27th July 2022 - Supporting Appendices

Wed 27 July 2022, 09:30 - 10:00

Agenda

1. Agenda Item 3.2 Quarter One Outcomes Report and updated trajectories for 2022/23

- 3.2b Performance Summary q1.pdf (2 pages)
- 3.2c Outcomes Framework Q1 Appendix.pdf (6 pages)

2. Agenda Item 3.7 a - Trosnant Branch Surgery Closure Application

- 3.7 a 2 Appendix One Branch Closure Process.pdf (15 pages)
- 3.7 a 3 Appendix Two Patient Engagement Report.pdf (10 pages)
- 3.7 a 4 Branch Surgery Closure Application.pdf (14 pages)
- 3.7 a 5 EQIA.pdf (15 pages)

3. Agenda Item 3.7 b - Glyn Ebwy Vacant Practice Process

- 3.7 b and c App 1 GMS Vacant Practice Policy.pdf (18 pages)

4. Agenda Item 3.7 c - St Brides Medical Practice Vacant Practice Process

- 3.7 c App 1 GMS Vacant Practice Policy.pdf (18 pages)

5. Agenda Item 4.1b Winter Plan 2021/22 Evaluation

- 4.1 c Appendix 2 Gwent RPB Winter Plan - Nov 21.pdf (15 pages)
- 4.1 d Appendix 3 Winter Plan 21-22 Assurance Report 02.07.22 rg v2 (003).pdf (9 pages)

6. Agenda Item 4.5 - Executive Team Report

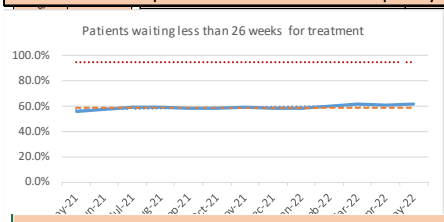
- 4.5 c Attachment Two.pdf (27 pages)

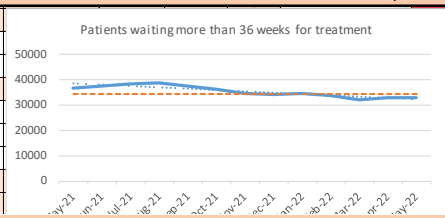
Integrated Performance Dashboard **May 22**

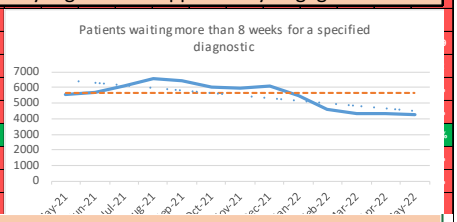
Appendix 1

Domain	Sub Domain	Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend	Performance Trend (13 Months)	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
		Patients waiting less than 26 weeks for treatment	May-22	95%	61.4%	61.2%			55.9%	57.5%	59.0%	59.0%	58.5%	58.5%	59.4%	58.4%	58.3%	59.8%	61.9%	61.2%	61.4%
		Patients waiting more than 36 weeks for treatment		0	33959	33177															

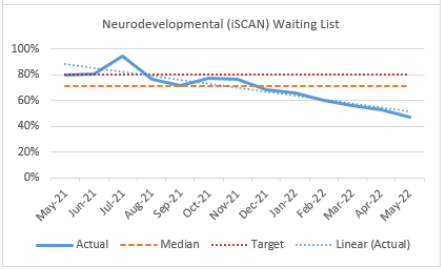
Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement

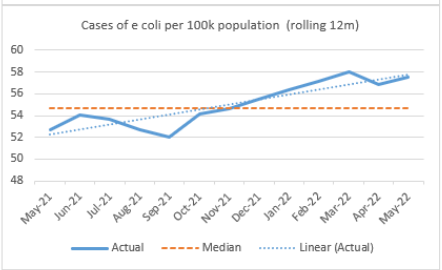


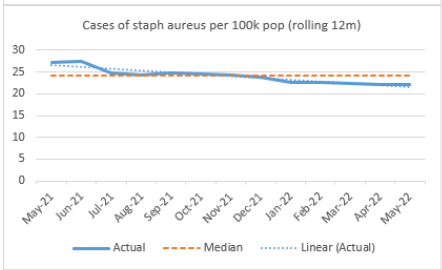


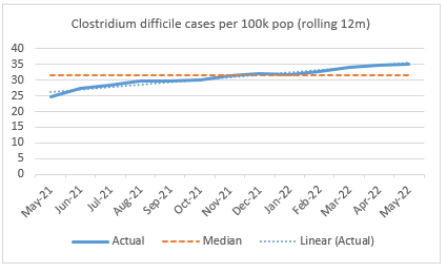


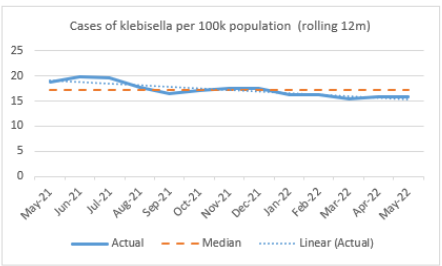
Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement

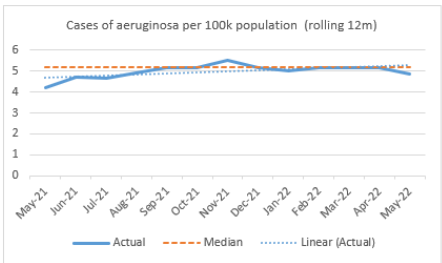


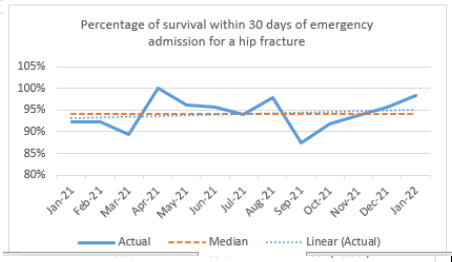


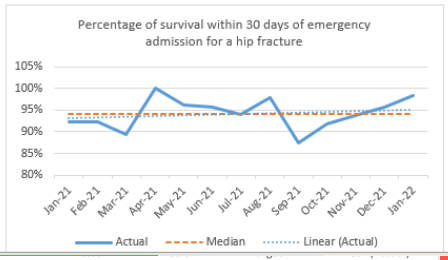




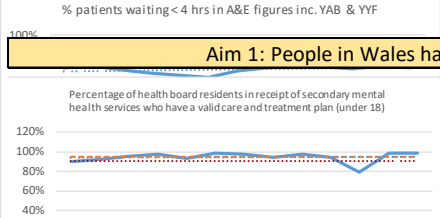


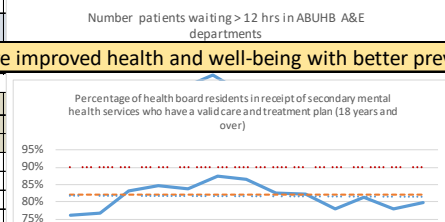


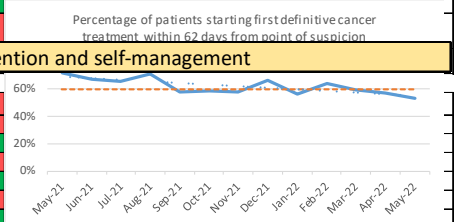




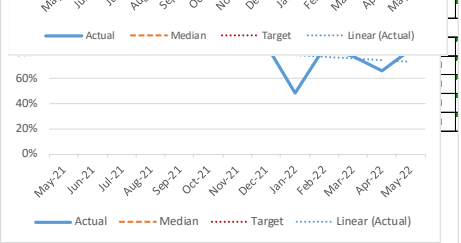
		Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion			21%	0%	8%		33%	39%	33%	32%	3%	8%	0%						

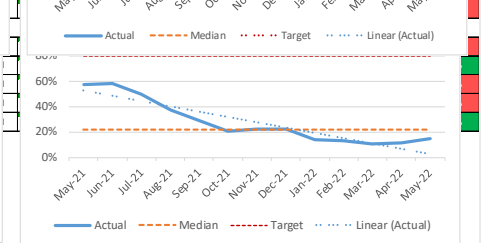


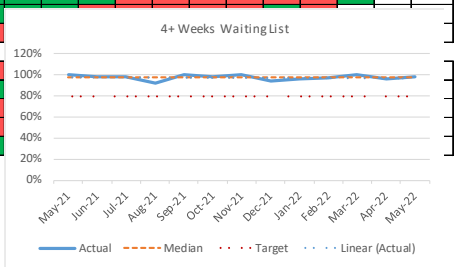




Aim 1: People in Wales have improved health and well-being with better prevention and self-management



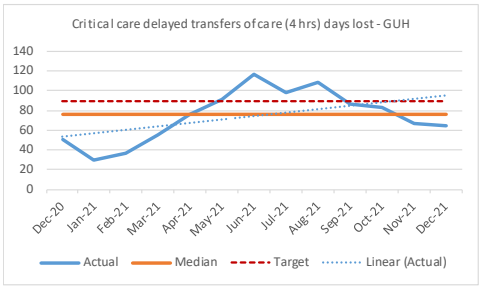


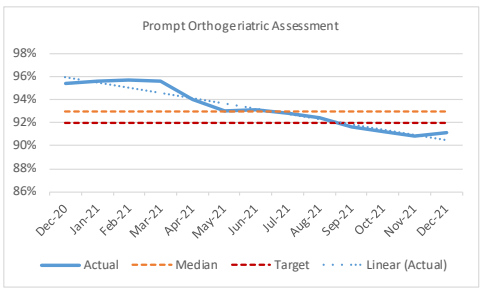


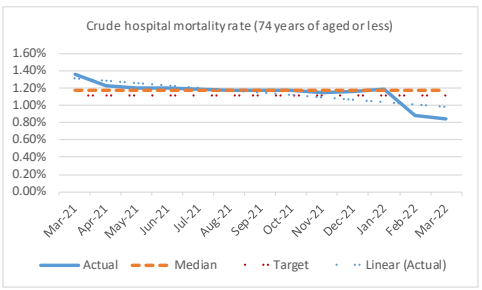
Achieving rating target and improved against previous reported position
Achieving rating target but deteriorated against previous reported position
Not achieving rating target but improved against previous reported position
Not achieving rating target and deteriorated against previous reported position

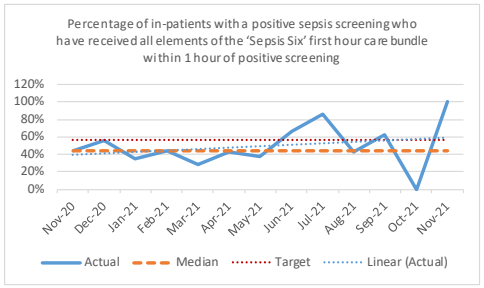
If measures are no longer in the Delivery Framework, current perfromance is measured against previous month

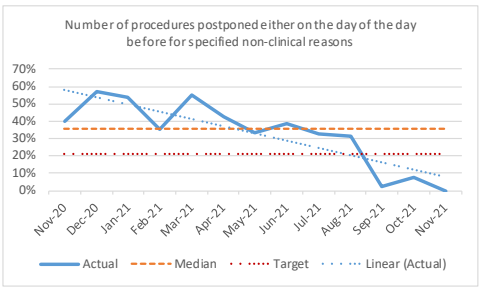
Aim 4:Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and

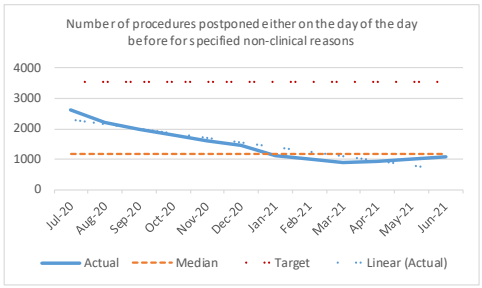


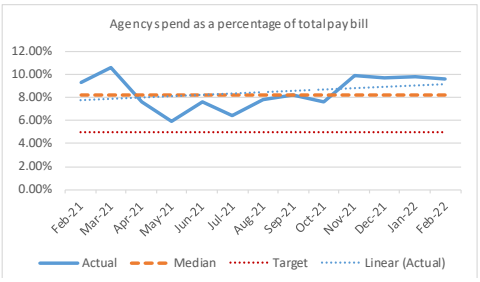




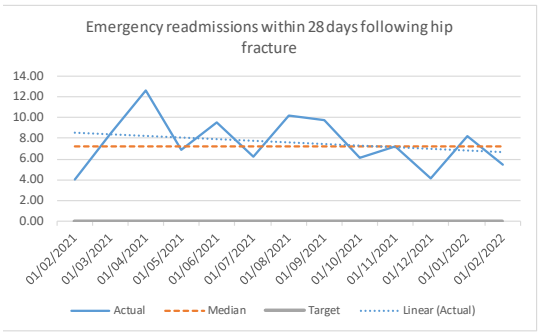


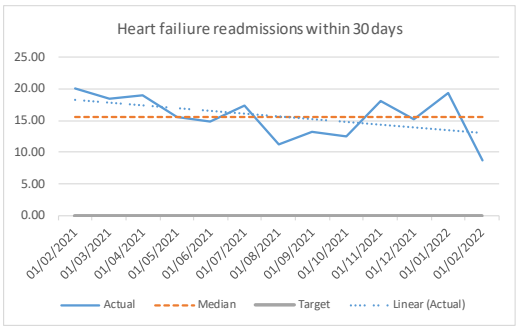






Local Measures





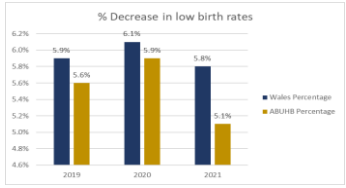
Priority Indicator Summary

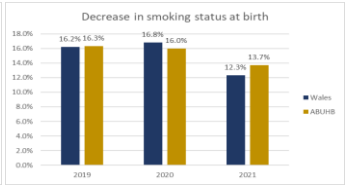
Type of change	P1 - Every child has the best start in life	P2 - Getting it right for children and young adults	P3 - Adults living healthily and aging well	P4 - Older adults are supported to live well and independently	P5 - Dying well as part of life	Total
Improved	2	2	6	2	2	**14**
Similar	2	2	3	0	1	**8**
Deteriorated	3	1	7	3	0	**14**
No data	1	2	1	1	2	**7**
Total indicators	**8**	**7**	**17**	**6**	**5**	**43**

Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. The 'No Data' category is used where the indicator is in development.

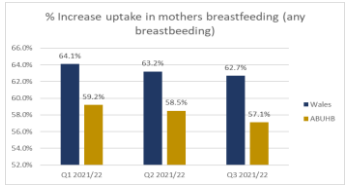
Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 1 - Every child has the best start in life	Improving Good Health in Pregnancy	Decrease in low birth rates	5.6%	4%	2021	5.1%	Improved	Decrease in indicator over the last 3 years. Significantly lower than the all Wales average.
		Decrease in smoking status at birth	16%	10%	2021	13.7%	Improved	Significant decrease between 2020 and 2021.
		Decrease in stillbirths	Indicator to be developed				No data	Indicator to be developed
	Optimising a child's long term potential	Increase update in mothers breastfeeding (any breastfeeding)	59.2%	65%	Q3 2021/22	57.1%	Deteriorated	Decrease in indicator over the last 3 quarters and significantly lower than the welsh average.
		Increase of eligible children measured and weighed at 8 weeks	62.5%	60%	Q3 2021/22	52.3%	Deteriorated	Continued decrease in indicator.
		Increase of eligible children with contact at 3.5 years pre-school	64.4%	60%	Q3 2021/22	59.6%	Deteriorated	Decrease in indicator, however, remains significantly higher than the welsh average.
	Increasing childhood immunisation and preventing outbreaks	Percentage of children who received 2 doses of the MMR vaccine by age 5	91%	95%	Q3 2021/22	90%	Similar	Indicator value has remained stable.
		Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	96%	95%	Q3 2021/22	97%	Similar	Indicator value has remained stable and target has been met.

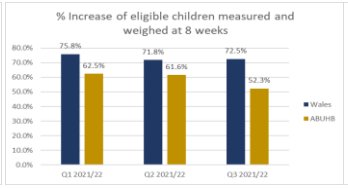
Improving Good Health in Pregnancy

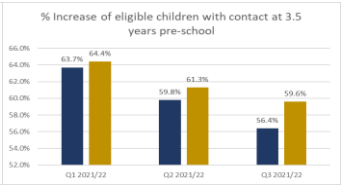




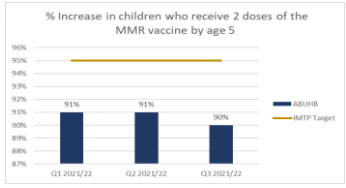
Optimising a child's long term potential

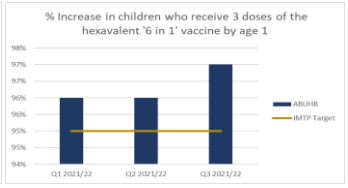




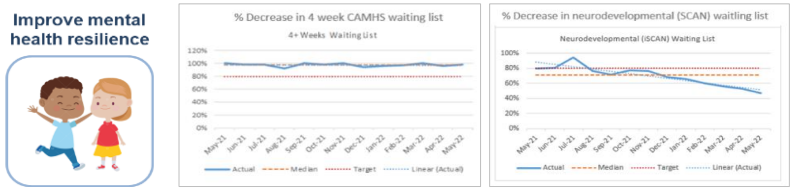


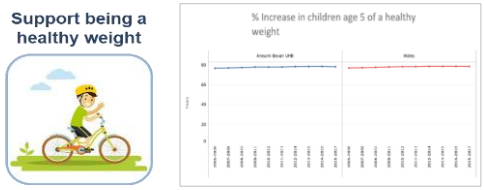
Increasing childhood immunisation

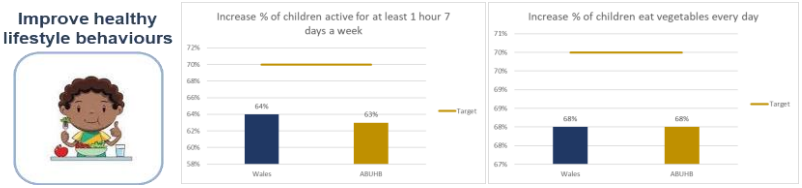




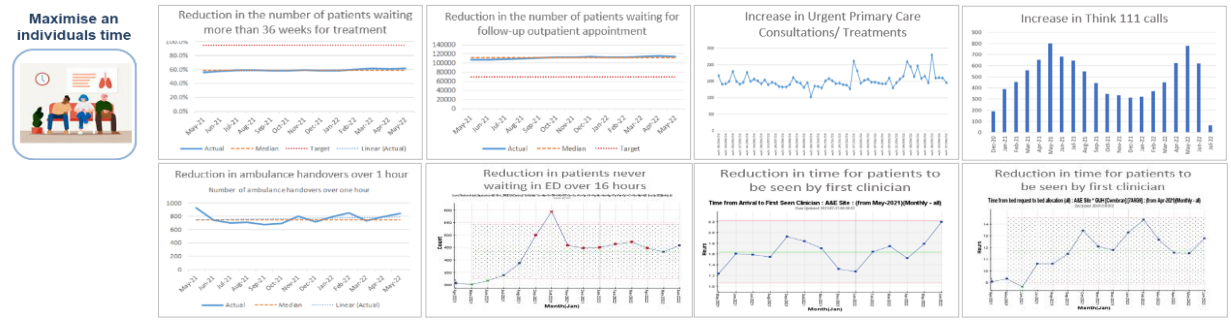
Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 2 - Getting it right for children and young adults	Improve Mental Health Resilience in Children and Young adults	Improvement in the mean mental health wellbeing score for children	Indicator to be developed				No data	Indicator to be developed.
		Decrease in 4 week CAMHS waiting list	95%	80%	Q1 2022/23	98.3%	Improved	Sustained and improved compliance against indicator target. Target met.
		Decrease in neurodevelopmental (SCAN) waiting list	80%	80%	Q1 2022/23	47.3%	Deteriorated	The indicator value has continued to decline since July 2021 due to a significant (103%) increase in demand. A recovery plan is in place to attain target by end of year.
	Support being a healthy weight	Increase in children age 5 of a healthy weight	73.1%	80%	2017	74.9%	Improved	Indicator has shown continued increases since 2006.
		Increase in adolescents of healthy weight	Indicator to be developed				No data	Indicator to be developed.
	Improve healthy lifestyle behaviours	Increase in the percentage of children (aged 2-7 years) who are active for at least 1 hour seven dats a week	62%	70%	2020	63%	Similar	Indicator value has shown signs of improvement.
		Increase in the percentage of children who eat vegetables every day	67%	70%	2020	68%	Similar	Indicator value has shown signs of improvement.

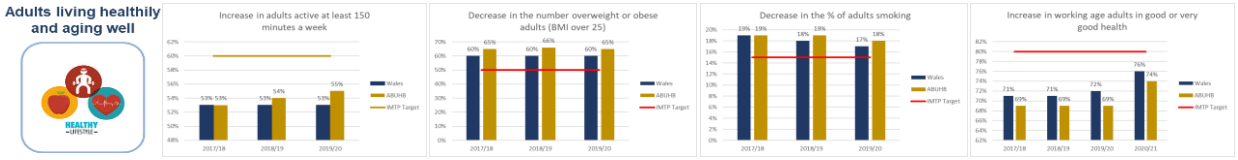


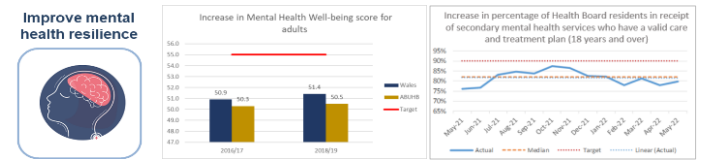


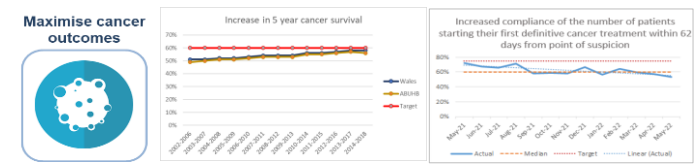


Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 3 - Adults living healthily and aging well	Maximising an individuals time	Reduction in the number of patients waiting more than 36 weeks for treatment	32202	0	Q1 2022/23	32959	Similar	Indicator value has increase during Quarter 1, following the trend oberserved over the last 12 months.
		Reduction in the number of patients waiting for a follow-up outpatient appointment	113107	69268	Q1 2022/23	114624	Similar	Small increase but similar to baseline.
		Increase in Urgent Primary Care Consultations/Treatments	6969	10000	Q1 2022/23	8336	Improved	Significant and continued increase in rate since 2021. On track to meet target.
		Increase in Think 111 calls	493	800	Q1 2022/23	673	Improved	Significant improvement in indicator value since Autumn 2021. On track to meet target.
		Reduction of handovers >1 hour	737	0	Q1 2022/23	793	Deteriorated	Trend reported in the increase in value since 2021. Indicator is breaching target.
		Reduction in patients never waiting in ED over 16 hours	417	0	Q1 2022/23	445	Deteriorated	Continued increase in indicator value. Rate has increased by 6.7% from baseline.
		Reduction in time for patients to be seen by first clinician	1.6 hours	2 hours	Q1 2022/23	1.8 hours	Deteriorated	Continued increase in indicator value. Rate has increased by 12.5% from baseline.
		Reduction in time for bed allocation from request	11.5 hours	8 hours	Q1 2022/23	11.9 hours	Deteriorated	Continued increase in indicator value. Rate has increased by 3.5% from baseline.
	Adults living healthily and aging well	Increase in adults active at least 150 minutes a week	53.0%	60%	2019/20	55%	Improved	Increased and continued improvement rate (1% year on year). Indicator value is consistently performing higher than the all Wales average.
		Decrease in the % of adults smoking	19%	15%	2019/20	18%	Improved	Decreased in indicator value, although remains higher than the all Wales average.
		Decrease in the number overweight or obese adults (BMI over 25)	65%	50%	2019/20	65%	Similar	No change observed.
		Increase in working age adults in good or very good health	69%	80%	2020/21	74%	Improved	Significant improvement in indicator value (+7.2%) from 2019/20 and 2020/21, however, value remained lower than the all Wales average.
		Increase uptake of National Screening Programmes	Indicator to be developed				No data	
	Improved mental health resilience in adults	Increase in Mental Health Well-being score for adults	50.3%	55	2018/19	50.5%	Similar	Small increase in value.
		Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	80%	90%	Q1 2022/23	78%	Deteriorated	Indicator value has decreased from baseline by -2.5%.
	Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	56.9%	75%	Q1 2022/23	53.4%	Deteriorated	Indicator value has consistently decreased over the last 12 months.
		Increase in 5 year cancer survival	51.0%	60%	2014-2018	58%	Improved	Significant improvements in rate reported over the last 10 years.



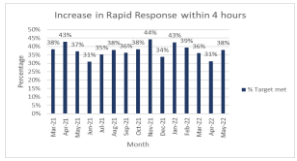


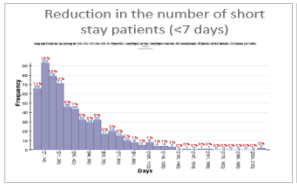


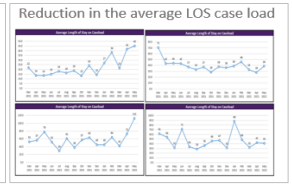


Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 4 - Older adults are supported to live well and independently	Prevention and keeping older adults well	Increase in older people in good health	Indicator to be developed				No data	Indicator to be developed.
	Delivering Care Closer to Home	Increase in Rapid Response within 4 hours	38%	50%	Q1 2022/23	35%	Deteriorated	Decrease in indicator value over the last 12 months across all 4 Local Authority areas (excludes Monouthshire).
		Reduction in the number of short stay patients (<7 days)	12%	5%	Q1 2022/23	11%	Improved	This indicator has improved since 2021/22.
		Reduction in average LOS case load	39.9 days	30 days	Q1 2022/23	52.7 days	Deteriorated	Significant increase (32%) in indicator value.
	Reducing admissions and time spent in hospital	Increase in Admission avoidance (month)	71	100	Q1 2022/23	68	Improved	An improvement in the indicator value across all 4 Local Authority areas (excludes Monmouthshire).
		Decrease (from 65 - 55%) in LOS over 21 days	56%	45%	Q1 2022/23	60%	Deteriorated	Increases in the indicator value since 2021/22.

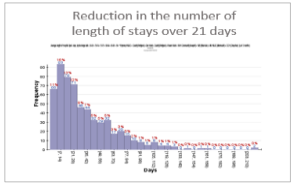
Delivering care closer to home



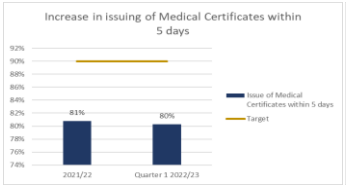


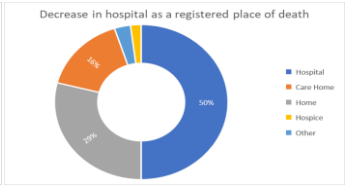


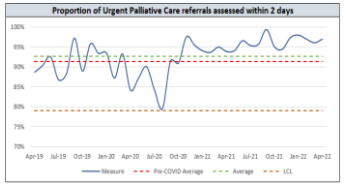
Reducing admissions and time spent in hospital



Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 5 - Dying well as part of life	Improve care at end of life	Decrease in the % of hospital as a place of death	53%	40%	2022	50%	Improved	Decrease reported over the last 3 years.
		Increase in compliance of issuing of Medical Certificates within 5 days	81%	90%	Q1 2022/23	80%	Similar	The reported rate is similar to baseline value and therefore current performance levels have remained. Target to be amended from 5 to 7days.
		Reduction in compliants	Indicator to be developed				No data	Indicator to be developed.
	Improved planning and provision of end of life care	Increase in propotion of Urgent Palliative Care referrals assessed within 2 days	91%	100%	Q1 2022/23	97%	Improved	Signficant improvement in the indicator value since July 2020 and on track to meet target.
		Increase in the number of Advanced Care Plans in place	Indicator to be developed				No data	Indicator to be developed.







Aneurin Bevan University Health Board

General Medical Services Branch Surgery Closure Policy

1.0 DEFINITION OF A BRANCH SURGERY

A subsidiary practice utilising the resources and staff of the parent practice. Usually attended only at specified, limited hours, with the opportunity for a patient to go to the parent practice in an emergency.

2.0 BACKGROUND

This document sets out a draft process for the management of branch surgery closure applications.

A branch surgery can be closed subject to agreement between the Health Board and the providing practice. Whilst there is limited guidance in this regard, the Primary Care Contract Quality Standards relating to "branch / split – site surgeries" (paragraphs 4.53 – 4.59) outlines a process under paragraph 4.56;

"A branch surgery can be closed subject to agreement between the PCO and providing practice. In the event there is no agreement the practice can give notice that it wishes to close its branch surgery. There will be a given period in which the PCO can issue a counter- notice, to allow for any required consultation, requiring the surgery to remain open until the issue is resolved. Normal appeal procedures will apply, or where both the practice and PCO agree that the surgery should remain open, then the PCO is required to continue supporting it with the necessary funding."

The PCO in this instance will be the Health Board.

The Health Board is required to put arrangements in place to consider branch surgery applications. This document describes a process and links to formal NHS appeals mechanism.

All arrangements for considering branch surgery closure applications will be managed by the Primary Care and Community Division.

The Health Board is aware that Aneurin Bevan Community Health Council, as a statutory organisation, could consider a Branch Surgery Closure to be a significant loss of service to the patients accessing services in this venue. The views of the Community Health Council will be presented to the Board independently as part of the decision making process.

3.0 PROCESS FOR CONSIDERING BRANCH SURGERY CLOSURE APPLICATIONS

The rationale for developing this process is to ensure that all interested parties work collaboratively to ensure that the delivery of patient care is paramount in all considerations.

