% UHB target. Retention will remain a key priority for 2019/20 to ensure workforce sustainability and targeted work will be undertaken to improve staff retention to minimise the loss of skills, experience and expertise.

Extensive work around skills, competencies, training and education, and workforce planning has been undertaken with our district nursing and nursing workforce which is providing significant information and evidence for future planning), and will continue over the next 12 months and beyond.

In 2019/20, workforce planning will commence within the Department of Sexual Health and HMP Cardiff to look at how the skills shortages can be supported across the workforce, looking at future demands and opportunities to work differently, as well as looking at other roles to support and releasing capacity, with improved career pathways. Plans are also in place to commence workforce planning for the Allied Health Professional staff groups, working across Clinical Boards, to consider future capacity and demands on these roles across services within primary and community services, whilst maintaining a sustainable workforce for secondary care.

District Nursing:
The creation of a 'Novice to Expert' pathway for District Nurses to support the education and development needs of the workforce in line with the DN principles, the interim guidance on staffing principles, as a result of Nurse Staffing Levels (Wales) Act 2016. Succession planning and talent development is ongoing to ensure the service continues to meet the SPQ requirements through the identification of staff and funding requirements to expedite the number of staff achieving SPQ over the next 2years.

The nursing role continues to be physically demanding with increasing patient complexity and whilst work continues to articulate and describe levels of patient acuity, the establishment is likely to remain unchanged at this time, however further modelling of the workforce will be needed once this is available. In addition the service will explore the role of a level 4 Healthcare Support Worker whilst also considering the career development pathways from unregistered to registered workforce in line with developments across Wales as part of ongoing succession plans and career aspirations of staff. Further aspirations include the journey towards a 'Community Nurse' which would incorporate the nursing provision currently situated in separate services (CRT Nurse, Frailty Nurse & DN Nurse) taking account of the learning from Community Nursing Pilots across Wales. The next steps will be to include specialist areas of work including Acute Response (ART), Continence and Nurse assessor teams.

OOH:
Significant progress has been made supporting the sustainability of OOH services across Cardiff and Vale. The multi-disciplinary model has been shared as a case study for inclusion in the Primary Care Compendium of roles/models demonstrating the service successes through the introduction of clinical practitioners, with a nurse or Paramedic registration, as an alternative where GP cover has been continually challenging.

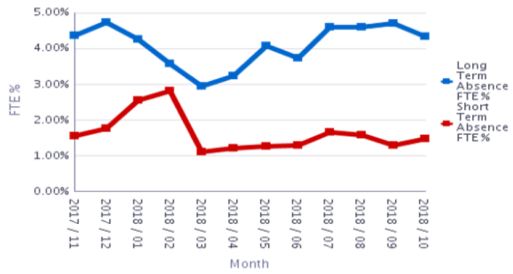
Recent demand and capacity modelling has supported the creation of a workforce plan and service model of the future which includes the continued development of the multi-disciplinary team focused on skills. To improve governance, and to reduce variation in practice and patient experience an education and competence framework is in development to ensure all clinicians have the cores skills required to work and develop in the service. Feedback from the recent Peer Review exercise was positive, however the workforce plan will need be reconsidered against the recommendations and to ensure affordability.

Continued use of new, advanced and extended roles will be key to releasing capacity of key professionals as well as further development of the multi-disciplinary and multi-agency, across Clinical Boards and sectors approaches to recruit and retain the workforce. Continued application of prudent healthcare principles to 'only do what only you should do', new ways of working through workforce planning and OD interventions will be key to the delivery and sustainability of the workforce in delivering the UHB Shaping Our Future Wellbeing strategy.

A Healthier Wales, also provides further opportunity to start working with our partners on developing integrated workforce plans and joint workforce planning with a view to bringing roles together in line with prudent healthcare principles to reduce waste, harm and variation, and improve individual outcomes with service user engagement to deliver local population focused seamless services.

Workforce Health and Wellbeing

Sickness rates remain at 5.68%, which is 1.01% above the 4.67% target, and 0.7% higher than the same time last year. Sickness has remained above 5% since December 2017, with long term sickness being the main issue for the Board. The introduction of Healthier Wales and the new Managing Attendance Policy focusing on the health and wellbeing of our directly employed and wider workforce will support a more proactive approach to keeping our workforce healthier at work. This will be key priority for the Board in 2019/20.



Month	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
LT FTE %	4.38%	4.74%	4.26%	3.57%	2.96%	3.23%	4.07%	3.74%	4.61%	4.61%	4.71%	4.34%
ST FTE %	1.55%	1.77%	2.56%	2.82%	1.11%	1.21%	1.27%	1.30%	1.67%	1.58%	1.29%	1.48%

Primary Care Workforce

Since 2016, the national context has placed more responsibilities on Health Boards, and Workforce and OD, to support the maturity development of Primary Care Clusters (9 in Cardiff and the Vale) and the sustainability of independent GP contractors (currently 63 practices) to support the whole health system. There remains challenges around the workforce in terms of national shortages, skills and further development of multi-disciplinary teams, to release capacity of GPs and practice nurses, and to support primary care both in and out of hours. OOH workforce planning, including skills, education and training requirements, has been underway and this received a positive response from the national peer review with more opportunities over the next 12 months to minimise risks and challenges that the service continues to face in terms of recruitment and retention.

Over the last 12 months significant work has been undertaken in workforce planning and OD to support primary care through dedicated expertise. Details of the priorities and focus for 2019/20 is shown under the Primary Care section below. The Auditor General for Wales Primary Care Services report provides some recommendations for further workforce and OD priorities.

