

Integrated Medium Term Plan (IMTP)

2020 - 2023

Welcome to Neath Cluster IMTP 2020-2023

Section 1 - Executive Summary

Welcome to Neath Cluster's first Integrated Medium Term Plan (IMTP), which sets out the cluster's direction of travel for the next 3 years.I have been Neath Cluster lead since 2016 and continue to enjoy the role and the many different experiences and learning opportunities this has afforded me that would not normally be part of my usual GP role. There have been challenges along the way but I feel these have given me the opportunity to grow in both the leadership role and personally.

I feel very lucky to be part of an enthusiastic, engaged cluster. We work extremely well together with common vision and willingness to move away from the traditional model of care looking more to Multidisciplinary Team (MDT) working and ways of dealing with local sustainability issues. The MDT model is helped by the cluster employing a pharmacy technician and we are in the process of appointing two cluster pharmacists. We look forward to seeing the benefits these bring. We have also run a series of training sessions upskilling HCSW staff and plan to develop a robust training plan for the wider primary care team..

We have a large range of cluster members with representatives from our primary care partners and the third sector. We have many projects with third sector partners including a project aimed at improving the wellbeing of young people with low-level mental health and social problems. The third sector is also vital for our patient engagement forum, which is an enthusiastic and proactive group of patients who meet on a quarterly basis.

We have been privileged to receive Welsh Government Pacesetter funding locally with which we have developed a primary care hub. This funding has been instrumental in the development of the cluster and the way we work together. The hub continues to grow and currently provides physiotherapy, audiology and mental health services for patients closer to home. It supports vision 360, improving communication for the health care professionals and enabling better patient care.

Although the cluster has made a lot of progress in testing out ideas, we still have concerns in relation to successful projects not being taken over by the Health Board and funded as core business. Also, the annual cluster funding cycle creates uncertainty. Despite these challenges, I feel we are a really well established cluster, which has achieved a great deal with cluster funding and look forward to continue building on our successes.



We are now benefiting from Transformation funding which offers the cluster the opportunity to develop further ideas at pace. We shall use the next 3 years to embed successful projects, strengthen our engagement and involvement of patients and partners and continue the drive to improve primary care sustainability and the wellbeing of our patients.

Plan on a Page

Strategic Overview

The transformation programme offers the cluster the opportunity to develop further ideas at pace. We shall over the next 3 years to embed successful projects, strengthen our engagement and involvement of patients and partners and continue the drive to improve primary care sustainability and the wellbeing of our patients. *Dr Deborah Burge Jones*.

Vision

To develop links within our community that will enable timely & appropriate care to those who require our services.
To work together to ensure those services are sustainable & of the highest quality possible, and provided from within the community wherever possible

What We Will Do

We will prioritise the following:

- *Prevention, wellbeing and self-care:* Diabetes pprevention, supporting the 'Safe & Resilient Communities' Programme, weight management, patient education, uptake of the influenza vaccine and the MMR vaccine in patients 16-24
- *Timely, equitable access and service sustainability*: Implementing the Access to In-Hours GMS Services Standards and exploring areas of collaboration with community pharmacies,
- *Rebalancing Care Closer to Home:* Supporting the development of a community phlebotomy service, delivering flu vaccinations to housebound patients, supporting further development of the Neath Primary Care Hub
- *Implementing the Primary Care Model for Wales***:** Engaging with the transformation programme, Increasing collaboration between primary care, social services and other Cluster partners, supporting the rollout of Primary Care Child and Family Early Years Wellbeing Service
- *Digital, Data and Technology Developments***:** Promoting the use of My Health on line and of 3rd sector services through information platforms such as DEWIS and infoengine,
- *Workforce Development including Skill Mix, Capacity, Capability, Training Needs and Development:* Identifying learning needs of practice staff and developing cluster based MDTs.
- *Estates Development;* Exploring options for improvement grants, and mapping current estates to identify available space to accommodate new services
- *Communications, Engagement and Co-production***:** Engaging with patients to understand their experience of services and to identify their needs, working with 3rd sector to increase presence in primary care and community settings, improving health literacy and signposting to Third Sector services
- *Improving Quality, Value and Patient Safety:* Engaging with patients to understand their experience of services and to identify their needs, working with 3rd sector to increase presence in primary care and community settings, improving health literacy and signposting to Third Sector services .

Section 2 - Cluster profile:

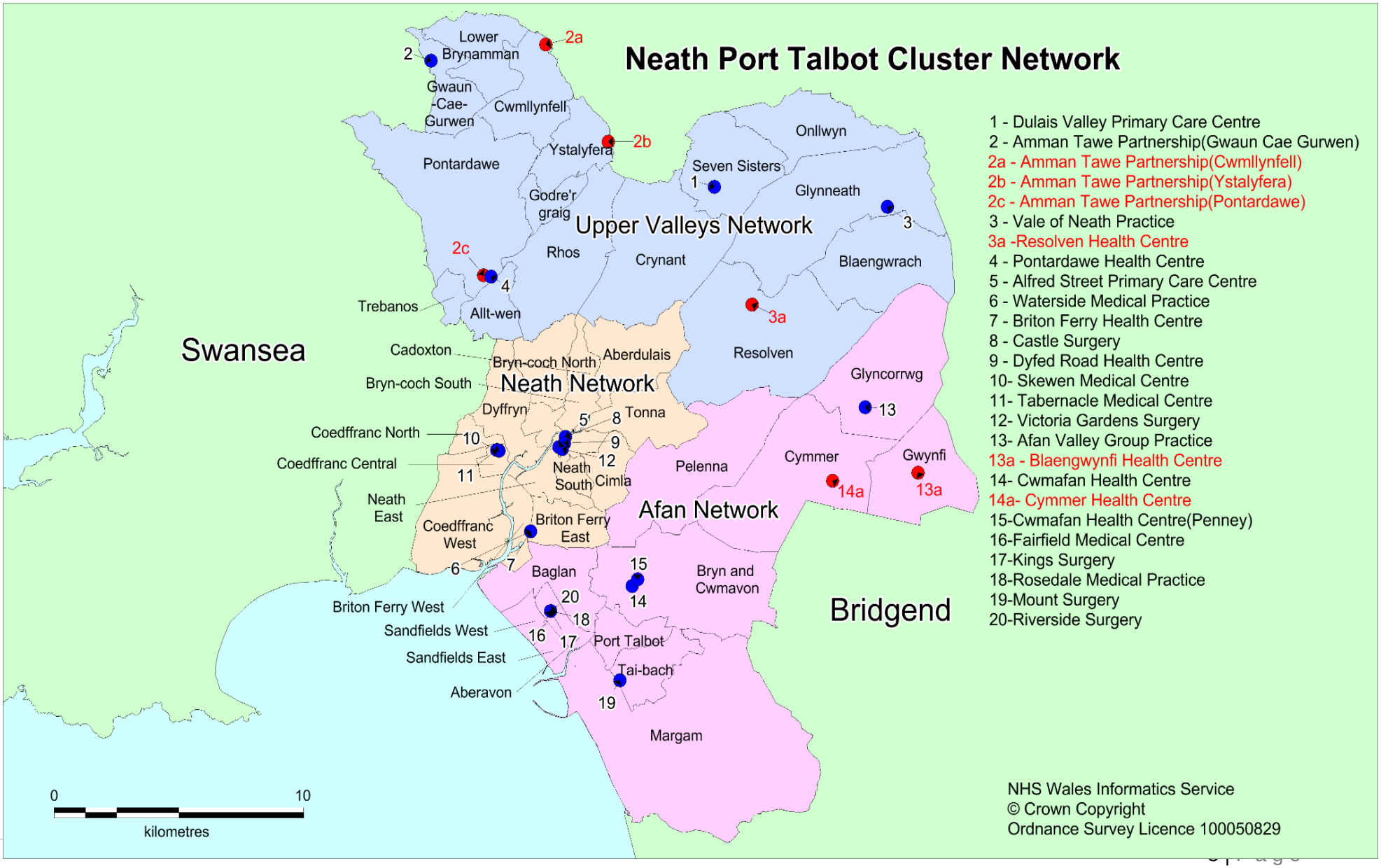
Neath Cluster is one of 8 Clusters in Swansea Bay University Health Board and is made up of eight general practices working together with partners from social services, the voluntary sector, and the ABMU health board. The Cluster serves about 56,820 patients registered with the GP practice

GP Practice	Practice Registered population July 2019
Alfred Street PCC	2478
Waterside Med Centre	5512
Dr. Wilkes and Partners	6148
Castle Surgery	10247
Dyfed Road Health Centre	9926
Skewen Medical Centre	8849
Tabernacle Medical Centre	5135
Victoria Gardens Surgery	8525

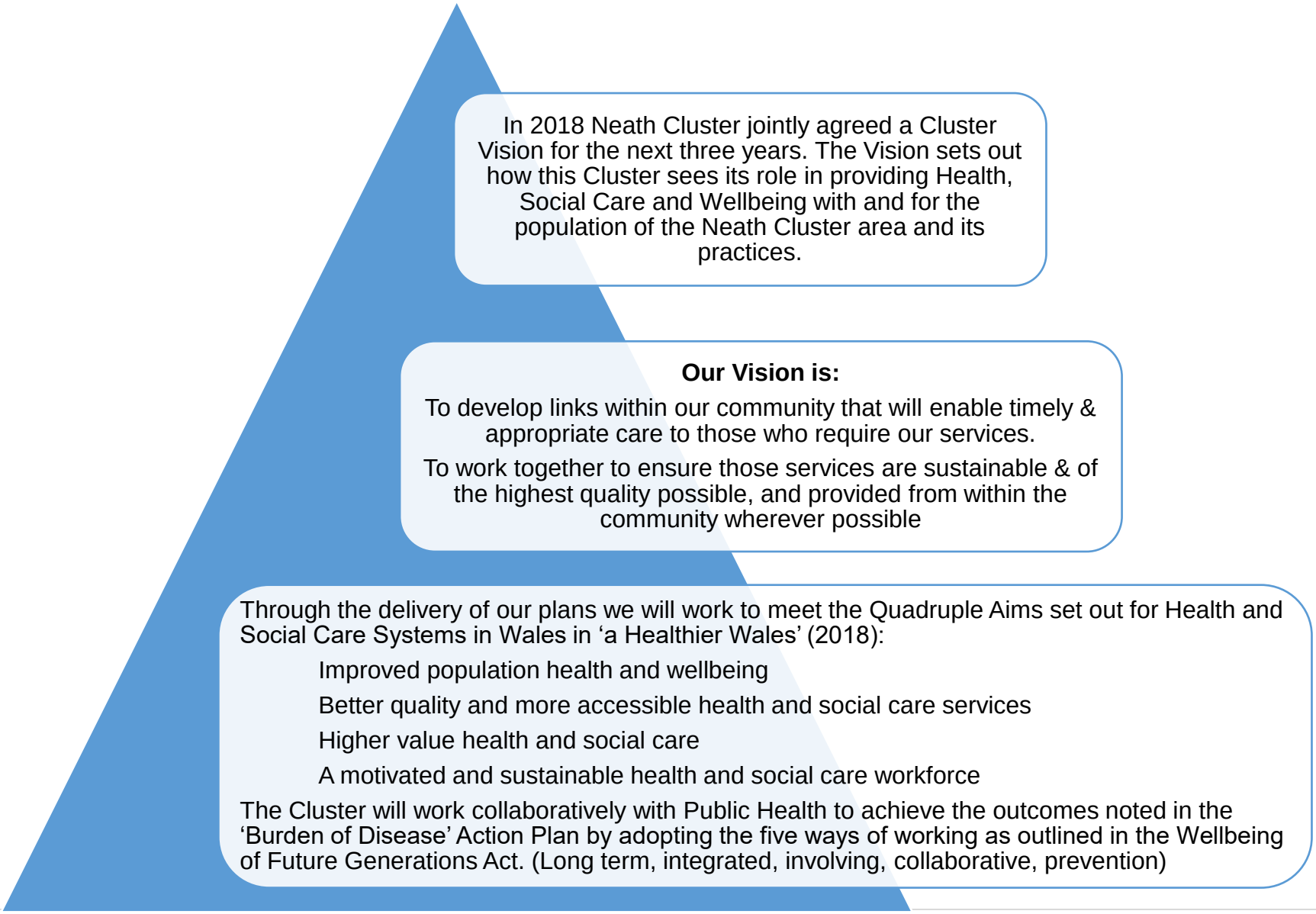
The cluster aims to work together to:

- Prevent ill health enabling people to keep themselves well and independent for as long as possible.
- Develop the range and quality of services that are provided in the community.
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.
- Improve communication and information sharing between different health, social care and voluntary sector professionals.
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community-based services and vice versa.