All arrangements for considering branch surgery closure applications will be managed by the Primary Care and Community Division

3.1 A Branch Practice review Panel will be established by the Primary Care and Community Division. This group will be responsible for the decision process, the end result of which will be a recommendation to proceed with the appropriate option for the branch practice.

Proposed membership of the Branch Practice review Panel is:

- ABUHB Divisional Director Primary Care & Networks / General Manager
- ABUHB Deputy Medical Director (General Practice) / Primary Care Clinical Director
- ABUHB Head of Primary Care / Deputy Head of Primary Care
- Senior Primary Care Manager
- Neighbourhood Care Network Lead / Head of Service
- Local Medical Committee (LMC) representative (voting rights)
- Aneurin Bevan Community Health Council (ABCHC) representative (Non-voting)
- Other Primary Care colleagues involved in the process
- Additional representatives may be invited as per local agreement and decision.

4.0 NOTIFICATION AND MANAGEMENT OF REQUEST TO CLOSE BRANCH PRACTICE

The practice formally writes to the Health Board with their request to close a branch surgery, detailing:

- Reasons for the proposed closure request including an up to date sustainability report (the income streams information is not required for the purposes of this process)
- Detail on any estate issues
- Opening times and surgery times of the branch and main surgeries
- Current access rates
- The list size of the practice
- Number of patients accessing the surgery services in the last three years, broken down by month
- Number of patients that have accessed services at the branch site alone in the last three years, broken down by month. Where the Practice is unable to identify patients who use the Branch Surgery,

then all patients registered with the practice will need to be consulted with

- Services that are currently being provided from the branch surgery
- Impact the closure will have on patients and services at the main site
- Proposals for how the information will be communicated to patients if the closure application is approved
- Details of the timing of the closure if approved, i.e. a phased closure.
- Details of any engagement already undertaken with key stakeholders including NCNs and neighbouring practices
- Impact on patients including consideration to vulnerable groups.

The Primary Care Team will:

1. Acknowledge the request for closure in writing within 5 working days of receipt and inform Aneurin Bevan Community Health Council and the Local Medical Committee that this has been received, asking for their views on the application.

   The Primary Care Team, in conjunction with the Practice will also identify the following:
   - Premises infrastructure concerns, i.e. costs to meet DDA compliance, statutory regulations compliance
   - Any other purpose for which the branch surgery is used
   - Details of the nearest GP practices and pharmacies. This should be presented on a map
   - Any proposed changes to services at the main practice
   - Details of public transport links from the branch site to the main practice site
   - Conduct and review the outcomes of an Equality Impact Assessment
   - Practice patient distribution map plus boundary maps of neighbouring practices.

2. Escalate the notification internally and establish the timeline for decision making, Branch Surgery Closure process and implementation of the outcome.

3. Issue confidential communication notice to WG, LMC and ABCHC.

4. Inform in confidence, AM/MPs and local councillors, issue patient letters and questionnaires, advising of consultation process.

5. The Primary Care Team will co-ordinate and agree the consultation process with Aneurin Bevan Community Health Council, identifying key stakeholders which may include:

- NCN Leads
- Local Medical Committee
- Aneurin Bevan Community Health Council
- Community Pharmacists in the area
- Other relevant Community Health Councils (outside the Health Board area)
- Other practices in the area which may be impacted upon from the closure
- Local politicians
- Patient Participation Group representation

A patient consultation process will take place, in conjunction with engagement with Local Politicians, using an approved questionnaire and other relevant forms, which will also be available in Welsh. All patients accessing the Branch Surgery will be consulted with. If the practice is unable to identify those patients, then the total practice population will be subject to the patient consultation.

Local drop in sessions for patient consultation may be considered by the Primary Care Team and advertised within the practice, details will also be included on the patient letters.

Consultation should last a minimum of four weeks (extended if this coincides with holiday periods) or the Community Health Council deems a longer period necessary. This will be agreed with the Community Health Council.

The Health Board and practices may choose to progress further patient consultation in addition to the questionnaire, for example attendance at patient forum and/or community group.

The Primary Care Team will progress an Equality Impact Assessment.

The Health Board will inform neighbouring Local Health Boards, of the request, that may be affected by the closure.

Once the consultation is completed the Primary Care Team will collate and review the responses to the questionnaire. A further review will be conducted on the additional information provided by the practice and Primary Care Team.

6. Arrange a Branch Practice Review Panel meeting. A Panel will be convened to consider the application from the Practice, the outcome of the patient consultation, views of Aneurin Bevan Community Health Council and Local Medical Committee, and the Equality Impact Assessment, to make a decision. The Primary Care Team will prepare the information packs and issue these seven days before the panel meeting will take place. The Practice will be offered the opportunity to present their case in the form of a 15 minute presentation during the

course of the meeting so that the panel are briefed and able to ask questions.

7. The Panel will consider the request from the Practice, the outcome of the patient consultation, views of Aneurin Bevan Community Health Council, Local Medical Committee and other interested parties and the recommendation from the Branch Practice Review Panel.

8. Representatives from Aneurin Bevan Community Health Council and Gwent Local Medical Committee (voting rights) will be in attendance to observe the process, ABCHC will not have voting rights.

9. If there is a change to service there will be a requirement that following the approval of the recommendation by the Executive Team, this decision is then considered by the Aneurin Bevan Community Health Council Executive Committee. The timeframe for this will be discussed and agreed accordingly.

10. The decision of the Board or Committee will be notified to all listed stakeholders which will include the practice and interested parties and patients.

    Where the closure application is approved, a clear communication plan will be agreed to ensure all registered patients are informed of the closure and how they will access services from the Practice.

    Practices should ensure a minimum of 3 months' notice following the Board approval to close, unless agreed otherwise with the Health Board.

    Where the closure application is approved it is the responsibility of the practice to meet all associated costs with closing the surgery including redundancy and practice information costs.

    Where an Improvement Grant has been provided to upgrade the premises which are being closed, the Health Board will assess whether this warrants a recovery, advise practice of same and implement a recovery plan.

    Where the closure application is not supported by the Board or Committee, the Primary Care Team will discuss with the Practice the sustainability implications of this decision.

11. Further correspondence to be issued to all stakeholders following the Branch practice review panel including the outcome of the patient consultation.

Each Branch practice review will need to be considered on its individual merits and the local context:

- Health Board Strategic Plan: this will be based on proactive planning from the cluster and sustainability framework
- Local population health needs including distance from other services, demography, local provider assets and other commissioned contractor services.

5.0 APPEALS

Any appeal against the decision of the Board in relation to Branch Surgery Closure applications will be resolved through the contractual appeals process "Contract Dispute Resolution – Part 7 of Schedule 6 to the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004("The Regulations").

The decision of the appeal will be made in consultation with the Community Health Council and the Executive Board.

The decision of the Board or Committee will be notified to all listed stakeholders which will include the practice and interested parties and patients.

OBJECTION FROM ANEURIN BEVAN COMMUNITY HEALTH COUNCIL

The Community Health Council has a right to undertake an independent consultation, should they not consider the Health Board's consultation to be a robust process.

If the Community Health Council objects to the Health Board's decision they have a right of appeal to the Minister for Health and Social Services (as per the Welsh Government Guidance for Engagement and consultation on changes to Health Services).

QUORACY

Review Panel will be quorate when the following are in attendance:
1 Clinical Representative
1 Head/Deputy Head of Primary Care/Senior Primary Care Manager
1 Divisional Director/General Manager
1 Independent Representative LMC/ABCHC

Annex1

PROCESS FOR CONSIDERATION OF BRANCH SURGERY CLOSURE APPLICATION

The practice formally writes to the Health Board with their request to close a branch surgery and provides additional information on access, opening times, impact on patients etc.

↓

The Primary Care Team will:

- Acknowledge the application **within 5** working days.
- Progress further information in conjunction with the practice.
- Inform the Local Medical Committee, Community Health Council and neighbouring Local Health Boards (if required).
- The Health Board will establish a Branch Practice Review Group.

↓

The Primary Care Team will co-ordinate the engagement process. Key stakeholders to include; Patients, Local Medical Committee, Community Health Council, Local Community Groups, Local politicians and Patient Participation Group representation.

↓

The Primary Care Team will implement the engagement process to include Patient Questionnaire and other forms of engagement as required - **Minimum of 4 weeks.**

↓

The Primary Care Team will conduct a Equality Impact Assessment to support the process.

The Primary Care Team will collate and review the responses to the questionnaire.

- The Branch Practice Review Panel will convene to review the application and information provided from patient consultations, Sustainability framework application, Equality Impact Assessment, LMC and CHC views.
- The panel will decide whether or not to support the closure application and make a recommendation for consideration by the Board. The practice will be offered the opportunity to present their case in the form of a 15 minute presentation at the beginning of the meeting.
- Each member of the panel will receive an information pack **7 days** before the date of the panel.

Recommendation from the Branch Surgery Review Panel, with the views of the LMC and Community Health Council(s) will be presented to the Board, who will make the final decision.

The decision of the Board will be notified to the Practice, Patients, Community Health Council(s), Local Medical Committee and neighbouring practices within **1 week.**

Appeal Process if required.

Annex 2

1 Reasons for the proposed closure, including an update on the practice's sustainability status plus any issues relating to your primary care estate i.e. costs to meet DDA compliance, statutory regulations compliance.

2 What are the current opening times of your main surgery and your branch surgery?

3 Practice current list size.

4 Number of patients accessing the **main** surgery services over the last three years, broken down by month.

Services	Year 1	Year 2	Year 3

5 Number of patients that have accessed services at the **branch** site alone in the last three years, broken down by month (if unable to identify these specific patients then all patients will need to be consulted with).

Services	Year 1	Year 2	Year 3

6 Detail on services currently being provided from the branch surgery including a timetable of clinics/services. Please also any other purpose for which the branch surgery is used.

7 What impact will the closure have on patients including vulnerable groups and how it will affect services at the main site?

8 Detail on how this proposal will be communicated to patients if application to close is approved by the Health Board.

9 Detail of any engagement already undertaken with cluster networks and neighbouring practices.

10 Detail of the timing of the closure i.e. will this be a phased closure?

11 Any other relevant information.

Annex 3

Time Frames

Detail of workflow	**Days**	**Timescale**	
Acknowledgement of formal request received from practice including further information if required.	**5 days**	**Within 5 working days**	**Within 5 working days**
Consultation with stakeholders	**4 or 8 weeks**	**By week 5**	**By Week 9**
PC Team to collate and review responses and complete EIA	**5 days**	**By week 11**	**By Week 15**
Panel meeting - documents issued prior to panel	**5 days**	**By week 12**	**By Week 16**
Panel meeting	**1 day**	**By week 13**	**By Week 17**
Inform stakeholders/IP's of recommendation		**By week 13/14**	**By Week 17/18**
Paper to be prepared for Executive Board	**1 day (following Monday after panel)**	**By week 14**	**By Week 18**
Paper to be presented to Executive Board	**1 day**	**By week 14/15**	**By Week 17/18**
Practice and all IPs notified of decision	**1 day (within 5 days of Exec decision)**	**By week 14/15/16**	**By Week 17/18/19**
Patients notified	**1 day**	**By week 14/15/16**	**By Week 17/18/19**

Annex 3

Revised Sustainability Framework Risk Matrix (including guidance notes)

The framework involves applying a Red/Amber/Green (RAG) weighted score against the risk matrix criteria. The following weighting has been applied:

- High/Red -10
- Medium/Amber – 5
- Low/Green - 1

The outcome of the risk assessment matrix score has been set as follows:

- High risk of unsustainability > or = 80
- Medium risk of unsustainability >55 -79
- Low risk of unsustainability <55

Practice:

Area	Indicator	Ranking	Ranking	
Demographics: STAGE 1	Open/closed list	Open	Low	
		Application submitted (formal/informal)	Medium	
		Closed	High	
	Welsh index of multiple deprivation (WIMD % of patients living in the two most deprived fifths)	<10%	Low	
		10 -20%	Medium	
		>20%	High	
	Practice population age spread %	<30% over 65	Low	
		30% - 50% over 65	Medium	
		>50% over 65	High	
Premises: STAGE 1	Number of sites/branch surgeries (to include both open and temporarily closed branch surgeries)	1 site	Low	
		>1 site	Medium	
		>3 sites	High	
	Condition of premises; (practices with more than 1 site will be ranked against a judgement of the total estate condition)	adequate/new or approved funding	Low	
		Poor, but working towards improving	Medium	
		Poor quality	High	
	Capacity of premises	Adequate for current needs only	Low	
		Inadequate to accommodate	High	

		current service needs		
Workforce – General Practitioner: STAGE 1	Partnership/singlehanded	Partnership	Low	
		Singlehanded	High	
	Patients 000's per WTE GP (WTE assumed as 8 sessions)	<2000 patients	Low	
		>2000 patients	Medium	
		>2500	High	
	Age profile (individual GP ages will be used to give an overall rank for age profile. To include all substantive GPs including principles and salaried posts.)	<50 years	Low	
		50-55 years	Medium	
		>55 years	High	
	Current vacancies Linked to % of WTE	<10%	Low	
		10 – 20%	Medium	
		>20%	High	
	Length of vacancies	< 6 months	Low	
		6 months	Medium	
		>6 months	High	
	Reliance on locums (sessions per average week)	<3 sessions	Low	
		3-5 sessions	Medium	
		>5 sessions	High	
Workforce General: STAGE 1	Patient 000's per WTE senior clinician (GP, Advanced Practitioner, Pharmacist etc.)	<2000	Low	
		>2000	Medium	
		>2500	High	
	No of unfilled clinical sessions per week	0	Low	
		<3	Medium	
		>3	High	
Income Streams: STAGE 1	Income loss arising after MPIG redistribution (as a % of GSE)	<10%	Low	
		10%-15%	Medium	
		>15%	High	
Access to Services: STAGE 1	Opening hours (per site) - recent changes (Relating to a reduction in hours only)	No	Low	
		Yes	High	
	Total			

High Risk	>70
Medium Risk	50-70
Low Risk	<50

North Road Branch Closure

Patient Engagement Responses

1 Introduction

The following paper provides information regarding the outcome of the eight-week patient engagement, which was undertaken following the request made by Trosnant Lodge Medical Practice to close their branch site North Road Surgery in Croesyceiliog.

2 Background

The Health Board received an application from Trosnant Lodge Medical Practice, Pontypool, Torfaen North, on 6 April 2022 to close their branch site North Road Surgery in Croesyceiliog. All branch surgery closure requests are subject to consideration under the process for "Considering Branch Surgery Closure Applications".

North Road Surgery is the branch site of Trosnant Lodge Medical Practice. It is open for 5 half days, Monday to Friday, each week and is based in Croesyceiliog, Cwmbran. The branch site is located 4 miles away from the main site. The patient list size for Trosnant Lodge Medical Practice as of 1 April 2022, was 7,282.

The decision on the closure of a branch surgery is the statutory duty of the Health Board as each GP is contracted to the Health Board for the provision of General Medical Services. Whilst there is limited guidance in this regard, paragraph 4.56 of the Primary Care Contract Quality Standards states:

> *"A branch surgery can be closed subject to agreement between the PCO and providing practice. In the event there is no agreement the practice can give notice that it wishes to close a branch surgery. There will be a given period in which the PCO can issue a counter-notice, to allow for any required* engagement*, requiring the surgery to remain open until the issue is resolved. Normal appeal procedures will apply, or where both the practice and the PCO agree that the surgery should remain open, then the PCO is required to continue supporting it with the necessary funding."*

The Primary Care Organisation (PCO) in the Welsh context is the Health Board.

As part of this process, a patient engagement exercise was undertaken to collect the views from patients in respect of how often they use the branch and main surgery, and the transport used to attend the surgeries. It is also used to gauge whether or not patients would have any difficulties in attending the main surgery at Trosnant Lodge Medical Practice and how far patients that use the branch surgery would have to travel to the main surgery.

3 Patient Engagement

The Health Board, in conjunction with the Community Health Council agreed an 8 week engagement period which ran 23 April 2022 to 17 June 2022.

As part of the engagement process, during the week commencing 18 April 2022, a letter was delivered to approximately 6,090 patients aged 16 and over registered with Trosnant Lodge Medical Practice (both the main and branch surgeries). The letter enclosed a QR code to access an online questionnaire using Microsoft Forms. During the engagement period the Health Board also asked Trosnant Lodge Medical Practice to send a reminder text message, with a link to the questionnaire, to every patient where they held a mobile phone number.

The text message reminder helped to improve the volume of engagement responses received and when the engagement period closed we had received 1,305 responses, which was comparative with the number of responses from previous branch closure engagement exercises.

The questionnaire requested the following information:

1. The patient's postcode
2. Does the patient attend the Branch Surgery at North Road, Croesyceiliog to see the Doctor or Nurse?
3. How many times has the patient been seen at the Branch Surgery in the last 12 months?
4. How does the patient normally travel to the Branch Surgery in Croesyceiliog?
5. Does the patient attend the Main Surgery in Pontypool to see the Doctor or Nurse?
6. How many appointments has the patient had at the Main Surgery in the last 12 months?
7. How does the patient normally travel to the Main Surgery in Pontypool?
8. Does the patient have any specific difficulty in accessing the Main Surgery in Pontypool?
9. Does the patient have any secondary concerns?

The questionnaire also asked patients to provide any further information which they felt should be considered as part of the engagement process.

4 Engagement Responses

4.1 Patient Questionnaires Received

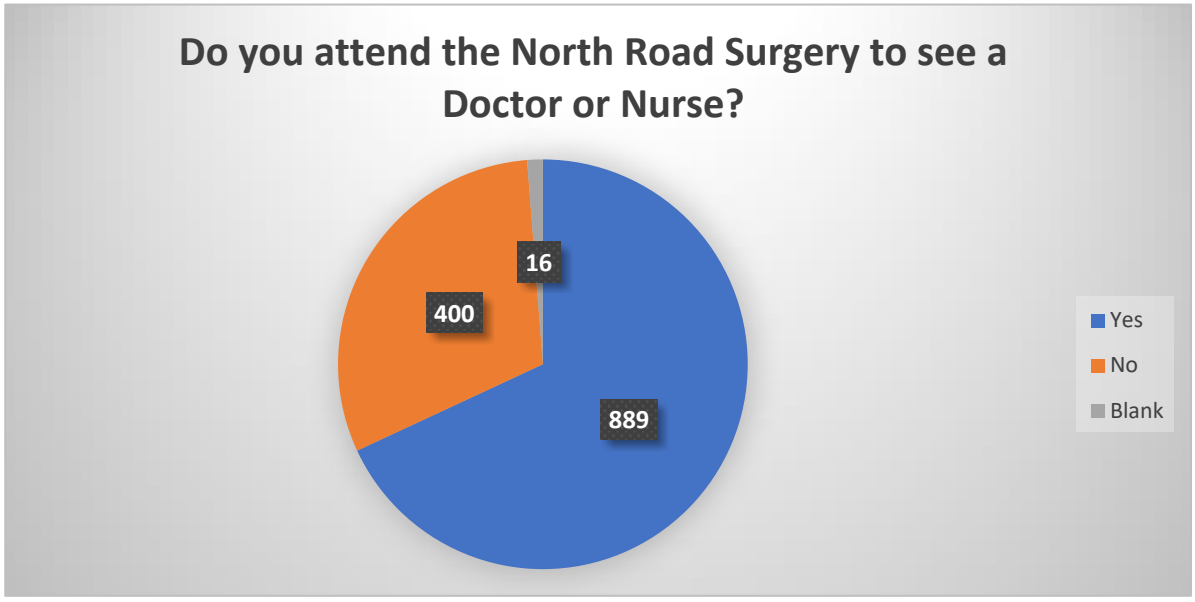
Approximately 6,090 questionnaires were issued to patients over the age of 16 years and 1,305 completed responses were received by the closing date of 17 June 2022, giving a response rate of 21.4%.

Using the information in the responses received, the following analysis was undertaken.

a) Number of patients who attend the North Road Branch Surgery in Croesyceiliog to see a Doctor or Nurse

Of the 1,305 completed responses received, Table 1 illustrates that 889 (68.1%) patients attend the Branch Surgery and 400 (30.7%) patients do not attend the Branch Surgery, 16 (1.2%) patients left the question blank.

Table 1:

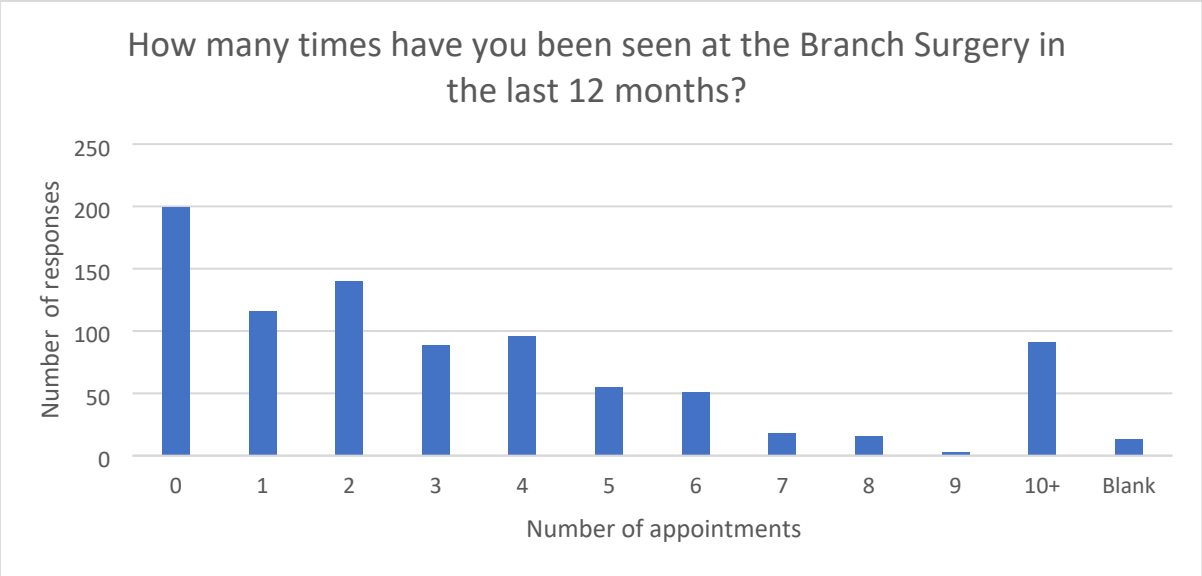


b) How many appointments patients had at North Road Surgery in the last 12 months?

From the 889 patients who confirmed they have attended the branch surgery, 497 (55.9%) patients stated they had between 1 and 5 appointments, 88 (9.9%) stated they have had between 6 and 9 appointments, 91 (10.2%) patients stated they had had 10 or more appointments. 200 patients (22.5%) had not attended the branch surgery in the past 12 months and 13 patients (1.5%) left the question blank.

Table 2 shows how many patients have been seen at the branch surgery in last 12 months.

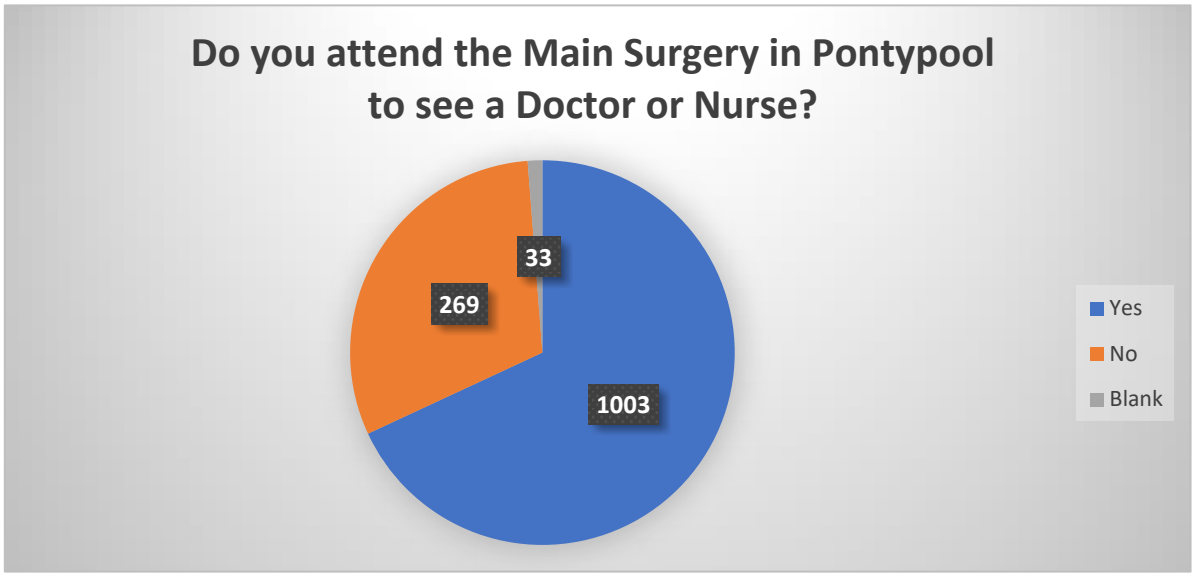
Table 2:



c) Number of patients who attend the Main Surgery in Pontypool to see a Doctor or Nurse

Of the 1,305 completed responses received, Table 3 illustrates that 1,003 (76.9%) patients attend the Main Surgery and 269 (20.6%) patients do not attend the Main Surgery, 33 (2.5%) patients left the question blank.

Table 3:



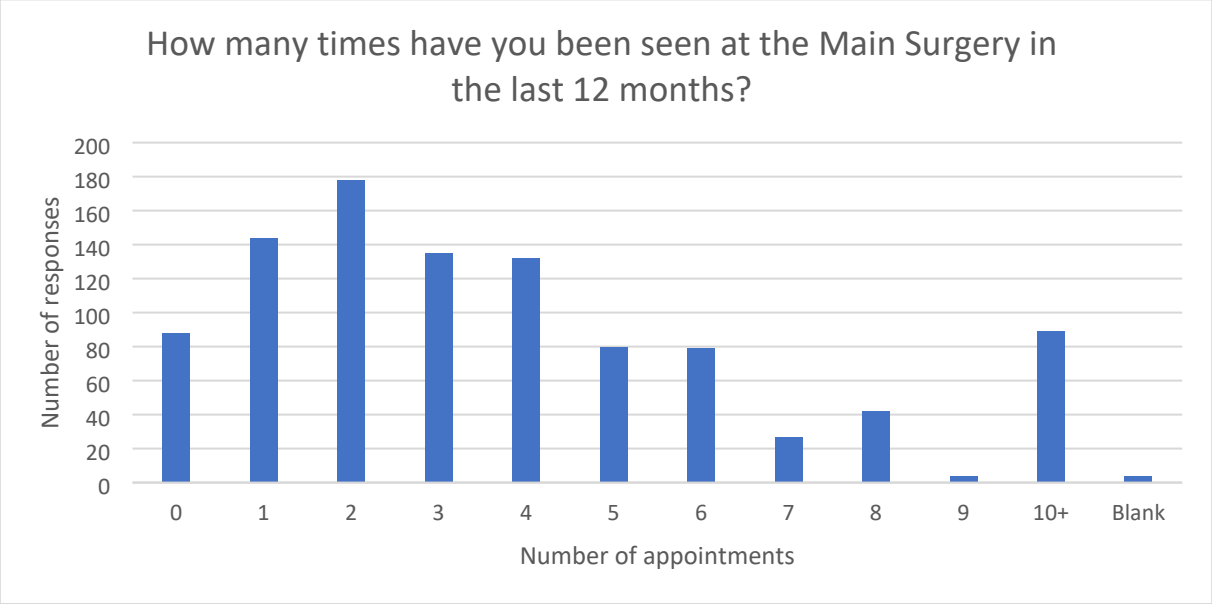
d) If they attend the Main Surgery in Pontypool, how many times they have attended in the last 12 months.

From the 1,003 patients who confirmed they have attended the main surgery, 670 (66.8%) patients stated they had between 1 and 5

appointments, 152 (15.1%) stated they have had between 6 and 9 appointments, 89 (8.9%) patients stated they had had 10 or more appointments. 88 patients (8.8%) had not attended the main surgery in the past 12 months and 4 patients (0.4%) left the question blank.

Table 4 shows how many patients have been seen at the main surgery in last 12 months.