There is evidence of a growth in the workforce employed by the Health Board and working in practices/clusters which also creates pressures on existing leadership structures, supervision arrangements and further roles from Mental Health and to support MSK will be rolled out this year and next year to support sustainability and to release GP capacity. Some challenges remain around 'employment model' as clusters are not currently a legal body so unable to employ so work is underway to develop a cluster partnership agreement to support engagement between the Health board and our independent GP contractors.

GP recruitment remains difficult as a national shortage. A GP Recruitment and Retention Group was set up in 2018/9 and will continue in 2019/20 to focus on supporting attraction and retention of this key part of the workforce. A GP Fellowship Scheme is planned to be rolled out in the remainder of 2018/9 and will be piloted over the next 12 months as an option to grow a future GP workforce, supported by the UHB. Further work will continue on retention in 2019/20. Work also continues around the skills, education and development of the practice nurse and practice manager roles.

Evaluation of the cluster pharmacist and primary care nurse for older people (PCNOP) took place in 2018/19 and the lessons learnt and actions from those processes will be taken forward into 2019/20, to consider whether there are opportunities to scale this up further.

There is significant transformation for PCIC Clinical Board in the next 12 months and beyond due to many different schemes. Project management expertise will be recruited to support the role out of a number of schemes, including the MH and MSK, 'Me, My Home, My Community' and others.

This extended workforce are key to the delivery of PCIC's IMTP and to the delivery of the UHB's Shaping our Future Wellbeing Strategy and delivery of the Welsh Government's A Healthier Wales: Our Plan for Health and Social Care. Details relating to the independent GP contractor workforce is shown under the national context below.

12.2 Workforce Priority Deliverables 2019/20

Key workforce challenges for the clinical board:

- Recruitment and Retention
- Primary and Community Care Transformation: Significant investment in transformation including the delivery of:
    - MH and MSK roles
    - 'Me, My, Home, My Community – Health, Independent Contractors, social care and 3rd sector to deliver seamless care

- Cluster Development, including leadership capacity, capability and maturity including the roll out of the Cluster Governance Framework and the management capacity to support delivery.
- Dementia team

- Leadership and management development – Cluster Development
- Workforce sustainability, including independent contractor workforce
- Workforce Capacity and Capability
- Workforce Plans – talent and succession plans

Significant progress has been made over the past 12 months in improving key performance indicators, linked to good leadership and engagement. The focus for the next 12 months and beyond will be on transformation and engagement to ensure sustainability and a more efficient workforce, which are appropriately trained and meet minimum competencies. This will provide a platform to develop the workforce further to meet future population needs and in doing so make this a 'great place to work and learn'.

National and Local Context - Primary Care Workforce (Independent GP Contractors)

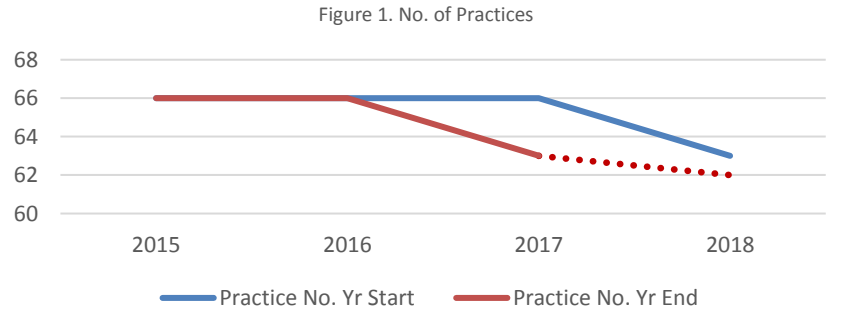
The Welsh Government 'A planned primary care workforce for Wales' up to 2018 ended in March 2018. The Parliamentary Review identified the quadruple aims followed by A Healthier Wales: Our Plan for Health and Social Care. Significant work has progressed in 2018/19 to deliver against the main areas of the 'A planned primary care workforce for Wales up to 2018'. Further extension and now appointment of dedicated workforce planning and OD expertise was key in supporting the engagement and development of clusters across Cardiff and the Vale of Glamorgan. General Medical Services (GMS) in Cardiff and the Vale of Glamorgan have become increasingly fragile over the last 12 months and the workforce and organisational development expertise have a key role in supporting sustainability, alongside the Localities and General Practice Support Team. The following actions are aligned to the UHB Workforce and OD Strategy and the following actions are proposed for 2019-20:

Primary Care: General Practice Workforce

Sustainability of Primary Care services remains a key priority for the Health Board. With the knowledge that General Practice is a less attractive career choice due to the increasing workload, increasing demands and the financial challenge and risks associated with the traditional partnership model a 'basket' of support was outlined to identify proactive support/options available to all GP Practices. This includes the Merger Discretionary Payment protocol as a tool to support practices to merge, as an alternative to handing the contract back.

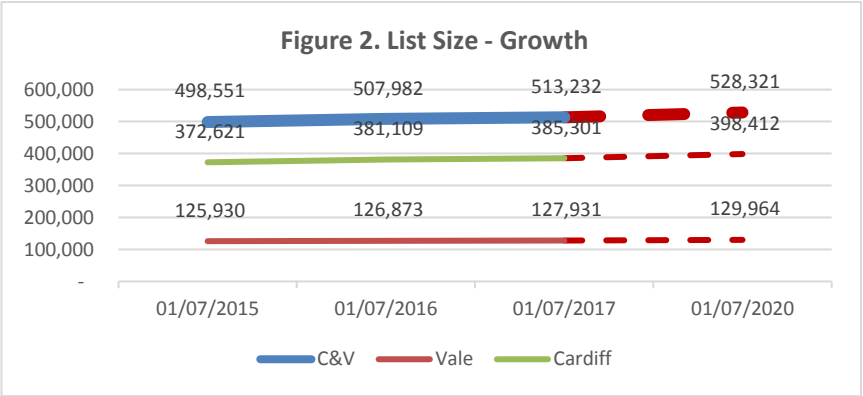
Three Mergers between neighbouring practices/business have taken place to date, with Organisational Development support provided to join up teams and processes both pre and post-merger. Figure 1 indicates the change in the number of practices across Cardiff & Vale.