The Cluster includes the electoral divisions of Aberdulais, Tonna, Neath North, Neath East, Neath South, Briton Ferry East, Briton Ferry West, BryncochSouth, Bryncoch North, Cadoxton , Dyffryn, Coedffranc West, Coedffranc North, Coedffranc Central and Cimla.


Neath Port Talbot Cluster Network
Upper Valleys Network
Neath Network
Afan Network
Swansea
Bridgend
Lower Brynamman
Gwaun -Cae- Gurwen
Cwmllynfell
Ystalyfera
Pontardawe
Godre'r graig
Onllwyn
Seven Sisters
Glynneath
Rhos
Crynant
Blaengwrach
Trebanos
Allt-wen
Resolven
Cadoxton
Bryn-coch North
Aberdulais
Bryn-coch South
Glyncorrwg
Dyffryn
Tonna
Coedffranc North
Coedffranc Central
Neath South
Cimla
Pelenna
Cymmer
Gwynfi
Neath East
Coedffranc West
Briton Ferry East
Baglan
Bryn and Cwmavon
Briton Ferry West
Sandfields West
Sandfields East
Port Talbot
Tai-bach
Aberavon
Margam
2a
2
2b
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2c
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8
9
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20
18
16
17
19
0
10
kilometres
1 - Dulais Valley Primary Care Centre
2 - Amman Tawe Partnership(Gwaun Cae Gurwen)
2a - Amman Tawe Partnership(Cwmllynfell)
2b - Amman Tawe Partnership(Ystalyfera)
2c - Amman Tawe Partnership(Pontardawe)
3 - Vale of Neath Practice
3a -Resolven Health Centre
4 - Pontardawe Health Centre
5 - Alfred Street Primary Care Centre
6 - Waterside Medical Practice
7 - Briton Ferry Health Centre
8 - Castle Surgery
9 - Dyfed Road Health Centre
10- Skewen Medical Centre
11- Tabernacle Medical Centre
12- Victoria Gardens Surgery
13- Afan Valley Group Practice
13a - Blaengwynfi Health Centre
14- Cwmafan Health Centre
14a- Cymmer Health Centre
15-Cwmafan Health Centre(Penney)
16-Fairfield Medical Centre
17-Kings Surgery
18-Rosedale Medical Practice
19-Mount Surgery
20-Riverside Surgery
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Vision



In 2018 Neath Cluster jointly agreed a Cluster Vision for the next three years. The Vision sets out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Neath Cluster area and its practices.

Our Vision is:

To develop links within our community that will enable timely & appropriate care to those who require our services.

To work together to ensure those services are sustainable & of the highest quality possible, and provided from within the community wherever possible

Through the delivery of our plans we will work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales in 'a Healthier Wales' (2018):

- Improved population health and wellbeing
- Better quality and more accessible health and social care services
- Higher value health and social care
- A motivated and sustainable health and social care workforce

The Cluster will work collaboratively with Public Health to achieve the outcomes noted in the 'Burden of Disease' Action Plan by adopting the five ways of working as outlined in the Wellbeing of Future Generations Act. (Long term, integrated, involving, collaborative, prevention)

Purpose and Values

- Delivery of primary, community and integrated services
- Planning and management of services best delivered at the Cluster level
- Delivery of Care Closer to Home where this is safe to do so and adds value to patient outcomes and experience
- Providing innovative alternatives to traditional outpatient or inpatient models of care
- Support whole populations to develop healthy lifestyles, through preventative programmes, self-care and out of hospital care.
- Integrating primary and community based services between health, social and voluntary sectors, physical and mental health services, with our partners
- Supporting the transition of care out of hospital into the community
- Promoting University Research and Undergraduate and Postgraduate Education in a vibrant community setting



Governance Arrangements

The Cluster members meet 5 times a year at formal Cluster Board meetings, to plan and review progress and strategic direction related to the Cluster IMTP and to routinely address: Cluster Plan, Cluster Spending Plan, Risk Register Update, Sustainability and Finance. Declarations of interest are addressed as standing items.

Welsh Government and Health Board allocated Cluster Funds are spent and allocated in accordance with Swansea Bay University Health Board's Standing Financial Instructions. Non-Welsh Government funds are administered on behalf of the Cluster by nominated GP practise with oversight by SBUHB in accordance with agreed Cluster and funding body policies and procedures

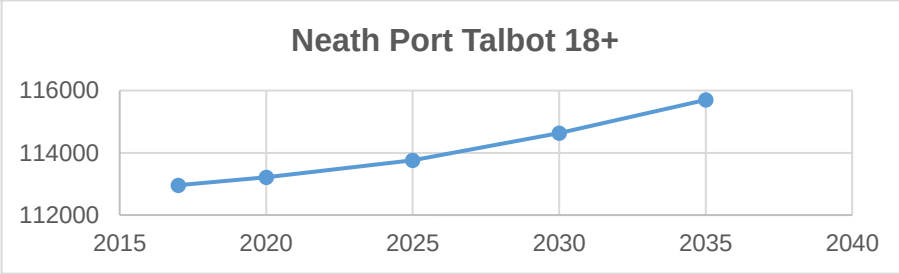
The Cluster reports progress through its own agreed communications programme to a range of stakeholders. Cluster business is also reported through the 8 Cluster Leads Forum (bi-monthly) and through the Cluster Development Team formally to the Primary Care and Community Services Delivery Unit Management Board on a regular basis. Where Clusters are closely aligned with respective organisations such as Community Interest Companies, reporting arrangements are set out by mutual agreement and available separately.

Demographic Profile

Some key population features for the Neath Cluster are as follows:

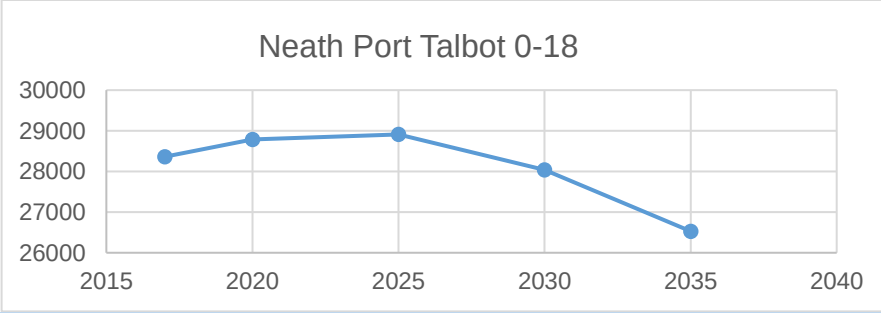
- There are 56,820 GP registered Patients (July 2019)
- There is an even split of 50% female and 50% male
- The cluster has an increasing elderly population (22.2% aged 65+ and 10.1% 75+). The population projection for NPT is for a steady increase in the number of people aged 18+ between 2017 and 2035

	Projected to	Neath Port Talbot
Population aged 18+	2017	112960
	2020	113210
	2025	113760
	2030	114630
	2035	115700



Conversely, the population of Neath Port Talbot aged 0- 18 is projected to start declining after 2025

	Projected to	Neath Port Talbot
Population aged 0-18	2017	28360
	2020	28790
	2025	28910
	2030	28040
	2035	26530



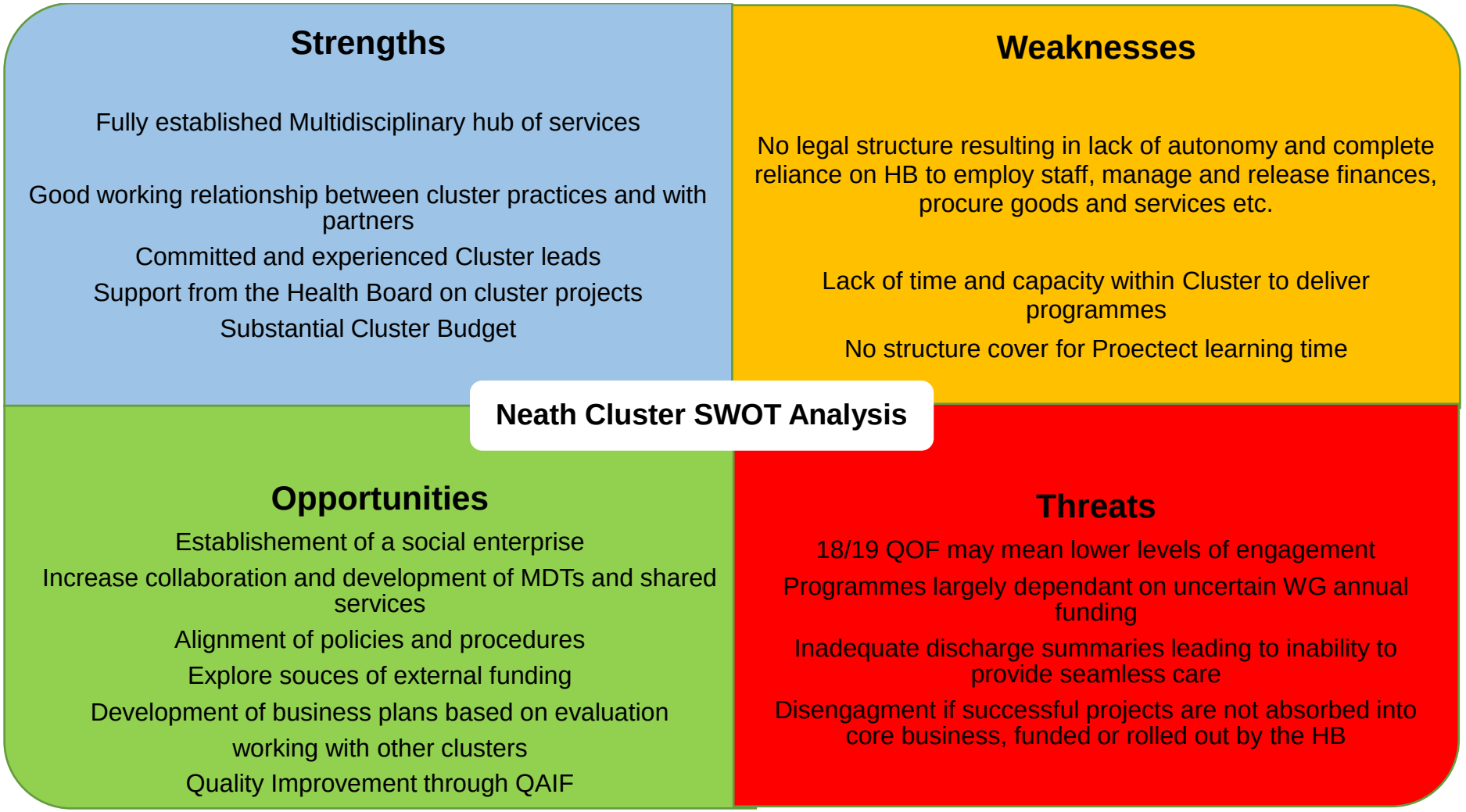
- 0.3% live in a Lower Super Output Area (LSOA) that is classified as rural.
- 46.2% live in the most deprived two fifths (40%) of areas in Wales
- 4.5% aged 65+ live in a nursing, non-nursing or other local authority care home
- 32.7% aged 65+ live alone
- 5.8% are unemployed (Census 2011)
- 34.9% of those aged 16 and over have no qualifications (Census 2011)
- 82.07% of People Aged 16 and over have a GP a record of alcohol intake

Community Assets

Neath Cluster is mainly an urban area but with some semi-rural areas. Neath developed as a market town for the surrounding rural areas and has a large number of listed buildings and ancient ruins.