Table 4:

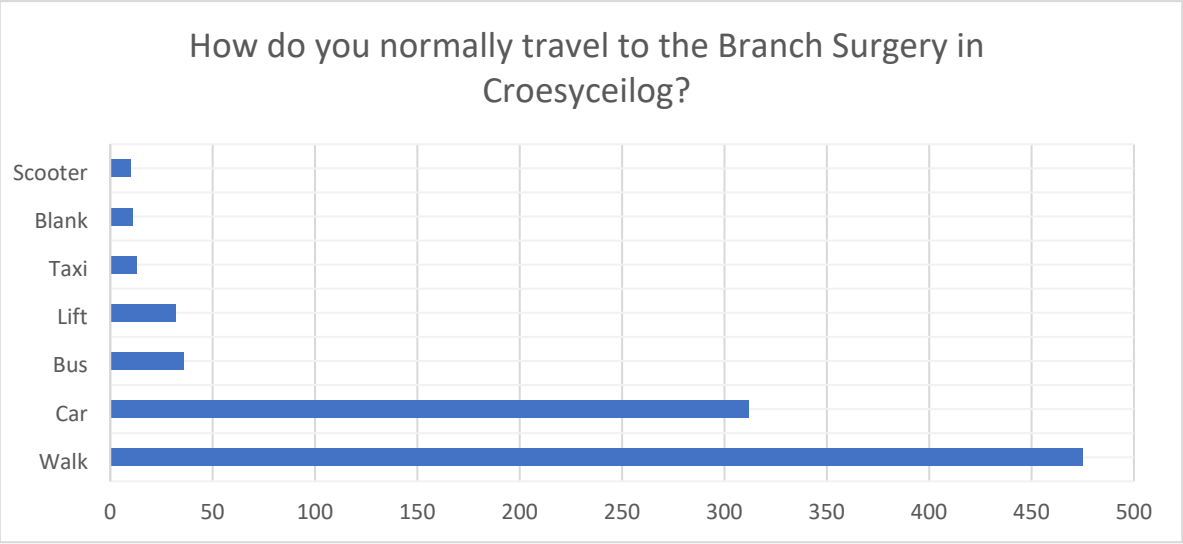


e) Mode of transport to the North Road Branch Surgery in Croesyceiliog

Patients were asked within the questionnaire, what mode of transport they use to get to the Branch Surgery. Table 5 illustrates that of the 889 patients who indicated that they attend the branch site:

- 475 (53.4%) patients walk to the surgery
- 312 (35.1%) patients indicated they drive to the practice
- 36 (4.1%) took the bus
- 32 (3.6%) patients receive a lift
- 13 (1.5%) travelled by taxi
- 11 (1.2%) left the question blank
- 10 (1.1%) patients use a scooter

Table 5:

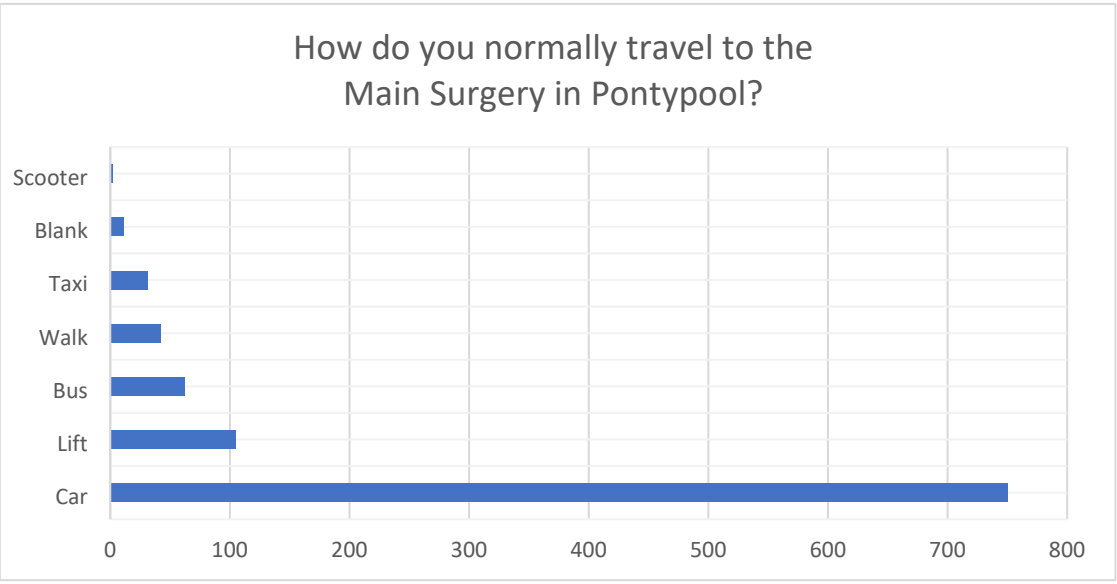


Mode of transport to the Main Surgery in Pontypool

To follow on from question C above, patients were also asked how they access the Main Surgery in Pontypool. Table 6 demonstrates that:

- 750 (74.8%) travelled by car
- 105 (10.4%) patients receive a lift
- 62 (6.2%) took the bus
- 42 (4.2%) pateints highlighted that they walk to the surgery
- 31 (3.1%) travelled by taxi
- 11 (1.1%) left the question blank
- 2 (0.2%) patients rode a scooter

Table 6:

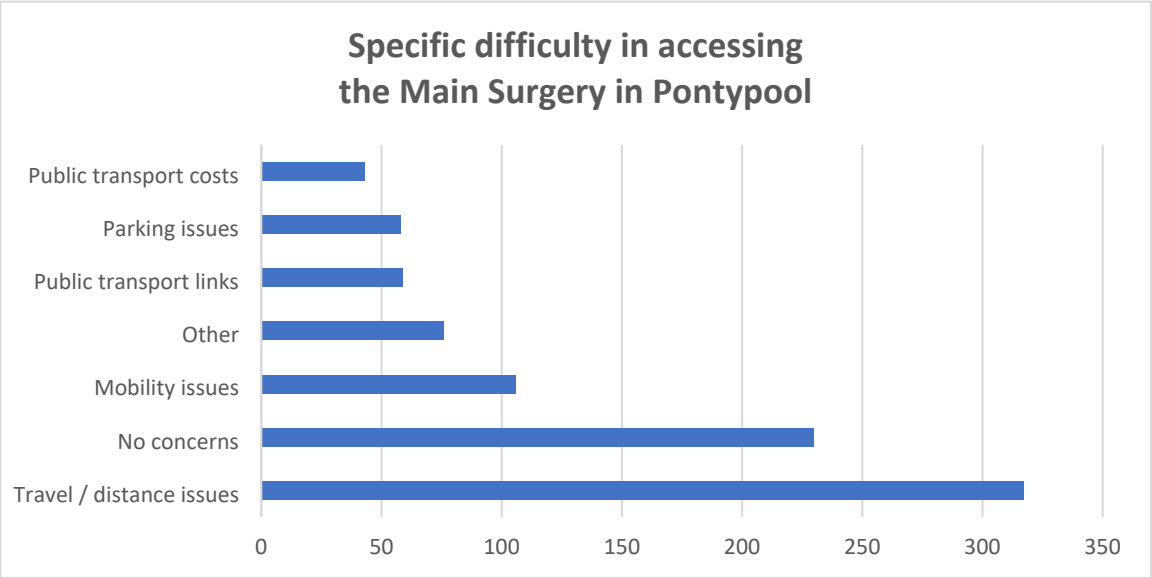


f) Specific difficulty in accessing the Main Surgery in Pontypool

In addition, to the above questions asked, patients were given the opportunity to comment on whether they would have difficulty in accessing the main surgery. Table 7 demonstrates that of the 889 patients who indicated that they **attend the branch site**, 230 (25.9%) patients had no concerns accessing the main surgery. The remaining 659 (74.1%) patients had the following concerns:

- 317 (48.1%) patients have an issue with the distance to travel
- 106 (16.1%) patients have mobility issues
- 59 (9%) patients have an issue with the public transport links
- 58 (8.8%) patients have parking concerns
- 43 (6.5%) patients have an issue with the public transport costs
- Additionally 76 (11.5%) patients have an "other" issue which mostly related to the issues above. There were some different personal issues including anxiety and caring for others.

Table 7:



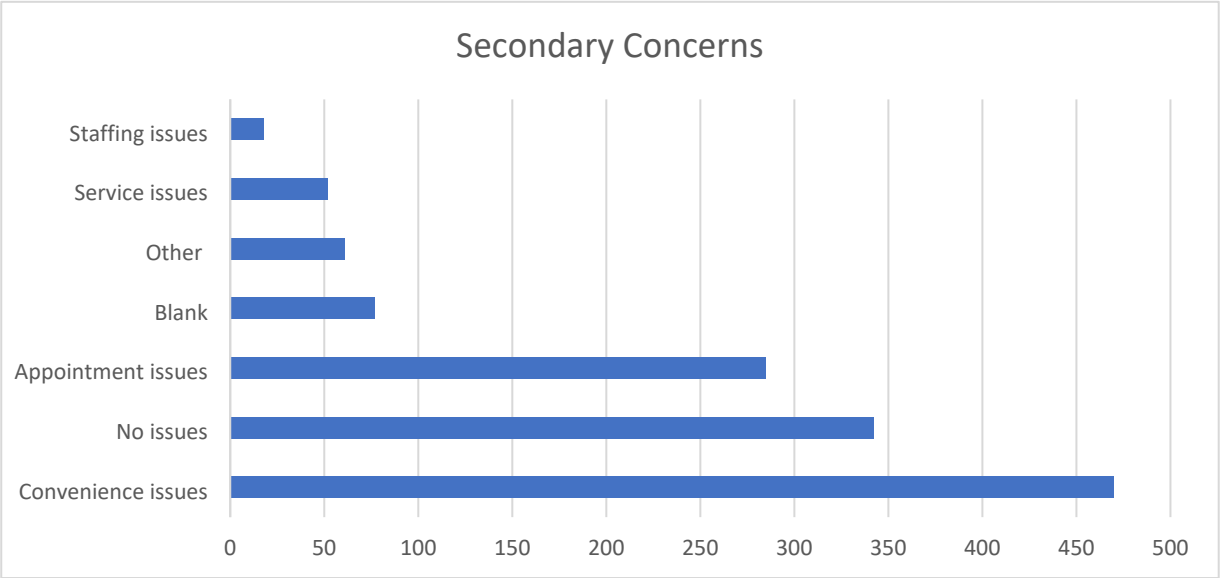
g) Secondary concerns

In addition, to the above question asked, patients were given the opportunity to comment on whether they had any other scondary concerns. There were 1,305 responses which covered the following issues:

- 470 (36%) patients have convenience issues
- 342 (26.2%) patients have no issues
- 285 (21.8%) patients have appointment concerns
- 77 (5.9%) patients left the question blank
- 52 (4%) patients have service issues
- 18 (1.4%) patients have staff issues

- Additionally 61 (4.7%) patients have an "other" issue which again mostly related to the issues above. There were different issues including the cost of petrol and collecting prescriptions.

Table 8:



h) Additional comments from patient questionnaires

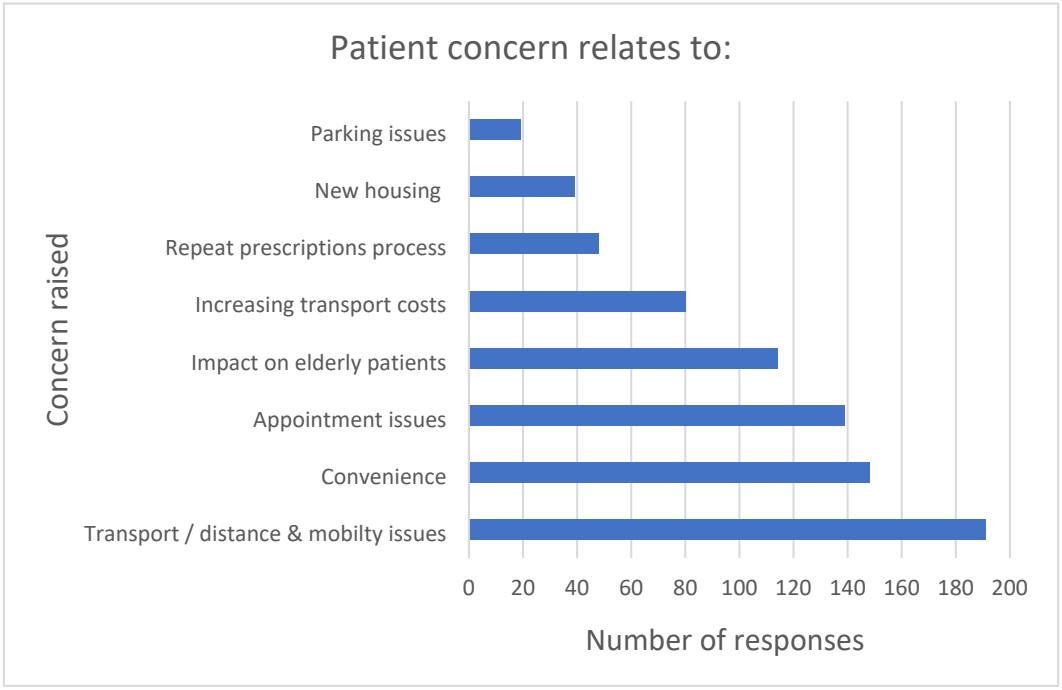
Patients were also given the opportunity to make any **additional comments** on the questionaire. There were 778 (74.3% of all respondents) individual comments .

These comments were categorised and reflect recurring themes, table 9 demonstrates that:

- 191 (24.5%) patients highlighted difficulties with the distance of travelling to Trosnant Lodge Medical Practice due to public transport (catching 2 buses and waiting times), lack of transport and mobility issues. Several elderly patients also mentioned that they were currently able to drive to Pontypool but were think about giving up driving soon.
- 148 (19%) patients raised the branch surgery being convenient, as they were able to walk to North Road. A number of patients mentioned that the loss of the surgery would impinge on their independence.
- 139 (17.9%) patients felt there would be a negative impact on the main surgery if the branch closed, as there would be more people trying to access the main site by telephone and attending for appointments. Also an added pressure on staff due to the increase in demand at one site.
- 114 (14.7%) patients stated the loss of North Road Surgery would significantly impact on them personally as they were elderly or had concerns for the vulnerable people within their community.
- 80 (10.3%) patients raised the increasing cost of travel to the main site including the cost of petrol and taxis.

- 48 (6.2%) patients were concerned that they would not be able to get to Pontypool to submit their repeat prescription request and that the current pharmacies they use in Croesyceiliog will not deliver to their homes.
- 39 (5%) patients mentioned the number of new housing developments in the local area that would increase patient numbers.
- 19 (2.4%) patients highlighted limited parking facilities for disabled people at the main site in Pontypool and the slope in the car park, as the practice is on a hill.

Table 9:



Further to analysing the questionnaires, a patient distribution map of all responses received is included at Appendix E and a patient distribution map highlighting the responses that expressed difficulties in accessing the main site in Pontypool is included at Appendix F.

54 of the total responses had blank or invalid postcodes.

4.2 Public and Political Correspondence

There has been public and political interest in relation to this application and the Primary Care Contracting Team has received concerns directly from members of the public and through local AM/MPs. See Enclosure 6 for briefing paper.

5 Conclusion

Of the 1,305 responses received, 889 (68.1%) patients accessed the North Road Branch Surgery.

This was the first time the Health Board have sent an online questionnaire and the response rate was comparative with previous engagement activities where paper questionnaires have been used, and as such should be judged a success.

A significant number of patients raised concerns regarding the impact if the application is approved including:

- The lack of transport – limited public transport with a need to take 2 buses, waiting times and then a walk to the practice. Other patients have no transport or reliant on others for help with transport.
- Access obtaining an appointment – patients already have long waits for appointments, this will worsen when all Croesyceiliog patients are trying to access Trosnant Lodge too, with an inability to get through on the telephone.
- Distance too far to travel – this includes cost implications for patients reliant on using a taxi and the increasing cost of petrol and diesel.
- Branch site convenience – an aging population with mobility issues.

Appendix E
Patient distribution map of all responses:

Appendix E -
Trosnant Lodge All (

Appendix F
Patient distribution map highlighting the responses that expressed difficulties in accessing the main site in Pontypool:

Appendix F -
Trosnant Lodge con

Report Prepared by:	**Kevin Jones, Primary Care Contracts Manager**
Sponsored by:	**Angela Williams, Service Development Manager**
Date prepared:	**29 June 2022**

Branch Surgery Closure Application – Trosnant Lodge Surgery

North Road Surgery

Business Case

1. Introduction

The Health Board received an application from Trosnant Lodge Surgery, Pontypool, Torfaen North, on 6 April 2022 to close their branch site North Road Surgery, Croesyceiliog, Cwmbran, Torfaen North. All branch surgery closure requests are subject to consideration under the process for "Considering Branch Surgery Closure Applications" (see Enclosure 2).

North Road Surgery is the branch site of Trosnant Lodge Surgery. It is open for 5 mornings per week, 8am – 1pm each day and is based in Croesyceiliog, Cwmbran. The branch site is located 4 miles away from the main site.

Trosnant Lodge Medical Practice is a 3 GP Partner practice with a registered list size of 7,282 at 1 April 2022. The practice is currently providing 23 GP sessions and 5 GP equivalent sessions via their Advanced Nurse Practitioner. Based on the list size the practice should be providing a minimum of 36.4 GP equivalent sessions, a shortfall of 8.4 sessions.

Over the last 2 years, due to GP Partner retirements, the practice has dropped 13 GP sessions.

The practice has advertised during this time for replacement GPs with flexibility on sessions offered, via NHS jobs, Welsh locum GPs, social media, and other sites. They have also tried recruitment agencies recently and have discussed with locums, but no success to date. They are currently reliant on locum GPs to cover some of the lost partner sessions.

North Road Surgery occupies a purpose-built premises. A survey undertaken by Oak Leaf Group in March 2019, and subsequent follow up visit in October 2021 has identified a large amount of improvement works are required to ensure the branch is fit for purpose. The main site can accommodate increased capacity.

At the start of the pandemic, the practice reduced the services at the branch site due to premises constraints which impacted on covid safety measures such as social distancing and one-way systems and the service has largely been nurse led with routine GP appointments pre-arranged as needed. As such, patients have become accustomed to attending the main site in

Pontypool. Additionally, spirometry, coils & implants, minor surgery and shingles vaccinations are only provided from the main site.

Trosnant Lodge Surgery occupies purpose-built premises built late 1980s / early 1990s and is working towards compliance with the Equality Act 2010. The main site can cope with increased capacity and has an adequate waiting area, a car park, and there is additional free parking surrounding the building, with no parking restrictions provided by the local council.

The main site is designed to cater for the needs of their patients and provides a full range of services including chronic disease management, child health surveillance, immunisations, investigations and sexual health clinics. The main site has 5 GP consulting rooms and 2 treatment rooms. Not all GP/clinical rooms at the main site are currently always used due to staff working across the 2 sites.

There are 3 pharmacies in Pontypool Town Centre approximately 0.3 miles away from the main surgery premises, additionally, other local pharmacies collect directly from Trosnant Lodge Surgery. The practice is confident that the pharmacy local to North Road Surgery would continue to provide a collection/delivery service from the main site if the application were approved.

The Primary Care Team advised all interested parties of the application and, in accordance with the process, a period of patient engagement was commenced. The Health Board, in conjunction with the Community Health Council agreed an 8 week stakeholder engagement period which ran 23 April 2022 until 18 June 2022. All patients aged 16 and over were sent a link to the approved electronic questionnaire which provides patients with the opportunity to consider how any potential change in service delivery may affect them.

The Health Board has received 1,305 completed patient engagement questionnaires (see Enclosure 5 for breakdown).

2. Case for Closure

Trosnant Lodge Surgery has cited several difficulties which have led to their decision to apply to close North Road Surgery, and these are documented below:

2.1 Maintaining a Safe and Efficient Service Provision:

- The practice has an insufficient number of clinical staff to cover both sites due to ongoing recruitment difficulties, and over the last 2 years they have lost 13 GP clinical sessions per week.
- Closing the branch would allow the practice to better utilise their resources and allow them to have a greater range of clinical expertise available under one roof, enhancing patient care and safety and provide better continuity of care. For example, spirometry services and some enhanced services can only be performed at the main site.

- The practice has always had a separate team on reception at each site. If a staff member is on long term sick leave, the practice is unable to provide safe staffing levels at each site. By consolidating the services to one site the practice will be able to sustain the full range of services for their patients.
- Many patients residing in Croesyceiliog already travel to Trosnant Lodge Surgery to be seen, as currently there is limited GP provision available in North Road Surgery due to changes made during the pandemic.
- A survey carried out by the Oakleaf Group on behalf of ABUHB in March 2019 has highlighted multiple issues with both surgery premises.
- North Road Surgery was categorised as 'Condition C' in 2019 with significant and moderate improvements required, total £58,819 and a recent valuation of the building has shown that it is only worth £85,000. These changes would therefore cost over 69% of the current value of the building.
- Trosnant Lodge Medical Practice was categorised as 'Condition B' in 2019 with significant and moderate improvements required, total £14,205.
- The partners have already began implementing some of the proposed changes to Trosnant Lodge Surgery such as new flooring, seating covers, a new boiler, decorating and they have recently submitted an improvement grant for 2022/23 to convert 2 admin rooms to clinical rooms. They have also submitted an improvement grant for 2023/24 to install an electric entrance door and alterations to a patient toilet to make compliant with the DDA.

2.2 Recruitment Issues and Sustainability:

- The longstanding senior partner retired in January 2020 and the practice were unable to recruit a replacement GP, therefore recruited a 10 session Advanced Nurse Practitioner to provide 5 GP equivalent sessions.
- Another partner unexpectedly gave notice to retire to the partnership, he subsequently left the practice during March 2022.
- A reduction from 5 GP partners to 3 over the last 2 years has created significant challenges for the practice, particularly when it comes to covering 2 surgery sites.
- The practice has had an advert out for a salaried GP with flexibility on sessions for over 2 years and have been unsuccessful to date.
- The surgery has tried various means of employing a GP including advertisements on NHS Jobs, Welsh Locum GP's, Facebook and other sites. The practice has also become a training practice, has actively

approached regular locums and more recently sought help from Menlo Park Recruitment, but have been unsuccessful in recruiting a GP.

- The practice is currently having to rely on locum GP's to provide core services to their registered population.
- The practice feels locum GPs only have a minimal effect in supporting the practice, as locums will often place restrictions on the number of patients they contractually will agree to see.
- Many locums will not work alone at the branch site due to safety concerns of working alone at an unfamiliar surgery. By condensing services from one site the practice feels these issues would no longer exist and locum staff would be able to support the team better and make the working day safer and more efficient for both staff and patients.

The practice finds themselves in a situation whereby they feel stretching their limited resources across 2 sites is totally unsustainable and they need to consolidate all resources under one roof at Trosnant Lodge Surgery. This should ensure a sustainable and stable practice and workforce that can provide continuity of care to its patients, involving the entire team that will be based on one site. The GP Partners are seriously concerned about how they will continue to provide any service at all should the application to close the branch site be unsuccessful.

The practice boundary would remain un-changed and the practice continues to be committed to treating patients residing in Croesyceiliog. As such, should the application be successful, patients who use North Road Surgery would remain registered with the practice but will need to be seen at Trosnant Lodge Surgery.

Patients who choose not to remain registered would have a choice of five other practices in Cwmbran as below, all of which have open lists (see Appendix D for boundary maps):

- New Chapel Street Surgery
- Clark Avenue Surgery
- Nant Dowlais Health Centre
- Cwmbran Village Surgery
- Oak Street Surgery

The range of services provided from North Road Surgery is limited, and patients would be able to access a wider range of services at the main site, including Long Term Conditions management, minor surgery etc.

The Practice are keen to emphasise that their genuine housebound patients will not be discriminated against and will not be affected by the change should the closure request be approved. Local pharmacies also offer collection and delivery services for prescriptions.

The transfer of all the existing appointments from the branch and the reduction in travel between surgeries, means GPs will be able to increase

their availability to all patients of the practice. It will also be beneficial during the holiday periods when it is difficult for the practice to cover staff on annual leave. Staff that currently work in the branch surgery would re-locate to the main site. 6 Practice Nurse sessions and 2 Phlebotomy sessions would relocate from the branch site to the main site if the application were to be approved.

The practice feels that they would be able to meet the increased demand and call volume at the main site as the reception/admin staffing levels would be transferred from the branch site.

The practice feels that having one site may help attract new GPs to the practice in the future and encourage potential new Partners.

3. Practice Opening Times and Access Standards

The current opening times of the main and branch surgery are as follows:

Trosnant Lodge Surgery (main site):

Day	Opening Times	Lunch Closure	Time of First GP Appointment	Time of Last GP Appointment
Monday	08:00 – 18:30	No	08:30	17:50
Tuesday	08:00 – 18:30	No	08:30	17:50
Wednesday	08:00 – 18:30	No	08:00	17:50
Thursday	08:00 – 18:30	No	08:30	17:50
Friday	08:00 – 18:30	No	08:30	17:50
Total Hours	53			

North Road Surgery (branch site)*:

Day	Opening Times	Lunch Closure	Time of First GP Appointment	Time of Last GP Appointment
Monday	08:00 – 13:00	N/A	N/A	N/A
Tuesday	08:00 – 13:00	N/A	N/A	N/A
Wednesday	08:00 – 13:00	N/A	N/A	N/A
Thursday	08:00 – 13:00	N/A	N/A	N/A
Friday	08:00 – 13:00	N/A	N/A	N/A
Total Hours	25			

*currently nurse led service, and GP appointments as necessary.

Access Standards

The practice did not attain full achievement against all active access standards for the financial year 2021-22.

Group Number	Standard Description	Achievement 2021-2022	Achievement 2020-2021
1	Standard 1 - Phone System	Yes	Yes
1	Standard 2 - Calls Answered	Yes	No
1	Standard 3 - Bilingual Message	No	No
1	Standard 4 - My Health Online	Yes	Yes
1	Standard 5 - Email	Yes	Yes
2	Standard 6 - Informing Patients	Yes	Yes
2	Standard 7 - Appointments	Yes	Yes

The Health Board has linked with the practice to support the Welsh Translation of their recorded welcome message to ensure they achieve this standard moving forward, as achievement of the above standards is a pre-requisite of Phase 2 of the access standards.

Standard 2 – 2 Minute Telephone Response

Practices will not be assessed on their achievement of Standard 2 with achievement assumed and counting towards Group 1 payments. However, like the approach taken with call abandonment, ongoing reporting against this measure will be required to inform understanding of system pressures.

Standard 8 – Demand and Capacity and Patient Satisfaction

Practices will not be assessed on their achievement of Standard 8, with achievement assumed and counting towards Group 2 payments.

4. Patient Population Profile

The list size is 7,282 as of 1 April 2022, with 1,700 (23.3%) of the registered list being aged 65 years and above.

Row Labels	0-4 Yrs	5-9 Yrs	10-14 Yrs	15-19 Yrs	20-24 Yrs	25-29 Yrs	30-34 Yrs	35-39 Yrs	40-44 Yrs	45-49 Yrs	50-54 Yrs	55-59 Yrs	60-64 Yrs	65-69 Yrs	70-74 Yrs	75-79 Yrs	80-84 Yrs	>85 Yrs	All Ages
Grand Total	**306**	**399**	**416**	**395**	**369**	**419**	**461**	**431**	**393**	**407**	**543**	**540**	**503**	**428**	**429**	**360**	**245**	**238**	**7282**
Croesyceiliog North	37	62	54	63	50	61	65	66	68	71	80	86	65	51	52	59	52	64	**1106**
Panteg	39	61	55	57	42	62	62	59	50	52	79	58	57	73	55	50	31	42	**984**
New Inn	27	32	26	35	35	26	41	29	37	37	61	48	46	41	46	48	30	17	**662**
Croesyceiliog South	18	34	39	25	28	18	26	45	26	35	30	47	51	42	53	48	34	39	**638**
Wainfelin	21	24	49	27	20	30	22	37	34	33	37	50	43	34	31	18	10	7	**527**
Trevethin	28	41	42	46	37	30	46	33	28	30	35	37	17	22	23	13	7	3	**518**
Cwmyniscoy	28	26	29	31	25	34	32	28	29	23	41	31	29	20	31	19	8	9	**473**
Brynwern	31	32	31	22	22	34	31	44	21	27	36	21	31	20	26	17	13	12	**471**
Pontypool	16	19	21	13	22	22	26	22	24	26	36	36	36	27	28	15	18	10	**417**
St. Cadocs & Penygarn	18	15	24	25	18	27	27	20	18	21	19	19	20	13	15	10	5	6	**320**
Pontnewynydd	18	15	14	6	13	24	32	13	16	12	10	18	12	9	6	6	4	3	**231**
Snatchwood	13	7	10	12	18	22	17	7	9	9	20	19	16	9	12	4	4	3	**211**
Abersychan	1	2	2	10	9	6	8	4	5	4	12	14	12	7	5	7	2	2	**112**
Pontnewydd	0	3	8	7	5	2	4	3	5	9	12	8	11	8	5	9	5	3	**107**
Llanyrafon North	4	8	2	3	5	3	7	4	8	4	3	7	12	5	5	3	7	1	**91**
Goetre Fawr	0	3	2	1	1	2	3	3	4	4	2	5	6	10	10	7	4	7	**74**
Llantarnam	2	5	2	4	7	3	3	5	2	2	7	4	10	5	5	4	0	0	**70**
Llanyrafon South	1	1	0	0	1	2	4	4	0	1	3	11	5	7	4	7	6	3	**60**
Upper Cwmbran	0	4	1	3	3	2	0	1	2	2	4	5	5	3	2	3	0	1	**41**
Greenmeadow	3	3	2	3	1	0	1	1	2	2	3	0	3	5	3	2	2	0	**36**
Two Locks	0	1	1	1	3	1	0	0	1	1	3	2	5	6	0	5	2	2	**34**
Fairwater	0	0	0	0	3	1	0	1	0	0	4	5	3	3	6	3	0	1	**30**
Llangybi Fawr	0	0	0	0	0	2	3	1	2	1	3	3	5	3	1	2	0	2	**28**
Coed Eva	1	0	0	0	0	2	0	0	0	1	1	2	1	3	5	0	0	0	**16**
St. Dials	0	0	1	0	0	2	1	0	0	0	1	3	2	2	0	0	0	1	**13**
Llanbadoc	0	1	1	1	1	1	0	1	2	0	1	1	0	0	0	1	1	0	**12**

See Appendix A for patient scatter map and practice boundary area.

5. Patients Currently Accessing Services

Appointment activity for the last 3 years:

Year	Trosnant Lodge Surgery (Main site)	North Road Surgery (Branch site)	Total (Both sites)
2019 - 20	21,660 (71.2%)	8,748 (28.8%)	30,408
2020 - 21	36,583 (95.9%)	1,557 (4.1%)	38,140
2021 - 22	40,299 (94.0%)	2,559 (6.0%)	42,858
Totals for 3 year period	98,542 (88.5%)	12,864 (11.5%)	111,406

Figures in the table above include Doctor, Nurse and Health Care Assistant consultations and demonstrate that just over 11% of appointment activity has taken place at the North Road branch site over the past 3 years. It is acknowledged that this has been driven by the pandemic as pre-pandemic contacts were significantly higher. The data also demonstrates how demand has drastically increased since the start of the pandemic with 2021-22 appointment activity seeing a **41%** increase compared to 2019-20 activity.

Current weekly GMS provision provided from North Road Surgery:

North Road Surgery (branch site):

Day	GP	ANP/Nurse Practitioner	Nurse	HCA
Monday	0	0	1	0
Tuesday	0	0	1	1
Wednesday	0	0	1	0
Thursday	0	0	2	0
Friday	0	0	1	1
Total	0	0	6	2

The practice has confirmed that all sessions currently provided from North Road would be transferred to the main site in Pontypool should the application be successful.