Figure 1. No. of Practices



The current forecast profiling confirms that the practice population for Cardiff and Vale will increase inline with growth expected as part of both Cardiff and Vale Local Development Plans, and by 2020 the population is likely to be as in the 'list size – Growth' graph shown in figure 2.

Whilst our population continues to increase the areas predicted to be impacted most is within our North West Locality, which includes the Cardiff North, Cardiff South West and Cardiff West Cluster areas.



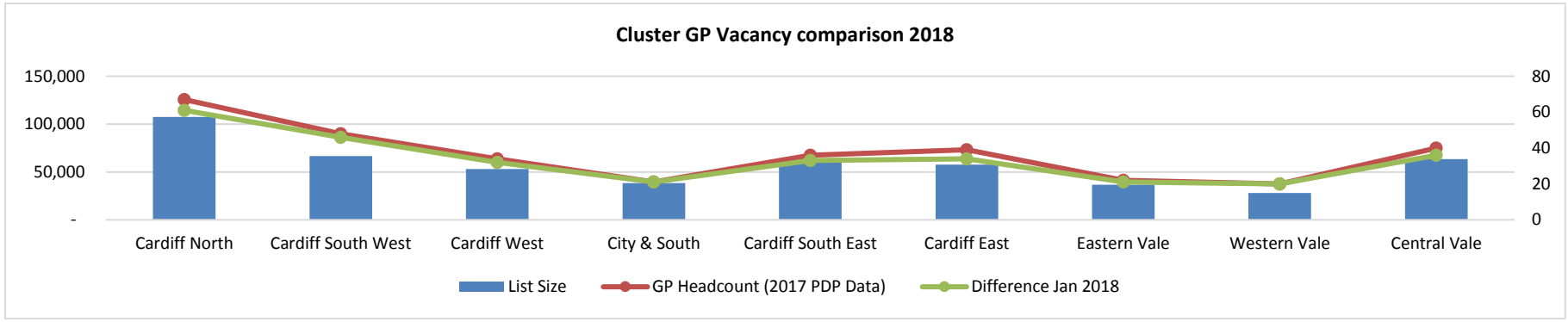
Our profiling based on practice development plans, and validated workforce submissions in 2017 provides us with a baseline to make comparison on the changing shape of the Medical and Clinical Workforce;

Further analysis demonstrates the change by Locality Area as follows:

Cardiff North West	Role/ Year	2015	2017	Difference	% inc /- dec	Cardiff South & East	2015	2017	Difference	% inc /- dec	Vale	2015	2017	Difference	% inc /- dec
	Partner	124	119	-5	-4.03		78	66	-12	-15.38		76	63	-13	-17.11
	Salaried	20	21	1	5.00		20	26	6	30.00		8	17	9	112.50
	Retainer	6	5	-1	-16.67		5	4	-1	-20.00		3	2	-1	-33.33
	Returner	0	0	0			2	0	-2	-100.00		0	0	0	
	Practice Nurses	73	70	-3	-4.11		50	50	0	0.00		42	49	7	16.67
	Healthcare Support Workers	18	28	10	55.56		10	14	4	40.00		7	10	3	42.86
	Other Clinical	1	1	0	0.00		0	0	0			0	3	3	

In the absence of QOF for 2018 the annual practice development submission is no longer a contractual requirement, therefore we have been unable to extend the analysis beyond 2017 at this time whilst we await the All Wales solution as part of the National Minimum Data (NMD) set that is currently being procured for Wales for implementation in April2019.

In January 2018, the Clinical Board developed a GP Recruitment and Retention Project Group, to provide expertise and recommendations to enable and support the flow of GPs into Primary Care practices across Cardiff and Vale. The Project Group gathered information to create a baseline position through surveying practices and GPs about vacancies/recruitment challenges and a separate survey to those categorise themselves as locums to understand the scale of the problem. The results were vacancy position as at January 2018, compared to 2017 was found to be as follows:



The growth in status of the GP locum role has created challenges for practices around their ability to respond to patient demand and set a workload which is comparatively more attractive than partnership or salaried GPs roles, which is compounding their current sustainability issues. A 32% response rate to a survey for Locum GPs was recorded in June 2018 identifying the following recurring themes as reasons/supporting factors as to why they have opted to work as a Locum:

- Family situation, choice and flexibility
- Role ends when the session ends
- Portfolio role/career
- No on-call duties
- Pay – increased benefits
- Personal health and wellbeing – able to manage risk of burnout

The information gleaned from this has informed the development of a GP Fellowship scheme for Cardiff and Vale. A proof of concept approach will be taken in the first instance, with a plan to recruit 3 wte GPs, to assess the level of interest from both practices and applicants before it is considered for wider roll out.

The Health board hosted two sustainability sessions for general practice which highlighted Mental Health and Physiotherapy as key services that would make a difference in Primary Care. As a result the delivery of First point of Contact Mental Health and MSK services are to be rolled out across Cardiff and Vale Locality areas during 2019.

The Group has also support the development and launch in May 2018 of CAVGP, the go to marketing and advertising platform for General Practice vacancies across Cardiff and Vale. Over the past 12 months, hits have increased and the site will continue to grow in 2019/20.