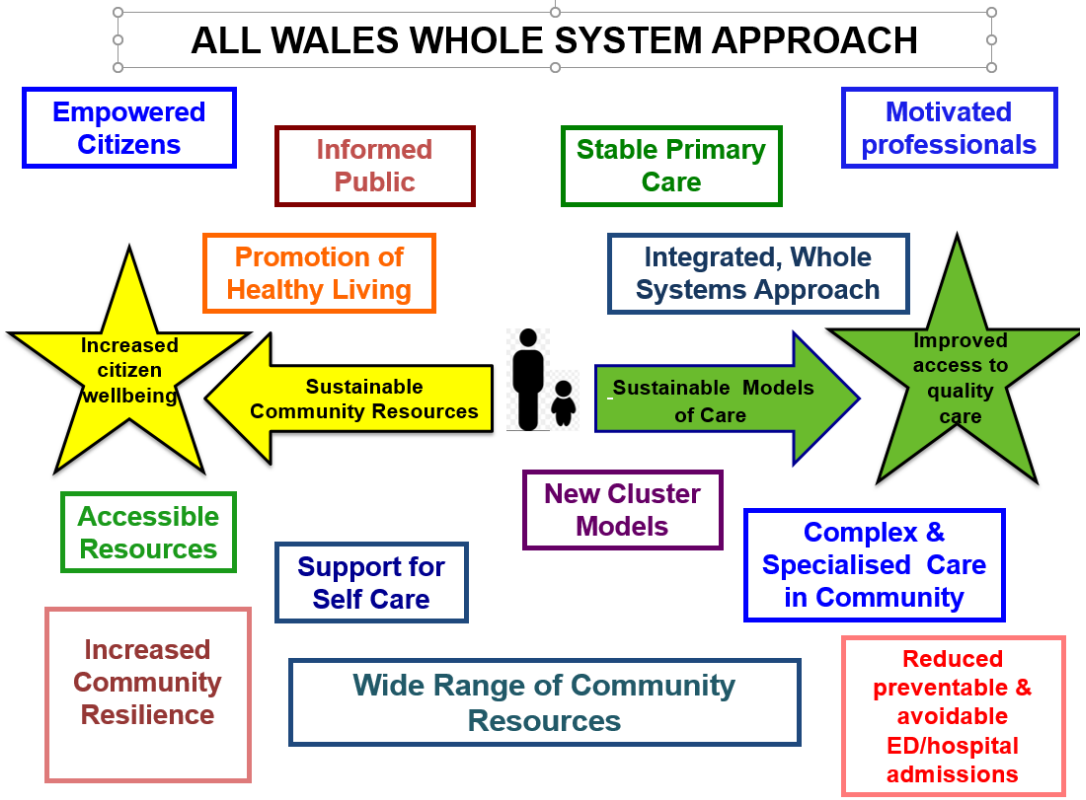
The cluster has:

- 8 GP practices delivering services from 8 sites
- 10 community pharmacies
- 7 Dental practices
- 5 Optometry services
- 2 Leisure Centres
- Several Community centre
- 2 Libraries
- 16 primary schools
- 5 secondary schools
- Voluntary Sector organisations including mental health, physical activity and other charities aimed at supporting health and wellbeing


Strengths
Fully established Multidisciplinary hub of services
Good working relationship between cluster practices and with partners
Committed and experienced Cluster leads
Support from the Health Board on cluster projects
Substantial Cluster Budget
Weaknesses
No legal structure resulting in lack of autonomy and complete reliance on HB to employ staff, manage and release finances, procure goods and services etc.
Lack of time and capacity within Cluster to deliver programmes
No structure cover for Proectect learning time
Neath Cluster SWOT Analysis
Opportunities
Establishement of a social enterprise
Increase collaboration and development of MDTs and shared services
Alignment of policies and procedures
Explore souces of external funding
Development of business plans based on evaluation
working with other clusters
Quality Improvement through QAIF
Threats
18/19 QOF may mean lower levels of engagement
Programmes largely dependant on uncertain WG annual funding
Inadequate discharge summaries leading to inability to provide seamless care
Disengagment if successful projects are not absorbed into core business, funded or rolled out by the HB

Section 3 Key achievements from 2018-21 plan

We aim to transform our cluster and plan and deliver services in the context of the Primary Care Model for Wales



The cluster strives to identify local needs and to address these through various projects. The sustainability of primary care is a key issue and in 2016, the cluster successfully applied for Welsh Government pacesetter funding to establish a shared resource, which would divert some of the GPs' workload to more appropriate healthcare professionals. .

The cluster set up a ***Primary Care Hub*** made up of physiotherapists, audiologists and a wellbeing social prescriber who could better manage issues such as MSK, hearing and low-level mental health and wellbeing issues respectively. Most of the practices have implemented a ***telephone first/triage*** access model to direct patients to the most appropriate health care professional and the efficiency of this service is reliant on the use of a shared appointment booking and clinical system. In 2018/19, the service received over 4000 referrals. Patients are reporting a high level of satisfaction with the service and based on its success, this model is now being replicated in some other clusters.



One of the priorities of the cluster has been developing links with patients. We have delivered several ***patient engagement*** events aimed at informing patients about what local services are available, where to get help and information as well gathering views about cluster based services. Our ultimate aim is to involve patients not only in the development of services but also in testing and evaluating them. We have established a patient engagement forum, which meets quarterly.

Patient Engagement Forum – June 2019

In order to improve access to information and encourage self-care, all the cluster practices have acquired ***QR Pods***, which give quick access to a wide range of information. The cluster has also developed a ***website.***

The cluster has implemented initiatives to prevent the onset of ill health. These include

- Rolling out an ***MMR*** mop up project targeted at 16 – 24 year olds who have not had 2 doses of the MMR vaccine.
- Establishing of a ***flu planning group*** to systematically deliver initiatives aimed at increasing the uptake of the flu vaccination in eligible 'at risk' groups. We signed up to the Vaccine Preventable Disease Programme 2018/19 targeting patients with chronic respiratory disease, proactively administered vaccines to housebound patients and surveyed patients who declined the vaccine to understand why.
- Identifying patients who are ***at risk of developing diabetes*** and inviting them in for blood tests, health checks and lifestyle counselling. About 1000 patients were seen under this Scheme in 2018/19

The cluster has commissioned a ***young person's wellbeing project*** from a third sector organisation to help individuals access support and develop resilience. Young persons who have issues such as social anxiety, or have experienced bereavement, family breakdown or bullying etc. can be referred to the service.



The cluster is keen to ***minimise medication waste*** and promote ***safe use of medicines***. We have:

- Appointed a ***cluster medicines management technician*** to support the reduction in GP medicines management workload. The technician carries out medicines re-authorisations, reconciliation, reviews, synchronisation, etc. This is taking away work, which a GP may otherwise have done.
- Funded a ***secondary care pharmacist*** post short term to review patients in care homes who are on antipsychotics to ensure the medications remain clinically appropriate and still meets the patients' individual needs.
- Have introduced ***CRP point of care testing*** to support GP decision-making, the reduction of antibiotic prescribing and reassure patients when antibiotics prescribing is not indicated

Section 4. Our Local Health, Social Care and Wellbeing Needs and Priorities

Information has been collated on a wide range of health needs within the Neath Cluster area in order to develop the priorities for this plan. Agreement on the objectives and actions within the plan has been reached through a combination of analysis of individual Practice Development Plans, a review of Public Health Priorities, QoF data, audit reports and a series of cluster meetings and patient engagement events.

The development of the plan has presented an opportunity for GP Practices in Neath to build on the progress made in the previous 3 years and has involved partners from Public Health Wales, other Health Board teams and directorates namely medicines management, physiotherapy, audiology, MSK, nursing; and the 3rd Sector and Social Services.

Health Profile

Indicator	Period	Former Abertawe BM	Neath
Prevalence of smoking	2013 - 2014	20.8	20.3
Healthy eating	2013 - 2014	32.5	32.5
Physical activity	2013 - 2014	29	28.5
Alcohol misuse	2013 - 2014	26.6	26.1
Prevalence of obesity in children (%)	2016 - 2017	12.2	
Prevalence of obesity in adults (%)	2017 - 2018	10.0	13.9

Diabetes

Indicator	Period	Former Abertawe BM	Neath
Prevalence of diabetes (%)	2018	6.2	6.6

All 8 of the cluster practices have signed up for the National Diabetes audit. For patients with Type 2 diabetes, NCN achieved 58.42% for all 8 care process, higher than the ABMU average of 53.48 and the Wales average of 45.87%. With regard to all 3 treatment targets, NCN achieved 41.9% - (Wales 34.97%; ABMU 38.97%). 65% of eligible NCN patients were offered Retinopathy (Wales78%; ABMU 79%)

Cancer

Indicator	Alive at	Abertawe BM	Neath
Prevalence of bowel cancer in males, by survival (%)	Up to 1 year	12.4	12.0
	> 1 to 5 years	35.9	39.3
	> 5 to 10 years	28.0	20.7
	> 10 to 21 years	23.7	28.0
Prevalence of bowel cancer in females, by survival (%)	Up to 1 year	12.2	8.5
	> 1 to 5 years	33.8	27.7
	> 5 to 10 years	27.2	30.8
	> 10 to 21 years	26.7	33.1
Prevalence of breast cancer in females, by survival (%)	Up to 1 year	9.0	9.1
	> 1 to 5 years	28.8	25.6
	> 5 to 10 years	28.0	31.1
	> 10 to 21 years	34.2	34.2

The Cluster participated in a bowel screening project in 2016/17 by recalling patients who had not taken up their invitation for screening. The cluster has also support the Rapid Diagnostic Centre project, referring in patients who's symptoms were not clear cut. The cluster is committed to ensuring that delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond. The cluster is participating in the Macmillan Cancer Quality Toolkit to explore how we deliver care and to develop actions to improve our services.