6. Services Provided and Impact of Closure

The proposed closure will potentially impact 498 patients who live in Cwmbran and 1,744 patients who live in Croesyceiliog, totalling 2,242 patients, 30.8% of the practice list. However, it is acknowledged that these patients would receive an enhanced level of General Medical Services from the main site in Pontypool, which offers a full range of services and is 4 miles away.

It is recognised that some patients may have further to travel to their appointment should the closure be approved, however patients have become accustomed to travelling to the main site during the pandemic.

7. Workforce

Below is a snapshot of the current clinical workforce:

GP Workforce Stats:

Job Role	Age	Number of Sessions	WTE	GP Actual WTE	GPs Required WTE	GP sessions under
GP Senior Partner	49	8	1	2.88	4.55	13.4
GP Partner	43	8	1			
GP Partner	43	7	0.88			

Additional Practice Employed Clinical Workforce Stats:

Job Role	Age	Hours Worked	WTE	GP Equivalent Sessions
Advanced Nurse Practitioner	53	37.5	37.5	5
Practice Nurse	57	25.5	37.5	N/A
Practice Nurse	37	19	37.5	N/A
Practice Nurse	37	28	37.5	N/A
Health Care Assistant	53	27	37.5	N/A
Phlebotomist	28	20	37.5	N/A
Phlebotomist	27	25	37.5	N/A

The practice has 5 GP equivalent sessions being delivered by extended roles, giving them 28 GP equivalent sessions (3.5 WTE), a shortfall of 8.4 sessions (1.05 WTE).

8. Nearest Primary Care Services

Details of the nearest GP Practices and Community Pharmacies (within 2 miles) are outlined below - a map of neighbouring surgeries and pharmacies are attached, see Appendix B.

The main surgery in Pontypool is 4 miles away from the branch site in Croesyceiliog (NP44 2EN) and is accessible by an approximate 9 minute car journey, 30 minute cycle ride or a 77 minute walk. The bus journey takes approximately 15 minutes direct or 30 minutes changing at Cwmbran Bus Station, dependant on the bus number/route taken.

GP Practices that have an open list and boundary covers Cwmbran, including Croesyceiliog:

GP Practice	Walk time	Distance by Car	Drive time	Public transport options
New Chapel Street Surgery NP44 1DU	22 mins	1.1 mile	4 mins	22 mins (No 2 bus + 1 Gold bus + 11 mins walk)
Clark Avenue Surgery NP44 1RY	17 mins	1.2 miles	4 mins	20 mins (No 30 bus + No 23 + 2 mins walk) **or** 28 mins (No 2 bus + No 8B bus + 2 mins)
Nant Dowlais Health Centre (Greenmeadow Site) NP44 3XQ	26 mins	1.3 miles	4 mins	23 mins (No 2 bus + 6 gold + 4 mins walk) **or** 27 mins (X1 bus + 6 gold + 4 mins walk)
Cwmbran Village Surgery NP44 3JS	26 mins	1.5 miles	5 mins	15 mins (No 2 bus + 6 gold + 2 mins walk) **or** 16 mins (No 30 bus + 6 gold + 6 mins)
Oak Street Surgery NP44 3LT	27 mins	1.6 miles	5 mins	15 mins (No 2 bus + 6 gold + 2 mins) **or** 11 mins (No 30 bus + No 6 bus + 6 mins)

Pharmacies:

- Boots Pharmacy, The Mall, Cwmbran – 1.0 miles
- Boots Pharmacy, 25 Commercial Street, Cwmbran – 1.6 miles
- Lloyds Pharmacy, Maendy Square, Cwmbran – 1.7 miles
- Lloyds Pharmacy, New Street, Cwmbran – 1.1 miles
- Lloyds Pharmacy, Edlogan Square, Cwmbran – 0.4 miles

- Lloyds Pharmacy, Llanyravon, Cwmbran – 1.0 miles
- Pontnewydd Pharmacy, Cwmbran – 1.0 miles

9. Premises and Infrastructure

North Road Surgery has not been used as extensively as the main site during the pandemic, due to issues with social distancing and the inability to introduce a one-way system. There are also steps at one exit point that would prove difficult for wheelchair users.

Trosnant Lodge Medical Practice occupies purpose-built premises built in the late 1980s or early 1990s and the practice have made improvements to comply with the Equality Act 2010. The main site can cope with increased capacity and has an adequate waiting area, a car park, and there is additional roadside parking and other car parks surrounding the building with no parking restrictions.

The main site is designed to cater for the needs of their patients and provides a full range of services including chronic disease management, child health surveillance, immunisations, investigations and enhanced services. The main site has 5 GP consulting rooms and 2 treatment rooms. Not all GP/clinical rooms at the main site are currently always used due to staff working across the 2 sites.

There are pharmacies 0.3 miles away from the main surgery premises in Pontypool Town Centre, additionally, other local pharmacies collect directly from Trosnant Lodge Medical Practice.

10. Public Transport Links

Details of car and local public transport links between North Road branch surgery and the main site in Pontypool can be found in the table below.

	Distance from North Road to Trosnant Lodge
Distance by Car	4.0 miles
Timescale by Car	9 minutes
Bus service (2 buses)	Service 002 (Stagecoach service from Croesyceiliog with numerous stops to Cwmbran Bus Station) then Service X24 (Stagecoach service from Cwmbran Bus

	Station to Blaenavon) **or** Service 021 (Stagecoach service from Cwmbran Bus Station to Blackwood)
Bus Timetable	**Out** from Croesyceiliog to Cwmbran Bus Station: Service 002 from North Road at 7:20 and 7:50 then 2 times per hour at same time each hour until 18:50. It is also possible to walk to Cwmbran Bus Station, in 10 to 20 minutes from Croesyceiliog. X24 out from Cwmbran Bus Station to Blaenavon, exiting the bus at Pontypool Town Hall, then a 4-minute walk to Trosnant Health Centre. Regular service at 7:45, 8:00, 8:18, 8:34, 8:49 then 4 times per hour at :04, :19, :34, :49 each hour then 19:07 and 19:22 **or** 021 out from Cwmbran Bus Station to Blackwood, exiting the bus at Pontypool Town Hall, then a 4-minute walk to Trosnant Health Centre. Service every hour 8:05, 9:10, 10:15 then every hour at :15 until 3:15 then 16:20 ending at 17:30. **Return** from Pontypool Town Hall to Cwmbran Bus Station: X24 Service starts at Pontypool Town Hill at 8:27, 8:42, 8:57, 9:12 then 4 times an hour at :27, :42, :57 and :12 until 15:41, 15:59, 16:14, 16:29, 16:45, 17:00, 17:15, 17:31, 17:39, 17:52, 18:05, 18:22, 18:35, 18:51, 19:02, 19:21 **or** 021 Service starts at Pontypool Market Square at 8:25 then 8:40, 9:50, then every hour :50 until 14:50 then 15:54, 17:02, 18:05 and last bus at 19:04 Return Cwmbran Bus Station to Croesyceiliog: 002 service starts at 8:15 then 8:45 and then 2 times an hour at :15 and :45, with the last bus at 18:45.
Timescale by bus	Approximately 5 minutes between Croesyceiliog and Cwmbran Bus Station, then 20 minutes to Pontypool House followed by a 5 minute walk. The journey time

	is approximately 30 minutes plus waiting time at Cwmbran Bus Station. The timescale will be similar for the return.

There are additional direct bus services between Croesyceiliog and Cwmbran Bus Station.

The 30 Service is operated by Phil Anslow Travel. There are pickups in Croesyceiliog at 8:43, 9:43, 10:43, 11:43, 13:43, 15:08, 16:08 and 17:08. The bus returns at 9:17, 10:17, 11:17, 13:17, 14:17, 15:27 and 16:42 from Pontypool Town Hall. The journey takes about 15 minutes.

The 63 Service is also operated by Phil Anslow Travel. There are pickups in Croesyceiliog at 7:20, 10:13, 13:13 and 16:43. The bus returns at 9:15, 12:15 and 16:25 from Pontypool Town Hall. The journey takes about 20 minutes.

Bus timetables can be found at Appendix C.

11. Options

1) Continue to provide services over two sites – this could pose a high risk to the sustainability of the main site due to the recruitment issues the partners are facing.

2) Close the branch site. Staff and services will transfer to the main site. Patients would also be transferred to main site.

12. Risks

- If the application is not approved there is a risk the practice may become unsustainable in the current climate and give notice on their contract to provide GMS services.
- Due to the demand in operating over two sites it could become difficult to obtain a balance between service provision and patient demand, and compromise the ability to deliver a safe, effective, and responsive service.
- Impact on neighbouring practices if patients decide to register elsewhere if the decision is made to close the branch.

- Vulnerable patients not being able to easily access GP services if the decision is made to close the branch.

13. Conclusion

Practice comment:

Trosnant Lodge Medical Practice provides patients with superior facilities and environment with improved access. By consolidating the available resources, we believe the practice would be able to provide a more equitable and efficient service to its patients from the one site.

The GP Partners are seriously concerned about how they will continue to provide any service at all should the application to close the branch site be unsuccessful. The GP Partners have asked for panel members to consider the content of the application.

Panel members are requested to consider the application and make a recommendation. The recommendation will require ratification by the Board. If a closure is recommended, normal practice would be for 3 months' notice of closure to apply.

Report Prepared by: **Kevin Jones, Primary Care Contracts Manager**

Sponsored by: **Angela Williams, Service Development Manager**

Date prepared: **29 June 2022**

Appendix A

ENC 3 - App A Boundary W93055 w

Appendix B

ENC 3 - App B Boundary W93055 w

Appendix C

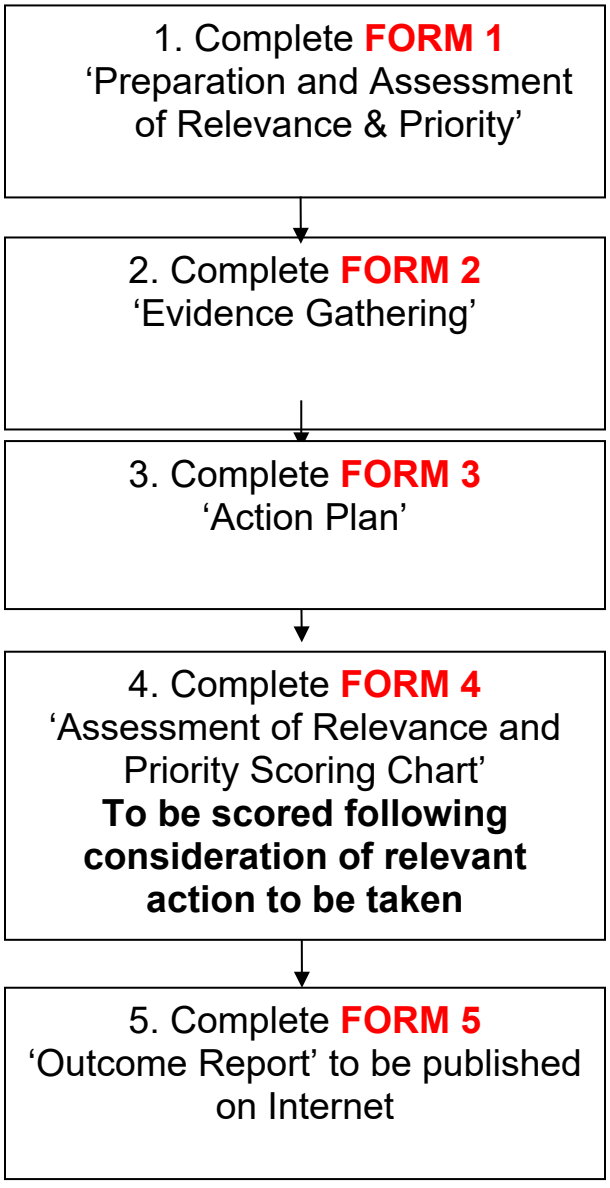
ENC 3 - App C Bus timetables.pdf

Appendix D

ENC 3 - App D Local Practices - Boundary

Aneurin Bevan University Health Board

Procedure for the Completion of Equality Impact Assessment



FORM 1

Equality Impact Assessment (EqIA)

Form 1

Part A: Preparation and Assessment of Relevance & Priority

Step1: Preparation

Title of Policy/strategy/action plan/proposal – North Road Branch Surgery Closure Application

1. What are you equality impact assessing?

Assessing the impact of the proposed closure of the branch site of North Road Branch Surgery located in Croesyceiliog and who will be affected by the closure:

- Community
- Patients
- Staff
- Main surgery
- Local Pharmacies
- Neighbouring practices
- Suppliers
- Premises Landlord

2. Policy Aims and Brief Description - What are its aims, give a brief description.

Aim:
To identify what the impact will be if the application to close the branch site is approved.

Objectives:

- Analyse responses from the patient questionnaire
- Consider access at the main site (demand and capacity)
- Consider demands on neighbouring practices

Background:
Premises:

- North Road Surgery is a branch site of Trosnant Lodge Medical Practice. The patient list size for Trosnant Lodge Medical Practice as of the 1 April 2022 is 7,282 and approximately 2,242 patients live in the Cwmbran/Croesyceiliog area.

Reasons for closure stated as:
Maintaining a Safe and Efficient Service Provision:

- The practice has an insufficient number of clinical staff to cover both sites due to ongoing recruitment difficulties, and over the last 2 years they have lost 13 GP clinical sessions per week.
- Closing the branch would allow the practice to better utilise their resources and allow them to have a greater range of clinical expertise available under one roof, enhancing patient care and safety and provide better continuity of care. For example, spirometry services can only be performed at the main site.
- The practice has a separate team on reception at each site. If a staff member is on long term sick leave, the practice is unable to provide safe staffing levels at each site. By consolidating the services to one site the practice will be able to sustain the full range of services for their patients.
- Many patients residing in Croesyceiliog already travel to Trosnant Lodge Medical Practice to be seen, as currently there is no GP provision available in North Road Surgery due to changes made during the pandemic.
- A survey conducted by the Oakleaf Group on behalf of ABUHB in March 2019 has highlighted multiple issues with both surgery premises:
- North Road Surgery was categorised as 'Condition C' in 2019 with significant and moderate improvements required, total £58,819 and a recent valuation of the building has shown that it is only worth £85,000. These changes would therefore cost over 69% of the current value of the building.
- Trosnant Lodge Medical Practice was categorised as 'Condition B' in 2019 with significant and moderate improvements required, total £14,205.
- The partners have already began implementing some of the proposed changes to Trosnant Lodge Surgery such as new flooring, seating covers, a new boiler, decorating and they have recently submitted an improvement grant for 2022/23 to convert 2 admin rooms to clinical rooms. They have also submitted an improvement grant for 2023/24 to install an electric entrance door and alterations to a patient toilet to make compliant with the DDA.

Recruitment Issues and Sustainability:

- The senior partner retired in January 2020 and the practice were unable to recruit a replacement GP, therefore employed a full time

Advanced Nurse Practitioner providing 10 sessions (5 GP equivalent sessions).

- Another GP partner unexpectedly gave notice on his partnership and subsequently retired from the practice at the end of March 2022.
- A drop from 5 GP partners to 3 over the last 2 years has created significant challenges for the practice, particularly when it comes to covering 2 surgery sites.
- The practice has had an advert out for a salaried GP offering flexibility on sessions, running for over 2 years, and more recently have sought help from an employment agency, the practice has been unsuccessful replacing the 2 GP partners.
- The surgery has tried many means of employing a GP which include advertisements on NHS Jobs, Welsh Locum GPs, Facebook, and other sites. The practice has also become a training practice, actively approached regular locums, and more recently, sought help from Menlo Park Recruitment, but have been unsuccessful in recruiting a GP to date.
- The practice is currently having to rely on locum GPs to provide a core service to their patients.
- The practice feels locum GPs only have a minimal effect in supporting the practice, as locums will often place restrictions on the number of patients they contractually will agree to see.
- Many locums will not work alone at the branch site due to safety concerns of working alone at an unfamiliar surgery. By condensing services from one site the practice feels these issues would no longer exist and locum staff would be able to support the team better and make the working day safer and more efficient for both staff and patients.
- The practice finds themselves in a situation whereby they feel stretching their limited resources across 2 sites is totally unsustainable and they need to consolidate all resources under one roof at Trosnant Lodge Surgery. This should ensure a sustainable and stable practice and workforce that can provide continuity of care to its patients, involving the entire team that will be based on one site. The GP Partners are seriously concerned about how they will continue to provide any service at all should the application to close the branch site be unsuccessful.
- The practice boundary would remain un-changed and the practice continues to be committed to treating patients residing in Croesyceiliog. As such, should the application be successful, patients who use North Road Surgery would remain registered with the practice but will need to be seen at Trosnant Lodge Surgery.
- Patients who choose not to remain registered would have a choice of five other practices in Cwmbran as below, all of which have open lists:

- New Chapel Street Surgery
- Clark Avenue Surgery
- Nant Dowlais Health Centre
- Cwmbran Village Surgery
- Oak Street Surgery

- The range of services provided from North Road Surgery is restricted. Patients would be able to access a wider range of clinics/services at the main site, including Long Term Conditions management and some enhanced services such as minor surgery.
- The Practice are keen to emphasize that their genuine housebound patients will not be discriminated against and will not be affected by the change should the closure request be approved. Local pharmacies also offer collection and delivery services for prescriptions.
- The transfer of all the existing appointments from the branch and the reduction in travel between surgeries, means GPs will be able to increase their availability to all patients of the practice. It will also be beneficial during the holiday periods when it is difficult for the practice to cover staff on annual leave. Staff that currently work in the branch surgery would re-locate to the main site. 6 Practice Nurse sessions and 2 Health Care Assistant sessions would relocate from the branch site to the main site if the application were to be approved.
- The practice feels that they would be able to meet the increased demand and call volume at the main site as the reception/admin staffing levels would be transferred from the branch site.
- The practice feels that having one site may help attract new GPs to the practice in the future and encourage potential new Partners.

3. Who Owns the Proposal? -
Who is responsible for the work?

Decision Maker: Branch Closure Panel/Board
Owner: Divisional Director of Primary Care & Community Services Division

4. Who is involved in undertaking this EqIA? - Who are the key contributors to the EqIA and what are their roles in the process?

The following parties have been involved in determining the application to close the branch site:

Branch Closure Panel Members (includes the following):

- Divisional Director Primary Care & Networks
- Deputy Medical Director/Clinical Director
- Community Health Council (non-voting)
- Local Medical Committee (non-voting)
- Head of Primary Care
- Senior Primary Care Manager
- NCN Lead

Decision of the application to be ratified by the Aneurin Bevan University Health Board

5. Other Policies- Describe where this policy/work fits in a wider context.

The National Health Service (General Medical Service Contracts) (Wales) Regulations 2004

Welsh Health Circular (2006) 063: General Medical Services Practice Vacancies – a Guide to Good Practice

ABUHB's Process for Considering Branch Surgery Closure Applications

6. Stakeholders – Who is involved with or affected by this policy?

- Patients
- Staff
- North Road Surgery
- Local Pharmacies
- Local Practices
- Community Health Council
- Local Medical Committee
- Premises Landlord
- Trosnant Lodge Medical Practice

7. What factors may contribute to the outcomes of the policy? What factors may detract from the outcomes? These could be internal or external factors.

Factors that have contributed to the impact:

The Aneurin Bevan University Health Board (ABUHB) has:

- Communicated the Regulations and issues with members of the Branch Closure Panel and regarding the application submitted by Trosnant Lodge Medical Practice.

- As part of the process an 8-week patient engagement exercise was undertaken, questionnaires circulated, and responses collated to identify any potential difficulties in accessing the main site. English and Welsh versions of the letter/questionnaire were sent to registered patients over the age of 16 years. ABUHB has also undertaken an analysis of all responses. Drop-in sessions were considered but in agreement with the CHC it was felt to be inappropriate in the current climate. Patient feedback will be sought during the outcome notification process including demographic details.

- Communication was sent to interested parties informing of the application received and the process to be undertaken, (local practices and pharmacies, Torfaen NCNs, Community Health Council, LMC, Local Councilors, MPs, and AMs).

Benefits of Closure

- Trosnant Lodge Medical Practice is having improvements to become a Disability Discrimination Act (DDA) compliant building, which will offer improved access to GMS services.

- The transfer of all the existing appointments from the branch and the reduction in travel between surgeries, means GPs will be able to increase their availability to all patients of the practice. It will also be beneficial during the holiday periods when it is difficult for the practice to cover staff on annual leave. Staff that currently work in the branch surgery would re-locate to the main site.

- The range of services provided from North Road Surgery is restricted. Patients would be able to access a wider range of clinics/services at the main site, including Long Term Conditions management and enhanced services such as minor surgery.

- Consolidating all resources under one roof at Trosnant Lodge Medical Practice should ensure a sustainable and stable practice and workforce that can provide continuity of care to its patients, involving the entire team that will be based on one site. It may also help with recruitment of new GPs/GP Partners to the practice.

Negatives of Closure:

- The questionnaire responses identified that 317 patients would have difficulties with the distance of travelling to Trosnant Lodge Medical Practice due to public transport, lack of transport, affordability of taxis and mobility issues. 269 patients responded on the engagement questionnaire that they had never attended the main site in Pontypool. Although some patients have answered "no" to attending

the main surgery they have subsequently provided a figure for the number of visits to the site.

- The questionnaire responses identified concerns from patients who use Trosnant Lodge Medical Practice, as they feel there would be added pressure with more patients trying to access appointments at the main site via the telephone and in person. Also, an added pressure on staff due to the increase in demand at one site.
- Inconvenience to patients.
- Financial implications to some patients who would be reliant on public transport or taxi fare costs. Additionally increased fuel consumption and expense for those patients with their own transport.
- Some patients felt others would be vulnerable without a service, and the distance would prevent them accessing the surgery when necessary to address their needs.
- May impact on other healthcare services e.g., if a patient cannot get an appointment more likely to increase burden on secondary care.
- Further to travel for patients to submit their repeat prescription request or urine samples.

Next Steps

For the next stage of the EqIA process please see form:
Part A, Step 2 - Evidence Gathering.

FORM 2

Aneurin Bevan University Health Board
Equality Impact Assessment: Part A Step 2 Evidence Gathering
Proposal – Application to close North Road Branch Site

Equality Strand	Evidence Gathered	Does the evidence apply to the following with regard to this work? Tick as appropriate								
		Harassment		Promoting Equality of Opportunity		Promoting Good Relations and Positive Attitudes		Encouraging Participation in Public Life	Taking account of difference even if it involves treating some individuals more favorably*	
Race	There is no evidence to suggest that race is relevant to this process and patients will not be discriminated against on the service change.			√		√		√		
Disability	There is evidence disabled people may be disadvantaged if reasonable adjustments are not made. This process will therefore, take into consideration a patient's disability when reviewing the application and questionnaire responses as to whether the patient would have difficulty in accessing GMS services from main site if branch site closes.					√				√
Gender	There is no evidence to suggest that gender is relevant to this process and patients will not be discriminated against on the service change.			√		√		√		
Sexual Orientation	There is no evidence to suggest that sexual orientation is relevant to this process and patients will not be discriminated against on the service change.			√		√		√		
Age	There is evidence to suggest that frail and elderly people may be disadvantaged if appropriate provision is not available. This process will therefore take into consideration questionnaire responses as to whether the patient would have difficulty in accessing GMS services from main site if branch site closes.					√				
Religion/ Belief	There is no evidence to suggest that Religion/Belief is relevant to this process and patients will not be discriminated against on the service change.			√		√		√		

Welsh Language	It is recognised that in accordance with the statutory requirements of the Welsh Language Measure (2011), patients have the right to have all information in Welsh. Decisions on each application can be translated into Welsh.				√		√		√		
Human Rights	There is no evidence that Human Rights issues are relevant to this process and patients will not be discriminated against on the service change.										

FORM 3

Aneurin Bevan University Health Board
Equality Impact Assessment Action Plan

Name of Proposal: Assessing the impact of the proposed closure of the North Road branch site

Recommendation	Expected Outcome	Response	Responsible person	Progress to date
Health Board to collate all the questionnaire responses submitted from patients and other relevant information which includes comments received from interested parties.	The panel will be informed of comments and the questionnaire responses and key themes identified.	Health Board to arrange a panel meeting to consider application and impact.	Divisional Director of Primary Care and Community Services	**Completed:** • Application received and acknowledged • Letters and questionnaire sent to patients informing of the application request • EqIA on the process undertaken • Patient questionnaire responses collated and analysed • Business case drafted
Consider business case.	Decision to be made on the application from the evidence provided: • Practice to present their case for closure • Business Case • Engagement responses • EqIA.	The decision will be recommended to the Board for ratification. The practice, patients and interested parties will then be informed of the decision. If the application is approved patients will be informed they have the choice to remain with Trosnant Lodge Medical Practice or register with an		**Further Action:** • Panel convened for 05/07/2022. Practice representatives will be in attendance to present their case. • Report to Board for ratification. • Inform practice, patients and interested parties of Board's decision. • If closure approved confirm date of closure. • Inform SSP of closure. • Practice to administrate closure.

The Health Board to communicate the decision made by the Board to practice, patients and interested parties.	Ensure that the practice have been informed of the decision by the Health Board. Ensure all patients and interested parties have been consulted regarding the outcome of the Board decision.	alternative GP of their choice. The Health Board to send a letter to the GPs regarding the outcome of the application. The Health Board to send a letter to all patients and interested parties regarding the outcome of the application.		**Actions:** • Draft a letter to inform GP Practice. • Draft Patient letter informing them of outcome. • Draft interested parties' letters. • Patients letter to be distributed via SSP. • The Health Board to send out letter to interested parties.

FORM 4

Aneurin Bevan University Health Board: Equality Impact Assessment
Assessment of Relevance and Priority – Scoring Chart

Proposal North Road Surgery Serious Difficulty Applications

Equality Strand	Evidence: Existing evidence to suggest some groups affected gathered from Part A Step 2.	Potential Impact: Nature, profile, scale, cost, numbers affected, significance.	Decision: Multiply 'Evidence' score by 'Potential Impact' score.
Race	1	0	0
Disability	3	-3	-9
Gender	1	0	0
Sexual Orientation	1	0	0
Age	3	-3	-9
Religion/ Belief	1	0	0
Welsh Language	1	0	0
Human Rights	1	0	0

Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Impact Decision	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Equality Impact Assessment (EqIA) Outcome Report

Policy Title	The Impact of Closure of the Branch site of Trosnant Lodge Medical Practice, North Road.
Organisation	Aneurin Bevan University Health Board
Name of proposal Assessors:	Primary Care & Community Services Division Branch Closure Panel
Division/ Department	Primary Care & Community Services Division
Proceed to Full EqIA:	It has been noted that if the application is approved and the branch site closes, this would impact significantly on the ageing population of the Croesyceiliog area. The assessors are satisfied that providing the EqIA action plan is implemented there will be no negative differential impacts from the implementation of this proposal. Therefore, a full EqIA is not recommended at this stage. However, the document will be reviewed through the monitoring mechanisms in place.
Summary of the EqIA process and key points to be actioned (if any)	This EqIA has been undertaken based on the guidance in the toolkit designed by the NHS Centre for Equality & Human Rights. The toolkit gives due consideration to each of the protected characteristics covered by the Equality Act (2010). In the interest of promoting an inclusive equality agenda, the toolkit also applies the same rigorous standards to the Welsh language and human rights. This report is not intended to provide a definitive account of the content and outcome of the EqIA screening process but offers a summary of the findings.
Responsibility for validation of the EqIA	Branch Closure Panel
Date:	29/06/2022

Monitoring Arrangements:	Action plan developed and implemented to ensure process is followed.
Policy expiry date:	**N/A**

This information is available on request in a range of accessible formats, Welsh and other community languages as required. For more information please contact: Aneurin Bevan University Health Board Policy Coordinator

Aneurin Bevan University Health Board

General Medical Services Vacant Practice Policy

Issue 3 – January 2020
Approved by Access Group
Review Date - tbc

GENERAL STATEMENT OF POLICY

Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice, provides advice to Local Health Boards (LHBs) on the recruitment of General Practitioners and reminds Local Health Boards of the steps they should follow when considering the future of vacant practices. The overriding concern is to ensure that primary medical services are delivered to a consistently high standard across the whole of Wales.

The WHC (2006) 063 details the process to be followed. This suggests a Vacant Practice Panel is developed to manage the process. The guidance relating to membership of this panel suggests that as many stakeholders as possible are involved, whilst recognising that it is for the Health Board to determine this. The recommendation from the panel will need to be agreed by the Board.

1.0 PROPOSED PROCESS FOR TAKING DECISIONS ON VACANT PRACTICES

A Vacant Practice Panel will be established by the Primary Care & Community Services Division. This group will be responsible for the decision process, the end result of which will be a recommendation to proceed with the appropriate option for the future vacant practice. The group will, upon notification of a confirmed or potential practice vacancy, be responsible for preparing a generic specification collating the necessary information to recommend to the Executive Team the appropriate stage to commence the recruitment process.

Proposed membership of the Vacant Practice Panel is:

- ABUHB Divisional Director Primary Care & Networks/ General Manager
- ABUHB Deputy Medical Director (General Practice) / Primary Care Clinical Director
- ABUHB Head of Primary Care/Deputy Head of Primary Care
- Senior Primary Care Manager
- LMC representative
- CHC representative
- Additional representatives may be invited as per local agreement and decision

1.2 TIMEFRAMES

Timeframe for replacement of services: this may impact on the decision making and initial outcome:

1.2.1 Contractual notice from a Partnership contract – a minimum of 6 months' notice must be given unless a shorter period is mutually agreed locally.

1.2.2 Contractual notice from a Single Handed Practitioner – a minimum of 3 months' notice must be given unless a shorter period is mutually agreed locally.

1.2.3 Immediate or significantly shorter notice period may be inevitable where a Single Handed Practitioner has died or become seriously unwell, where there is a serious breach of contract or the Partnership has dissolved.