Cluster Development

Since the introduction of dedicated Organisational Development expertise all Clusters were encouraged and supported to develop a terms of reference, outlining their vision, purpose, membership and decision making criteria to improve cluster governance.

Clusters have also invested funds in the development of roles/models and been supported to evaluate their investments to date. Using a logic model of evaluation, the Cluster Pharmacists and Frailty/Primary Care Nurse for /Older People (PCNOP) roles were reviewed. The evaluation identified further actions to inform the future development of the roles/services to improve governance, consistency and outcomes in line with a 'Once for Wales' for approach. In addition the lessons learnt from our experiences and investments to date will be used to inform the development of the Partnership Agreement between the Health Board and Clusters as part of the MSK/MH roll out. It will also inform our understanding of the education and training requirements of the emerging MDT roles working with practices/clusters.

The capacity and capability and the future role of Cluster Leads will need to be considered in light of the Cluster Governance 'A good practice guide'. A Cluster Leads workshop took place in October 2018 to focus on cluster governance, plans and priorities, roles and responsibilities, evaluation and sharing good practice.

The following priority actions were agreed;

- Self-assessment of cluster maturity against agreed matrix to be undertaken by Cluster Leads to update the current position for Cardiff and Vale through a shared understanding that will inform the OD requirements on a Cluster/Locality basis.

- To support and develop a cluster leads network within Cardiff and Vale focussed on peer support, action learning and sharing of good practice as an enabler of cluster development through strong leadership.
- To review and indentify an appropriate infrastructure of support for Cluster Leads/Clusters informed through job planning, cluster plans and transformation plans.
- To propose an appropriate financial framework in which Cluster Leads/Clusters will operate to enable more autonomy and quicker decision making, underpinned by governance aligned to existing financial instructions/frameworks.

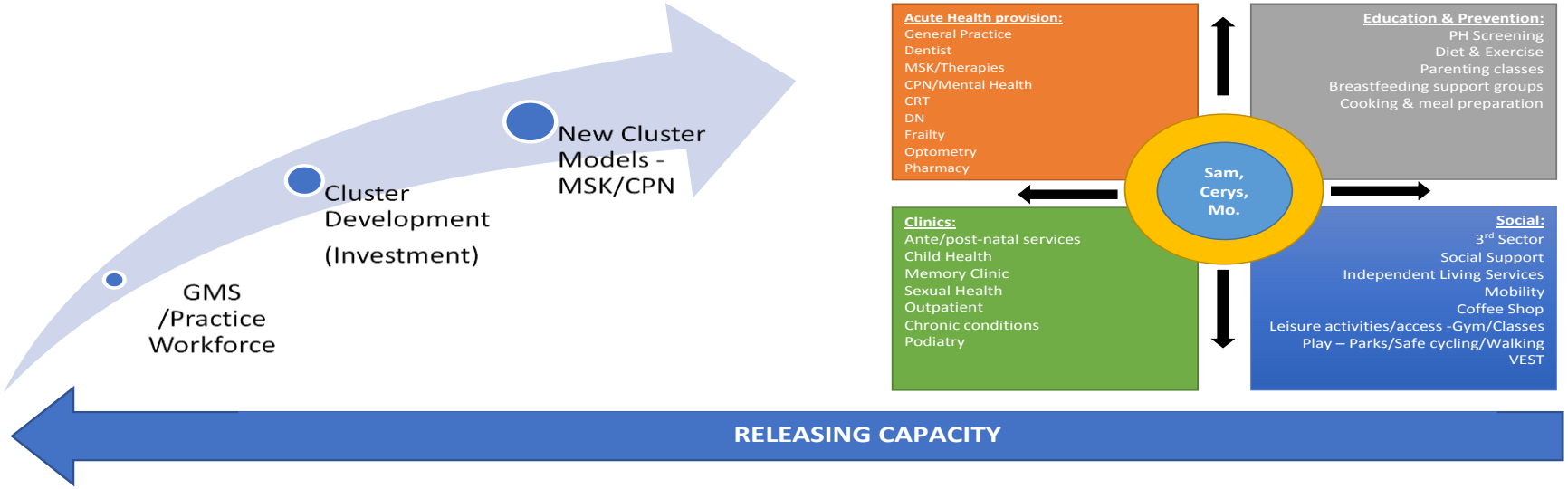
The outcomes from this work will provide an accurate/current assessment of cluster maturity and will be used to inform OD plans and measures to assess the development of Clusters and Leads.

Investment in OD Practitioners, including Workforce Planning skills, and Project Management support has been secured on a permanent basis and will be aligned to work with/across Localities to create an organisational development plan bespoke to their needs to support the continued development and evolution of their cluster in line with the good practice framework.

The Workforce Planning & OD Manager has co-facilitated a South Wales Cluster Leadership Programme 'Leading with Purpose, Passion and Perseverance' with Academi Wales. The programme is designed to support Cluster Leads whether they be GP's or from other professions, to strengthen their leadership contribution to improving care delivery for patient and clients across their Clusters. Coaching and facilitation support, together with key leadership skills such as influencing, will enable them to be optimally effective and support the development of effective strategies for facilitation and group management. The programme framework also provides a peer support mechanism through Action Learning, enabling personal and service change and promoting quality care in line with Prudent Principles. To date two Cluster Leads in Cardiff and Vale have experienced this programme, with a celebration of learning and success planned for December 2018. On completion it is anticipated that Cardiff and Vale will have the skills and support to be able to run the programme locally.

Locality/Cluster Wellbeing Hub Development:
North West Locality have actively engaged all partners in a series of workshops to date, with a further workshop planned for November 2018 as part of the Shaping our Future Wellbeing Strategy and to respond to the challenges of the Cardiff Local Development Plan (LDP). The focus and the priority of the work is the development of the wellbeing Hub within the Cardiff West Cluster area. Workshops have been designed collaboratively with stakeholders using the population health needs assessment to ensure services are designed, modelled and delivered around the patient to identify a range of scenarios/options to inform decision making, estates and planning.