COPD

Indicator	Period	Former Abertawe BM	Neath	Wales	UK
Prevalence of COPD (%)	2018	2.2	2.2	2.29	1.93
Prevalence of asthma (%)	2018	7.4	7.3		

Cardiovascular conditions

Indicator	Period	Former Abertawe BM	Neath	Wales
Prevalence of coronary heart disease (%)	2018	3.8	3.8	3.7%
Prevalence of heart failure (%)	2018	1.0	0.9	1.03%
Prevalence of stroke and TIA (%)	2018	2.3	2.3	2%
Prevalence of hypertension (%)	2018	15.3	15.8	15.7%

Screening

The cluster is just below the national target for screening uptake as shown below

Indicator	Period	Former Abertawe BM	Neath
Uptake of bowel screening (%) (Target 60%)	2017-2018	56.2	57.2
Uptake of breast screening (%) (minimum standard 70%)	2017-2018	73.1	74.8
Uptake of cervical screening (%) (Target 80%)	2017-2018	75.1	75.6
Uptake AAA (%) (Target 80%)	2017-2018	80.2	83.3

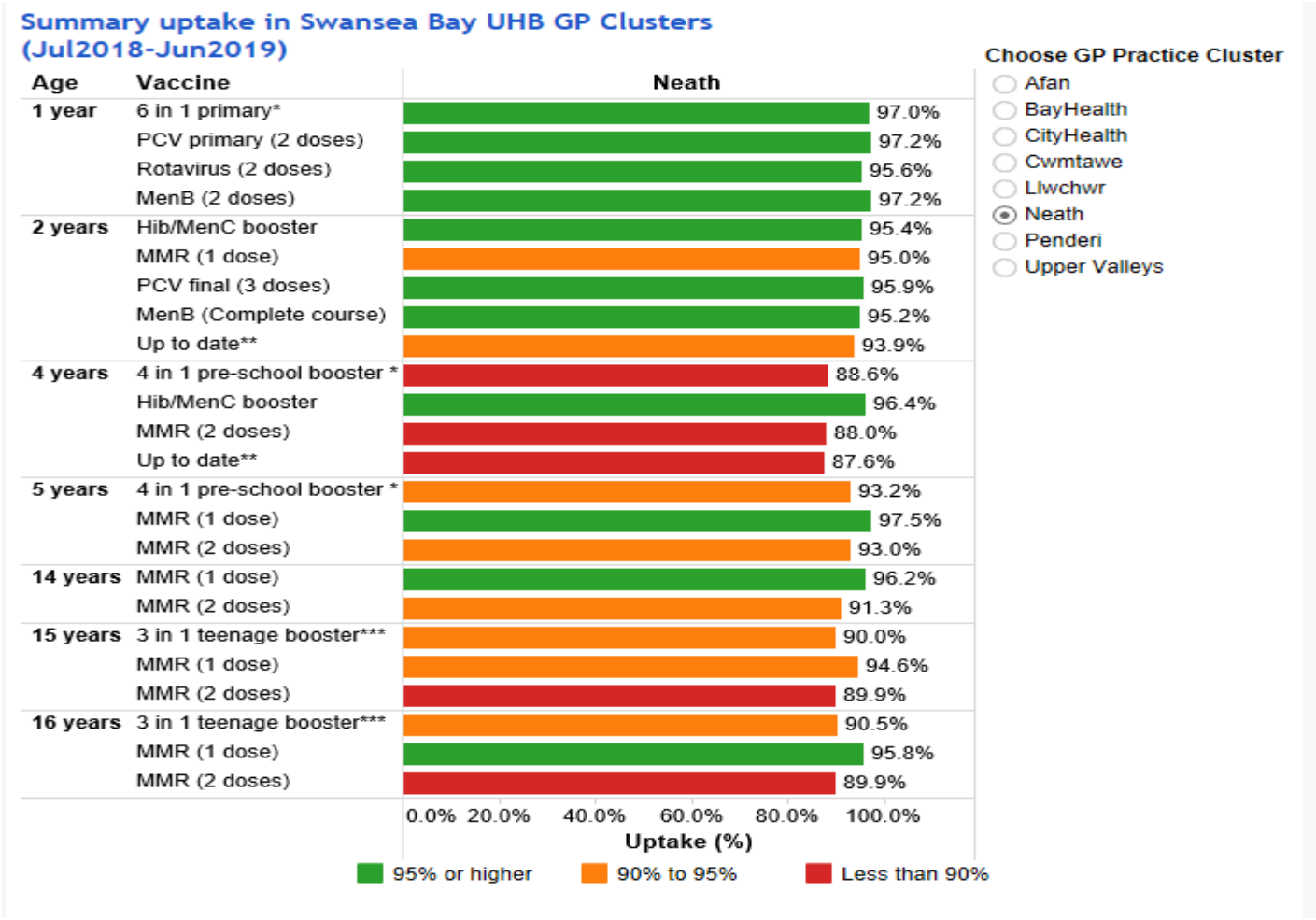
Flu

The cluster has been working towards increasing flu vaccination uptake. More work needs to be done on this as the figures do not yet show an improvement.

	2017/2018	2018/2019	+/-
>65 (National Target 75%)	67.9%	67.4%	-0.5%
<65 at risk (National target 55%)	49.1%	45.9%	-3.2
2 and 3 year olds	47.6%	45.3%	-2.3

Childhood Immunisations

The cluster's performance in uptake of childhood imms is shown below. Further analysis is needed to identify why uptake in certain areas is poor and ideas developed to improve performance.



Indicator	Period	Former Abertawe BM	Neath
Prevalence of dementia (%)	2018	0.7	0.7

Unscheduled Care

	Period	Cluster	Number of admissions	R (1k) all ages
Emergency Admissions:	1/08/2018 – 31/07/2019	City Health	2,727	26.68
		Neath	2,709	23.99
		Bay Health	2,319	15.56
		Afan	2,315	22.70
		Cwmtawe	2,138	25.09
		Llwchwr	1,883	19.72
		Penderi	1,870	24.49
		Upper Valleys	1,337	21.21
		SBUHB average	2,162	22.43

	Period	Cluster	Number of admissions	R (1k) all ages
Emergency Attendances:	1/08/2018 – 31/07/2019	Afan	19,657	192.77
		Neath	18,084	160.12
		City Health	14,920	145.96
		Bay Health	13,299	89.22
		Cwmtawe	12,965	152.14
		Penderi	11,360	148.78
		Llwchwr	10,065	105.42
		Upper Valleys	8,417	133.50
		SBUHB Average	13,596	141.00

	Period	Cluster	Number of admissions	R (1k) all ages
OOHs contacts	1/08/2018 – 31/07/2019	Afan	8,644	84.77
		Neath	8,242	72.98
		City Health	7,706	75.38
		BayHealth	6,782	45.5
		Cwmtawe	6,620	77.68

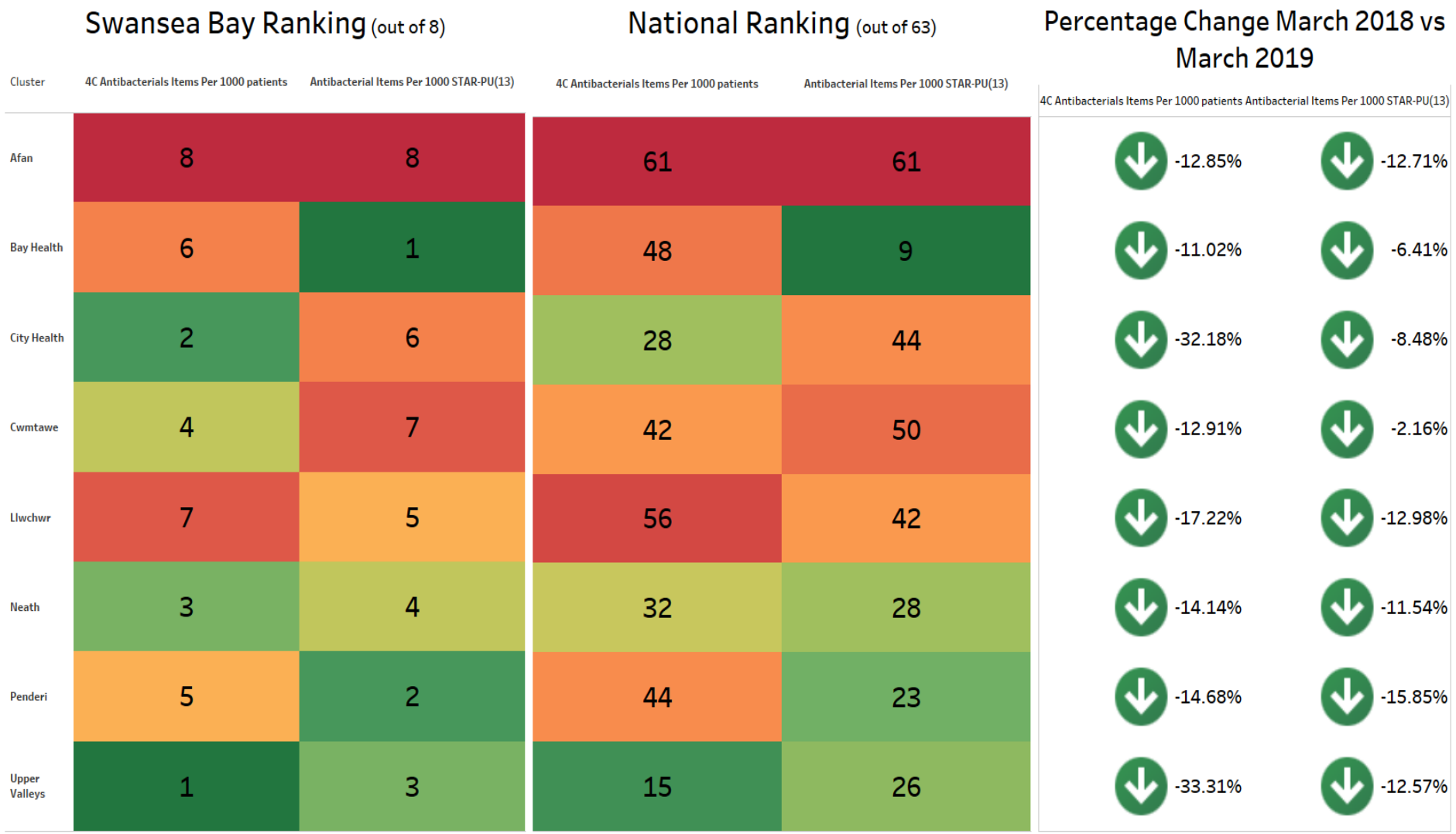
	Period	Cluster	Number of admissions	R (1k) all ages
		Penderi	6,326	69.83
		Llwchwr	6,316	82.72
		Upper Valleys	3,781	59.97
		SBUHB Average	6,802	71.1

Antimicrobial Stewardship

In January 2019 the UK 5 year Antimicrobial Resistance (AMR) National Action Plan 2019 -2024 was published, which underpins the UK AMR Strategy 20 year vision. Building on achievements seen in 2018/19 improvement goals are set for Heath Care Acquired Infection and Antimicrobial Resistance, which will be reported at a National level. The Primary Care goals in relation to prescribing are:

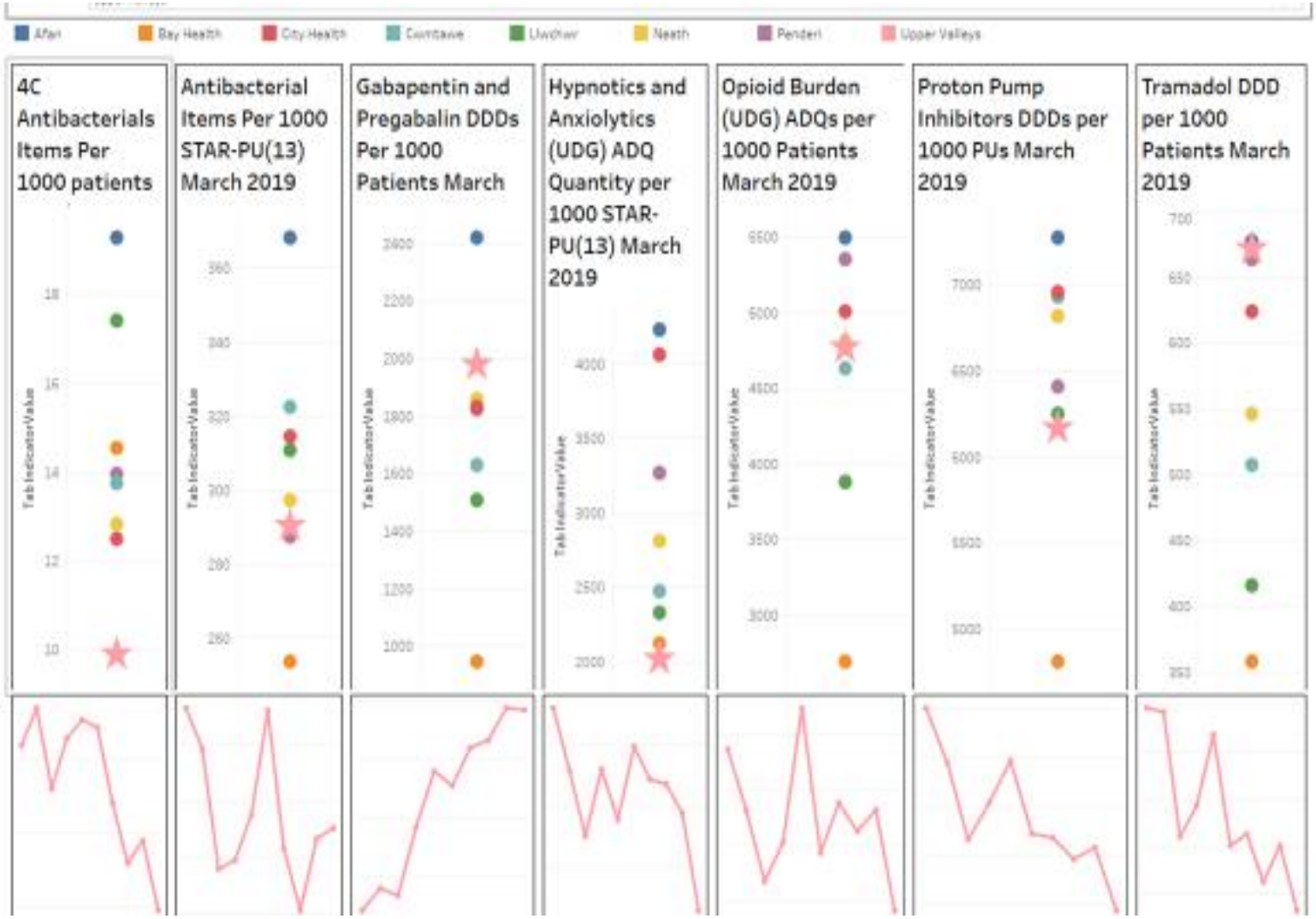
- All prescribers should document indications for all antimicrobial prescriptions; it is expected that an appropriate read code will be entered whenever antimicrobials are prescribed.
- Primary Care clusters should ensure urgent dental cases are seen by dental services rather than by GMS.
- Wales Quality Improvement: Antimicrobial Stewardship – Supporting measures to improve UTI prevention, multidisciplinary diagnosis and management of UTI, making use of 'UTI 9' standards. Materials are available to support GPs and clusters to review MDT diagnosis and management of adults with UTI.
- To continue to reduce overall antimicrobial consumption by 25% from baseline year of 2013 by 2024. Nationally a 12% reduction has been seen between 2013 to 2017.

From the graphs and data, all based on National Prescribing Indicators, it can be seen that Swansea Bay clusters have made good improvements over the last year. Neath Cluster is 3rd out of the 8 SBUHB clusters for 4c Antibacterial items per 1000 patients (national ranking 32nd out of 63) and 4th for antibacterial items per 1000 STARPU (National ranking 28th out of 63)


Swansea Bay Ranking (out of 8)
National Ranking (out of 63)
Percentage Change March 2018 vs March 2019
Cluster
4C Antibacterials Items Per 1000 patients
Antibacterial Items Per 1000 STAR-PU(13)
4C Antibacterials Items Per 1000 patients
Antibacterial Items Per 1000 STAR-PU(13)
4C Antibacterials Items Per 1000 patients
Antibacterial Items Per 1000 STAR-PU(13)
Afan 8 8 61 61 -12.85% -12.71%
Bay Health 6 1 48 9 -11.02% -6.41%
City Health 2 6 28 44 -32.18% -8.48%
Cwmtawe 4 7 42 50 -12.91% -2.16%
Llwchwr 7 5 56 42 -17.22% -12.98%
Neath 3 4 32 28 -14.14% -11.54%
Penderi 5 2 44 23 -14.68% -15.85%
Upper Valleys 1 3 15 26 -33.31% -12.57%

PMS + Scheme

The data below relates to the PMS+ part of the incentive scheme, where practices made prescribing improvements in areas such as inhalers, home blood glucose monitoring, low value medicines etc and not linked to NPIs



Other influencing factors

- Relatively stable practice list sizes (-0.6% change between 2011 – 2017)
- Increasing number of patients with comorbities and complex presentations
- Aging workforce
- Difficulties GP and other HCP with recruitment
- Relatively good road and transport links
- Aging primary care infrastructure
- Limited employment opportunities
- New Housing developments as part of L

Sectoin 5. Cluster Workforce Profile

Doctors

Head count	Whole time equivalent	GP/Patient Ratio
46	25.7	2035.2

Nurses

Head count	Whole time equivalent	Nurse/Patient Ratio
14	10.6	

Direct Patient Care (Employed by GP Practices)

Additional Staff					
Clinical pharmacist		**HCSW**		**Pharmacy technician**	
Total Hours	**Head Count**	**Total Hours**	**Head Count**	**Total Hours**	**Head Count**
31	6	324.5	12	37.5	1
Advanced Paramedic		**Physicans Associate**		**Physiotherapist**	
30	1	37.5	1	30	2
Minor Ailments Nurse		**Phlebotomists**			
37.5	1	75	2		

Direct Patient Care (Funded from Cluster allocation for the Neath Primary Care Hub MDT)

Additional Staff							
Physiotherapists		**Wellbeing worker**		**Primary care hub admin/manager**		**Pharmacy technician**	
Total Hours	**Head Count**	**Total Hours**	**Head Count**	**Total Hours**	**Head Count**	**Total Hours**	**Head Count**
37.5	2	37.5	1	75	2	37.5	1

Administrative/Non-Clinical Staff

Practice Manager		Reception Staff		Admin Staff	
Total Hours	**Head Count**	**Total Hours**	**Head Count**	**Total Hours**	**Head Count**
290	8	1569.2	55	575.5	20

Health Board Staff (cluster footprint)

Staff Title	Neath Cluster	Shared Resource across SBUHB cluster footprint
Audiologist/Clinical Scientist, Band 8A	0.5	
Audiologist/ Clinical Scientist Band 7	0.7	
Associate Audiologist	0.7	
School Nursing Service		41
Looked After Children Service		11

Some practices have strengthened their multi-disciplinary teams with clinical pharmacists, undertaking medication, polypharmacy and new patient reviews; along with any medication related queries from all staff in primary care. The cluster is in the process of employing 2 cluster based clinical pharmacists and has a pharmacy technician in post.

Community Pharmacy - Independent Prescribers:

All clusters have worked collaboratively with Health Education Wales [HEIW] and Swansea University to increase the number of Independent Prescribers working within community pharmacies across the Swansea Bay University Health Board footprint. University in March 2020.

Independent Prescribers will be able to provide an enhanced Common Ailments Service enabling independent prescribers to diagnose, assess and manage acute conditions within the Pharmacy. This will relieve pressure on GP practices and increase accessibility for patients seeking condition specific appointments.

Dental - Contract Reform:

The General Dental Service Contract Reform programme has been rolled out to every cluster across SBU HB. The dental reform programme was established based on the learning from the Welsh Dental Pilots (2011-2015) and dental prototype practices in Swansea. The current General Dental Service (GDS) model is based on delivery of Units of Dental Activity (UDAs), a proxy for counting dental treatments. The system does little to encourage utilisation of skill-mix and delivery of risk and need-based preventive dental care. Patient outcomes are also not monitored. Many people who need and want to access dental services cannot access dental services while many apparently 'healthy' patients attend every 6 months.

The programme is a positive change to the way dental services are currently provided, moving away from dental practices trying to achieve annual targets and replacing this with a service focused on preventative care and active engagement with patients to look after and improve their oral health. The objectives of the dental reform programme are to reducing oral health inequities, delivering improved patient experience and outcomes by implementation of Prudent Healthcare Principles, evidence based prevention and to development of culture of continuous improvement, are key in ensuring NHS dental services are sustainable.

Section 6 - Cluster Financial Profile

Neath Cluster has a recurrent financial allocation from the Welsh Government of £183,705 per annum. In addition, the cluster has participate over the years in the Prescribing management scheme+ and has realised a benefit of £18,216 in 2018/19.

In previous years, the cluster has applied it's allocation to various projects as identified in the Cluster Plan. Current spend plans are as follows:

Neath Cluster Funding 2019-20	
Welsh Government allocation	£183,705
PMS+ Monies	£18,216
Total	**£201,921**
PLANNED SPEND	
Project	**Spend allocated**
Pharmacy Technician	£32,399
Flu Project	£8,000
Cluster IM&T support	£15,000
Pre Diabetes (SLA)	£44,000
CRP Testing	£18,000
2 Cluster Pharmacists	£58,000
MMR	£7,158
Total allocated	**£182,557**
To be allocated to projects in development	**£19,364**

Pacesetter Funding

The cluster has benefitted from pacesetter funding from Welsh Governement designed to support innovative projects within primary care and support the sharing of learning across Wales. Neath has used this funding to set up the Neath Primary Care hub of health care professionals including physiotherpaists, a wellbeing service and audiology service. This is now being rolled out across Neath Port Talbot as a hub and spoke model.

Transformation Programme:

The Whole System Transformation programme which will be rolled out across Swansea Bay University Health Board was initiated in Neath Cluster in April 2019 and will run form 18 months. Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vison for the programme is to achieve a transformed model of a Cluster led integrated health and social care system for the Cluster population. The programme will concentrate on implementing a range of projects to improve well- being across the age spectrum, co-ordinate services to maximise independence and care closer to home; and to support the implementation of A Healthier Wales and the new model of primary care.

Integrated Care Fund (ICF)

The ICF aims to drive and enable integrated and collaborative working between social services, health, housing, the third and independent sectors. It is intended to help regional partnership boards develop and test new approaches and service delivery models that will support the underpinning principles of integration and prevention. Evaluation and learning lie at the core of the ICF and it is essential that any ICF programmes or projects are designed with this in mind.

Statutory Guidance identifies the following groups as priority areas of integration and all regional ICF programmes must address them proportionately, in line with their regional population assessments and area plans:

- Older people with complex needs and long term conditions, including dementia;
- People with learning disabilities;
- Children with complex needs;
- Carers, including young carers.

For these priority groups, the fund aims to find new integrated service delivery models and approaches that will:

- enable older people to maintain their independence and remain at home, avoiding unnecessary hospital admissions and delayed discharges;

- enable families to meet their children's needs and help them to stay together;
- support carers in their caring role and enable them to maintain their own wellbeing;
- support the development of integrated care and support services for individuals with complex needs including people with learning disabilities, children with complex needs and autism;
- offer early support and prevent the escalation of needs;
- promote emotional health and wellbeing as well as prevent poor mental heath

The sums below have been distributed, by theme and on a regional basis across SBUHB using a multi-agency approach. A wide range of projects is being delivered; however even though none is Neath cluster specific, they deliver services to meet local needs.

.Theme	**£**
Older People	5,224,000
LD/MH/CN/Carers =	2,590,000
Edge of Care	1,942,000
People with Dementia = £1	1,175,000

Section 7 Neath Cluster Three Year Action Plan

Prevention, wellbeing and self care						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
1.1.	Identify pre-diabetics & tackle problem of increasing levels of diabetes in Cluster population • Continue to engage with Pre-diabetes scheme to identify patients at risk of pre-diabetes • Train appropriate staff to deliver intervention • Monitor outcomes at regular intervals	NCN practices	March 2020/21	The onset of diabetes is delayed or prevented.	Staff time Cluster funding	The NCN continues to engage in the pre diabetes project
1.2.	Actively support and engage as part of the multiagency Safe & Resilient Communities Programme in Neath	NCN	March 2020/21	The Neath population will be supported and empowered to recognise the importance of prevention and take responsibility for their own health.	Staff time	Programme in development
1.3.	Support patients to manage their weight • Contribute to the obesity pathway delivery review:	NCN Dietetics Team	March 2020/21	Patients engage in exercise programmes Improved education on healthy eating	Staff time Cluster funding PHW support	Obesity Pathway delivery review commenced in Swansea Bay March 2019.

