Integrated Medium Term Plan (IMTP)

2020 - 2023

Welcome to the Cwmtawe Cluster IMTP 2020 – 2023

Section 1
Executive Summary/Plan on a page

"Welcome to the Cwmtawe Cluster Plan 2020-2023 which highlights the Cluster vision and priorities and how we will achieve them over the next 3 years leading the vanguard for Wales and a social model of health and wellbeing

In recent years we have placed a great deal of emphasis on developing cluster led projects working closely with the Health Board. This resulted in us being the first cluster in Swansea Bay to be successful in taking forward our transformation programme. In real terms this means whole system remodelling with over 20 projects aimed to deliver care closer to home. Successful transformation projects have the potential to influence the positive development of wider National Health Services (NHS) Wales primary care – to effectively be a blueprint for the future.

Complimenting transformation work is the cluster plan and much has been achieved already, for example working with partners such as Swansea Community Voluntary Service (SCVS) to increase the multi-disciplinary team so that patients see the most appropriate person to meet their needs, such as the Social Prescriber; Early Years Worker; or Young Peoples Counsellor…… but our drive to ensure that our patients have the maximum possible support to access healthy lifestyles continues. Patients were asked what services they would like to see within the cluster and their response, together with the regard given to both clinical and partner priorities, has enabled a new Cluster plan to be developed that continues to aim high to achieve those needs."

Dr Iestyn Davies
Cluster lead

Plan On A Page
Vision
Cwmtawe Cluster aims to be a vanguard within Wales enabling a social model of health and wellbeing, ensuring patients have the maximum possible support to access the mechanisms needed to live a healthy lifestyle. It will do this by developing a hub of services for its population, involving GP practices, the community themselves and key partners; delivering this collaboratively with a social ethos, ensuring real and tangible benefits for the patients of Cwmtawe Cluster
Strategic Overview
Cwmtawe Cluster will continue to deliver a Whole System Transformation programme. Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vison is to achieve a Cluster led transformed model of integrated health and social care for the Cwmtawe 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 bring care closer to home. Cwmtawe Cluster will endeavour to use this exciting opportunity to support the implementation of A Healthier Wales and the new model of primary care. Consideration has been given to the Primary Care Cluster Governance Assurance: A good practice guide, in the development of this IMTP; our Cluster will be undertaking a maturity assessment and develop subsequent actions as a result to build on the work done to date. This will feed into the Health Board overarching Cluster Development Plan.
Cwmtawe Cluster Priority Areas

- Develop working relationship with associated Community Interest Company to establish a joint agenda for patient health and wellbeing
- Develop partnership aims and objectives with other 'blue light' services to improve local area knowledge and understand patient needs and improve services for vulnerable patients including patients experiencing domestic abuse
- Developing and delivering a preventative work programme focusing on reducing rates of Obesity - identifying additional funding to allow the cluster to commission a developed lifestyle coach/physical trainer to develop a series of exercise programmes to be delivered through community group sessions, targeting weight management, pain management, diabetes, hypertension
- Developing and delivering a preventative work programme focusing on improving diagnosis of Dementia and ongoing support for patients, families and carers.
- Work with Swansea Social Services 'Crest Recovery College' to develop and implement a referral process from primary care to provide specialist mental health resources with an emphasis on recovery, work and educational opportunities
- Delivery of care closer to home of services that meet community health and wellbeing needs such as the Primary Care Child and Family Wellbeing Team and heart failure linked to Primary Care Child and Family Wellbeing Team
- Continue to implement and evaluate the Transformation programme for the establishing of the new model of Primary Care (Whole System) in the Cluster,
- Building on known community asset and patient and citizen involvement in the development of peer support and community capacity, co-producing services and improving health literacy, and continuing to increase capacity for social prescribing and aligning with Transformation (Our Neighbourhood Approach)
- Continuing to support Business Case development for Physiotherapy, Pharmacists and Early Years Worker
- Extending the implementation of Cluster and Transformation communication strategies to both external and internal stakeholders, and using messages to maximise ability to address workforce recruitment issues.
- Develop and deliver a work programme, maximising support available to improve population health and wellbeing through prevention and self-care, with a focus on our priority areas of need for dementia, obesity (weight management, diabetes, hypertension, pain management), mental health (social prescribing, access to new services, increased capacity in Cluster), flu, childhood immunisations and vaccinations, perinatal health and chronic pain.
- Ensuring that cluster has suitable estates strategy and capacity to deliver required range of services
- Ensuring care is delivered closer to home wherever possible, including delivery of Diabetes and Care Homes Enhanced Services, and community clinics such as Audiology, Children and Adolescent Mental Health Service (CAMHS), Cardiology, Sexual Health.
- Improving screening rates, particularly for Bowel Cancer
- Improving access to GMS services, enabled by delivery of further development of cluster and practice based Multi-Disciplinary Team (MDT), together with use of Information Technology (IT) and review of enhanced services.
- Undertake a rigorous programme of Quality Improvement in key nationally identified areas.