The following diagram illustrates the journey towards sustainability based on the engagement and inclusion of partners to date:



Practice Nurse Workforce

In 2017/18, progress was made around the creating a baseline for our practice nurse workforce. A review of skills, education and training is underway to assess what we have in place and what is needed for the future. A nurse mentorship scheme and a Primary Care Nurse development programme are also being created. This work will continue into 2019/20 to build resilience and future proofing the role.

Nursing/Care Home Workforce

Work has been undertaken in relation to commissioning pre registration numbers for the nursing home workforce working very closely with them to support them in recruiting and retention of staff. We will be looking to work with some providers in 2019 onwards in enhancing the role of the HCSW across the commissioned and PCIC provided services. We continue to encourage the care homes to support student placements and work with our nurse assessor teams to widen the student nurses knowledge in relation to places within the community setting where nurses can work and develop meaningful careers.

A Healthier Wales – Regional Partnership Board Proposal

“Me, My Home, My Community” ambition for Cardiff and the Vale of Glamorgan provides for significant opportunity, however engaging staff and partners will be critical to its success, in addition to the development of integrated workforce plans across our health and social care system.

12.2 Workforce Priority Deliverables 2019/20

TRANSFORMING WORKFORCE
Enable quality, productivity & continuous improvement

Action(s)	Outcome	Target/Measure
Continue to support ongoing cluster development/ maturity of, and succession planning for primary care clusters and the sharing of best practice - Continue to roll out OD programme to support cluster development and maturity - To continue to engage and work with Public Health Wales Primary Care cluster development team project group to share learning from across Wales, aligned to the emerging model for Primary Care and pacesetter work - To support and influence the evaluation of cluster projects, maximise the use of advanced and extended skills for possible roll out of initiatives in other areas across Cardiff and Vale e.g. cluster pharmacist and diabetes specialist nurse etc	Identified business models and direction aligned to a clear vision/purpose. Better informed decision making and cluster governance. Learning from pacesetter and pathfinder projects shared. Evidence of the impact of new roles/models evaluated to inform scale up opportunities OD plans in place for each Cluster to support development aligned to maturity matrix and Cluster vision/purpose.	Development of emerging models of working and evidence of impact. Embedded evaluation exercises and PDSA cycles of all new roles/models of working to inform service improvement. All Clusters working towards maturity level 2. 100% of Cluster Leads attended/completed a recognised Leadership programme.
Action(s)	**Outcome**	**Target/Measure**
Putting in place the foundations for a more robust approach to workforce planning - Build on the baseline workforce data to inform the basis of initial workforce plans - To continue to horizon scan the environment in order to objectively challenge cluster and practice plans linked to future sustainability, business continuity and emergency planning.	Sustainable multi-disciplinary workforce for GMS	Workforce plans drafted Education and commissioning numbers agreed to ensure future supply
Continue to invest in the development of the wider primary care workforce • To continue to support skill mixing and develop further the ethos of integrated teams - GPs, nurses, pharmacists, paramedics, midwives, health visitors, dentists, optometrists, physiotherapists, podiatrists,	Improved GMS sustainability	Development of new roles and new skills

healthcare support workers, social workers and others.		
• Develop links and map out plans for the foundation for the development of a joint process for workforce including workforce education, skills and development and workforce planning	Robust/integrated workforce plans across Health and Social Care services Joint training programmes	Development of a 'training passport' of core skills across health and social care roles.
• To support the roll out of the MH and MSK roles into Primary Care through the development of a cluster partnership agreement and cross clinical board working through • To support the delivery of the transformation schemes for "Me, My home, My Community" through workforce and OD interventions • To support the development of the Dementia Team	Support the sustainability of General Practice Further development of the MDT role	Release capacity of GPs/practice staff Agreed Cluster Partnership agreement Deliverables against WG/BCAG objectives
• Through Primary Care Clusters review best use of the skills of optometrists to deliver sustainable eye care services	Alignment to Healthier Wales to deliver seamless care	Action plan developed
• Continue to work with other HBs re OOH regional working and 111	Potential economies of scale and improved sustainability for out of hours service to support in hours	improved and sustained fill rate
• Pilot new roles within PCIC and primary care e.g. HCSW Band 4, apprenticeships and PA roles	Evidence of new roles trialed and evaluated as part of PDSA cycles	Evaluation against set objectives/measures
Action(s)	**Outcome**	**Target/Measure**
• Continued OD plans for further integration in the Vale of Glamorgan Community Resource Team using team based working	Improved working arrangements and clear roles and responsibilities	Integrated teams

SUSTAINABLE WORKFORCE

Ensure the right people, in the right roles, in the right place, at the right time.

Action(s)	Outcome	Target/Measure
• Develop integrated workforce plans for fragile services e.g. DN, OOH's clusters and all contractor professions - Understand the workforce demographics, age profile and ageing workforce in terms of succession planning - Support local development plans. • Scope out further workforce planning initiatives to build on the submission to WG in support of the future Primary Care workforce sustainability • Outline scope of practice for MDT roles working within Primary Care services to inform training and education requirements and skill mapping activities.	Skill mix and skill mapping across workforce Workforce developed to meet population needs to develop a sustainable, multi skilled and multi disciplinary primary care workforce Meet future workforce supply needs and influence educational programmes Improved fill rates and pay for OOH service and Improved sustainability of the service Improved flexibility, workforce capability and skill mix	Workforce plans in place aligned to commissioning intentions & cross cutting themes with detailed delivery plans Identified skills and workforce numbers for Primary Care Reduced time to hire working towards <34% UHB target Reduced expenditure and improved fill rates and staff in post
• Continue to support organisational design in line with the function of the clusters and the delivery of bespoke OD programmes. • Continue to develop toolkits to support GMS contractors and cluster development plans for clusters and support emerging models of primary care	Sustainability of primary care services Guides and resources developed for use by GMS contractors Training and spotlight sessions developed for GMS contractors.	All Clusters working towards level 2 maturity. Research emerging models of care, linked to All Wales work pacesetters to inform guides and resources: advertising, retention, appraisal and delegation principles Business models identified and developed

CAPABLE WORKFORCE

Meet learning & leadership skills needs through delivery of quality training & development.