Prevention, wellbeing and self care						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
	○ Completion of baseline survey by practices ○ Participation in qualitative interviews	Swansea Bay public health team Cluster leads cluster development managers		Reduction of obesity Obesity pathway delivery review completed Greater understanding of level 2 provision in primary care, in order to improve and deliver a consistent and coherent patient centred obesity pathway		Level 2 insight with primary care to commence September 2019
1.4.	Promote self-care through patient education	All Practice staff Public Health resources	March 2020/21	Generally improve health of patient population Reduce burden on GP Practices	Staff time Communications support	Self-care to be promoted as part of the patient engagement evenst
1.5.	Increase uptake of influenza vaccine in target groups • Regularly review IVOR data for flu vaccination • Develop and implement cluster flu pla	NCN PHW	March 2020/21	Reduce morbidity / mortality / hospital admissions due to influenza Reduced variation across cluster, Health Board and	Staff time Cluster funding	Cluster flu champions identifiedy Cluster signed up to 2018 VPDP Flu plan developed and being rolled out

Prevention, wellbeing and self care						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
	• Deliver flu vaccinations to housebound patients			all Wales Position (Primary Care Measures)		
1.6.	Increase uptake of the MMR vaccine in patients 16-24	NCN	March 2021	Increased protection of population from measles Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	Staff time Cluster funding	Mop up project introduced
1.7.	Develop a consistent approach within Cluster to reduce smoking Work with Local Public Health team to develop and implement sustainable processes/initiatives that lead to increased referrals to the Help Me Quit local smoking cessation services" Increase engagement with the local Pharmacies Level 3 service.	NCN Community Pharmacies Help Me Quit	March 2021	GP time saved Increased referrals to "Help Me Quit" Reduced local prevalence of smoking – reduced morbidity / mortality Patients are seen at the right time by the right person at the right place	Staff time Communication ssupport	Practices are now referring to services as appropriate
1.8.	Increase and improve signposting to Third Sector services	GP Practices 3rd Sector	March 2020/21	To provide more specialist and appropriate support for patients	Staff time Cluster funding	Hub development worker signposting to 3rd sector and other services

Prevention, wellbeing and self care						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
	• Widen engagement with 3rd sector linked to identified cluster themes	Wellbeing Mental Health Support Worker			NPTCVS support	Mental Health and Wellbeing small grants scheme instituted and referrals of 7-18 years to referrals to Bulldogs 3rd sector services to commence Oct 2018

Timely, equitable access and service sustainability						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
2.1	Work towards and implement the In-Hours Access GMS Service Standards	All Practices	March 2021/22	100% Achievement of Access Standards Improved patient access	Telephone infrastructure Communications	Practice access position will reviewed to reflect requirements to meet new standards.
2.2	Manage patients with common ailments in the community rather than in GP Practice. Improve patient education	LHB Community Pharmacies GP practices	March 2020/21	GP practices see fewer patients with common ailments	Staff time Meeting facilitation	Links made with Community practices are now referring to the pharmacies under the common ailments scheme

Timely, equitable access and service sustainability						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**

Rebalancing Care Closer to Home						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
3.1	Work with the Transformation programme to develop a phlebotomy service in the community	NCN	March 2021	Primary care sustainability is supported Patients receive appropriate care	Staff time Project support	Transformation leadership egroup established
3.2	Manage demand in GP practices by utilising and supporting the development of services available at the Neath Primary Care Hub	Hub Operational Manager GPs, clinical and admin staff Staff employed in Hub	March 2020/21	Improved access to appropriate services and healthcare professional Reduction of GP workload that is not appropriate	Staff time Transformation funding	The Hub continues to provide access to physiotherapist, MH support worker and audiologist..
3.3	Improve community care of patients with heart failure by ensuring patients with	Cluster	March 2023	Improve identification of patients with heart failure.	Funding	Primary care target framework awaited.

Rebalancing Care Closer to Home						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
	heart failure have a flu vaccination and creating self-management educational programmes with patients	Community Heart Failure Team		Optimise treatments in the community to maximal tolerated doses. Undertaking 6 monthly reviews of patient diagnosed with chronic heart failure	Venue	Whole systems approach business plan being created with HB
3.4	Improve community care of patients with COPD by ensuring patients with COPD have a flu / Pneumoccocal vaccination and creating self-management educational programmes with patients	Cluster Pulmonary Rehab Team	March 2023	Improve identification of patients with COPD using Spirometry Optimise treatments in the community with appropriate inhalers/ Referrals to Pulmonary Rehabilitation Undertaking annual reviews of patient diagnosed with COPD	Funding Venue	Primary Care target framework awaited. Whole systems approach business plan being created with HB
3.5	Diabetes care closer to home for patients with type 2 diabetes, ensuring delivery of the three National Enhanced Services	Cluster Lead GPs	March 2020/21	Improved outcomes for patients with diabetes Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	NES funding	The cluster has participated in the pre-diabetes imitative and key staff have received training.

Implementing the Primary Care Model for Wales						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
4.1	Increase collaboration between GP practices and other primary care providers, social services, Community Resource Team and other Cluster partners	GP practices Other primary care providers	March 2020/21	GP practices are better able to manage demand & improve patient care / experience	Staff time	Partners are involved in development of projects Additional work needs to be undertaken to ensure alignment with other service aimes e.g. HV, DN, CRT,social services etc.
4.2	Engaging with the transformation programme, explore the feasibility of establishing a social enterprise to facilitate and progress relevant cluster projects	NCN Transformation board	March 2021	Legal vehicle for implementing cluster programmes is established	Staff time Project support Transformation funding	Trandformation leadership group established
4.2	Support the development of Business Cases for sustainability of key service delivery schemes which support Primary Care: • Physiotherapy • Mental • Pharmacists • Other identified services	All	March 2021	Areas of work have been piloted by Clusters over recent years and have been seen to provide benefits to access and patient experience alike. The principle that Cluster monies were provided to facilitate innovation now means there is a need to identify alternative funding for such projects where	Staff time Project support	Areas of work are to be included for consideration in this year's IMTP process in both Swansea Bay University Health Board & Cwm Taf.

Implementing the Primary Care Model for Wales						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
				benefits have been demonstrated		
4.3	Support and engage in the rollout of Primary Care Child and Family Wellbeing Service (Early Years) across all Clusters	NCN PSC Unit	October 2023	Stratified service delivery based on levels of demand/prevalence to best meet the population needs Significant reduction in demands on GP services, medicines Reduction in impact on Mental Health Services, Social Care Improved patient reported outcome measuresApprox £25-£30k per Cluster, configured to demand across the Health Board	Staff time Project support	No service in place in Neath Cluster, scheme tested and evaluated in 3 Clusters.

Digital data and technology developments						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
5.1	Set out the priority population level needs of the Cluster to inform programme development	Health Board BSM	Refreshed when new data available	Services are developed according to local population need	Staff time Data analysis support	Demographics have been considered during formulation of this cluster network plan.
5.2	Promote the use of My Health on line in • Increase patient registration • Roll out use of MHOL for repeat prescriptions	NCN	March 2020/21	Patients have quick and improved access to services	Staff time Communication support	Not all the practices currently use the full range of MHOL options
5.3	Continue to work towards standard utilisation of guidelines for practice data entry and collection	NCN	March 2020/21	Standard data available for development of projects	Staff time	The cluster has been using the services of IT companies to develop standardised guidelines
5.4	Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of: • Infoengine • Dewis • Local Area Coordination	NCN	March 2020/21	Individuals are more informed about how to manage their conditions and the importance of wellbeing and prevention	Staff time NPTCVS support	The cluster has worked with NPTCVS to raise awareness of 3rd sector services

Workforce development including skill mix, capacity, training needs and leadership						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
6.1	Identify learning needs of practice staff	NCN	March 2020/21	Practices have a skilled work force	Staff time Cluster funding	Some training has been delivered to HCSW
6.2	Ensure appropriate use of Cluster Technician and Pharmacist	Improved Medicines management Remove burden of Meds Mgt from GPs	March 2020/21	GP practices Medicines Management Technician Cluster Pharmacist	Cluster pharmacy tech in post and working across practices	Technician in pot and has been supporting practices
6.3	Upskill multi-disciplinary team	Cluster	March 2020/21	Trained and skilled workforce within the cluster	Funding	Training development audit to be completed to inform cluster transformation
6.4	Develop cluster workforce strategy	Cluster	March 2021	Robust workforce and succession plan	Workforce planning tools	All practices have completed the National Workforce Reporting tool.

Estates						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
7.1	Work with SBUHB to support improvement grant applications where needed for improvement of practice premises to enable capacity to deliver new pathways and increase capacity	NCN SBUHB Estates department	March 2020/21	Improved facilities and sustainable services	Staff time Estates department support	
7.2	Work with SBUHB to map and identify available space to accommodate new services	NCN SBUHB estates department	March 2020/21	Free space identified to host new services	Staff time Estates department support	The primary care hub is hosted in Health Board premises at Dyfed Road

Communication, Engagement and Co-production						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
8.1	Work with 3rd sector to increase presence in primary care and community settings	NPTCVS	March 2020/21	Patients are aware of local services	NPTCVS support Staff time	Work is ongoing

Communication, Engagement and Co-production						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
8.2	Engage with patients to understand their experience of services and to identify their needs and facilitate their participation in the development and evaluation of services	NCN	March 2020/21	Patients have the opportunity to influence service development Projects are developed based on patient need	NPTCVS support Staff time	Patient engagement to date includes vaccination last year why not, to try to establish their reasons so this can be addressed in future years.
8.3	Continue to work towards improving health literacy and	NCN	October 2020	Patients have the information they need	Cluster funding Staff time Communications support	Cluster website and QR Boards developed

Improving Quality, Value and Patient Safety						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
9.1	Engage in prescribing management schemes	NCN Med management team	March 2020	Reduction in wastage of medicines and Improved prescribing practice Reduced variation across cluster, Health Board and	Staff time Medicines management time	Practices have signed up to the cluster prescribing benefits share scheme and to the PMS

Improving Quality, Value and Patient Safety						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
				all Wales Position (Primary Care Measures)		
9.2	Continue to implement CRP POC testing to improve anti-biotic prescribing.	NCN	March 2020/21	Reduction in antibiotic prescribing rates for Upper Respiratory conditions Patients receive appropriate care	Staff time Cluster funding	Utilise CRP testing in order to reduce the use of antibiotics for adult patients with upper respiratory tract infections 3 out of 4 practices are participating in the project Co-amoxical audit conducted
9.3	Engage in agreed cluster QAIF projects • Patient safety Programme (mandatory) • Reducing stroke risk through improved management of Atrial Fibrillation	NCN Partners	October 2020	Adults with suspected UTI are reviewed and managed Reduced reduce the stroke risk associated with suboptimal prescribing of anticoagulant and antiplatelet therapy	Staff time Project support	
9.4	Further improve antimicrobial stewardship	GP practices Medicines Management team Practice Antibiotic Lead	March 2020/21	Improved outcomes and reduced resistance and side effects	Staff time	Particular focu on LRTI to date.