Section 2: Cluster profile

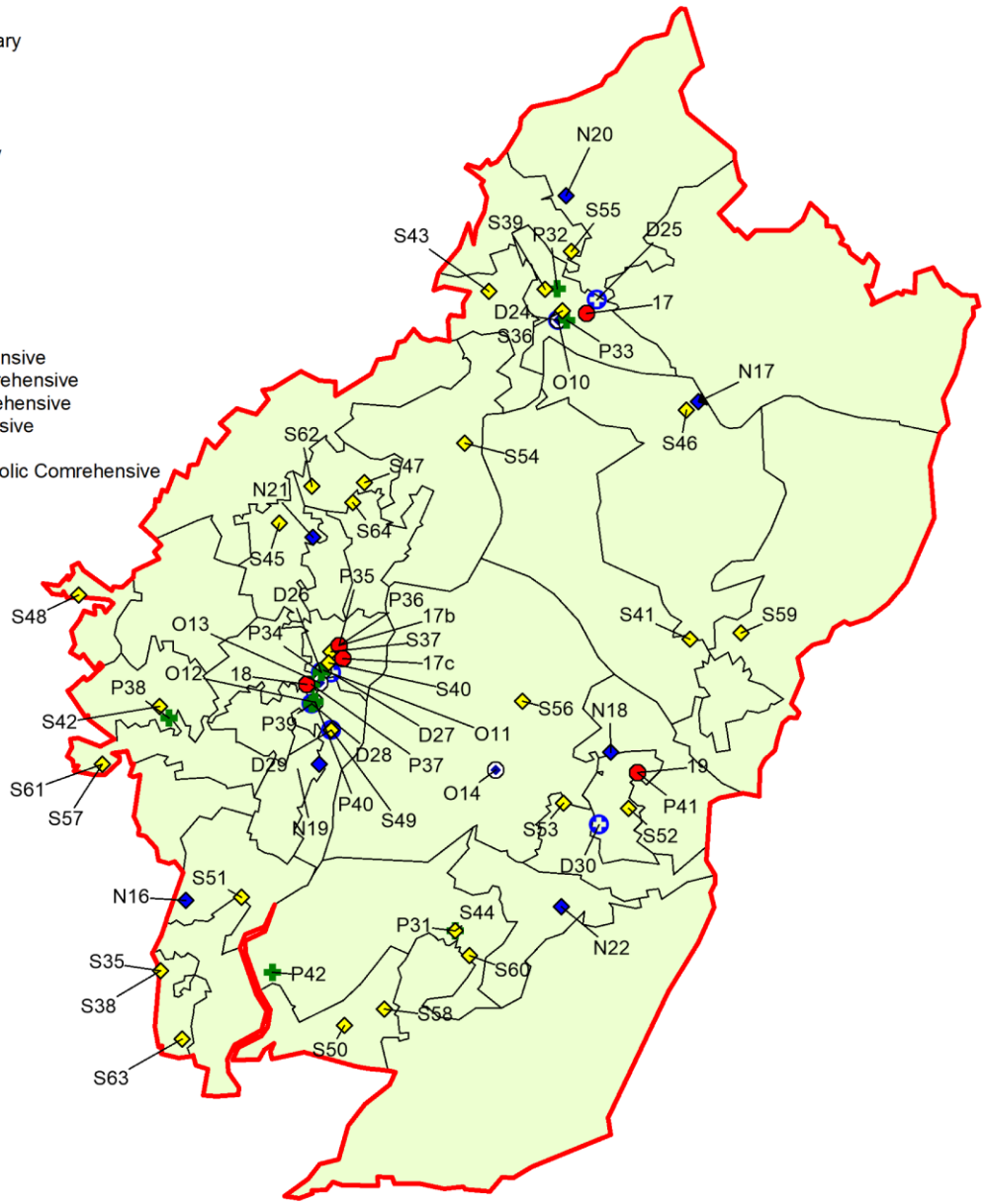
The Cwmtawe Cluster is one of eight clusters in Swansea Bay University Health Board, geographically covering south east and central Swansea, which includes the areas of Bonymaen, Clydach, Landore, Llansamlet, Morriston and Mynyddbach and is made up of 3 general medical practices working together with partners from key Local Authority Departments such as Social Services and Poverty and Prevention, the Voluntary Sector, Community Pharmacies, Dentists and Optometrists and the wider ABMU Health Board. Practice populations range from 6759 to 25264, amounting to a cluster total of 42,580 (July 2019 data).