Action(s)	Outcome	Target/Measure
• Develop a Senior Clinical Board Team leadership development programme - Undertake baseline assessment of management leadership competences and identify gaps using NHS Leadership Framework self- assessment - Organise Team Development session using Compassionate/Collective Leadership Methodology and agree team objectives which cascade through the Clinical Board, aligned to UHB priorities	Improved team working through agreed objectives and role clarity. Clear priorities for all and improved engagement from clinical board teams Team objectives developed by each team to support improved engagement and clarity on priorities	Improved engagement score Increased participation in the next staff survey Reduced sickness absence from 5.52% to 4.67% or lower Increased PADR compliance from
• To increase PADR compliance using Compassionate/Collective Leadership Methodologies • Introduce Team PADRS	Improved engagement and individual performance	Increase PADR compliance from 63% to 85 % PADR April 2019
• Support all PCIC leaders/Managers to attend relevant UHB leadership training/360 feedback • Promote a coaching culture by promoting awareness of the benefits of coaching and an expectation that all managers attend the Coaching for Managers course • Develop core induction programme for new leaders • Develop guidance for leaders/managers on recruitment/shortlisting	Improved leadership effectiveness leading to improved engagement and retention	Increased engagement index PADR compliance – 85%
• Increase and improve PCIC staff compliance against core statutory and mandatory training through employee engagement and empowering staff	Increased staff health and wellbeing mandatory through increased statutory skills compliance reducing sickness absence and efficiency gains.	85% sustained in 10 core subjects

Action(s)	Outcome	Target/Measure
• Assess staff in post against District Nursing principles and develop action plan – see Appendix B for more details on DN principles. • Embed career conversations into PADR/1-1 discussions to inform succession plans.	Maximising workforce	Baseline clinical skills competency and identified plan to address gaps. 100% achievement of SPQ requirements. Training and development plans in place for each team/locality.
• Develop competency frameworks and training and development plans for wider MDT workforce including; - Out of Hours - Department of sexual Health - Prison services - Community/Cluster clinical roles	Efficient workforce Improved safety and governance Empowered and educated workforce	Competency frameworks in place 100% of staff trained in core competencies of role/service area
• Enhance existing nurse mentorship programme to support new nurses within primary care and train more in the Community to support others. • Develop and implement a Primary Care Practice Nurse Internship/Traineeship programme. • Develop a Primary Care Nurse Bank to support primary care contractors in accessing suitably trained/qualified Nurses with additional capacity	Improved recruitment and retention Increased morale and support Improved sustainability of general practice	% nurses attended/supported through mentorship Increased number of nurses trained to enter Practice Nursing as a first career choice Primary Care Nurse bank process in place
• Review of existing education programmes to ensure they remain fit for purpose. Continue to improve skills and competences of Practice Nurses to meeting professional standards and revalidation requirements through education. - Establish baseline competencies of current workforce against matrix to support the development of an informed education and training plan	Appropriately skilled, trained and competent workforce. Improved quality and safety of patient care and patient experience	Baseline completed To ensure that professional standards and registration/revalidation requirements are maintained

Action(s)	Outcome	Target/Measure
• Continue to work with providers to understand the capacity and demand of the nursing/care home workforce understanding the role of the 'nurse' for now and future skills and competencies and career pathways	Improved whole system workforce sustainability Improvement in skills and consistent practice	Baseline data on numbers, skills and training Development of future needs to meet demand
• Define baseline competencies for all HCSW • Continue to train and assess Band 3 HCSW in line with the Skills and Career Framework across primary and secondary care • Development of a Band 4 role/competence framework to release Nurse Capacity within District Nursing, DOSH, Prison, OOH.	Improve non registered (HCSW) academic capability	Baseline completed 50% of HCSW achieving the appropriate academic qualifications in line with the Skills & Career Framework Increase number of Band 4 HCSW's supporting Registered workforce.
• Develop baseline competencies for Allied Health Professionals working within Primary Care. • Develop advance practice pathways to support staff to work within/at their level of education/competence • Continue to improve skills and competences of all staff • Develop workforce plans to support in line with cluster development/population needs that inform education and commissioning decisions.	Skilled AHP workforce to meeting future population needs and ensure future supply	Baseline completed Workforce plan in place ?% of staff supported to work at Advanced Practice (4 pillars) Increased advance practice/extended practice education commissioning requirements

ENGAGED WORKFORCE

Create conditions which unleash more capability, potential, & commitment to the goals and values

In the last 12 months, significant work has been undertaken to improve staff engagement in response to the NHS staff survey results from 2016/17, with the development of the Local Workforce Recognition Scheme. District Nursing and OOH have taken part in the Value based recruitment training to improve recruitment and retention of staff, values and behaviour training and the re-introduction of the Local Partnership Forum. The PCIC Newsletter continues and in November 2018, PCIC delivered it's 2nd Celebratory Event themed around 'access' linked to the National Primary Care agenda, health and wellbeing and 70 years of the NHS, which was well attended and received. The focus in 2019/20 will be on the latest staff survey results and evaluation of the engagement programmes to date.