2.0 NOTIFICATION OF CONTRACT RESIGNATION

On receipt of a contact resignation from a GMS Contractor, the Primary Care Contracting (PCC) Team will:

1. Acknowledge receipt of the resignation from the Contractor. Meet with the contractor to clarify their expectations, responsibility for closing down the contract and to outline their future plans and options under the Vacant Practice process

2. Escalate the notification internally and establish the timeline for decision making, Vacant Practice process and implementation of the outcome

3. Issue confidential communication notice to WG, LMC and ABUHB CHC.

4. Arrange a meeting with practice staff to advise of the process

5. Inform AM/MPs and local councillors

6. Notify Shared Services Partnership and NWIS

7. Issue patient letters (if required at this stage)

8. Arrange a meeting with the NCN/neighbouring practices (optional). This may be required to discuss the options, consider the impact and assess sustainability across the NCN to inform decision making process. Discussions may take place regarding the "preferred option" however, this will not determine the final decision until the the Vacant Practice Panel provides a recommendation to the Executive Team, which is subsequently approved

9. Arrange a Vacant Practice Panel meeting. Decision making needs to be informed and timely, it is expected that the timeline between Contractual Notice being served and a ratified decision being made would be no more than 6 weeks. Where an immediate or shorter notice period (1.2.3) is enacted, a rapid decision making process will be required that should take no more than 2 weeks.

   There will be a requirement that following the approval of the recommendation by the Executive Team, this decision is then considered by the Aneurin Bevan Community Health Council Executive Committee. The timeframe for this will be discussed and agreed accordingly.

10. Further correspondence to be issued to all stakeholders following Vacant Practice Panel including patient engagement.

Each Vacant Practice will need to be considered on its individual merits and the local context:

- LHB Strategic Plan: this will be based on proactive planning from the cluster and sustainability framework.

- Local population health needs including distance from other services, demography, local provider assets and other commissioned contractor services

The PCC Team will prepare the generic specification which will reflect and be influenced by the following key issues:

- Strategic Context of the LHB and the NCN/Cluster
- Practice list size
- Workforce model required to deliver the services and available local assets
- Sustainability within the LHB and Cluster, where the Vacant Practice is on a Cluster or LHB border, the neighbouring LHBs and Clusters should be consulted
- Demography of the registered practice population
- Number and location of neighbouring practices and sustainability of these
- Geography of the Practice area including where patients are registered, the practice boundaries and access to transport, location of neighbouring practices
- Financial impact of each option including an assessment of value for money
- Practice income/future viability
- The number and range of services provided
- Clinical governance and quality issues
- Premises – ownership/potential lease arrangements

An assessment of any shortfalls which may need to be addressed before the final outcome.

Feedback received from neighbouring contractors, services and key stakeholders

Recommendation and justification which of the six options outlined in section 3 below is preferred.

Proposed implementation plan including timeline of the recommended option.

Consider management arrangements/action plan for the next steps for the process.

3.0 VACANT PRACTICE PANEL

When a Practice becomes vacant, the Health Board will want to determine the most appropriate, sustainable option for the delivery of services to the registered population.

At the Vacant Practice Panel meeting, the options for the future of the practice where a vacancy is declared are discussed and a recommendation reached. The options are listed below (options 1-6 do not have to be considered in sequencial order, and/or each one implemented before considering the next option. Option 1,2 and 3 maybe considered together):

Option 1: Aim to fill vacancy through local interest under a GMS Contract, (the practice could be passed completely over to another practice in the borough under GMS Contract arrangements (through inviting local expressions of interest)).

Option 2: Aim to fill vacancy through national interest under a GMS Contract, (the whole practice would be advertised nationally as a vacancy under current GMS Contract arrangements).

Option 3: Managed list dispersal with existing neighbouring practices (through inviting local expressions of interest). Practices to consider taking on a proportion of the list.

Option 4: If vacancy not filled, the LHB take on the management and delivery of GMS services, in accordance with GMS Regulations.

Option 5: Dispersal of practice list (the LHB decide to disperse the practice list).

Option 6: Fill the vacancy through interest from existing/remaining partners (where clauses 525-529 of the GMS contract do not apply (existing partners agree to the transfer of the existing contract to one or more of the existing partners following dissolution)) aim to fill the vacancy through interest from existing partners.

The Health Board will be required to undertake a procurement exercise in relation to options 1-3. This process is detailed in Appendix 1. Practices may be required to attend for interview at a later stage.

** Options 1, 2, 4 and 6 maybe subject to Policy for the Reassignment of Patients whose Address is outside the Catchment Area of their Registered GP & Application Process.

4.0 RECOMMENDATION

The Vacant Practice Panel prepares a recommendation on preferred option(s) to commence recruitment process for the Health Board Executive Team to consider.

Should the decision be made to advertise the practice (may apply to options 1, 2 and 3), a Vacant Practice Interview Panel would convene to undertake this task.

The Interview Panel will consider and interview candidates (options 1, 2 and 3).

The interview panel will make a recommendation to the Executive Team to appoint to the vacant practice or to progress to another stage of the agreed process.

This recommendation if supported by the Executive Team will be reported to the Board.

The Vacant Practice Panel Interview Panel to consist of:

- Independent Board Member (optional)
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- Deputy Medical Director General Practice / Primary Care Clinical Director
- ABUHB Head of Primary Care/Deputy Head of Primary Care
- Senior Primary Care Manager
- Business Partner Accountant
- LMC representative
- CHC representative
- Neighbourhood Care Network Lead
- Head of Service
- Additional representatives may be invited as per local agreement and decision

Appendix 2 provides details for the complete timeline for the process outlined above.

5.0 ENGAGEMENT

The Health Board should develop a clear and comprehensive communication plan whenever a change of contract is implemented and this should provide for open and ongoing sharing of information and management of feedback. This should include communication with the following stakeholders:

- Current Contract Provider
- Neighbouring Practices
- Registered patients of the practice
- Local community groups
- Local Politicians/Councillors
- Community Health Council
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- Local NCN service providers
- NCN Lead/Head of Service
- Health Board departments where there may be a service impact e.g. communications, patient support, medical records etc.
- Welsh Government Primary Care leads

5.1 Communication should clearly articulate the change, the expected impact and the timeline for change.

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VPP group will be quorate when the following are in attendance:
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Appendix 1

PROCUREMENT PROCESS

FIRST STAGE EXPRESSION OF INTEREST (OPTIONAL)*

An advert is circulated to GP Practices (locally/nationally) in the Health Board area and advertised in the BMJ (nationally). The advert invites a simple expression of interest by a certain date.

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THE PROCESS – SECOND STAGE FULL BUSINESS CASE

Successful applicants are requested to produce a full business case detailing the proposal. In order to assist applicants, they are provided with an information pack enclosing all relevant up to date information about the practice, a template for the business case (Annex 1, optional to use) and the scoring criteria used when evaluating the submissions (Annex 2). A deadline is provided to all applicants for the receipt of the completed business case, and provisional details of the interview panel.

Applicants are expected to prepare a 15 minute presentation, followed by a question and answer session related to their submission and presentation. After which the panel evaluate and allocate scores for each of the headings identified in the scoring template.

The decision of the panel is then presented to the Executive Team.

Annex 1

BUSINESS CASE TEMPLATE

FOR APPLICATIONS TO PROVIDE A PERMANENT GMS CONTRACT FOR XXX PATIENTS REGISTERED WITH XXX MEDICAL PRACTICE

Business Case proposals are sought for delivery of services for the whole/part registered list of xxx Medical Practice.

Name of applicant(s)			
Contact Address			
Contact Telephone			
Contact Email			

Signature			

Date of Submission of Business Case	

Please answer ALL questions fully but concisely, please refer to Annex 2, Scoring Template at the end of the document to identify how responses will be scored. (space will expand)

Please return completed templates to XXXXXX by (enter date)

SECTION 1: Workforce (15 points)		**Score** ***(LHB use)***
1.1	Please provide a summary of the partnership that is making this application, to include the main qualifications and accreditations.	

1.2	Please provide the details of the partnership and whether there is an existing written and signed partnership agreement. Where there is no existing partnership please state this and advise of the timeframe of establishment. Please enclose the decision making structure to be put in place (or already in place) so that decisions can be made with ease.	
1.3	Please provide a summary of the clinical team, including number of clinical sessions per week that will deliver care to patients including any special interests or enhanced skills. Please include all GPs, qualified nurses or other qualified and registered clinical staff involved in direct patient care.	
1.4	Please provide a summary of the administrative team that will deliver services to the patients to include an organisational structure for the merged practice.	
1.5	Please provide a summary of the systems and processes you will put in place to manage the transition of appropriate staff needed to deliver the contract (to include your management of duplication of roles, inconsistencies in duties, differences in salaries etc.)	

SECTION 2: Premises (15 points)		**Score** ***(LHB use)***
2.1	Please provide a summary of the premises you will use to provide services for the XXX number of patients currently registered at XXX Medical Practice (including information on your long term strategy for use of the premises).	
2.2	Please identify any changes or amendments to the premises or equipment that will be needed to deliver the contract for the XXX number of patients currently registered at XXX Medical Practice.	

SECTION 3: IM&T (5 points)		**Score** ***(LHB use)***
3.1	Please provide a summary of the clinical and telephone system you will use to deliver services to the XXX number of patients currently registered at XXX Medical Practice.	
3.2	Please identify any changes or amendments to the hardware or software needed to deliver the contract for the XXX number of patients currently registered at XXX Medical Practice (consideration needs to be given to the type of system each practice uses, contracts in place, age of the systems and data protection issues).	

SECTION 4: Service Model (30 points)		**Score** *(LHB use)*
4.1	Please describe your proposed model for delivering services for patients between 8am and 6.30pm Monday to Friday. This should include the: • number of sessions per week • the timing of appointments throughout the working day • method for ensuring that the proposed model meets reasonable patient need.	
4.2	Please describe what changes would need to be made to the enhanced services currently offered, this may include stopping, reducing or increasing services offered based on the skills and competencies of available clinicians.	
4.3	Please describe what clinical governance processes you will put in place to minimise any risk of harm to patients during transition periods at the start of the contract.	
4.4	Please describe what processes and systems you will put in place to reassure the registered patients about the changes and respond to any concerns raised (to include ways in which you intend to communicate any proposed merger to your patients).	

SECTION 5: Financial Model (10 points)		**Score** *(LHB use)*
5.1	Please provide a summary of your financial model for delivering the contract, identifying any additional financial support you might require (taking into consideration the financial position of the managed practice).	

SECTION 6: Timetable (0 points)		**Not Scored** *(LHB use)*
6.1	Please provide an overview of the timetable in which you feel that you could reasonably take up the contract, including any interim actions that will need to be resolved.	

SECTION 7: Continuity (5 points)	**Score** *(LHB use)*

7.1	Please identify actions and processes to be put into place to ensure the safe delivery of services to the registered patients and to support the handover of care.	
7.2	Please outline contingency plans that you will put in place to mitigate any other risks identified as part of taking on this new GMS contract.	

SECTION 8: Any other information (0 points)		**Not Scored** ***(LHB use)***
8.1	Please give any other supporting information that you feel is relevant and needs to be taken into consideration as part of the decision making process.	

Annex 2

Weighting For Short-listing of Tenders

Scoring Template

Each question indicates whether it is specifically scored, those with a zero score are for the purpose of clarifying or assurance information.

Where a question is scored it is weighted according to its relative value. Each scored question has specific criteria that qualifies it for a **ZERO**, **LOW** or **HIGH** score. The range within that level will be determined as outlined below:

	Max Score = 5	*Max Score = 10*	*Max score = 15*
Meets specific **HIGH** criteria **AND** Exceeds Expectations – excellent response over and above requirements	5	10	15
Meets specific **HIGH** criteria **AND** Complies - Fully meets requirement and response gives thorough and comprehensive detail	4	7	10
Meets specific **LOW** criteria **AND** Complies - Fully meets requirement and response gives thorough and comprehensive detail	3	5	7
Meets specific **LOW** criteria **AND** Partially Complies – Broad outline provided relevant to the question asked with some ambiguity around details and at least one piece of information missing	2	3	5
Meets specific **LOW** criteria **OR** Very Poor Response – little evidence	1	2	3
Meets specific **ZERO** criteria **OR** Does Not Comply - No evidence	0	0	0

Specific Criteria: the criteria outlined below are intended to provide very clear, specific and objective measures to help guide the panel in their scoring of proposals.

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
1.1 Please provide a summary of the partnership that is making this application, this needs to include the main qualification and accreditations.				
1.2 Please provide the details of the partnership and whether there is an existing written and signed partnership agreement. Where there is no existing partnership please state this and advise of the timeframe of establishment. Please enclose the decision making structure to be put in place so that decisions can be made with ease.				
1.3 Please provide a summary of the clinical team, including number of clinical sessions per week that will deliver care to patients including any special interests or enhanced skills.	10	1 clinical session per week for more than 225 patients	1 clinical session per week for 200-225 patients	1 clinical session per week for between 175-200 patients
1.4 Please provide a summary of the administrative team that will deliver services to the patients (include an organisational structure for the merged practice).	5	Less than 5 WTE admin staff or no clear plan or staff in place	5 – 7.9 WTE admin staff	More than 8 WTE admin staff
1.5 Please provide a summary of the systems and processes you will put in place to manage the transition of appropriate staff needed to deliver the contract (to include your management of duplication of roles, inconsistencies in duties, differences in salaries etc.)				
2.1 Please provide a summary of the premises you will use to provide services for the XXX patients currently registered at XXX (including information on your long term strategy for use of the premises).	10	3 or less clinical rooms	Minimum 4 clinical rooms to deliver services AND Meets premises minimum standards	Minimum 5 clinical rooms to deliver services AND Meets premises minimum standards
2.2 Please identify any changes or amendments to the premises or equipment that will be needed to deliver the contract for the XXX patients currently registered at XXX.	5	Requires investment from LHB OR Requires no investment from LHB but delay of 4 weeks or more in rooms being available	Requires no additional investment from LHB although may incur investment from contract holder. Premises available within 4 weeks	Requires no additional investment and premises available immediately

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
3.1 Please provide a summary of the clinical and telephone system you will use to deliver services to the xxx patients currently registered.				
3.2 Please identify any changes or amendments to the hardware or software needed to deliver the contract for the XXX patients currently registered at XXX (consideration needs to be given to the type of system each practice uses, contracts in place, age of the system and data protection issues).	5	Requires investment from LHB OR Requires no investment from LHB but delay of 4 weeks or more in clinical system being available	Requires no additional investment from LHB although may incur investment from contract holder. Clinical system available within 4 weeks	Requires no additional investment and clinical system available immediately
4.1 Please describe your proposed model for delivering services for patients between 8am and 6.30pm Monday to Friday. This should include the: • number of sessions per week • the timing of appointments throughout the working day • method for ensuring that the proposed model meets reasonable patient need.	15	Does not fully meet access standards and HB expectations	Partially meets the access standards, fully meets HB expectations (5A principles) and positive principles for good access	Fully meets the access standards, fully meets HB expectations (5A principles) and positive principles for good access
4.2 Please describe what changes would need to be made to the enhanced services currently offered, this may include stopping, reducing or increasing services offered based on the skills and competencies of available clinicians.	5	2 or more enhanced services to be stopped with no plans for reintroducing services or sharing work with other practices in the area	No more than 2 enhanced services to be temporarily stopped OR Plans in place for sharing work with other practices in the area	All current enhanced services to be maintained
4.3 Please describe what clinical governance processes you will put in place to minimise any risk of harm to patients during transition periods at the start of the contract.	5	No clear or robust plans, limited/no mitigating actions	Reasonable plans in place OR Identified mitigating actions	Robust plans in place with identified mitigation actions

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
4.4 Please describe what processes and systems you will put in place to reassure the registered patients about the changes and respond to any concerns raised (to include ways in which you intend to communicate any proposed merger to patients).	5	No/limited communication plan	Reasonable communication plan for patients only	Robust communication plan in place for patients and key stakeholders and interested parties
5.1 Please provide summary of your financial model for delivering the contract, identifying any additional financial support you might require to assist you (taking into consideration the financial position of the managed practice).	10	No clear plan in place	Plan in place but limited in clarity, sustainability	Clear and sustainable financial plan that operates within the existing GMS financial envelope
6.1 Please provide an overview of the timetable in which you feel that you could reasonably take up the contract, including any interim actions that will need to be resolved.				
7.1 Please identify actions and processes to be put into place to ensure the safe delivery of services to the registered patients and to support the handover of care.				
7.2 Please outline contingency plans that you will put in place to mitigate any other risks identified as part of taking on this new GMS contract.	5	Limited / no risk assessment or action plan	Some indication of risk assessment with no clear or accountable plan	Clear risk assessment undertake, with mitigating actions, named individuals and a clear accountability structure
8.1 Please give any other supporting information that you feel is relevant and needs to be taken into consideration as part of the decision making process.				

Appendix 2

TIMETABLE – VACANT PRACTICE

Action	Timescale including EOI Partnership	Timescale including EOI Partnership
Initial Notification: • Contractor acknowledgment • Executive Team • LMC, CHC and WG • NWSSP in confidence • NWIS in confidence • PPV in confidence	Week 1 Within 3 days Within 3 days Within 3 days Within 3-7 days Within 3-7 days Within 3-7 days	Week 1 Within 3 days Within 3 days Within 3 days Within 3-7 days Within 3-7 days Within 3-7 days
Meet with partners and meeting with practice staff	By week 3	By week 2/3
Inform: AM/MPS, local councillors in confidence	By week 3	By week 2/3
Issue 1st patient letter (if required)	By week 3	By week 2/3
Arrange meeting with local GP practices, if required	By week 3	By week 2/3
Arrange Vacant Practice Panel	By week 3/4	By week 2/3
Executive Team to consider recommendation	By week 4	By week 3/4
Issue further correspondence to all relevant stakeholders, if needed	By week 4/5	By week 4
Advertisement of Vacant/Managed practices (1st Stage – requesting expression of interest optional)	By week 5	By week 4/5
Patient engagement, if needed	By week 5	By week 5
Closing date expression of advert	By week 11	By week 7

Consider expression of interests received	By week 12	By week 7/8
Additional information to be provided to those applicants submitting a full business case	By week 12	By week 8
Full Business Case to be submitted	By week 14	By week 9
Interview Panel	By week 16	By week 10
Contract Award (subject to Board ratification)	By week 22	By week 10/11
Issue correspondence to IPs and patients	Subject to approval date	Subject to approval date
Patient engagement, if needed	Subject to approval date	Subject to approval date
Proposed Transfer Date	TBC*	TBC*

***Notes:**

1. **It is recommended practice transfers take place immediately at the start or end of any financial year quarter period.**
2. **Normally following the award of a contract there is a 3 month lead in time to the transfer date. However, the UHB accepts a flexible approach may need to be adopted particularly where the vacant/managed practice is to merge with another established practice.**

Aneurin Bevan University Health Board

General Medical Services Vacant Practice Policy

Issue 3 – January 2020
Approved by Access Group
Review Date - tbc

GENERAL STATEMENT OF POLICY

Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice, provides advice to Local Health Boards (LHBs) on the recruitment of General Practitioners and reminds Local Health Boards of the steps they should follow when considering the future of vacant practices. The overriding concern is to ensure that primary medical services are delivered to a consistently high standard across the whole of Wales.

The WHC (2006) 063 details the process to be followed. This suggests a Vacant Practice Panel is developed to manage the process. The guidance relating to membership of this panel suggests that as many stakeholders as possible are involved, whilst recognising that it is for the Health Board to determine this. The recommendation from the panel will need to be agreed by the Board.

1.0 PROPOSED PROCESS FOR TAKING DECISIONS ON VACANT PRACTICES

A Vacant Practice Panel will be established by the Primary Care & Community Services Division. This group will be responsible for the decision process, the end result of which will be a recommendation to proceed with the appropriate option for the future vacant practice. The group will, upon notification of a confirmed or potential practice vacancy, be responsible for preparing a generic specification collating the necessary information to recommend to the Executive Team the appropriate stage to commence the recruitment process.

Proposed membership of the Vacant Practice Panel is:

- ABUHB Divisional Director Primary Care & Networks/ General Manager
- ABUHB Deputy Medical Director (General Practice) / Primary Care Clinical Director
- ABUHB Head of Primary Care/Deputy Head of Primary Care
- Senior Primary Care Manager
- LMC representative
- CHC representative
- Additional representatives may be invited as per local agreement and decision

1.2 TIMEFRAMES

Timeframe for replacement of services: this may impact on the decision making and initial outcome:

1.2.1 Contractual notice from a Partnership contract – a minimum of 6 months' notice must be given unless a shorter period is mutually agreed locally.

1.2.2 Contractual notice from a Single Handed Practitioner – a minimum of 3 months' notice must be given unless a shorter period is mutually agreed locally.

1.2.3 Immediate or significantly shorter notice period may be inevitable where a Single Handed Practitioner has died or become seriously unwell, where there is a serious breach of contract or the Partnership has dissolved.

2.0 NOTIFICATION OF CONTRACT RESIGNATION

On receipt of a contact resignation from a GMS Contractor, the Primary Care Contracting (PCC) Team will:

1. Acknowledge receipt of the resignation from the Contractor. Meet with the contractor to clarify their expectations, responsibility for closing down the contract and to outline their future plans and options under the Vacant Practice process

2. Escalate the notification internally and establish the timeline for decision making, Vacant Practice process and implementation of the outcome

3. Issue confidential communication notice to WG, LMC and ABUHB CHC.

4. Arrange a meeting with practice staff to advise of the process

5. Inform AM/MPs and local councillors

6. Notify Shared Services Partnership and NWIS

7. Issue patient letters (if required at this stage)

8. Arrange a meeting with the NCN/neighbouring practices (optional). This may be required to discuss the options, consider the impact and assess sustainability across the NCN to inform decision making process. Discussions may take place regarding the "preferred option" however, this will not determine the final decision until the the Vacant Practice Panel provides a recommendation to the Executive Team, which is subsequently approved

9. Arrange a Vacant Practice Panel meeting. Decision making needs to be informed and timely, it is expected that the timeline between Contractual Notice being served and a ratified decision being made would be no more than 6 weeks. Where an immediate or shorter notice period (1.2.3) is enacted, a rapid decision making process will be required that should take no more than 2 weeks.

   There will be a requirement that following the approval of the recommendation by the Executive Team, this decision is then considered by the Aneurin Bevan Community Health Council Executive Committee. The timeframe for this will be discussed and agreed accordingly.

10. Further correspondence to be issued to all stakeholders following Vacant Practice Panel including patient engagement.

Each Vacant Practice will need to be considered on its individual merits and the local context:

- LHB Strategic Plan: this will be based on proactive planning from the cluster and sustainability framework.

- Local population health needs including distance from other services, demography, local provider assets and other commissioned contractor services

The PCC Team will prepare the generic specification which will reflect and be influenced by the following key issues:

- Strategic Context of the LHB and the NCN/Cluster
- Practice list size
- Workforce model required to deliver the services and available local assets
- Sustainability within the LHB and Cluster, where the Vacant Practice is on a Cluster or LHB border, the neighbouring LHBs and Clusters should be consulted
- Demography of the registered practice population
- Number and location of neighbouring practices and sustainability of these
- Geography of the Practice area including where patients are registered, the practice boundaries and access to transport, location of neighbouring practices
- Financial impact of each option including an assessment of value for money
- Practice income/future viability
- The number and range of services provided
- Clinical governance and quality issues
- Premises – ownership/potential lease arrangements

An assessment of any shortfalls which may need to be addressed before the final outcome.

Feedback received from neighbouring contractors, services and key stakeholders

Recommendation and justification which of the six options outlined in section 3 below is preferred.

Proposed implementation plan including timeline of the recommended option.

Consider management arrangements/action plan for the next steps for the process.

3.0 VACANT PRACTICE PANEL

When a Practice becomes vacant, the Health Board will want to determine the most appropriate, sustainable option for the delivery of services to the registered population.

At the Vacant Practice Panel meeting, the options for the future of the practice where a vacancy is declared are discussed and a recommendation reached. The options are listed below (options 1-6 do not have to be considered in sequencial order, and/or each one implemented before considering the next option. Option 1,2 and 3 maybe considered together):

Option 1: Aim to fill vacancy through local interest under a GMS Contract, (the practice could be passed completely over to another practice in the borough under GMS Contract arrangements (through inviting local expressions of interest)).

Option 2: Aim to fill vacancy through national interest under a GMS Contract, (the whole practice would be advertised nationally as a vacancy under current GMS Contract arrangements).

Option 3: Managed list dispersal with existing neighbouring practices (through inviting local expressions of interest). Practices to consider taking on a proportion of the list.

Option 4: If vacancy not filled, the LHB take on the management and delivery of GMS services, in accordance with GMS Regulations.

Option 5: Dispersal of practice list (the LHB decide to disperse the practice list).

Option 6: Fill the vacancy through interest from existing/remaining partners (where clauses 525-529 of the GMS contract do not apply (existing partners agree to the transfer of the existing contract to one or more of the existing partners following dissolution)) aim to fill the vacancy through interest from existing partners.

The Health Board will be required to undertake a procurement exercise in relation to options 1-3. This process is detailed in Appendix 1. Practices may be required to attend for interview at a later stage.

** Options 1, 2, 4 and 6 maybe subject to Policy for the Reassignment of Patients whose Address is outside the Catchment Area of their Registered GP & Application Process.

4.0 RECOMMENDATION

The Vacant Practice Panel prepares a recommendation on preferred option(s) to commence recruitment process for the Health Board Executive Team to consider.

Should the decision be made to advertise the practice (may apply to options 1, 2 and 3), a Vacant Practice Interview Panel would convene to undertake this task.

The Interview Panel will consider and interview candidates (options 1, 2 and 3).

The interview panel will make a recommendation to the Executive Team to appoint to the vacant practice or to progress to another stage of the agreed process.

This recommendation if supported by the Executive Team will be reported to the Board.

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Successful applicants are requested to produce a full business case detailing the proposal. In order to assist applicants, they are provided with an information pack enclosing all relevant up to date information about the practice, a template for the business case (Annex 1, optional to use) and the scoring criteria used when evaluating the submissions (Annex 2). A deadline is provided to all applicants for the receipt of the completed business case, and provisional details of the interview panel.

Applicants are expected to prepare a 15 minute presentation, followed by a question and answer session related to their submission and presentation. After which the panel evaluate and allocate scores for each of the headings identified in the scoring template.

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FOR APPLICATIONS TO PROVIDE A PERMANENT GMS CONTRACT FOR XXX PATIENTS REGISTERED WITH XXX MEDICAL PRACTICE

Business Case proposals are sought for delivery of services for the whole/part registered list of xxx Medical Practice.

Name of applicant(s)			
Contact Address			
Contact Telephone			
Contact Email			

Signature			

Date of Submission of Business Case	

Please answer ALL questions fully but concisely, please refer to Annex 2, Scoring Template at the end of the document to identify how responses will be scored. (space will expand)

Please return completed templates to XXXXXX by (enter date)

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1.3	Please provide a summary of the clinical team, including number of clinical sessions per week that will deliver care to patients including any special interests or enhanced skills. Please include all GPs, qualified nurses or other qualified and registered clinical staff involved in direct patient care.	
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1.5	Please provide a summary of the systems and processes you will put in place to manage the transition of appropriate staff needed to deliver the contract (to include your management of duplication of roles, inconsistencies in duties, differences in salaries etc.)	

SECTION 2: Premises (15 points)		**Score** ***(LHB use)***
2.1	Please provide a summary of the premises you will use to provide services for the XXX number of patients currently registered at XXX Medical Practice (including information on your long term strategy for use of the premises).	
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SECTION 3: IM&T (5 points)		**Score** ***(LHB use)***
3.1	Please provide a summary of the clinical and telephone system you will use to deliver services to the XXX number of patients currently registered at XXX Medical Practice.	
3.2	Please identify any changes or amendments to the hardware or software needed to deliver the contract for the XXX number of patients currently registered at XXX Medical Practice (consideration needs to be given to the type of system each practice uses, contracts in place, age of the systems and data protection issues).	

SECTION 4: Service Model (30 points)		**Score** *(LHB use)*
4.1	Please describe your proposed model for delivering services for patients between 8am and 6.30pm Monday to Friday. This should include the: • number of sessions per week • the timing of appointments throughout the working day • method for ensuring that the proposed model meets reasonable patient need.	
4.2	Please describe what changes would need to be made to the enhanced services currently offered, this may include stopping, reducing or increasing services offered based on the skills and competencies of available clinicians.	
4.3	Please describe what clinical governance processes you will put in place to minimise any risk of harm to patients during transition periods at the start of the contract.	
4.4	Please describe what processes and systems you will put in place to reassure the registered patients about the changes and respond to any concerns raised (to include ways in which you intend to communicate any proposed merger to your patients).	

SECTION 5: Financial Model (10 points)		**Score** *(LHB use)*
5.1	Please provide a summary of your financial model for delivering the contract, identifying any additional financial support you might require (taking into consideration the financial position of the managed practice).	

SECTION 6: Timetable (0 points)		**Not Scored** *(LHB use)*
6.1	Please provide an overview of the timetable in which you feel that you could reasonably take up the contract, including any interim actions that will need to be resolved.	

SECTION 7: Continuity (5 points)	**Score** *(LHB use)*

7.1	Please identify actions and processes to be put into place to ensure the safe delivery of services to the registered patients and to support the handover of care.	
7.2	Please outline contingency plans that you will put in place to mitigate any other risks identified as part of taking on this new GMS contract.	

SECTION 8: Any other information (0 points)		**Not Scored** ***(LHB use)***
8.1	Please give any other supporting information that you feel is relevant and needs to be taken into consideration as part of the decision making process.	

Annex 2

Weighting For Short-listing of Tenders

Scoring Template

Each question indicates whether it is specifically scored, those with a zero score are for the purpose of clarifying or assurance information.