Clusters aim to work together in order 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.*

Primary Community Services Cwmtawe Cluster

17 - Cwmtawe Medical Group
17b - Sway Road Surgery(Llys Meddyg -Branch)
17c - New Cross Surgery(Branch)
18 - Strawberry Place
19 - Llansamlet Surgery
D24 - Cwmtawe
D25 - Laurels Dental Practice
D26 - Gower Healthcare
D27 - Ty Gwyn
D28 - Woodfield Dental Practice
D29 - The Family Practice
D30 - Pantyffynon
N16 - Castle Graig Nursing Home
N17 - Glais House Nursing Home
N18 - Peniel Green Nursing Home
N19 - St Martins Court
N20 - Frood House Nursing Home
N21 - Ael Y Bryn Nusing Home
N22 - Hengoed Court Nursing Home
O10 - JE Barnes
O11 - Norma Davies
O12 - Specsavers
O13 - Bater and Stout
O14 - Tesco Vision Express
P31 - Bonymaen Pharmacy(K Thomas)
P32 - Lloyds Pharmacy
P33 - Lloyds Pharmacy
P34 - KM Jones Pharmacy
P35 - Lloyds Phamacy
P36 - Lloyds Pharmacy
P37 - Lloyds Pharmacy
P38 - Well
P39 - Well
P40 - Boots UK Ltd
P41 - Hanfords Chemist Ltd
P42 - Boots UK Ltd
S35 - Brynhyfryd Infants
S36 - Clydach Infants
S37 - Pentrepoeth Infants
S38 - Brynhyfryd Juniors
S39 - Clydach Juniors
S40 - Pentrepoeth Juniors
S41 - Birchgrove Juniors
S42 - Clase Primary
S43 - Craigfelen Primary
S44 - Cwm Glas Primary
S45 - Cwmrhydyceirw Primary
S46 - Glais Primary
S47 - Glyncollen Primary
S48 - Llangfelach Primary
S49 - Morriston Primary
S50 - Pentrechwyth Primary
S51 - Plasmarl Primary
S52 - Talycopa Primary
S53 - Trallwn Primary
S54 - Ynystawe Primary
S55 - YGC Gellionnen
S56 - YGC Lon Las
S57 - YGC Tirdeunaw
S58 - St Illtyd's RC Primary
S59 - Birchgrove Comprehensive
S60 - Cefn Hengoed Comprehensive
S61 - Daniel James Comprehensive
S62 - Morriston Comprehensive
S63 - Pentrehafod Schol
S64 - Bishop Vaughan Catholic Comrehensive



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NHS Informatics Service August 2019

Purpose and Values:

The Swansea Bay UHB Clinical Service Plan sets out a list of key facets for the roles of the cluster

- 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 member's meets 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.

Non-Welsh Government funds are administered on behalf of the Cluster by Swansea Bay University Health Board and SCVS 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 5 Cluster Leads Forum (bi-monthly), 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

Swansea Wide headline information

- Population: 242,400.
  High concentrations of population in and immediately around the City Centre, the adjacent wards of Cwmbwrla and Uplands (6,800 people per square km, the highest density in the county) and also in Townhill and Penderi
- Population has steadily grown between 2001 and 2015. Main driver of population growth in Swansea has been migration. Recorded live births has steadily risen since 2001 and number of deaths have fallen.
- Life expectancy in Swansea is increasing: Average life expectancy for males is 78 (Wales 78.5) and 82.4 for females (Wales 82.3). This will impact significantly on the provision of health, social care and other public services in Swansea
  Projected population Change: Welsh Government's latest trend based population projections suggest that Swansea's population will grow by 9% (21,600 people) between 2014 and 2039
  2011 Census suggests that 14,326 people in Swansea were from a non-white ethnic group: 6% of the total population and 20,368 (8.5%) of Swansea's Population were non-white British. (Above the Wales average (6.8%). Census data (2011) suggests the largest non-white ethnic groups are: Chinese 2,052 (0.9%), Bangladeshi 1,944 (0.8%), Other Asian 1,739 (0.7%), Black African 1,707 (0.7%), Arab 1,694 (0.7%)
- Welsh Language: Proportion of people able to speak Welsh in Swansea decreased from 13.4% (28,938) in 2001 to 11.4% (26,332) in 2011. A fall of 9% despite an increase in population.