Action(s)	Outcome	Target/Measure
• Focused work on promotion of health and wellbeing initiatives to improve health and reduce stress aligned to Managing Attendance and Healthier Wales • Support managers to attend the UHB Managing Attendance training and promote a more compassionate and personal approach to managing sickness	Proactive wellbeing initiatives to aid the workforce feeling healthier at work	Reduce sickness absence to 4.67% and improve attendance % of managers trained
• Work in partnership with LED to implement a questionnaire across PCIC to review the effectiveness of the PADR Discussion	Improved engagement index	PADR compliance – 85%
• Refresh of Employee Engagement Plan alongside results of 2018 All Wales Staff Survey • Evaluate local workforce recognition • scheme and refine • Develop change management toolkit • Develop medical engagement plan	Improved Staff Engagement Support staff reward and recognition Improved staff involvement	Staff Engagement score Medical Engagement score Reduced turnover Increased engagement score Toolkit in place
• Continued partnership working with Trade unions • Evaluation of LPF	Improved engagement of the workforce through working together	Effective LPF
• Analysis of areas/teams with high turnover – OOH, Prison, DOSH,Roath DN team,	Improved staff engagement	Turnover – 9% Engagement index

Action(s)	Outcome	Target/Measure
Primary Care		
• To explore the use of positive action employment initiatives with regards to protected characteristics e.g. identify learning disability placement opportunities within the Board	Upholding equality and diversity principles	Review of current practice Placement enacted
• Development of a local staff charter for community workers • Work with staff and managers to improve reporting and responses to dignity at work issues	To ensure that people are respected and free from abuse, harassment, bullying and violence	Staff Charter Improved engagement score/staff feedback
• Develop a delivery plan, in line with the Strategic Equality Plan "Fair Care" to 2020, that places ownership for actions across the Directorates - Continue to ensure that EQIAs are completed in a timely and robust manner - Promotion in Local Partnership Forum, Employee Engagement Group and in local staff newsletter	Promotion of equality and diversity	Delivery of actions within the Strategic Equality Plan Fair Care up to 2020.
• Develop an overarching Welsh Language Action Plan to meet the Welsh Language Plan & Standards - Proactive promotion of opportunities for learning and training - Continue to promote use of Welsh language e.g. In our staff newsletter, at our annual health & wellbeing day	Increased Welsh Language knowledge and skills Additional workforce skills developed to allow more flexible and responsive workforce	No. of staff who can speak or understand Welsh Improve patient access and experience through the provision of Welsh Language services

EFFICIENT WORKFORCE

Achieve target workforce key performance indicators

Action(s)	Outcome	Target/Measure
• Embed workforce planning principles and approaches within each service area/Locality. • Utilise relevant workforce intelligence through horizon scanning to inform and develop effective resourcing plan to attract and recruit shortage professions e.g. nursing and GP posts. • Review how recruitment processes can be improved to betters support innovation and redesign in primary care • Map recruitment plans against priority areas • Implementation of hard to fill/service critical post resourcing strategies for DOSH junior medical staff and Band 6 nurses, Band 5 nurses across the patch, SALT and GPs	Improved workforce capacity and improved quality of care to patients	All service areas/Localities actively engaged/undertaking workforce planning Reduce vacancy rate to <5% vacancies
• Improve retention of staff by: - Analysis of reasons for leavers in hotspot areas, information from exit questionnaires and focus groups - Develop action plan with key areas of improvement	Sustainable workforce retaining skills and expertise	Reduction in voluntary resignation/turnover rate from 9.30% to 6.34%
• Map resourcing plans against priority areas aligned to workforce plans • Roll out of GP Fellowship Scheme to support future GP recruitment and evaluate outcomes • Band 5 nurses across the patch (links to student streamlining), focusing on key areas such as sexual health and Prison and GPs	Improved workforce capacity and improved quality of care to patients	Reduce vacancy rate to <5% vacancies
• Improve the quality of PADR conversations • Maintain Medical appraisal compliance	Improved staff performance and efficiency Links to engagement and capable and sustainable workforce.	Increase compliance from 63% to 85% plus 85% medical appraisal minimum compliance

Action(s)	Outcome	Target/Measure
• Refresh Sickness Action Plan in accordance with the new All Wales Managing Attendance Policy to support practices to improve workforce health and wellbeing • Focussed attention on hotspot areas • Implementation of staff flu plan to achieve 60% staff vaccinated.	Improved attendance	95.73% (4.37% sickness) 60% frontline staff vaccinated
• Ensuring formal cases are performance managed in line with the appropriate HR policy	Improved values and behaviours and reduced impact on workforce capacity	Fast track disciplinary within 1 month (non medical) Complete investigations in 90 days 50% appeals heard within 28 days ER KPIs
• Maintain job planning compliance of 100% to support service demand and delivery	Optimise medical workforce sessions Improved engagement with Clinical Board priorities Low variable pay rates	100% job plans of eligible job holders

12.3 High level 2020/21 and 2021/22 Actions

The high level PCIC clinical board's workforce actions for 2020/21 and 2021/22

ACTIONS TO DELIVER WORKFORCE AND OD FRAMEWORK – 2020/21 – 2021/22		
ACTION	**OUTCOME**	**MEASURE**
• Continue to support the development of Primary Care Clusters in line with the Cluster Governance ' Good Practice Guide' and maturity matrix	Evolved/Developed Clusters Cluster business/financial plans embedded to inform future planning priorities	All clusters working at/ beyond level 2 maturity.
• Skills Development to enable the workforce shift from secondary to primary care, focusing on the role of clusters, significant service change and supporting an engaged, motivated and empowered workforce. • Whole system workforce- with capacity in the correct sector to deliver efficient pathways of care to individuals		