Where a question is scored it is weighted according to its relative value. Each scored question has specific criteria that qualifies it for a **ZERO**, **LOW** or **HIGH** score. The range within that level will be determined as outlined below:

	Max Score = 5	*Max Score = 10*	*Max score = 15*
Meets specific **HIGH** criteria **AND** Exceeds Expectations – excellent response over and above requirements	5	10	15
Meets specific **HIGH** criteria **AND** Complies - Fully meets requirement and response gives thorough and comprehensive detail	4	7	10
Meets specific **LOW** criteria **AND** Complies - Fully meets requirement and response gives thorough and comprehensive detail	3	5	7
Meets specific **LOW** criteria **AND** Partially Complies – Broad outline provided relevant to the question asked with some ambiguity around details and at least one piece of information missing	2	3	5
Meets specific **LOW** criteria **OR** Very Poor Response – little evidence	1	2	3
Meets specific **ZERO** criteria **OR** Does Not Comply - No evidence	0	0	0

Specific Criteria: the criteria outlined below are intended to provide very clear, specific and objective measures to help guide the panel in their scoring of proposals.

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
1.1 Please provide a summary of the partnership that is making this application, this needs to include the main qualification and accreditations.				
1.2 Please provide the details of the partnership and whether there is an existing written and signed partnership agreement. Where there is no existing partnership please state this and advise of the timeframe of establishment. Please enclose the decision making structure to be put in place so that decisions can be made with ease.				
1.3 Please provide a summary of the clinical team, including number of clinical sessions per week that will deliver care to patients including any special interests or enhanced skills.	10	1 clinical session per week for more than 225 patients	1 clinical session per week for 200-225 patients	1 clinical session per week for between 175-200 patients
1.4 Please provide a summary of the administrative team that will deliver services to the patients (include an organisational structure for the merged practice).	5	Less than 5 WTE admin staff or no clear plan or staff in place	5 – 7.9 WTE admin staff	More than 8 WTE admin staff
1.5 Please provide a summary of the systems and processes you will put in place to manage the transition of appropriate staff needed to deliver the contract (to include your management of duplication of roles, inconsistencies in duties, differences in salaries etc.)				
2.1 Please provide a summary of the premises you will use to provide services for the XXX patients currently registered at XXX (including information on your long term strategy for use of the premises).	10	3 or less clinical rooms	Minimum 4 clinical rooms to deliver services AND Meets premises minimum standards	Minimum 5 clinical rooms to deliver services AND Meets premises minimum standards
2.2 Please identify any changes or amendments to the premises or equipment that will be needed to deliver the contract for the XXX patients currently registered at XXX.	5	Requires investment from LHB OR Requires no investment from LHB but delay of 4 weeks or more in rooms being available	Requires no additional investment from LHB although may incur investment from contract holder. Premises available within 4 weeks	Requires no additional investment and premises available immediately

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
3.1 Please provide a summary of the clinical and telephone system you will use to deliver services to the xxx patients currently registered.				
3.2 Please identify any changes or amendments to the hardware or software needed to deliver the contract for the XXX patients currently registered at XXX (consideration needs to be given to the type of system each practice uses, contracts in place, age of the system and data protection issues).	5	Requires investment from LHB OR Requires no investment from LHB but delay of 4 weeks or more in clinical system being available	Requires no additional investment from LHB although may incur investment from contract holder. Clinical system available within 4 weeks	Requires no additional investment and clinical system available immediately
4.1 Please describe your proposed model for delivering services for patients between 8am and 6.30pm Monday to Friday. This should include the: • number of sessions per week • the timing of appointments throughout the working day • method for ensuring that the proposed model meets reasonable patient need.	15	Does not fully meet access standards and HB expectations	Partially meets the access standards, fully meets HB expectations (5A principles) and positive principles for good access	Fully meets the access standards, fully meets HB expectations (5A principles) and positive principles for good access
4.2 Please describe what changes would need to be made to the enhanced services currently offered, this may include stopping, reducing or increasing services offered based on the skills and competencies of available clinicians.	5	2 or more enhanced services to be stopped with no plans for reintroducing services or sharing work with other practices in the area	No more than 2 enhanced services to be temporarily stopped OR Plans in place for sharing work with other practices in the area	All current enhanced services to be maintained
4.3 Please describe what clinical governance processes you will put in place to minimise any risk of harm to patients during transition periods at the start of the contract.	5	No clear or robust plans, limited/no mitigating actions	Reasonable plans in place OR Identified mitigating actions	Robust plans in place with identified mitigation actions

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
4.4 Please describe what processes and systems you will put in place to reassure the registered patients about the changes and respond to any concerns raised (to include ways in which you intend to communicate any proposed merger to patients).	5	No/limited communication plan	Reasonable communication plan for patients only	Robust communication plan in place for patients and key stakeholders and interested parties
5.1 Please provide summary of your financial model for delivering the contract, identifying any additional financial support you might require to assist you (taking into consideration the financial position of the managed practice).	10	No clear plan in place	Plan in place but limited in clarity, sustainability	Clear and sustainable financial plan that operates within the existing GMS financial envelope
6.1 Please provide an overview of the timetable in which you feel that you could reasonably take up the contract, including any interim actions that will need to be resolved.				
7.1 Please identify actions and processes to be put into place to ensure the safe delivery of services to the registered patients and to support the handover of care.				
7.2 Please outline contingency plans that you will put in place to mitigate any other risks identified as part of taking on this new GMS contract.	5	Limited / no risk assessment or action plan	Some indication of risk assessment with no clear or accountable plan	Clear risk assessment undertake, with mitigating actions, named individuals and a clear accountability structure
8.1 Please give any other supporting information that you feel is relevant and needs to be taken into consideration as part of the decision making process.				

Appendix 2

TIMETABLE – VACANT PRACTICE

Action	Timescale including EOI Partnership	Timescale including EOI Partnership
Initial Notification: • Contractor acknowledgment • Executive Team • LMC, CHC and WG • NWSSP in confidence • NWIS in confidence • PPV in confidence	Week 1 Within 3 days Within 3 days Within 3 days Within 3-7 days Within 3-7 days Within 3-7 days	Week 1 Within 3 days Within 3 days Within 3 days Within 3-7 days Within 3-7 days Within 3-7 days
Meet with partners and meeting with practice staff	By week 3	By week 2/3
Inform: AM/MPS, local councillors in confidence	By week 3	By week 2/3
Issue 1st patient letter (if required)	By week 3	By week 2/3
Arrange meeting with local GP practices, if required	By week 3	By week 2/3
Arrange Vacant Practice Panel	By week 3/4	By week 2/3
Executive Team to consider recommendation	By week 4	By week 3/4
Issue further correspondence to all relevant stakeholders, if needed	By week 4/5	By week 4
Advertisement of Vacant/Managed practices (1st Stage – requesting expression of interest optional)	By week 5	By week 4/5
Patient engagement, if needed	By week 5	By week 5
Closing date expression of advert	By week 11	By week 7

Consider expression of interests received	By week 12	By week 7/8
Additional information to be provided to those applicants submitting a full business case	By week 12	By week 8
Full Business Case to be submitted	By week 14	By week 9
Interview Panel	By week 16	By week 10
Contract Award (subject to Board ratification)	By week 22	By week 10/11
Issue correspondence to IPs and patients	Subject to approval date	Subject to approval date
Patient engagement, if needed	Subject to approval date	Subject to approval date
Proposed Transfer Date	TBC*	TBC*

***Notes:**

1. **It is recommended practice transfers take place immediately at the start or end of any financial year quarter period.**
2. **Normally following the award of a contract there is a 3 month lead in time to the transfer date. However, the UHB accepts a flexible approach may need to be adopted particularly where the vacant/managed practice is to merge with another established practice.**

Gwent Regional Partnership Board

Integrated Winter Plan 2021-22

November 2021

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

Partnership & Integration PMO

Executive Summary

The Minister for Health and Social Services published the Health and Social Care Winter Plan for 2021-22, which sets eight priority areas for preventative activity with the intention of ensuring patient safety and the provision of social care for people in most need. The plan places significant emphasis on the projections of increased demand across the system in the coming months.

Welsh Government acknowledge the role of Regional Partnership Boards (RPB) as a key driver for regional change, and have made £1.846million available to Gwent RPB to support delivery of an integrated plan, complementary to the restart and recovery plans developed by our constituent partners.

In addition to restart and recovery plans, the exacerbated and ongoing pressures within the system experienced within Gwent, has resulted in the reinstatement of the regional Strategic Co-ordination Group under our civil contingency measures. A number of sub-groups have been established to support immediate and short term actions within the system, bringing together cross-membership of the Regional Partnership Board and Public Service Boards.

This Regional Integrated Winter Plan references alignment of the aforementioned restart and recovery plans, integrated action plans of our sub-groups, and identifies additional and integrated activity within the Regional Partnership to support our citizens and the resilience of our health and social care system over the coming months.

This additional activity provides four key areas of investment as complementary support to our partners:

- Integrated approaches to recruitment of health and care support workers
- Collaborative efforts to resolve the capacity constraints of our therapeutic workforce
- Multi-disciplinary assessments at the front door to prevent unnecessary hospital admissions
- Additional technology solutions to support independence/wellbeing

Discussions enabling the above are taking place within the broader membership to include the Welsh Ambulance Service and Gwent Police.

Consideration is required on any integrated risk appetite to address the challenges in delivering identified solutions. The Regional Integrated Winter Plan articulates all planned activities of our partnership organisations within Priorities 1 to 7, and whilst identified within these priorities, the specific areas of investment and RPB support are identified for consideration by the Regional Partnership Board within Priority 8.

Introduction

The publication of the Health and Social Care Winter Plan 2021-22 brings together key messages within the guidance provided to partner organisations on the use of restart and recovery funds to support system resilience over the coming months. Significant additional investment has been made across health, social care and the third sector directly from Welsh Government to support restart and recovery following the impact of Covid-19. The development of the restart and recovery plans has been undertaken collaboratively across health and social care, the contents or which are reflected within this Regional Integrated Winter Plan.

In addition to ongoing forums within the Regional Partnership, as a civil contingency measure and at the request of Gwent Police, the Strategic Coordinating Group (SCG) was re-established to develop immediate actions to address growing system pressures within all emergency services. As a reflection of the issues that were identified within the SCG, a Tactical Coordinating Group was convened to meet on a weekly basis to address the challenges at pace and established four key areas of activity; identified as Demand, Workforce Supply, Data and Communications. A sub-group was established for each area of activity, with cross-membership of the Regional Partnership and the Public Service Boards within the Demand and Workforce Supply sub-groups.

As an output of this activity several action plans have been developed, and recently brought together within a Regional Winter Planning Group. This group was established to develop integrated solutions over the winter period, supported by Regional Partnership Board funding within the Integrated Care Fund and Transformation Funds. A review of the plans identifies regional priorities and challenges within the following areas:

- Preventing Hospital Admission

  Identifying and supporting high risk cohorts of the population to remain at home.

- Increase Reablement capacity

  Health Care Support Workers providing low level Reablement support in the community; recruitment undertaken within ABUHB to strengthen capacity. Permanent recruitment risk underwritten by ABUHB.

  Additional therapy resource; impacted by lack of locum availability and inability to recruit temporarily

- Domiciliary Care Resilience & Capacity

  Identification of additional capacity: Additional hours of existing workforce maximised where possible, whilst protecting wellbeing of workforce. Recruitment of temporary staff impacted by competing workforce market and inability to recruit on a temporary basis

  Supporting provider sustainability issues; care hours being returned in some areas, and viability concerns noted.

- Step Closer to Home / Expediting Discharge

  Increasing bed availability for step down from hospital; impacted by covid-19 incidence within care homes

Subsequently, and following the publication of the Health and Social Care Winter Plan 2021-22, further funding was identified to support Regional Partnership Boards in the delivery of integrated plans. Gwent RPB has received an allocation of £1.846million to support system resilience up to 31st March 2021. This funding is provided via the Integrated Care Fund and issued to Health Boards on behalf of Regional Partnership Boards.

This funding, together with any available funds from existing Regional Partnership Board budgets, will provide investment for additional regional activity over the coming months. It is anticipated at this stage the Regional Integrated Winter Plan 2021-22 will have an investment value of £2.5million, and will provide targeted support within the following areas:

- Integrated approaches to recruitment/resilience of health and care workforce: New ways of commissioning care, piloting of micro enterprises and integrated recruitment solutions

- Collaborative efforts to resolve the capacity constraints of our therapeutic workforce: Exploring shared resource, alternative ways of working and sourcing additional capacity where available

- Multi-disciplinary assessments at the front door to prevent unnecessary hospital admissions
  Expanding the Home First model with additional multi-disciplinary expertise to aid holistic single patient assessments

- Additional technology solutions to support independence/wellbeing
  Utilising technology to support wellbeing and independence, reduction in isolation and reablement

Deliverable options to address the above areas are currently being explored with partners, and will be included in a final Regional Integrated Winter Plan for submission to Welsh Government on 25 November 2021.

Delivery of Priorities

Priority 1: Protecting us from Covid-19

This priority is a reflection of the ABUHB Restart & Recovery / Winter Plan. No specific/additional RPB activity has been identified at this stage.

Following the Joint Committee on **Vaccination and Immunisation** (JCVI) releasing advice on the booster programme, ABUHB have developed a staged plan for implementation delivered via Mass Vaccination Centres, Health Board Mobile Teams, and NCN led Community Vaccination Centres. The booster programme will amalgamate all priority groups currently described as: 'those registered with a General Practitioner (GP) in the Aneurin Bevan University Health Board (ABUHB) area or anyone residing in Gwent that are either (a) resident in a care home, (b) aged fifty and above (c) working in a frontline health or social care role and anyone aged sixteen to forty-nine who are either classified as (d) clinically extremely vulnerable (CEV) or (e) having specific underlying health conditions'.

The **testing** approach adopted within the Health Board reflected the Welsh Governments Coronavirus Control Plan, based on the following principles:

- Test to diagnose – inclusion of multiplex testing (COVID, Influenza A/B & RSV).
- Test to safeguard – Enclosed settings with symptomatic residents will be screened using multiplex testing.
- Test to find – Continuation of community based testing using mobile and permanent testing facilities.
- Test to maintain – Regular asymptomatic testing will underpin our ability to maintain key services (Health care, education and other workplaces).
- Test to enable – Utilising testing to enable the COVID passport system, protecting from virus transmission as normal life is maintained

To reflect an expected increase in demand through the winter internal testing capacity is being increased.

Gwent **Test, Trace, Protect** Service has played an essential role in helping to maintain downward pressure on Covid-19 case rates and remains a crucial mitigation. With the isolation of contacts no longer the default position we will focus contact tracing where it can have the most impact. Our revised approach to contact tracing, heading into Winter 2021/21 will centre on:

- Protecting vulnerable individuals. Rather than automatically following up all cases and their contacts in person, contact tracing teams will focus on identifying those who work in vulnerable settings (such as health and social care workers or emergency services) or who are not fully vaccinated.

- Working towards digital by default. We will automate more of our tracing via digital contact and target calls at those who require tailored advice. We will use behavioural insights to make every contact count including how to communicate the importance of vaccination when tracers interact with unvaccinated cases/contacts, and signpost accordingly.

- Managing risks from international travel. The increasing relaxation of international travel requirements poses a significant risk of importing cases and variants of concern from abroad. It remains critical that arriving travellers into Wales are contact traced to ensure those who are required to isolate are aware of their legal duty to do so.

Supporting self-isolation will continue to be a critical element of TTP with financial support remaining through the self-isolation support payment and local authorities and the third sector continuing to provide wider support mechanisms

Priority 2: Keeping People Well

The Health and Social Care Winter Plan identifies potential increase in seasonal flu and respiratory syncytial virus (RSV) that would lease to greater pressures than usual, with evidence of increasing number of hospital admissions with bronchiolitis. The also highlight some evidence of people infected with both flu and Covid-19 are expected to have longer lengths of stay in hospital, and at greater risk of death.

Self-Care

Within the TCG Communications sub-group, messaging and public engagement is being undertaken to ensure people know which services to access over the winter, and are aware of the unprecedented pressures within the system presently.

Seasonal Influenza

The influenza vaccination programme is underway, and additional means of reaching carers workforce are currently being explored. Messaging to the staff and the public on the importance of receiving both influenza and Covid-19 vaccinations is being provided to encourage take up of the immunisations. This continues to be monitored via Public Health and our Community Care Sub-Group.

Respiratory Conditions

Spirometry clinics will be introduced in primary care to address the backlog of 550 patient waiting tests in secondary care and absorb new demand of circa 300 referrals per week until the end of March 2022. The clinics will provide a service for patients awaiting diagnostic spirometry tests and delayed diagnosis. Potential increased demand on A&E, OOH and GP contacts. Lack of spirometry will potentially impact on patient treatment pathways and onward care.

Long Term-Conditions

Community Health Checks for people with chronic condition will enable reviews for 'high risk patient cohort' (HRPC) identified via Lightfoot exercise in an effort to proactively plan the care for patients at highest risk of hospital admission. Service aims to keep to people well and remain at home through identification of potential deterioration working in collaboration with our Community Voluntary Councils.

Priority 3: Maintaining Safe Health Services

Additional bed capacity has been enabled within the health board to support the increase in demand, in both acute and community services, with community services providing a step down from the Grange University Hospital and Local General Hospitals where appropriate.

The health board, in collaboration with local authorities, have commissioned private providers in some areas to provide packages of care via complex health care, this additional capacity is intended to alleviate the number of patients in hospital beds waiting for a long term package of care.

Health Inequalities and Vulnerable Groups

The planned activity referenced within the Integrated Winter Plan is targeted at the priority areas for integration, namely older people with complex needs, people with dementia, children with complex needs, people with learning disabilities and unpaid carers.

The impact of the pandemic has been significantly highlighted within these population groups with collaborative and integrated actions identified to best support them over the coming months.

Mental Health and Wellbeing

The pandemic has led to increasing mental health related demand in primary care mental health services. Activity within the partnership has established mechanisms that will provide support as we enter the winter period, including but not limited to:

- Foundation Tier and Melo Website: Enabled by the Transformation Fund, this project provides community base resources to support individuals to help themselves without the need of a referral.
- Sanctuary Model providing a safe place for individuals to seek support as an alternative to contacting a GP, attending ED or using other emergency services.

In addition to the above, the MH & LD Division within ABUHB are introducing the following for the winter period:

- Psychological Wellbeing Practitioner Service (approx. 1300 support per month)
- Increased capacity within Primary Care Mental Health Support Service
- A new support house will open in November 2021 and will provide an alternative to admission, with assessment undertaken through the Crisis/Home Treatment Team.
- New Peer Mentor roles attached to the crisis liaison service will be based in the Emergency Department of the Grange University Hospital, and existing resources of the crisis liaison service relocated based on demand.
- Extended working hours of the Older Adult Psychiatric Liaison
- Where viable, strengthen MDT staffing on inpatient areas

Primary Care and Community Services

In respect of primary care activity ABUHB are seeking to initiate actions which will assist GP and Primary Care services to meet the expected demand. Primary Care practices moved to a predominantly remote triage and consultation through the early phases of the pandemic. The move down the Covid alert levels has seen a gradual increase in the number of Face to Face appointments within primary care alongside the remote consultations, and whilst the number of virtual appointments has dropped the levels of overall activity continues to increase.

For primary care, the aim is to build resilience into the system, and a number of schemes will be implemented including:

- Improving primary care access through additional GP / practice staff sessions
- Increase resilience of GP OOH/ UPCC
- Further Psychological Wellbeing Practitioner (PWP) business case and support for other Multi-Disciplinary Teams (MDT) workforce
- Pathways – respiratory, falls, diabetes

Access to urgent primary care is also key in providing alternative routes to urgent care. The first point of contact for patients with urgent care needs should be local GP services or NHS 111. The operationalisation of Urgent Primary Care services at RGH and NHH alongside the promotion of the NHS 111 service as the first point of contact for patients is designed to facilitate a system where patients are directed to the most appropriate services prior to attendance and the delivery of a symptom based timely intervention at locations close to home. This will also prevent unnecessary conveyance to Hospital by managing the demands into our services at both the front door and through WAST. This has been further supported nationally with the development of a number of alternative pathways for patients with common presenting conditions who may be better served by services outside of secondary care emergency departments. A national pathway for palliative patients for example has been developed alongside the continued work on falls pathways, with our deployment of a local falls service and a WAST led falls vehicle

The following plan reflects the additional planned activity of ABUHB Primary Care & Community division for the winter period:

Scheme	Description	Impact
Community hospital beds	Open additional 12-14 beds Ruperra ward at St Woolos Hospital and 14 beds on Tyleri Ward YAB	Extra community/ step-down beds will support patient flow from GUH/eLGHs
Commissioning Care Home beds	The Health Board has recently engaged with nursing home providers to commission step down beds to facilitate early discharge from acute sites. It is anticipated the number can increase to 50 beds if required	Ability to discharge longer stay patients waiting for next stage of care
Commissioning packages of care	The Health Board has arranged to purchase POC from a private provider to alleviate the number of patients on acute sites waiting for a long term package of care	Ability to discharge longer stay patients waiting for next stage of care
Rapid Response Team	Advanced paramedic practitioner has been employed to temporary contract in Caerphilly, band 6 ANP employed on temporary contract in Blaenau Gwent and 2 Trainee band 6 employed in Newport and Monmouthshire.	Increase to RRT allowing patients to remain at home with treatment and avoid hospital admission

Scheme	Description	Impact
Reablement capacity	Recruitment of additional 25 band 3 reablement support workers 5 per borough.	Reablement Support Workers to increase Reablement Care capacity within Gwent, thereby releasing hospital bed capacity through greater admission avoidance and through facilitating quicker discharge home.
Direct admission pathway	Implement a 'direct' admission to community hospital pathway including a 'retrieval' pathway	Ensure rapid transfer to community hospital and discharge home
Appoint agency staff to DN service	Appoint District Nurses via agency (block booking for 6 months)	Provide cover for vacancies within DN service
Wound care	Chronic Wound Care Services recruitment of HCSWs to support patients without the need to see GP / practice staff	Hub-based and home-visiting models to reduce demand on GPs. Agreed to introduce the project to one or two boroughs instead of five which will minimise the number of staff needed.
Front-door pharmacy services	Provision of pharmacist to the ED at GUH	Improved medicines reconciliation and early supply of medicines, leading to earlier discharge/ transfer Improve Patient education/counselling Improve medicines management in ED reducing waste and cost Positive impact for staff education & training Improved clinical governance reducing risk
Additional hospital pharmacy capacity for winter wards	An increase in pharmacy staff is required over winter to cover site pressures and maintain patient flow. This includes cover for the increased bed base at eLGHs, with currently an additional 2 wards at RGH, 1 at STW, and additional beds at NHH and YYF.	Ensure adequate pharmacy provision to support patient flow and expedite discharge

Scheme	Description	Impact
Pharmacy Transcribing Service	Pharmacy will work with informatics to adapt the e-learning module to create a medicines module. This will allow Pharmacy to accurately complete and record the patient medicines reconciliation on admission to an acute site on CWS	Reduce waiting time and errors and enable patient flow through pharmacy medicines reconciliation and transcribing for discharge

Urgent and Emergency Care

The Health Board have put in place a number of key actions to support patient experience during these challenging times to ensure the environment, the communication and the support patients receive improve the experience for patients whilst they wait for access to care. Feedback and learning work are also ongoing to continue to improve this experience for the patient. The following summarises the actions being taken or planned to improve patient experience as part of the urgent care system.

Actions already taken

- Provision of refreshments and food for long waiting ED patients
- Patient Liaison Officers at GUH to support patients waiting in ED
- Additional reception staff in ED to support communication and advice

Plans underway

- Expanding ED wait space to improve space, social distancing and experience
- Community response to support WAST Escalation
- PALS Rollout

The Health Board continues to use its staff and patient feedback mechanisms to continually appraise the patient experience issues and respond appropriately.

Bed Capacity

Modelling suggests to meet the projected demands would require the ability to flex to an additional 170 beds in across our system. Built into this model is the continuation of elective delivery at existing capacity, recognising that there is also the ambition to increase planned procedures as part of the recovery of backlogs. The opening of the Grange University Hospital has enabled the protection of elective activity particularly at the Royal Gwent and in balancing the 5 harms it is important that we retain as much activity as possible. In a typical winter the cessation of elective activity and the conversion of beds from surgical care to acute medical care takes place, this is already happening to an extent in our system with the existing system pressures. Whilst there may be a need at times of pressure to adjust capacity in this way we must clearly understand the risk and consequences for our patients in doing this, particularly given the current demands for elective care.

Whilst the opening of the Grange University Hospital means that physical bed capacity is not a constraint we know if is staff who make hospitals and will be the rate limiting factor in increasing our capacity. Therefore plans to flexibly increase our capacity over winter are predicated on the availability to safely staff such capacity, surge capacity will be reliant on additional bank, agency and locum staffing. Actions to support patients to return to their home will have a greater impact on system safety than increasing hospital capacity.

Within our existing bed base of 1588 we are already operating a zoned system (Green, Amber, Red) to ensure patient safety and flex this capacity between zones to meet the need of the pandemic, for example in this third surge of Covid-19 we peaked at Covid-19 Occupancy (Red Beds) of 111 beds. The zoning of beds adds a further complication as it can distort available beds to use for urgent care demand due to the need to protect different types of capacity. We will continue to use the system we have now to flex between zoning in order to meet the needs of the pandemic.

Additional Flexible Surge Capacity by site:

RGH	NHH	YYF	SWH
28	28	12	12

As you can see from the above table, this falls short of the maximum number of beds which would be required under the reasonable worst case scenario. These plans are based on the continued protection of an element of elective capacity. Therefore if our early warning system indicates we are likely to exceed this capacity, we will need to move to the next phases of our surge plans, which would necessitate the cancellations of elective activity in order to release the staff to meet the acute medical capacity.

Priority 4: Maintaining our Social Care Services

The Social Care sector is experiencing ongoing challenges significantly exacerbated by the pandemic that is having a great impact on the level of social care workforce leaving the profession, and growing difficulties in the recruitment of new care staff. The fragility of our provider care sector is evident, with an increasing number of care hours being returned to commissioners.

Increased pressures are also noted in relation to higher demand, costs and increasing complexity of needs for care experienced children.

The planned activity within our social care sector can be summarised as follows:

Supporting People

- Increased financial support for GWICES to improve timely provision of equipment to promote independence, enable people to remain at home and support timely hospital discharge.
- Additional respite care services for children and families
- Exploration of regional direct payments service and regional telecare service
- Where viable, implement night time response services
- Additional support to foster carers to improve stability of placements
- Increased support for unpaid carers
- Strengthening community care volunteering schemes to encourage people to reconnect with their communities

	▪ Provide appropriate accommodation to enable people with a Learning Disabilities to remain in their communities.
Supporting Providers	▪ Maximise the number of service users that can receive domiciliary care without compromising the financial viability of providers or the wellbeing of the workforce. ▪ Additional resources for third sector organisations to facilitate hospital admissions and discharges, and possibly night support services ▪ Block purchase of additional step up beds ▪ Increase local sectoral fund over winter as central funding is withdrawn
Strengthening the Workforce	▪ Increase capacity and reach of domiciliary care ▪ Additional Occupation Therapy capacity to support both admission avoidance and discharge ▪ Additional support worker capacity within children's services ▪ Additional commissioning resources at locality level to increase capacity to source care appropriately ▪ Additional children's safeguarding resource ▪ Additional adult protection workforce ▪ Additional capacity to support Older Adult Mental Health services ▪ Market supplement payments for Adult Mental Health Practitioners employed within out of hours team ▪ Additional capacity to support testing in Care Homes

Priority 5: Supporting our Health and Social Care Workforce

In order to respond to the significant winter challenges there will be a need to increase our staffing capacity to meet this challenge. The range of staffing solutions that were implemented during the previous waves of COVID-19 is not available as we restore professional training programmes and services resume. We also know our workforce have worked tirelessly throughout the COVID-19 pandemic and there remains continuing levels of staff absence. Whilst temporary staff is essential to maintain services, we recognise that a permanent and stable workforce offers continuity of care.

Staff wellbeing remains at the fore of the discussions as we consider how we can generate additional capacity across the system. Partnership organisations provide wellbeing support to their respective workforces and continue to explore new ways of supporting their wellbeing.

For Health Boards, Large scale overseas recruitment remains suspended and the next cohort of registered nurses will not complete training until September 2022.

Collectively we have ongoing recruitment campaigns for Allied Health Professionals, though the availability of temporary or locum cover is proving challenging across the Region. With a limited existing workforce of Allied Health Professionals, namely Occupational Therapists, consideration as to how we can generate/safely transfer therapeutic capacity in the system.

Domiciliary care remains an ongoing issue both regionally and nationally, with ongoing discussions held with Welsh Government on how this can be mitigated. Partners continue to explore commissioning arrangements, reviews of packages of care and provider availability though there is a growing number of hours of care being returned to Local Authority Commissioners. The Health Board has explored arrangements via Complex Health Care and has been able to support several packages of care via this mechanism. Collaborative efforts will continue to explore all available capacity and mechanisms that may generate earlier successes to recruit and retain staff in this sector.

All workforce are encouraged and reminded of the immunisation programmes this winter; communications to the workforce have been circulated in this respect, and arrangements made to ensure all staff have access to immunisation opportunities.

Priority 6: Supporting Unpaid Carers

Through a number of mechanisms, increased financial support has been provided to unpaid carers through the pandemic. Support continues to be provided via the Regional Partnership through direct carers support services, and a regional carers grant scheme. In addition, Welsh Government have provided further funding via the Social Care Recovery Fund to provide targeted support for unpaid carers in financial hardship, and for Carers needing 'Me Time'.

All Local Authorities have reflected additional support for unpaid carers within the restart and recovery plans for the winter period 2021-22.

Where needed, should existing grant funding be utilised earlier than planned, additional funds could be provided via the Regional Partnership Board to provide support to as many carers as possible this winter.

Priority 7: Keeping Everyone Informed

Communications have been developed within all action plans to support public and workforce understanding of our current pressures. Collaborative efforts have been established for joint communications within the TCG Communications sub-group that targets the following areas:

1. To reduce the number of incidents of winter respiratory viruses including Influenza and COVID-19.
    - Increase the uptake of immunisations using targeted communications and interventions amongst staff and the public.
    - Remind the public and staff that Covid is still circulating in our communities and we need to continue to share national best practice advice (eg. Hands, face, space, ventilation, outdoor socialising where possible).
    - Ensure a particular focus on RSV and the impact it has on children, including helping parents to understand how and where to access help.