Improving Quality, Value and Patient Safety						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
9.5	Promote shared learning and good practices through regular incident reporting	NCN	March 2020/21	Improved safety and quality	Staff time	
9.6	Continue to engage with a robust clinical governance and information governance process ensuring that practices and cluster services are GDPR compliant using data and quality impact assessments as required.	NCN	March 2020/21	Improved safety and quality	Staff time	DSA in place for MSK project Consent to share audit data in place GDPR leaflets and material distributed
9.7	Improve **Cancer** diagnosis • Macmillan Primary Care Cancer toolkit • Continue to support RDC	NCN	March 2020/21	Patients with suspected cancer receive a rapid diagnosis	Staff time Project support	Support the NPTH rapid cancer diagnosis centre pilot NCN practices have actively been referring patients with suspected cancer to the RDC Cancer Red Wales training
9.8	Work together with partners to ensure that	Practices	March 2020/21	Integrating cancer care into holistic chronic disease	MDT support	Cancer diagnosis rates issues – Anjula

Improving Quality, Value and Patient Safety						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
	delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond. • Involve the MDT in supporting people affected by cancer, and integrating cancer care into holistic chronic disease management in Primary Care. • As clinical pathways are shared through the Single Cancer Pathway programme, review local experience to inform implementation. • Work to embed anticipatory care planning as routine practice			management in Primary Care. Ensuring that the multidisciplinary primary care team has the necessary skills and knowledge to support the SCP and detection and diagnosis of cancer. Improved end of life experience		do you have a link on something data wise for Cluster level

Improving Quality, Value and Patient Safety						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
9.9	Map current and discuss future enhanced service provision at cluster level	Cluster	March 2021	Equity of services delivered closure to home	Enhanced services funding Infrastructure	

Communication and Engagement

The matrix below demonstrates how Cluster related issues and developments are shared and communicated with the Cluster, its partner organisations and the wider community

Communications Matrix	Cluster Meetings	Cluster Spend Plan	Cluster IMTP	Newsletter	Media Releases
Cluster Lead	✓	✓	✓	✓	✓
Cluster GPs	✓	✓	✓	✓	✓
Cluster Practice Staff / Employees	✓	✓	✓	✓	✓
Patients/Citizens			✓	✓	✓
Local Schools	✓		✓	✓	✓
Neath Port Talbot Council for Voluntary Services	✓	✓	✓	✓	✓
Service Providers			✓	✓	✓
Non GMS Contractors	✓		✓	✓	✓
Primary Care Team	✓	✓	✓	✓	✓
Health Board Community Team	✓		✓	✓	✓
Public Health Team	✓		✓	✓	✓
Local Authority Team	✓		✓	✓	✓
Local Medical Committee	✓		✓	✓	✓
South Wales Police			✓	✓	✓
Welsh Ambulance Service Trust			✓	✓	✓
Community Health Council			✓	✓	✓
Citizens Advice Bureau			✓	✓	✓
Welsh Government	✓	✓	✓	✓	✓
Local AMs / MPs			✓	✓	✓
Media			✓	✓	✓
Chairman / Executive Team	✓	✓	✓	✓	✓
Heads Of Clinical Services	✓		✓	✓	✓
Out Of Hours			✓	✓	✓
SBUHB Patient Feedback Team			✓	✓	✓
Shared Services Partnership			✓	✓	✓
NWIS			✓	✓	✓

Section 8 - Strategic Background

'A Healthier Wales' was published by Welsh Government in June 2018 and set out a clear long term strategy and future vision for Health and Social Care in Wales that everyone in Wales **'should have longer, healthier and happier lives, able to remain active and independent in their own homes for as long as possible.'** The strategy describes a **whole system approach to health and social care,** in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives, a "wellness system" which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

This future ambition is underpinned by the ongoing philosophy of prudent healthcare alongside a quadruple aim:

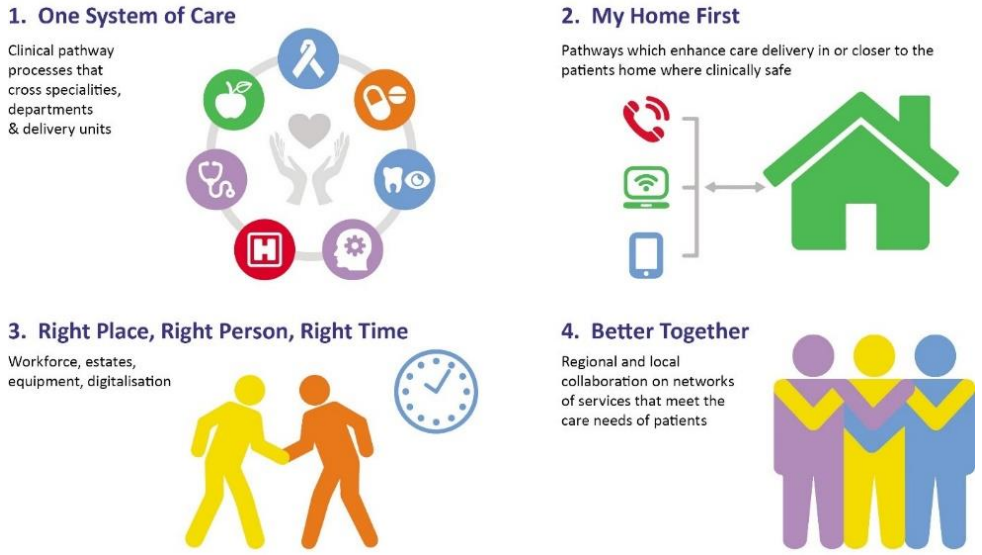
- Improved population health and wellbeing
- Better quality and more accessible health and social care services
- Higher value health and social care
- A motivated and sustainable health and social care workforce

and Ten Design Principles namely:

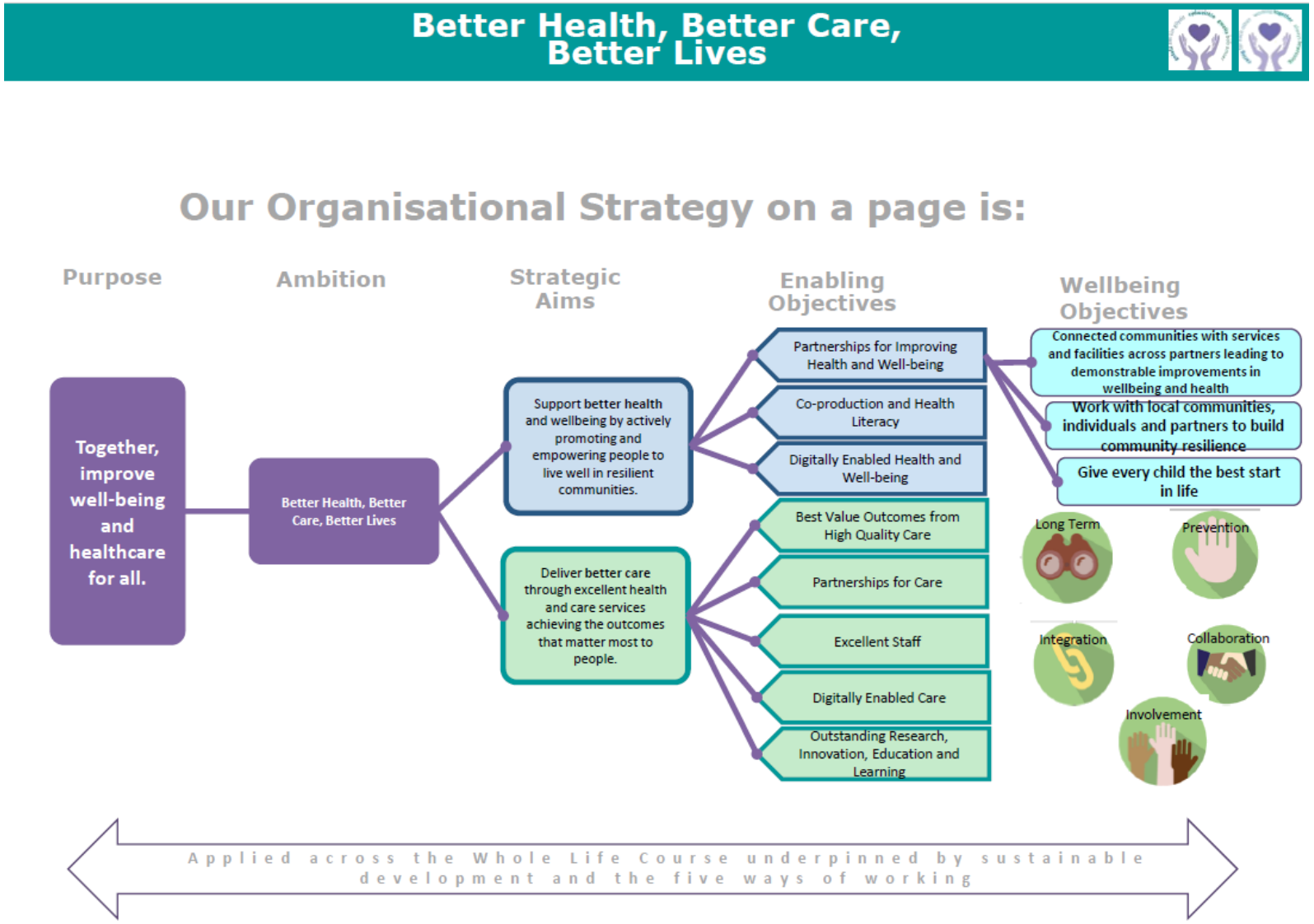
- **Prevention and early intervention** – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing
- **Safety** – not only healthcare that does no harm, but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other forms of harm
- **Independence** – supporting people to manage their own health and wellbeing, be resilient and independent for longer, in their own homes and localities, including speeding up recovery after treatment and care, and supporting self-management of long-term conditions
- **Voice** – empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care; simple and timely communication and coordinated engagement appropriate to age and level of understanding
- **Personalised** – health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes

- **Seamless** – services and information which are less complex and better coordinated for the individual; close professional integration; joint working, and information sharing between services and providers to avoid transitions between services which create uncertainty for the individual
- **Higher value** – achieving better outcomes and a better experience for people at a reduced cost; care and treatment which is designed to achieve 'what matters' and which is delivered by the right person at the right time; less variation and no harm
- **Evidence driven** – using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working
- **Scalable** – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations
- **Transformative** – ensuring new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add a permanent extra layer to what we do now

In addition, there are a number of Health Board interrelated supporting strategies, specifically within Swansea Bay University Health Board, the **Primary and Community Strategy 2017 – 2022**. The overarching Health Board framework, the **Clinical Services Plan** is central to the organisation's ambition to provide Better Health and Better Care to enable Better Lives for all our communities. The key principles are:



The Health Board Organisational Strategy is set out below in summary:



There are a number of key regional, partnership and organisational strategies and priorities including:

Swansea Wellbeing Plan:

- Early Years: To ensure that children have the best start in life to be the best they can be
- Live Well, Age Well: To make Swansea a great place to live and age well
- Working with Nature: To improve health, enhance biodiversity and reduce our carbon footprint
- Strong Communities:Live well, age well, to make Swansea a great place to live and age well

Neath Port Talbot Wellbeing Plan:

- Children in their Early Years, especially those at risk of Adverse Childhood Experiences
- Safe, confident and resilient communities, focussing on vulnerable people
- Ageing Well
- Wellbeing through work and in the Workplace

(Green Infrastructure and Digital Inclusion runs through all areas)

The West Glamorgan Regional Partnership now focuses on three areas of 'transformation', all with associated projects and work streams being delivered in the context of the Social Services and Wellbeing (Wales) Act 2014.

- **The Adult's Transformation Board** (the key priorities of which include Older Adults, the Commissioning for Complex Needs Programme, Dementia, the Mental Health Strategic Framework, the Learning Disability Strategic Framework).
- **The Children and Young Adults' Transformation Board** (key priorities of which include the Multi Agency Placement Support Service, Children with Complex Needs and the Regional Strategic Development Plan).
- **The Integrated Transformation Board** (the key priorities of which include Carers, Digital Transformation, Transformation in Networks and the Welsh Community Care Information System).