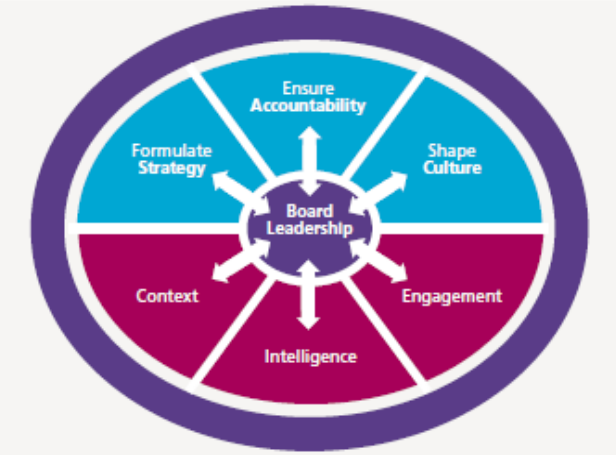
ACTIONS TO DELIVER WORKFORCE AND OD FRAMEWORK – 2020/21 – 2021/22		
ACTION	**OUTCOME**	**MEASURE**
• Development of joint education and training across Health and Local Authority looking at prevention, collaboration and patient involvement • Development of generic joint roles across Health/Social care • Consideration of wider public sector integration	Development of an Integrated workforce Supporting a healthier community	Workforce plans in place or working towards. Measures from Healthier Wales
• Develop the workforce plan to support the delivery of the Eye Care Plan	Improved skill mix across secondary and primary care services. Sustainable and skilled staff to deliver eye care services out of hospital and in the community	Workforce analysis/profile Transfer of eye care services from hospital to community releasing capacity
• Continued development of the 'community nurse' model and workforce plans for nursing workforce across primary and community services.	Improved skills, competencies and workforce resilience	Prudent healthcare principles
• Continued workforce planning for nursing/care homes	Improved skills, competencies and workforce resilience	No of vacancies/turnover of staff

C12 GOVERNANCE & DELIVERY

12.1 Clinical Board Governance Structure

The role of the PCIC Clinical Board can be seen via the diagram below, taken from "The Healthy NHS Board 2013 Principles for Good Governance"

Roles and building blocks of the PCIC Clinical Board



- **Formulating Strategy**: for the PCIC Clinical Board in the form of the Integrated Business Plan (IBP).
- **Ensuring accountability**: by holding the Clinical Board to account for the delivery of the strategy and service provision.
- **Shaping a healthy culture**: for the Clinical Board, ensuring a focus on quality and safety.
- **External context**: ensure the Clinical Board is informed by the external environment in which it operates.
- **Intelligence**: are informed by local people's needs, trend and comparative information on how the Clinical Board is performing.
- **Engagement**: prioritising engagement with stakeholders

The PCIC Clinical Board functions as decision-making body. Officer Members and Independent Members are full and equal members and share corporate responsibility for all the decisions of the Clinical Board. The Clinical Board meets formally on a bi-monthly basis, with meetings chaired by the Clinical Board Director. The Clinical Board acts in accordance to agreed terms of reference. The following points should be noted, with regard to the PCIC Clinical Board:

- Must remain largely supervisory and ensure a strategic focus
- Will ensure high standards of corporate (and clinical) governance and personal behavior – embedding the values and behaviours of the organisation
- Ensure dialogue with external bodies and local communities – and manage stakeholder relations
- Ensure the Clinical Board has an informed consideration of risk
- Ensure the PCIC CB is giving the UHB assurance that it is delivering against the UHB objectives

A number of groups and committees report to the Clinical Board or inform Clinical Board discussions, as set out below:

Meeting	**Chair**	**Frequency**
Clinical Board Development Sessions (to incorporate Business Unit Service Reviews)	Clinical Board Director	Bi-monthly
Quality, Safety and Experience	Community Director, Governance	Bi-monthly
Health & Safety	Director of Operations	Quarterly
Service Delivery Group	Director of Operations	Monthly
CD Forum	Clinical Board Director	Monthly
Local Partnership Forum	Lead Staff Rep / Director of Operations	Bi-monthly

NB: the above does not include Business Unit meetings / governance structures.

12.2 Clinical Board Performance Management Arrangement

The PCIC Clinical Board has a monthly Executive Performance Review meeting where Clinical Board performance issues are discussed and addressed with members of the Executive team. This forum also allows for issues and risks to be highlighted and proposed actions agreed.

In terms of PCIC Business Unit performance management, a number of mechanisms are used to monitor performance and agree plans to address any deterioration in performance. These include:

- The Service Delivery Group meets on a monthly basis and receives performance update reports from each business unit, with the focus on operational performance indicators and service developments.
- The PCIC Q,S&E Quality Dashboard is used to track and monitor performance against a number of key quality, safety and patient experience measures which are reviewed and discussed at the PCIC Q,S&E Committee.
- Each Business Unit is also subject to an annual Service Review, which provides dedicated time with members of the Clinical Board team for areas of success and progress to be highlighted, as well as the opportunity to look in detail at areas of risk and any poor performance.

12.3 Engagement

In developing this IMTP two stakeholder workshops have taken place with a wide range of PCIC staff and wider stakeholders to inform this document and gather feedback on key issues, suggestions and areas to focus on. These workshops took place in September and October 2018, with over 80 people attending across the two sessions, ranging from UHB clinical and non-clinical staff at various levels from all PCIC services, representatives from primary care contractors including GPs and practice managers, Cardiff and Vale Public Health colleagues, and staff-side representation.