Cwmtawe Cluster information

- 8625 (19.9%) patients aged 65+ (Swansea 19.2%) and a further 3831 (8.9%) patients aged 75+ (8.9% Swansea)
- Deprivation greater than Welsh Average and variable across the area
- Population likely to grow by 9% (3858 patients) between 2014 and 2039
- The age population is broadly similar to Swansea's overall but with slightly higher proportions aged 0-15 at 12.7 compared to 11.7 for Swansea.
- Lower proportions aged 16-24. The age range for 25-44 is slightly higher within the cluster at 26.3 compared to 24.7 in Swansea along with 45-64 years at 26.1 and 24.7 for Swansea (Swansea Wellbeing plan 2017)
- Low student population
- Low ethnic minority patient numbers
- The area has a higher percentage of people able to speak Welsh than the Swansea average (Swansea Wellbeing plan 2017)
- Household composition in line with Swansea but with slightly higher proportions of couples within the cluster 32.7% compared to 30.4% in Swansea and lone parent households at 13.5 compared to 11.7% in Swansea. (Swansea Wellbeing plan 2017)

- There is an above average of semi-detached properties. Slightly higher number of houses owned with a mortgage/loan (2011 Census)
- Low asylum seekers numbers
- Air Quality Management Area (AQMA) extended with areas of congestion currently being monitored in Morriston and Llansamlet.
- LDP Strategy- There are significant numbers of new housing developments planned within the cluster boundary. Included within the planning application are plans for a GP surgery at Felindre which falls within the cluster boundary.
- Poverty - Bus fares have fluctuated a little but generally the trend has been upward, worsening the poverty premium, (the amount people living in poverty have to pay for essential items).
- Some areas have limited transport links to the city centre and across the cluster.
- Swansea Council have agreed to go for re designation for Phase 7 for the World Health Organisation's 'Healthy Cities'. Cluster examples will be used from across Swansea Bay University Health Board in the case study submission to showcase cluster work at an international level
- Pockets of deprivation across the cluster result in higher demands for care due to anxiety and stress. (Swansea Wellbeing plan
- 2017)

Population & Community Assets

- Extensive green space e.g. Lliw Reservoir, Swansea Vale Nature Reserve, Primrose Park, Morriston Park.
- Active Community and Voluntary Organisations.
- Rugby Club
- Leisure Centres
- Libraries
- Community Hubs

- The Major employers within the cluster are City and County of Swansea; The Mond Nickel Works; DVLA; DWP; HSBC and Land Registry.

Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis: City Cluster

Strengths	Weaknesses
• Strong leadership by the Cluster Lead • Strong collaborative working relationship between Partners on projects • Developing infrastructure within the cluster • Willingness to lead development of new models of primary care and take forward a Whole System Transformation Programme • Undertaking decisions and actions for the good of the cluster not just the practice • External funding sources	• Consistency in ensuring that the cluster message is relayed back to partner organisation and that their thoughts are fed into the cluster • The delay in being able to mainstream effective projects in order to release funds enabling innovation to continue • The lack of time/resource available in practices and partner organisations for cluster work due to competing demands • Sustainability for schemes beyond the Transformation Fund
Opportunities	**Threats**
• To increase closer working with secondary care and CAMHS • To further develop Wellbeing within the work of the Cwmtawe Cluster • Training and development for primary care teams to engage with new ways of working and the direction of travel and aims of the cluster • To embed the extended multi-disciplinary team within the Cluster • Transformation Funding • Digitalisation/Modernisation • Improving Access	• The inability to re-invest in new projects due to successful ones not being mainstreamed • Reduced allocation of budget by Welsh Government • Change of Government Policy regarding Clusters • Increase in list sizes due to housing developments • Number of Nurses due for retirement in the next 5 years. • SBUHB organisational changes

Section 3
Key achievements from 2018-21 plan

Cwmtawe have placed a great deal of emphasis on the social model of health and wellbeing taking care to ask patients what services they would like to see taking place within the cluster area as well as having regard for both clinical and partner priorities. This has included questionnaires on the communities thoughts regarding Health and Wellbeing services provided within the Cluster, the outcomes have shaped the social model of health adopted. As a result of this model of working and a willingness to change working practices Cwmtawe was the first cluster of the SBUHB to be successful in taking forward its Transformation programme.