Transformation (Clusters – A Whole System Approach) - a programme which aims to test out the components set out in 'A Healthier Wales', and provide learning to be shared across Wales, using the individual clusters in our region as a basis for delivery at local level, thus making significant progress toward achieving the future vision as laid out. The overarching vision of the programme is **to achieve a transformed, sustainable, model of cluster led integrated health and social care,** across all eight cluster populations in the West Glamorgan Partnership area**,** with the main aims of:

- Improving health and wellbeing across the age spectrum, including a key focus on **facilitating self-care and building community resilience,** and with targeted population groups dependent on cluster demographics.
- Coordinating services **to maximise wellbeing, independence and care closer to home** including flexibility to coproduce, design and implement services in partnership with the community.
- **Testing out the vision and aims described with 'A Healthier Wales'** and implement components of the overall model, demonstrating proof of concept and an ability to evaluate and redesign.

In addition, the Cluster's 'Whole System Approach Programme' must be viewed in the context of, and as part of a wider health and social care regional transformation process. It will dovetail with both 'Our Neighbourhood Approach' and the 'Hospital to Home' Programmes, embedding the prevention and early intervention agenda, improving community resilience to achieve a much greater focus on self-care, the integration of health and social care systems and at a local level the delivery of care closer to home.

Section 9 - Health Board and Cluster actions to support Cluster Working and Maturity

The Health Board Cluster Development Team, supported by other departments, together with Cluster members will act as partners to continue to develop and provide/access wide-ranging support to Clusters.

This may include;

- Building on external relationships with the Primary Care Hub for delivery of national programmes such as Confident Leaders, Governance Frameworks, Compendium of MDT roles, and Primary Care Health Needs Assessment Tool, councils for Voluntary Services, Public Health Wales, Local Authorities and internally with pertinent Health Board functions and delivery units.
- Provision of general guidance for cluster development
- Performance management, financial reporting, general cross-cluster reporting
- Developing the Cluster IMTPs
- Developing internal cluster training
- Acting as key links for national Transformation programmes
- Providing capacity to support key stages of the Transformation programme where required
- Developing business cases
- Identification of and flagging new funding or research opportunities
- Providing Clinical Leadership for Cluster Development
- Providing opportunity for common discussion points through clearly set out governance arrangements such as the Cluster 8 Leads meeting
- Accessing strategic documentation/programmes to support articulation of Cluster strategy development

The Clinical Services Plan sets out a number of ambitions (below), which have been translated into Whole System Plans. The Cluster IMTPs have considered the Clinical Services Plan priorities, and in addition have mapped out below the actions within those Whole System plans, which the Cluster Plan is supporting to address.

- Population Health
- Planned Care
- Older People
- Unscheduled care
- Maternity, Children & Young people

- Mental Health & Learning Disabilities
- Cancer

The cluster will continue to work towards achieving the Level 3 of the Maturity Matrix of the Primary Care Model for Wales. An initial assessment of maturity is shown in the table below. A more indepth analysis will be conducted in year 1 of this IMTP.

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
Informed Public	Case for change agreed by whole cluster team	Cluster Communication and Engagement Strategy agreed and publicised, including vision, purpose and functions of cluster	Clear understanding by public of: • Case for change • New systems of care • How to access local information, advice, support and care
	Key messages for local communication agreed, aligned to national priorities	Systems and channels for public engagement/communication established, reflecting preferences of stakeholders	Cluster Communication and Engagement Strategy in active use, with wide range of communication methods and resources
	Cluster stakeholder groups identified	Communication and engagement with public & service users underway	Clear understanding of how to access health information & advice, including self care information and use of on line symptom checkers through 111
Empowered Citizens	Options for engaging and involving service users in information / service design have been researched and agreed by cluster team	Systems for promoting and receiving feedback from service users are established within the cluster	All new & redesigned local services and assets developed through co-production with service user reps

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	Widespread support for use of behaviour change techniques by professionals	Active engagement and involvement of service user representatives in design of cluster services & assets	Service user feedback actively used in redesign of cluster services
	Resources are available to support culture and behaviour change amongst local stakeholders	All members of cluster team trained in behaviour change techniques	Evidence of widespread culture / behaviour change in stakeholders, with ownership of well-being and appropriate use of services
	All members of cluster team understand and actively promote *Making Choices Together* and *Every Contact Counts*	All members of cluster team understand and actively use *Making Every Contact Counts*	Local cluster champions in place to promote and support new initiatives
		All members of team trained in shared decision-making and use *Making Choices Together* techniques for a few prioritised conditions	Service users actively encouraged and supported to make informed choices on all care and treatments
			IT systems in place with designs to support decision-making
			Activation measures used to monitor service user motivation& empowerment
Support for Wellbeing, Disease Prevention and Self Care	Options for signposting and care navigation systems have been researched and understood	Cluster plans and business cases address gaps in local services that promote well-being and self-care	Widespread information, advice and support are available to promote ownership of health and wellbeing, esp. amongst young people

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	Smart technologies that support self-care and self-monitoring have been scoped and costed	Signposting and navigation systems direct service users to information and support for self-care	Wide range of local health & wellbeing resources are available to support self-care, promoted through cluster signposting / navigation
		Technologies that support self-care are included in cluster business plans	Smart technologies in widespread use to support self-monitoring and self-care, especially for long term conditions
			Pro active use of 111 /NHS Direct symptom checkers
Community Services	Cluster teams and Regional Partnership Boards use Population Needs & Wellbeing Assessments to fully understand community health and wellbeing requirements	Cluster plans and business cases address gaps in local community services & assets through • Prioritisation of cluster projects to address service needs • Service user reps involved in planning / design of all new services • Robust evaluation of initiatives to ensure value for money • Active consideration of factors relating to special needs, equality and health literacy is integral to prioritisation and design of services	Comprehensive up-to-date Directory of Cluster Services published, including sources of information, advice & support in choice of formats; accessible through national Directory of Service hosted on 111 platform with links to other national directories eg. DEWIS Cymru
	Cluster plans are integral to IMTPs of Health Boards and Local Authority planning mechanisms	Methods and technologies enabling service users to access support & advice from healthcare teams researched	Range of methods is available to access support, advice and treatment quickly and easily: e.g. phone, email, video-call

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	Existing cluster services and assets are scoped and analysed	Cluster services with direct access / selfreferral routes are promoted e.g. community pharmacy, optometry, audiology and physiotherapy services	Systems for signposting are in place to direct people to community resources easily and quickly
	Gaps in cluster services and assets that support well-being, disease prevention, care and treatments within local community are actively addressed in next planning round		Wide range of community services established for care and treatment, tailored to needs of the community and redressing health inequalities
			Systems are in place to empower people with differing levels of health literacy and sensory impairments to access advice, care and treatment
Cluster Working	Joint agreement by integrated cluster team on vision, purpose and functions of their cluster		
	Cluster strategy has been drawn up, shaped by cluster data and intelligence	Cluster operational model agreed through use of options appraisal, with legal advice sought as necessary	Cluster model in operation to promote multidisciplinary approach & integrated care
	Cluster Lead in post	Cluster governance framework in place, with robust processes for cluster decision-making, risk management and accountability for all partner organisations.	Cluster partnership working is promoted through co-location of staff, joint contracts, shared learning, staff rotations, etc.

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	Code of conduct and Terms of Reference is agreed by Cluster Stakeholder Team	Integration and partnership working actively promoted within cluster	Range of professionals in post to increase capacity and expertise of cluster team, delivering holistic care closer to home
	Cluster workforce plans drawn up, based on assessment of population needs and cluster skills/capacity requirements	Cluster recruitment / sustainability plans agreed to ensure stability of Primary Care services	Contractual arrangements for cluster staff in place to ensure effective lines of accountability, robust indemnity and pension arrangements
		Primary Care training placements are established for cluster staff	All cluster professionals are supported by appropriate training, clinical supervision, mentorship arrangements
Call-handling, Signposting, Clinical Triage / Telephone First Systems	Clear understanding of cluster callhandling, signposting, clinical triage / Telephone First systems & processes by cluster team:		GP practices and Primary Care services are stable and sustainable, employing a workforce trained in cluster environment
	Service users involved in designing feedback systems to evaluate callhandling, signposting and triage systems	Use of service user feedback to design signposting, call-handling, triage systems	Safe and effective cluster call-handling & triage systems in place to assist service users in accessing right information, advice & care from clinical and non-clinical services
		Agreement by cluster team on operational models for call-handling, signposting, clinical triage systems	Non-clinical referrals are assisted by link workers, social prescribers, care navigation, etc and citizens

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
			are signposted using the national Directory of Service
		IT systems installed to support safe and effective call-handling / triage processes	Robust protocols, guidance and support are in place for all cluster call-handling, signposting and triage systems
		Guidance and protocols in place for all cluster call-handling and triage systems	Service user feedback, monitoring, significant event analysis & audits inform redesign of systems
		Training and refresher courses attended by all staff involved in cluster callhandling & triage systems / processes	Regular refresher courses attended by staff delivering call-handling/triage services
111 and Out-of Hours Care	Systematic patient feedback systems embedded in 111/GPOOH services	Regular risk assessment & audits for all cluster call-handling and triage systems	Excellent communication systems across in- and out- of-hours interface with handover of care through effective sharing of 'Special Patient Notes' and Anticipatory Care Plans
	Flexible boundaries to allow patients to be assessed in service closest to home (not where they are registered)	OOH advice & care delivered by multiprofessional team including core disciplines available to all services – eg. pharmacists, nurses, doctors, paramedics	OOH and 111 Staff have access to relevant, up-to-date records through Welsh GP Record
	Equitable access to emergency/urgent dental conditions in line with national specification		People effectively signposted to appropriate advice & care by use of MDT in OOH period, with potential for scheduling into alternative pathways (eg.

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
			community services) by 111/GPOOH service without hand-off back to own GP
	Flexible workforce solutions that allow professionals to work remotely		Specialist skills available during OOH period through regional working (eg. Mental Health Specialists)
	Consistent policies on management of home visits		Use of digital technology to improve patient experience and efficient service delivery
			Integrated pathways between 111/GPOOH and 999 service
People with Complex Care Needs	People with more complex needs are identified by use of benchmarking, disease registers, risk stratification tools, admissions data, etc	Multi-professional teams increase cluster capacity and tailor consultation times to the needs of more complex patients	CRTs, Frailty and Integrated Health & Care teams support complex care through MDT approach within primary care / community settings
	Analysis of cluster professional capacity and skills to deliver complex care undertaken, e.g. GPwSIs, ACPs, Community Resource Team, Frailty Team, Integrated Health & Care team, specialist teams	Cluster Outreach Services deliver specialist care through an MDT approach, closer to home	Virtual Wards and Community Hubs are used to care for acutely ill people, with hospital specialists working alongside cluster teams
	Increased emphasis on disease prevention for long term conditions in cluster community, using LPHT support / expertise, PNAs and PWBAs	Community diagnostic services support complex care closer to home	Increased range of planned care delivered within the community, with local access to specialist expertise and diagnostics

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
Infrastructure to support Transformation	Good understanding by cluster team of infrastructure requirements for effective cluster working: estates & facilities, IT systems, community diagnostic services, etc.	Cluster infrastructure scoped to identify development needs, with prioritisation Appropriate channels, mechanisms and support are used to escalate significant deficiencies in cluster infrastructure, with clarity on risks to safe, effective cluster working	Local estates and facilities are fit for purpose, sustainable and support multiprofessional team working and training
	Support and expertise is readily available to promote and support cluster working, e.g. • PNAs and cluster planning • Business case development • Data analysis, IT systems, new technologies	Where appropriate, business cases address deficiencies in infrastructure and facilities, e.g. community diagnostic services, smart technologies	Informatics and telephony systems in place with designs that support and promote multi-professional working
			Digital options that enable service users to access care quickly and easily are commonplace
			Direct access to range of diagnostic services is available to cluster teams