- Sharing national guidance on Covid-19 testing and local information about how, when and where people can get tested.

2. Educate and inform the public on how to help themselves and others to stay healthy and manage long-term conditions

    - Encourage people not to leave worrying symptoms unchecked and urging people to visit their GP or local pharmacist
    - Promoting services that can help with adult and children's mental health issues
    - Help people understand how to effectively manage their long-term conditions
    - Urge people to take care of themselves in inclement weather (ie. Stay warm, exercise caution when out and about in icy conditions)
    - Encourage local people to take care of their more vulnerable family members, friends and neighbours

3. Increase public awareness on the reasons behind the current pressures and how people can best access our services.

    - Reminding local people that their NHS services have changed to make them fit for the future, with an emphasis on care closer to home
    - Help people to understand that we are still operating in a pandemic and the changes made to services are necessary and may never be the same again
    - The pressure on services is not unique to our Health Board – there are national problems due to staff shortages and an increase in demand due to Covid-19 and its knock-on effects
    - Influence the public to change their behaviour when accessing health services
    - Engage and work with the public to increase their understanding

Priority 8: Working Together Across Wales

Partnership working as been at the centre of our efforts to respond to the challenges within our system over the last 18 months. The increasing demand on statutory services, workforce capacity constraints and increasing complexity of those requiring our support, is placing unprecedented pressure on our integrated system.

This Integrated Plan articulates a broad range of planned activities to best mitigate further deterioration of our system pressures during a period of projected increased demand as we enter the winter period. The complexity of our situation with Covid-19 incident rates couple with a projected worsening of the seasonal flu incidence and impact on health and wellbeing, will further test the strength of our system.

Whilst the ambitions established within this plan are achievable, there are a few key challenges that have been highlighted that present a risk within the system if we are unable to sufficiently address. As a partnership we have identified these as areas of additional regional intervention and will utilise RPB winter funding to support the following:

1. Occupational Therapy

   As a role that supports both assessment at the front door and discharges, and also providing Reablement capacity within the community, our OT workforce is not meeting the current system demands with growing waiting lists for assessment and intervention. Health and Social Care continue to attempt recruitment into the temporary posts aligned with funding cycles, the vacancies are not being fulfilled, and little to no locum cover has been identified. As a Regional Partnership Board will be undertaking a joint permanent recruitment campaign underwritten by any available RPB budget to ensure we are able to right size our community therapy resource.

2. Domiciliary Care Workforce Stabilisation

   The challenges associated with the domiciliary care workforce mirror that of the therapy workforce, recruitment and retention are a growing concern, in a market where more lucrative opportunities exist within the retail or hospital sectors. This area is a priority for Welsh Government and has been identified both within the Health and Social Care Winter Plan and the Programme for Government commitments to address this issue. Ongoing discussions regarding an appropriate pay scale for this workforce are taking place, greater than that of the National Living Wage. In response to any confirmed pay rate for the sector, Gwent Regional Partnership Board will bring forward any implementation timeframes to further support recruitment, retention and resilience of the workforce over the winter period.

3. Micro enterprises

   We will be undertaking pilot establishment of micro enterprises as an alternative domiciliary care workforce

4. WAST Collaboration

   We are undertaking detailed scoping of viable options for short term initiatives in collaboration and wider partners to establish community based solutions to address system congestion/reduce conveyance (in addition and complementary to any existing planned activity)

5. Additional funding for unpaid carers

   Working closely with our regional partner for Carers Grants, Carers Trust South East Wales, we will consider any further funding requirements based on demands of unpaid carers so ensure we are supporting as many unpaid carers as possible over the winter period.

6. Extending our Step Closer to Home Pathway

   Support complex patients within the Step Closer to Home pathway who require support beyond the planned 6 week intervention timeframe.

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

Gwent Regional Partnership Board

Regional Integrated Winter Plan 2021-22

ASSURANCE REPORT

Executive Summary

The health and social care system entered the 2021-22 winter period with significant workforce challenges and capacity constraints. This shared position across Wales was reflected by the Minister for Health and Social Care in the All Wales Health and Social Care Winter Plan.

The national Winter Plan introduced eight priority areas for Regional Partnership Boards, Local Authorities and Health Boards, focussed on preventative activity with the intention of ensuring patient safety and the provision of social care for people in most need. The plan placed significant emphasis on the projections of increased demand across the system over the winter period.

The Gwent RPB Integrated Winter Plan brought together key actions of the ABUHB winter plan, and the social care recovery and restart plans, to identify our regional system resilience efforts. Several initiatives were tested to introduce alternative bedded capacity across the system to support flow through the hospitals into appropriate care where needed; these efforts are described under the term Step Closer to Home, providing the greatest tests of change within the integrated winter plan.

Under this approach, a step closer to home pathway was developed at pace, working with several care home providers utilising vacancies and supporting sustainability of the sector. It is recognised through the review that bedded capacity is not sufficient on its own to ensure people are able to optimise outcomes; there is a window of opportunity following a period of illness to support optimum recovery, this reablement and recovery is facilitated by both occupational therapy and physiotherapy support.

Partnership working was integral to the ongoing joint management of the system during the winter period, where the most significant system-wide challenges were experienced. Making use of multiple partnership forums across the Regional Partnership Board and Local Resilience Forum arrangements provided opportunity for thorough joint consideration of issues, resulting in a number of collaborative task groups. A governance framework was established reflecting these structures, to both support the management of the integrated winter plan and lines of accountability. As our system attempts to return to business as usual, enhanced joint planning within statutory partner organisations and partnership forums, facilitated by expanded membership, would provide the necessary whole system consideration in the development of winter plans going forward.

There are many aspects of the Integrated Winter Plan 2021-22 that can be repeated to provide the short-term additional capacity needed to respond to the expected rise in demand and increased staff shortages through illness during a winter period. There are also areas identified for further development, particularly those that are attempting to create additional capacity within the system to respond to the ongoing community workforce constraints. There is a balance to be sought between temporary short-term solutions to address additional winter demand, and longer-term sustainable solutions that will support ongoing system flow challenges, exacerbated through the pandemic.

Our joint efforts sought to overcome long standing challenges with temporary solutions, with limited success. Refreshed joint planning arrangements will need to reflect on the learning obtained through this review in the development of sustainable solutions in readiness for the winter period 2022-23, in alignment with the national 1000 beds initiative.

Background

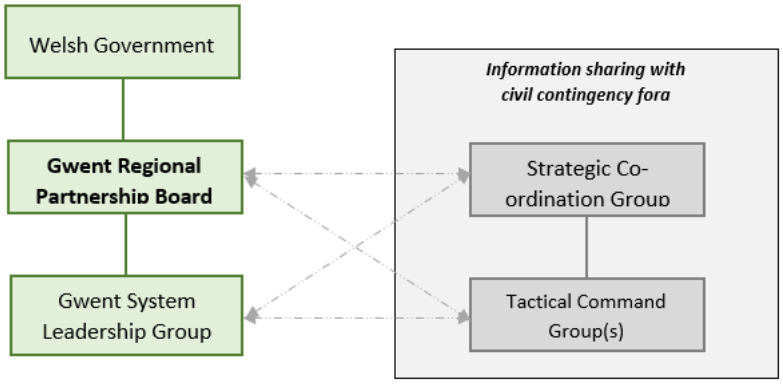
The Gwent Integrated Winter Plan 2021-22 was developed in alignment the All Wales Health and Social Care Winter Plan 2021-22. The plan was reflective of all system resilience and/or covid restart and recovery activity aligned with the priorities identified by Welsh Government. Positive feedback was provided to the RPB, ABUHB and Local Authorities. The detailed approaches, reflective of the hospital bed capacity modelling included within the plan, are commended within the feedback.

To support the delivery of the winter plan, a specific governance framework was developed that referenced the relationship between local resilience forums and the Regional Partnership Board, and its substructure. The governance framework identified the Community Care Sub-group as a key vehicle and proposed its evolution to a System Leadership Group with expanded membership. Whilst the expanded membership was reflected, the group continued to be referred to as the Community Care sub-group, and was chaired by a Director of Social Services.

System Leadership Group

This strengthened forum brought together all statutory partnership organisations as extended membership of the Regional Leadership group, to contribute towards joint risk mitigation and action delivery related to the business of the Regional Partnership Board. The lines of accountability and information sharing are visualised in Diagram 1 below.

Diagram 1. Winter Governance Structure and Information Sharing



Given the expanded membership of the group, decision making was achieved by consensus during meetings, however, the governance framework established quorate decision making within urgent circumstances along with nominated deputyship where needed.

Links to other partnerships

Regional Leadership Group

As the formal mechanism for the monitoring and governance of the RPB work programme, the planned meetings of the Regional Leadership Group, scheduled on a bi-monthly basis, were upheld to ensure wider RPB matters were discussed. Updates were provided from the Community Care Sub-Group (System Leadership Group) at these meetings.

Gwent Adults Strategic Partnership

As the key strategic partnership aligned with the activity of the Regional Integrated Winter Plan, Gwent Adult Strategic Partnership continued to meet monthly through the winter period, and was sighted on the developments within the Community Care Sub-Group (System Leadership Group) to support ongoing collaborative efforts.

Strategic Coordinating Group (SCG)

As the lead civil contingency forum, the Strategic Coordinating Group met on a regular basis to address system pressures that present potential threat to life. Information sharing was established between the SCG and RPB to support collaborative efforts and reduce any areas of duplication. A data dashboard was developed and circulated on a weekly basis to all SCG and CCSG members, comprising performance data from ABUHB, Social Care (aggregated data from 5 Local Authorities), Gwent Police, WAST and South Wales Fire and Rescue.

Assessment

Priority 1 within the plan focussed on the vaccine and immunisation booster programme, and the revised approach to test, trace and protect services. This work continued to be successful through the course of the winter period, and was reviewed on a weekly basis within our community care sub-group. Collaborative efforts across health and social care ensured we were able to maximise the care workforce included within this programme. In addition to health board staff across all disciplines, domiciliary care workers, social workers, allied health professionals, care home staff, along with unpaid carers, were all included in the vaccination programme. Opportunities were ceased to vaccinate vulnerable groups and staff groups at the same time where possible.

1,312,353 vaccines have been delivered between December 2020 and March 2022. An accelerated booster programme delivered 100,825 of these vaccinations to our higher risk and vulnerable groups, as well as the workforce described above. Across Wales, four of our five local authority areas feature within the six highest uptake rates for those aged 50 and over.

The approach undertaken in the management and implementation of the covid-19 vaccination programmes yielded success. The collaborative approach ensured the reach of the programme responded to the needs of our vulnerable groups, an approach that could be repeated or learning applied to other vaccination programmes in future.

Priority 2 and 7 centred on prevention and keeping people well. The national winter plan identified the potential increase in season flue and respiratory syncytial virus (RSV) that would lead to greater pressures than usual, with early indications of increasing number of hospital admissions with bronchiolitis.

Communications were undertaken across all statutory partners organisations via a range of mechanisms. Social media platforms proved very beneficial in supporting individuals to make the right choices when they need health or social care support. Communication and engagement were discussed regularly within partnership meetings, and a sub-group of the SCG established to support collaborative communications across the system, particularly in relation to the following areas:

1. Covid related communications: provided targeted communication to support uptake of immunisation programmes; sharing national best practice to mitigate risk of covid-19 and

guidance on accessing covid-19 testing; a focus on respiratory viruses to ensure people know where to seek help.

2. Informing the public how to stay healthy and manage long-term conditions

3. Increasing public awareness on the reasons behind system pressures and how best to access services.

In addition to proactive messaging and community engagement, preventative measures included within our restart and recovery activity to support respiratory pathways, committed to the development of a spirometry hub to provide direct access via GP referrals. The hub was successfully established in December 2021, and provided capacity 4 days per week. Six patients were able to be reviewed each day in alignment with social distancing and infection, prevention and control procedures. Up to the end of March, 493 patients were referred to the spirometry diagnostic hub, of which 441 were referred via primary care, and 52 by secondary care services. Of those that have been referred, 266 patients have been reviewed to date (2 July 2022), along with 64 failed attendances. The remaining patients awaiting review are booked with the hub and will be seen during July and August.

This work and the continued infection prevention and control measures within our communities has resulted in lower levels of flu and norovirus than those typically expected during a winter period. The flu vaccine uptake for those aged 65 and over was the highest in Wales, at 80%.

Activity to support Priority 3 – maintaining safe health services – provided additional capacity across the system, ensuring mental health support was available in our emergency department at GUH and extended working hours to provide additional Older Adult Psychiatric Liaison. The crisis support home opened in December 2021, to provide a safe alternative to inpatient admissions for those experiencing a mental health crisis.

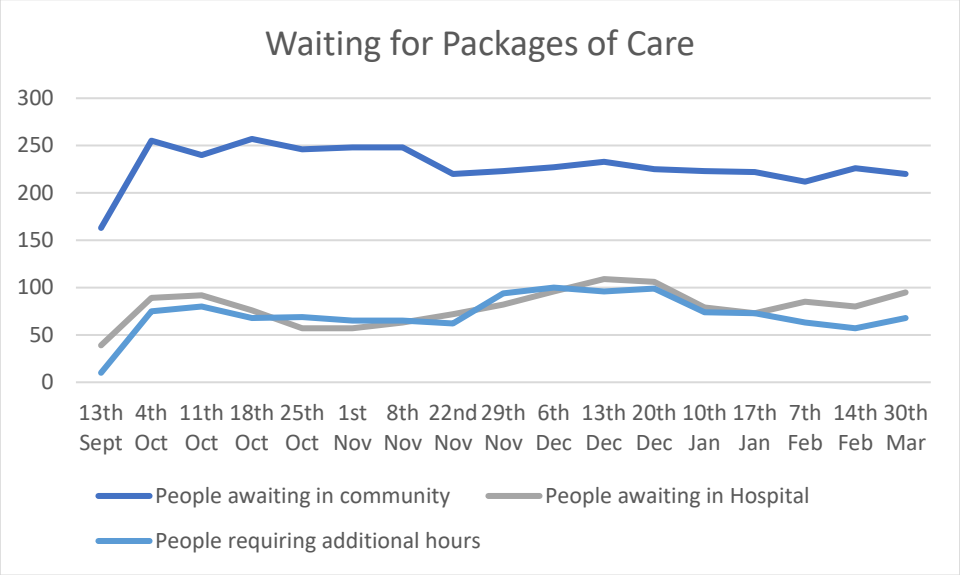
With the capacity constraints faced by social care, the ability to discharge patients from hospital was significantly impacted. In recognition of the system pressures and workforce constraints there was emphasis within this priority area to create additional capacity to support flow within the system. Under the step closer to home approach, a decommissioned ward within St Woolos Hospital was repurposed as a Step Closer to Home 10-bed Unit, supporting patients to manage their own health conditions, restoring functionality, improving wellbeing and supporting self-care. The staffing model for this unit was therapy led, with nursing care also provided. Medical support for the model was provided by Urgent Primary Care GPs.

70 patients have been admitted and discharged from the unit. The average length of stay for these patients was 9.87 days, a significant improvement to the occupancy previously indicated within a "green ward" environment. In terms of care needs and outcome of enhanced interventions during their stay, there has been an overall average Package of Care reduction of 1.38 calls per person per day. 32% of patients were discharged from the unit fully independent of care needs despite initial discharge plan indicating a requirement for a package of care.

The unit was set up quickly with limited opportunity for robust and thorough Health Board-wide communication regarding ethos and processes. Consequently, there was mixed understanding of the purpose and remit of this unit. Ensuring workforce engagement on pathways available will be key for future tests of change.

The test of change enabled within Step Closer to Home Unit will see the model now move to a community setting. It is proposed that 8 of the 15 beds within the locality-based step up/down facility in Parklands Residential Home, Newport, will be ringfenced for this model as a step-down from hospital. This capacity forms part of the existing RPB Place Based Graduated Care Programme.

Priority 4 – Maintaining our Social Care Services – placed significant emphasis on the resilience needed within the domiciliary care sector. Existing packages of care have been reviewed to release capacity where possible. The community care sub-group and SCG reviewed weekly figures regarding the workforce position within social care, and sought to maximise the use of the step closer to home pathway to support the position. Our complex care team also provided assistance with the commissioning of community packages of care to further support patient discharge via the step closer to home pathway.



Alternative approaches to commissioning continue to be tested across the region to ensure right sizing of packages of care, to free up capacity wherever possible. The support provided via the complex care team utilised available domiciliary care capacity within the Step Closer to Home pathway, with significant benefits realised in Caerphilly due to available capacity of New Directions. This additional support has been welcomed by social care colleagues.

Priority 5 – Supporting our Health and Social Care Workforce has been a key consideration of the plan and regularly discussed within our community care sub-group. ABUHB and local authority partners have implemented additional wellbeing and psychological support for its workforce. In addition, where possible, incentives have also been provided to the workforce.

The Melo website was established providing a useful resource of self-help materials, along with the Connect5 training programme to support emotional wellbeing of those in receipt of training, also aiding identification of those that may need emotional wellbeing support. This area of work remains as part of the RPB Enhanced Foundation Tier programme.

Priority 6 – Supporting our unpaid carers was a key component of the social care restart and recovery programmes, and reflects the existing work and commitments of the Regional Partnership Board. Additional grants have been made available to our unpaid carers and, where viable, alternative respite solutions offered.

2022-23 saw the greatest level of financial support available for unpaid carers. A significant amount of grants were provided across the region during this time facilitated by Carers Trust South East Wales, now operating as the Carers Collective. In addition, unpaid carers were prioritised for covid-19 vaccinations, and continue to be in receipt of free PPE and LFTs via local authorities.

Priority 8 – working in partnership – has been at the centre of our efforts to respond to the challenges within our system over the last 2 years. The increasing demand on statutory services, workforce capacity constraints and increasing complexity of those requiring our support, has placed unprecedented pressure on our health and social system.

This priority area focussed on the joint responses supporting delivery of the winter resilience efforts, and the utilisation of specific winter funding provided to the Regional Partnership Board.

The investment plan reflected the key consideration of the Regional Partnership Board of the support needed within the care sector to maintain resilience of the existing workforce capacity, particularly with the known impact of the Christmas retail period, where pay rates are significantly higher than that of the care sector. The RPB provided over £1million to support an increased salary to community carers to best mitigate further staff loss during this time.

The financial support provided to existing care staff commissioned by social care during the winter was received positively. Feedback from Heads of Adult Services the positive stabilising effect this had, preventing further deterioration of the workforce. However, recruitment continues to prove challenging given the ongoing cross-sector workforce competition and lack of competitive pay rates for care workers. In many instances, providers have already exceeded the pay level and still face recruitment challenges. Rising fuel costs are now also adding to the challenges facing the carer workforce, and consideration needed on the support that can be equitably provided across the region.

Ongoing recruitment efforts for occupational therapy posts have not yielded success to date. Close working has been established to join the NHS streamlining process for Occupational Therapy graduates, and recruitment efforts continue across all local authorities.

<u>Step Closer to Home Pathway</u>

The step closer to home pathway was established to utilise available care home capacity to provide step down for patients who were unable to return home without support. The pathway was developed at pace with social care colleagues to support decision making for patients suitable for the pathway. It established two mechanisms of capacity; utilisation of bedded capacity within care homes across the region, and additional domiciliary care runs facilitated by New Directions. Both mechanisms were facilitated by ABUHB's complex care team. It was intended patients would be placed on this pathway for approximately 6 weeks, the average length of stay for those supported was just over 8 weeks.

95 patients were supported in this pathway during the 2021-22 financial year, of which evaluation has been possible for 93 of the patients due to data availability. 53 individuals were discharged home, of which 35 were directly discharged via New Directions with domiciliary care support.

Of those patients that were supported via this pathway within care homes, 12 individuals passed away, 2 of which died post placement, 18 individuals were discharged home, and 14 individuals remained as a resident of the care home following the placement. This demonstrates for patients discharged and supported within a care home via the existing pathway, 23% remain as a permanent resident. It also identifies 10% of patients transferred to a care home placement died whilst on the pathway. The average length of stay within hospital prior to discharge for patients who died was 105 days.

Information relating to advanced care plans was not considered during this review, however, learning must be utilised in the development of new solutions to ensure Advance Care Plans are considered when deciding discharge pathways.

Further analysis was undertaken to understand a person's whole pathway, exploring a hypothesis of a longer length of stay in hospital prior to discharge via the step closer to home pathway would have a negative impact on longer term outcomes. The evaluation demonstrated the longest average length of stay prior to hospital discharge was for the patients who died within pathway – no further correlation was identified between length of stay prior to discharge, duration of medically fit within hospital, or the time spent within the pathway.

The introduction of the pathway has provided much needed capacity within the system, however, utilisation of the pathway can only be described as moderate. Professional views obtained during the winter plan review identified both mechanisms of additional domiciliary care capacity and access to bedded care provide valuable support, but acknowledged the wrap around support needed for any bedded capacity to ensure outcomes can be optimised for each individual to ensure maintenance of personal independence skills wherever possible.

Joint Approaches to Planning

Partnership working was integral to the ongoing joint management of the system during the winter period, where the most significant challenges were experienced. Making use of multiple partnership forums across regional partnership board and local resilience forum arrangements, provided opportunity for thorough consideration of issues, resulting in a number of joint task groups. A governance framework was established reflecting these structures, to both support the management of the integrated winter plan and lines of accountability. Enhanced joint planning within statutory partner and partnership forums, facilitated by expanded membership, would provide the necessary whole system consideration in the development of solutions.

Colleagues included within the review identified the mechanisms utilised to both develop and manage key actions in response to winter pressures and continued system resilience. Whilst several partnership mechanisms were in place, there was acknowledgement to a lack of integrated and joint planning that would aid a whole system approach to our resilience plans.

The transparency and information sharing established within the data dashboard has led to the development of a whole system data viewer, supported by Lighfoot Solutions. This viewer combines live health board data with static weekly uploads of data from other sectors of the local resilience forum, and will be available as a tool to aid our whole system planning efforts and joint responses through the 2022-23 winter period.

Conclusion

As a response to any winter period, where additional capacity can be generated within our existing workforce, this supports expected periods of increased ill-health across the workforce during the winter period. Introducing enhanced services, such as additional clinics and/or additional sessions also supports a planned influx of demand across the system.

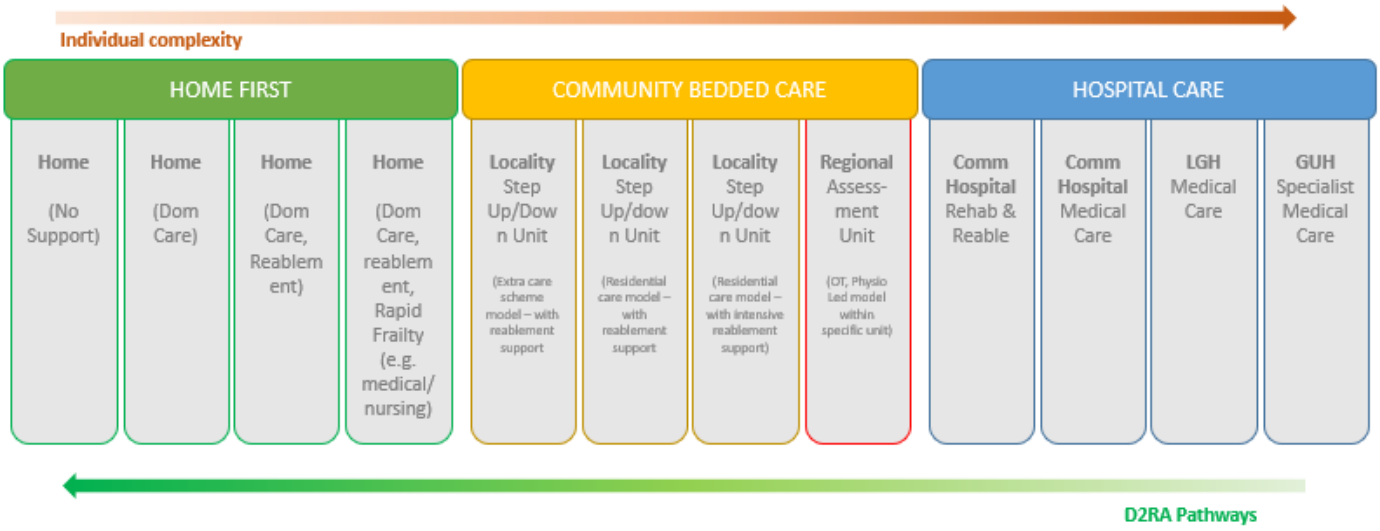
The planned efforts within the winter plan to introduce additional community capacity on a temporary basis proved a useful test of change, however, the short term nature of new models accompanied by some reticence of our providers to engage in short term activity, suggests that a longer term solution is needed to support system resilience all year.

These findings particularly relate to the Step Closer to Home pathway developed at pace in preparation for the winter period. It is recommended that both the additional domiciliary care capacity and bedded care provided within the pathway continue, however, an alternative model of bedded care is currently being scoped to respond to the learning from the review.

The recommendation is to develop one or two regional facilities as an immediate graduated response from a hospital where needed. It is proposed that these facilities would either be provided from an entire wing of a residential care setting, or where possible a whole building. This approach is in favour of ad-hoc bed utilisation as our greatest chance of providing wrap around reablement support, would be to do so centrally.

The placement of this capacity within the system is shown within a visual interpretation of graduated care across the health and social care system, referenced as the Regional Assessment Unit. A specification will be developed at pace to engage with the provider forum via a tendering process the availability of this capacity.

Diagram 2. Visual Interpretation of Graduated Care



This approach will be at the more complex end of a menu of graduated care options that will be identified and articulated to our health and social care staff. As identified within the learning of the step closer to home unit, nearly a third of patients were identified as having a requirement for a package of care upon discharge but were able to be discharge home fully independent following a small period of reablement intervention.

Engagement with the workforce on both the discharge pathways available and Discharge to Recover and Asess (D2RA) approaches to ensure full assessments of care needs are not undertaken where rehabilitation and reablement can be provided, supporting a right sizing approach within our communities and appropriate utilisation of our domiciliary care capacity.

There has been great value in bringing together colleagues from across the system to reflect on the delivery of the winter plan, and the forum established to support this is proposed to continue to support ongoing planning activity. Furthermore, it is recommended that partnership colleagues are included within specific Health Board winter planning meetings to ensure collaborative and seamless planning efforts.

TECHNOLOGY ENABLED CARE

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National VC Programme

Scale & Spread Project

Prof Alka Ahuja National Clinical Lead

Sara Khalil Programme Lead

TEC in Wales

Excellent work undertaken…

BUT

- **Slow and fragmented**
- **Lack of clarity around needs**
- **Organisational ownership**
- **Technology led**
- **Cultural change**
- **Short term funding**
- **Limited scale & spread**
- **Lack of evidence**
- **No platform to scale up / prioritise investment**

Supporting the Shift to Technology Enabled Care

TECHNOLOGY ENABLED CARE
tec
CYMRU

Increasing the understanding and knowledge of Technology Enabled Care

Support the rapid scaling of Technology Enabled Care

Supporting culture change

Provide the evidence base for TEC investment and implementation

Scale & Spread of Video Consulting

What has happened so far?

From April 2020, Video Consultations (VC) were rolled out nationally across Welsh Health Boards. Since then, there have been over 330k consultations in over 50 specialities that has helped maintain a continuity of care between clinicians and patients. VC has improved equity and access to care and helped to increase digital skills, knowledge & confidence within the workforce.

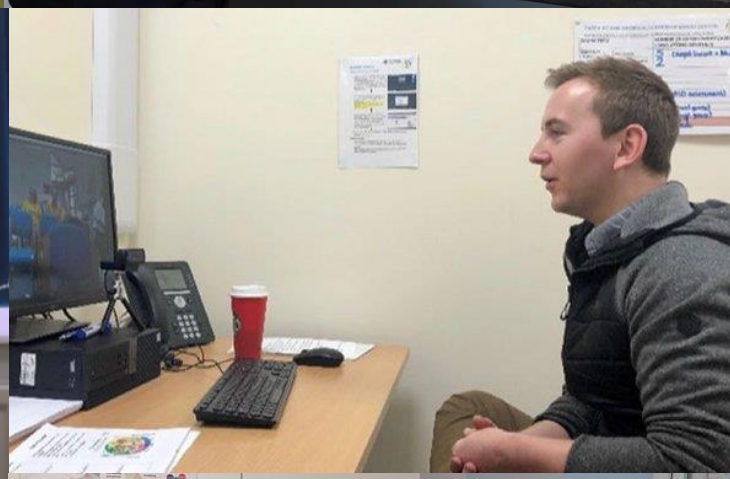
What is the aim of Scale and Spread?

The overall aim of VC Scale and Spread is to increase the uptake of the number of clinics, users and consultations across services and put measures in place to ensure its sustainability going forward. This will be achieved by identifying a series of specialities and user groups that are high-flyers using VC and that can help to improve the service for others adding to existing campaigns surrounding VC. This will include targeted VC consultancy, training and the creation of deliverable resources.


PROTECT YOURSELF OTHERS & THE NHS
GIG NHS




lenovo


Collaboration & Focus Points

How can you help us?

Within Scale and Spread we would like to know:

- **Your experience** – How are you using VC? What are your motivations and attitudes towards using it?
- **Adaptations** – Have you made any changes to conduct your practice online? How do you identify if VC is suitable for the appointment?
- **Areas of concern** – Any technical, safeguarding, suitability and utilisation issues going forward?
- **Recommendations** - What can TEC do for you developing channels of support, collaborating to develop top tips and hints?

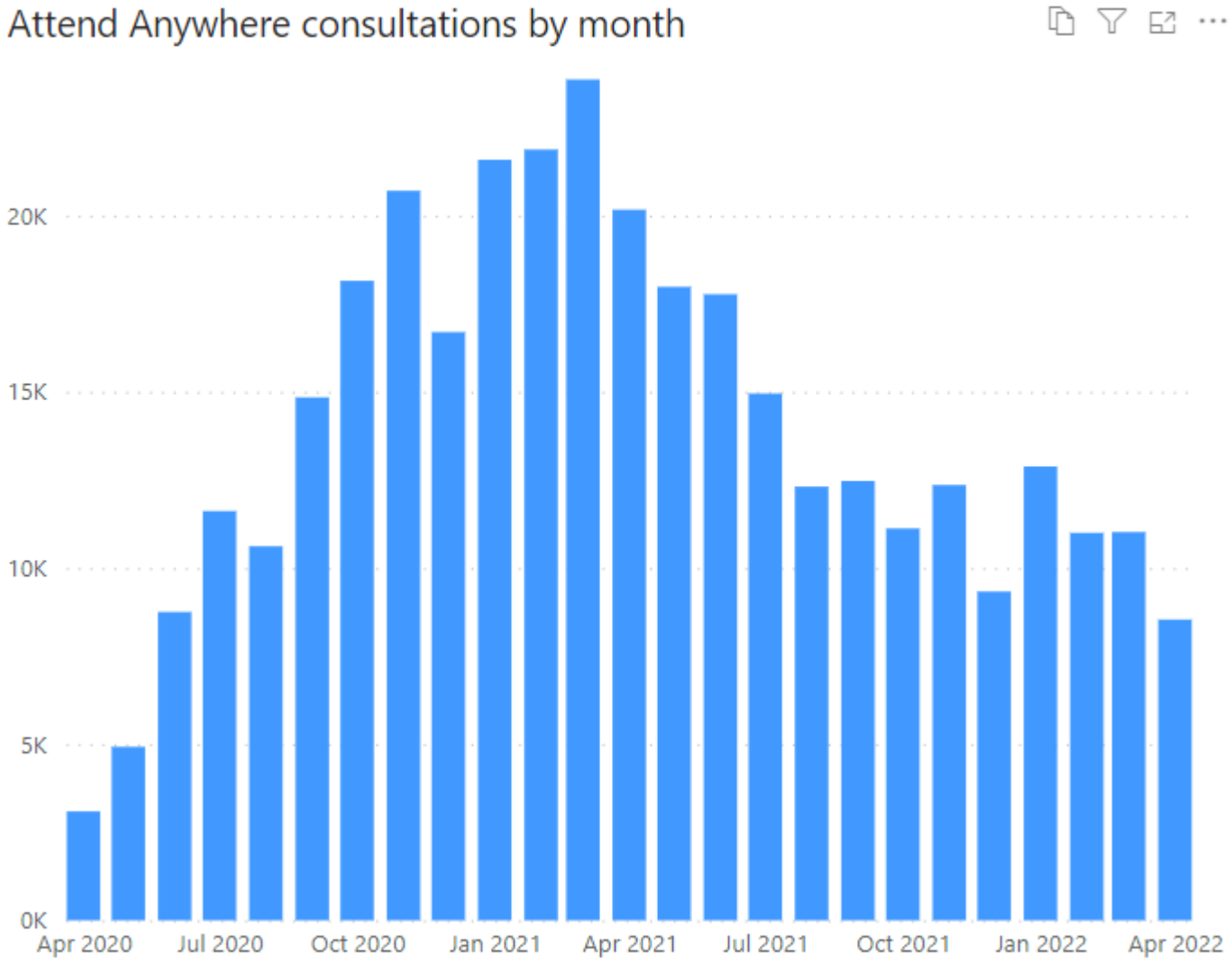
Key focus points:

- Identifying VC Champions
- Sharing best practice across HBs and specialties
- Resolving technical challenges
- Better supporting your patients
- Improving understanding and benefits of using VC for clinicians and patient

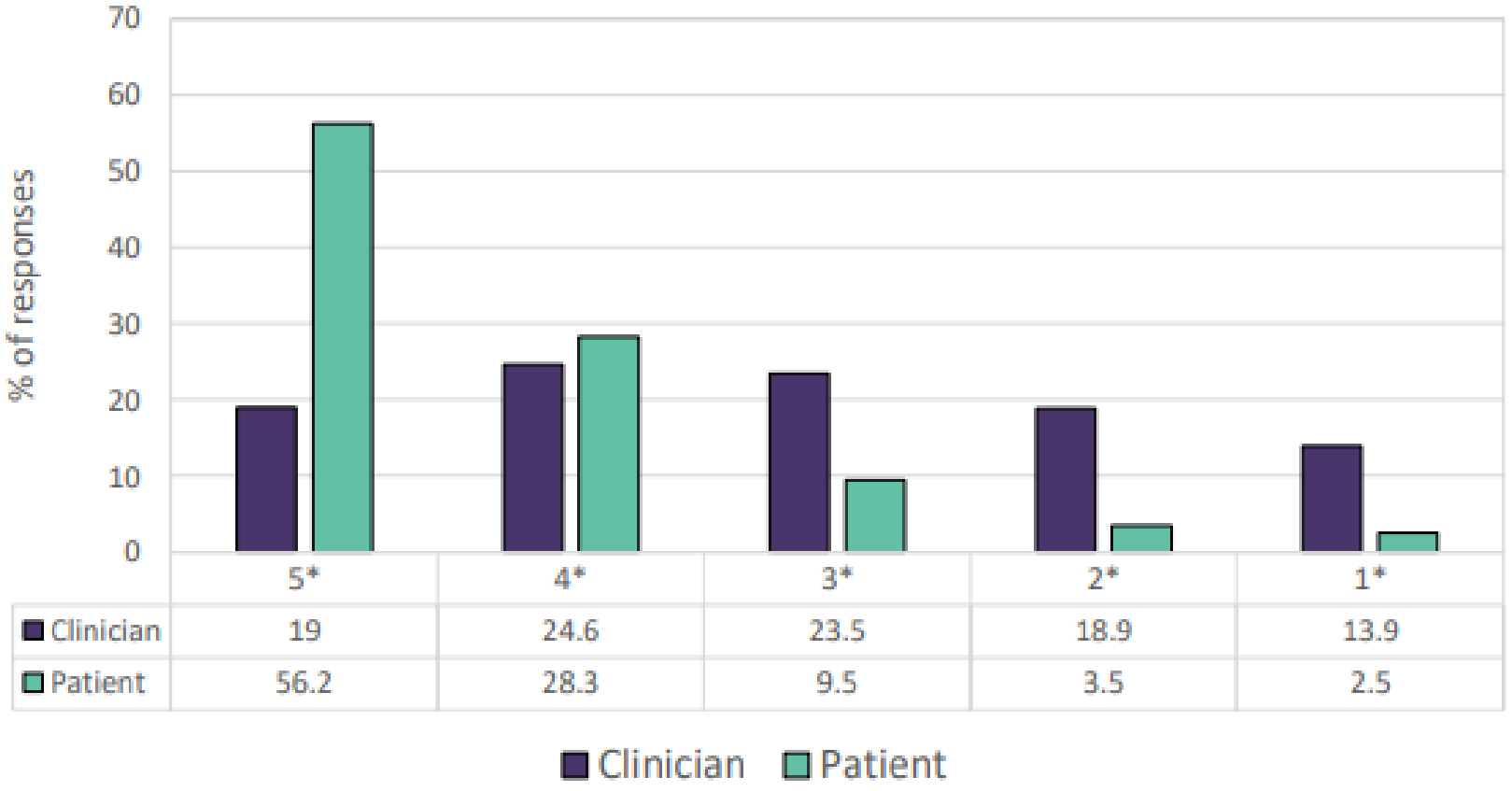
Top 10 Areas

Row Labels	ABUHB	BCUHB	CTMUHB	CVUHB	HDUHB	PTHB	SBUHB	Total
Physiotherapy	3354	109	254	2325	630	1247	1918	9837
Speech & Language Therapy	3842	493	654	1344	575	167	1106	8181
Psychiatry & Old Age	363	0	0	6338	55	0	0	6756
Community Mental Health	2134	119	1481	0	810	679	0	5223
Child & Adolescent Psychiatry	256	840	2294	61	745	396	0	4592
Obstetrics & Gynaecology	0	0	221	2783	272	0	1225	4501
Dietetics	426	98	80	304	1405	138	533	2984
Occupational Therapy	53	0	12	1609	491	13	190	2368
Paediatrics	1209	53	10	245	130	60	414	2121
Mental Health Nursing	568	0	0	0	0	0	1265	1833
Neurology	33	272	0	792	3	0	713	1813

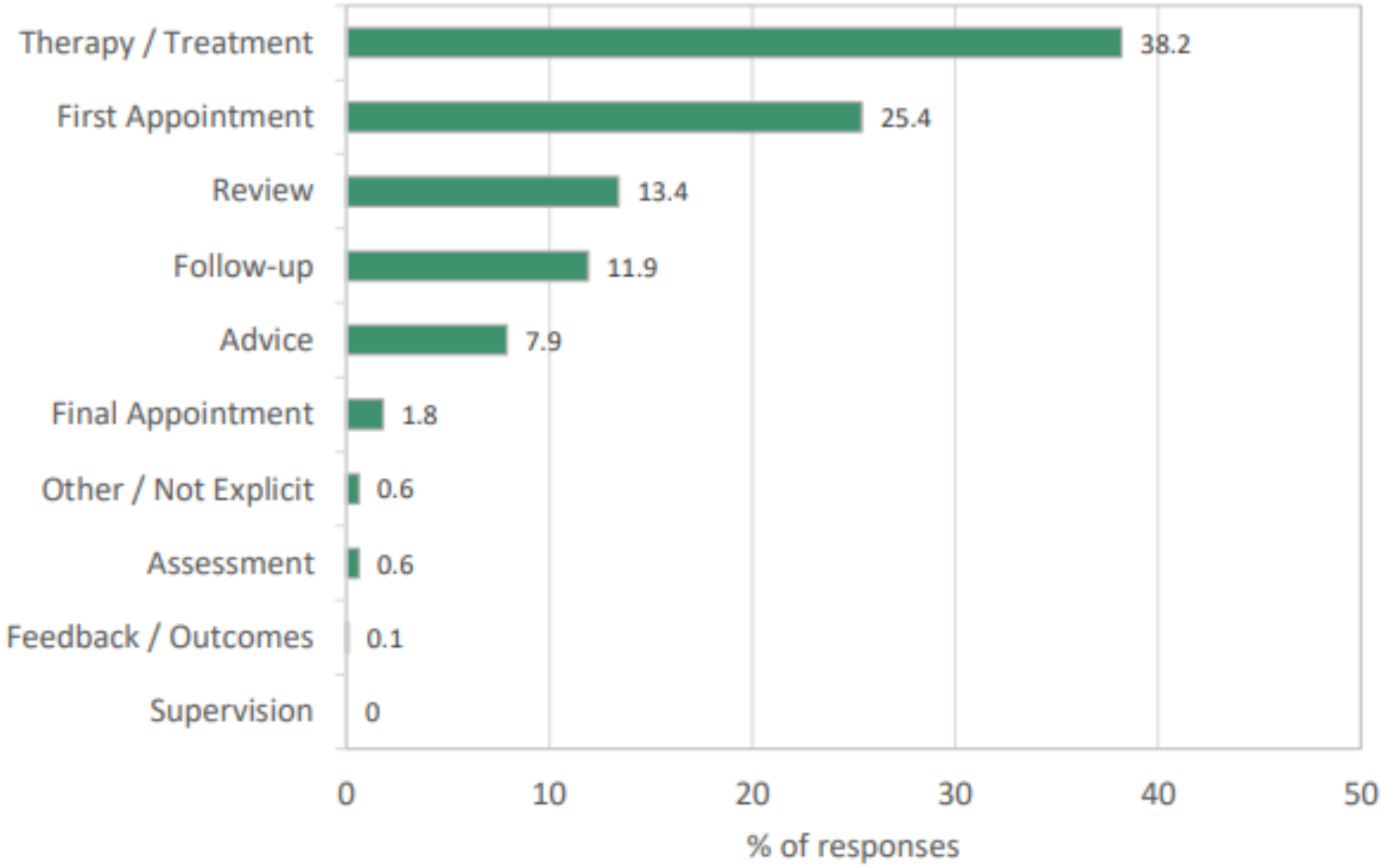
Usage by month – sustainability



Quality Rating of AHPs



Appointment Types for AHPs



What we are doing next...

- Contacting clinical leads within each Health Board to discuss Collaboration and Focus Points
- Looking at the use of a Virtual Receptionist/admin support to help clinicians with IT issues and the organisation of VC appointments
- Organising community of practice events with Physiotherapists and Speech and Language Therapists to promote benefits for patients and clinicians when using VC to ensure its future use
- Organising an engagement dinner / workshop

<Insert department or service>

<Insert organisation>

TECHNOLOGY ENABLED CARE
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Our experience

How are you using VC? What are your motivations and attitudes towards using it?

Adaptations

Have you made any changes to conduct your practice online? How do you identify if VC is suitable for the appointment?

Recommendations

What can TEC do for you developing channels of support, collaborating to develop top tips and hints?

Areas of concern

Any technical, safeguarding, suitability and utilisation issues going forward?

Case Study example

Use this area to share an interesting patient story using VC…

Highlight something special about your practise…

Top Tip for VC

Share your best tip to get the most out using VC in practice…

Our favourite thing…

Share something you enjoy about using VC…

Check out our website and you tube channel for…

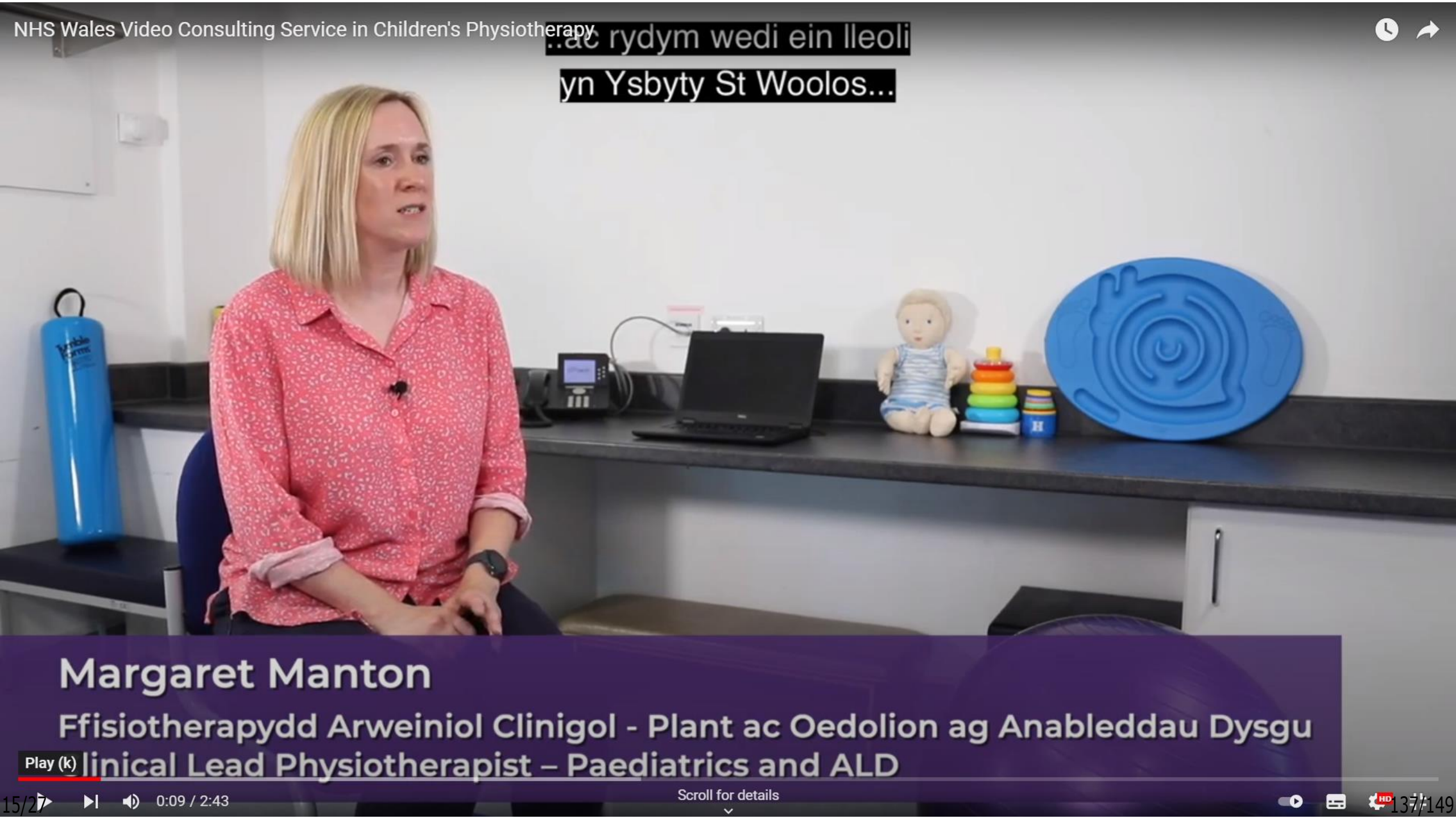
Video Case Studies - YouTube

Explainer Videos for patient and professionals

A range of training courses ...including virtual groups

TEC Project Register

Research and Evaluation | Publications and Reports


NHS Wales Video Consulting Service in Children's Physiotherapy
..ac rydym wedi ein lleoli
yn Ysbyty St Woolos...
Margaret Manton
Ffisiotherapydd Arweiniol Clinigol - Plant ac Oedolion ag Anableddau Dysgu
linical Lead Physiotherapist – Paediatrics and ALD
Play (k)
0:09 / 2:43
Scroll for details
15/27
137/149


NHS Wales Video Consulting Service in Podiatry & Vascular Services
Mae Attend Anywhere wedi bod
yn ddefnyddiol iawn...
Melissa Blow
Podiatrydd Arweiniol Clinigol Diabetes a Hyfywedd Meinwe
Clinical Lead Podiatrist Diabetes and Tissue Viability
Play (k)
0:07 / 3:19
Scroll for details


NHS Wales Video Consulting Service in Speech & Language Therapy
My name is Delyth Dando,
and I work at Aneurin Bevan...
Delyth Dando
Therapydd Iaith a Lleferydd Arbenigol
Specialist Speech and Language Therapist
Play (k)
0:06 / 2:10
Scroll for details

Physical Assessments in a Virtual World

21 September 2021, 09:00 - 10:30

With video consulting (VC) entering business-as-usual and not just a pandemic response, more and more specialities in NHS are incorporating VC in to their practice.

Do you need to conduct physical assessments of patients as part of your role or to provide intervention/treatment? Are you using video consulting to its fullest potential? In this webinar you'll hear from clinicians who have adapted to using video consulting to conduct physical assessments and are offering intervention virtually.

Who attended?

- Art therapists
- Music therapists
- Drama therapists
- Dieticians
- Occupational therapists
- Orthoptists
- Orthotists
- Paramedics

Using Video Consulting in NHS Physiotherapy

Video Consulting & Physiotherapy

Using video consulting to deliver physiotherapy advice, support or treatment has been in place in NHS Wales for more than two years, with many success stories and many reported patient, family, clinician, and NHS benefits.

Benefits of Video Consulting

- ✓ Less travel, parking & CO2
- ✓ Less stress & anxiety for patients/families
- ✓ More flexibility and convenience
- ✓ More coordinated and independent care

What can be done virtually?

Given the 'hands-on' nature of physiotherapy, there can be a misperception that delivering it virtually may be unsuitable.

However, NHS feedback suggests that virtual physiotherapy can support patient needs in many ways.

There are multiple ways video consulting can be used in physiotherapy

- Triage & screening
- Virtual demonstrations
- Virtual exercise routines
- Check-ins and advice
- Patient self-management
- Virtual groups
- Post-operative care

Please note this is draft and under consultation

Using the 'ears, eyes or hands' triage tool

When clinically determining a patient triage for a physiotherapist appointment, use the 'ears, eyes or hands' technique to help.

Ears

Do you need to listen to patients to provide advice or to provide verbal support?

If so, the telephone appointment may be suitable for this type of patient need.

Eyes

Do you need to see the patient, such as observing them complete an exercise?

If so, a virtual appointment with a camera may be suitable for this type of patient need.

Hands

Do you need to put your hands on the patient to do a physical examination ? Or is the patient at any risk or harm?

If so, a face-to-face appointment is suitable for this type of patient need.

Think of a patient's 'needs' over general 'requirements'

Recommendations

1 Planning Prior to VC

Familiarise yourself on how to set up and join a video appointment.

Keep a telephone number handy for IT support if you have an issue.

2 Extra Considerations

Physiotherapists could provide patient information in advance. This may include:

- 'How to guides and videos' on the how to use the video appointment platform.
- A list of appointment choices as a 'blended approach' for physiotherapy.
- Offer a pre-appointment to 'test out' a video appointment system, digital ability and device/internet quality.
- Discuss additional requirements, e.g., who needs to be present for appointment, or any additional resources that may be needed.
- Send email or text reminders a day or two before each video appointment.
- Consider using a 'virtual receptionist' model (due to be piloted by TEC Cymru)

Video Consulting: Use, Preference & Value

TEC Cymru interview analysis found that demonstrate there were particular situations in which physiotherapists preferred or valued video appointments.

For example, appointments for:

- Geographically remote patients
- Complex needs patients
- Multidisciplinary teams or multiple clinicians
- Highly stressed or anxious patients
- Paediatric patients, with parents who struggle to get time off of work / patients from school.

> Its good for connecting people. For instance we could have two physiotherapists from two totally different areas in the health board meet up to help someone without having to travel anywhere.
>
> - Physiotherapist, CAVUHB

Physiotherapist Testimonies

> "It is particularly useful in some of our younger children who don't feel very comfortable in clinic settings... Being able to have that window into their home to see them and how they'd behave at home is a real asset to our assessment skills..."
>
> - Physiotherapist, BCUHB,

> "We're using the video calls as more of a triage system. So the patient will feel happy that if we are happy that we have seen everything what we need to see. But... we can still see them face to face"
>
> - Physiotherapist, BCUHB

3 IT Considerations

Physiotherapist may want to establish a relationship with their local IT support team.

Many IT problems can be easily resolved using simple troubleshoot solutions.

Speak to your IT team about these.

3 In Case of Emergency

Keep contact details / address on hand in case there is a need for contact or physical emergency.

Ensure safety netting is in place.

Ensure clinical suitability has been established.

Red Flags

In some situations , physiotherapists consider video appointments as "clinically inappropriate".

These can include a patient who:

- Has complex needs or co-morbidities.
- Are high risk or safeguarding concerns.
- Need a physical assessment.
- Need in-person, emotional support.
- Are considered too frail or vulnerable.
- Has limited access or ability to technology or good internet speeds.

Diolch
Thank you

Cadwch mewn cyswllt…
Stay in touch…

teccymru@wales.nhs.uk

digitalhealth.wales/teccymru

@teccymru

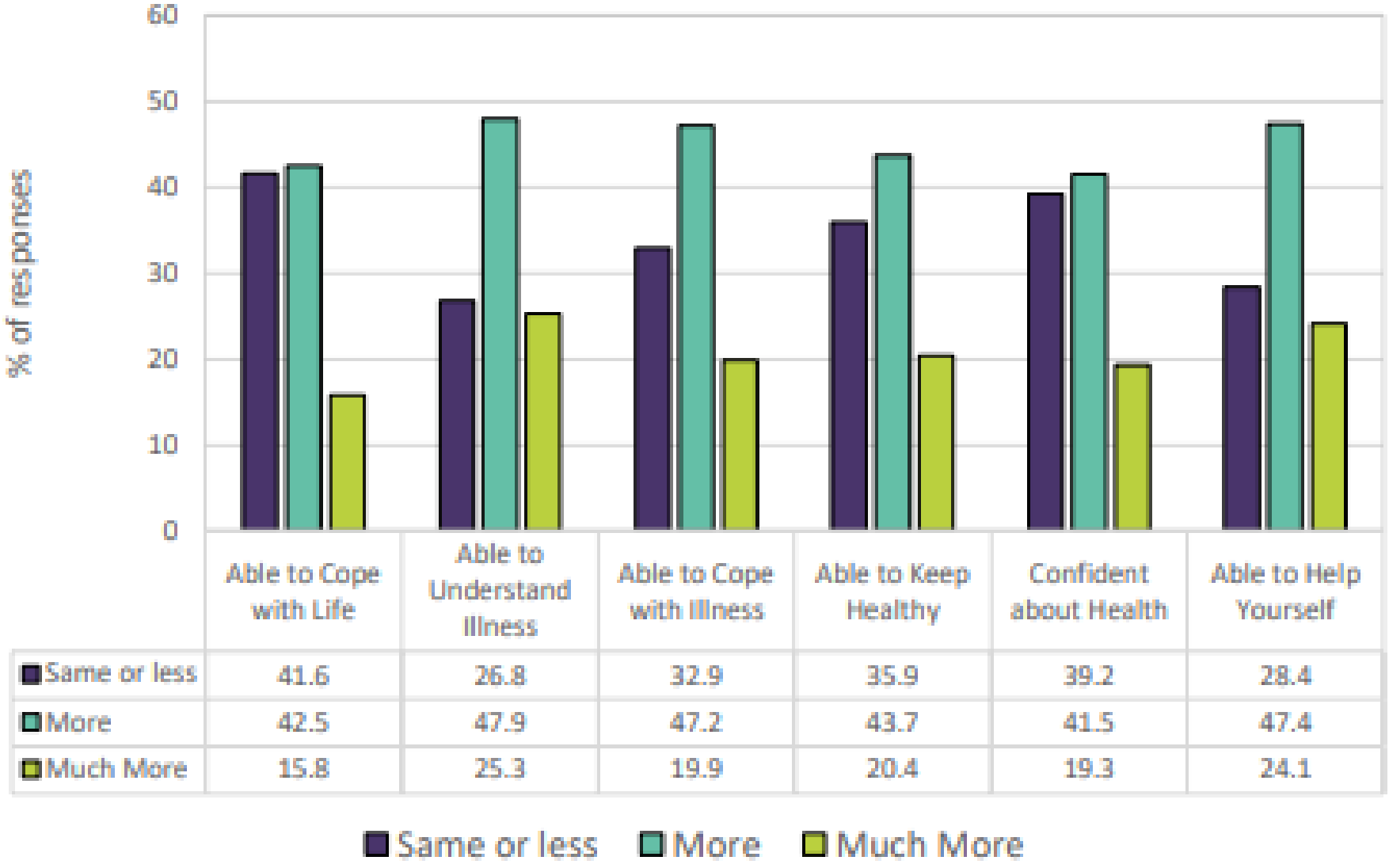
@teccymru

TEC Cymru

Patient Benefits

Patient Benefits of VC	Saved Time & Preparation	Saved Travel & Parking	Saved Environment	Saved Taking Time Off	Saved Money	Improved Access to Care	Improved Convenience	Improved Family Involvement	Lowered Risk of Infection
Not at all	1.3	1.1	1	4.1	4.4	2.3	1.9	5.9	0.8
Not	1.4	1.7	1.3	5.8	5.6	2.4	2.7	6.3	0.8
Quite	9.9	5.7	6.8	9.7	10.1	9.9	8.9	10.9	4.8
Beneficial	25.6	15.1	18.1	18.4	18.2	23.3	19.2	20.5	14
Very beneficial	61.7	76.4	72.8	62	61.6	62.2	67.3	56.4	79.6
Total Responses	5512	5261	5323	3960	3893	5105	5447	3545	5494

Patient Enablement Scores



	Able to Cope with Life	Able to Understand Illness	Able to Cope with Illness	Able to Keep Healthy	Confident about Health	Able to Help Yourself
Same or less	41.6	26.8	32.9	35.9	39.2	28.4
More	42.5	47.9	47.2	43.7	41.5	47.4
Much More	15.8	25.3	19.9	20.4	19.3	24.1

Clinician Benefits

Clinician Benefits of VC	More Efficient use of time/space	Saved Travel & Parking	Saved Environment	Increased Access to Care	Reduced Wait Times	Reduced DNA	Improved Family Involvement	Lowered Infection Rates
Not at all	3.6	3.3	4	3.8	7.3	8.2	8.2	1.3
Not	7.8	3.1	5.3	11.8	18.1	18.1	16.3	0.9
Quite	22	14	13.9	20.6	15.8	23.7	22	6.2
Beneficial	29.2	27	28.2	28.6	25.6	22.9	25.8	13.1
Very beneficial	37.5	52.6	48.7	35.2	33.2	27	27.7	78.5
Total Responses	3532	3491	3486	3436	3075	3196	2969	3536

Patient Challenges

Patient Challenges with VC	Issues with Device	Issues with Internet	Issues with Visuals	Issues with Audio	Issues with Safe Space	Lack of Confidence	Not Suitable for Clinical Needs	Preference for FTF or Phone
Not at all	83.2	84.3	81.4	73.5	96.6	87.1	86.8	55.7
A little	10.8	10.2	11.5	16.6	2.4	9.5	8.2	19.2
Some	4.6	3.8	4.5	6.2	0.7	2.7	3.3	13.5
A lot	1.4	1.7	2.6	3.7	0.2	0.8	1.7	11.6
Total Responses	5527	5450	5561	5542	5442	5478	4673	4880

Clinician Challenges

Clinician Challenges with VC	Issues with Device	Issues with Internet	Issues with Visuals	Issues with Audio	Issues on Patients side	Lack of Confidence	Not Suitable for Clinical Needs	Preference for FTF or Phone	Patient's Preference for FTF
Not at all	74.9	67.5	58.1	58	61.1	93.3	75.7	51.9	58.4
Quite	8.2	11.7	15.7	13.3	14.4	4.6	14.6	18.2	17.9
Relevant	7.9	10.5	11.1	11.6	13	1.6	6.4	18	14.5
Very Relevant	9	10.3	15.1	17.1	11.4	0.5	3.3	12	9.2
Total Responses	3298	3300	3379	3346	3299	3109	3143	3171	2977