- Received Welsh Government Transformation Funding to realign health care services providing them closer to patients homes, increasing the size of the MDT within practices
- Continued to develop and deliver the Social Prescribing Link Worker Role (with the support of SCVS) to improve patient wellbeing and provided an alternative option for when GP's don't feel a non-medical intervention is preferable. Expanding the activities to which patient can self-refer.

- Shared learning with other practices, Welsh Government and Swansea University regarding the Social Prescribing Link Worker Role
- Continued to deliver in partnership with the SCVS a service to deliver counselling to young people
- Provided a bereavement counselling service
- Established a Community Interest Company to improve wellbeing within the area.
- Successfully obtained funding to deliver a Dementia Support worker and training for front-line staff regarding dementia awareness.
- Developed capacity for the cluster team to access patient records throughout the cluster by adopting Vision 360 and Vision Anywhere
- Continued to employ a part-time senior member of staff to deliver the aims of the Cluster
- The community pharmacist continues to regularly undertake polypharmacy reviews.
- Continued with regular cluster practice managers meetings in order to drive the action plan and develop a shared vision for the Cluster.
- Completed the Merger of Cwmtawe Medical Group with New Cross Surgery practice to improve sustainability within the cluster
- Received the interim report of the Social prescribing link worker post.
- Developed a calendar of 3 questionnaires each year to obtain views and needs from services. Feedback from the questionnaires told the cluster that they wanted help and support around wellbeing generally, they wanted to see more support for those living with dementia. Feedback from the CIC community engagement effect highlighted the need for more support for those with poor mental health

- Continued use of Dermatology and Ears Nose and Throat advice lines
- Promoted the use of the Healthy City Directory with staff and patients
- Quick Response (QR) Boards for provide patients with access to up to date practice and information.
- Provided the vulnerable over 70's with a room thermometer and Winter Wrapped up Booklet to help keep them well.
- Practices have signed up to the Care Home Directed Enhanced Service (DES) to deliver an enhanced service.
- Begun to develop links with other public sector staff working with vulnerable people within the cluster
- Shared learning 6 months of practice data from last year shared with City Cluster
- EmploLocal Coordinator in post in Llansamlet area with positive feedback
- More phlebotomy clinics offered in the community and home visits linking with Acute Clinical Outreach Team
- Audiology Service being developed to begin April 2019.
- Dental: A dental Syrian refugee programme was developed and implemented within Cwmtawe cluster in reaction to the UK Government increasing opportunities for entry to the UK of refugees from Syria and surrounding areas. Effective planning has been undertaken by cluster teams to ensure necessary arrangements are put in place to ensure general dental practices are supported to enable the provision of dental care for these

Section 4 - Health and Wellbeing Needs Assessment

Information has been collated on a wide range of health needs within the Cwmtawe 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 profile data, a review of Public Health Priorities, the disease register, audit reports and a series of Cluster meetings.

Obesity	Screening
The cluster has the highest levels of obesity within Swansea at 11.7% compared to the lowest cluster figure at 6.1%.	Bowel Screening -56.1% uptake within the Cwmtawe Cluster during 2017/18 in comparison to the former ABMU average of 56.2% for the same period. Breast Screening – 72.3% uptake within the cluster during 2017/18 in comparison to 73.1% for the former ABMU average for the same period Cervical Screening 76.9% uptake during 2017/18 in comparison to the former ABMU average of 75.1% for the same period

Smoking / Lung Cancer

An estimated 7390 people, 18.1% of the Cluster population smoke. Welsh Government have set a target of 16% by 2020.

Mental Health

Around 32,200 people aged 16 or over in Swansea may have one Common Mental Disorder e.g. anxiety depression and Obsessive and Compulsive Disorder.

0.9% of patients are registered with their GP as having mental health disorder. Which is in line with both Swansea and the former ABMU figures for 2017 of 1.1%.

Influenza Vaccination

Cwmtawe	Influenza immunisation uptake (%) 2017/18 and 2018/19					
	Patients 65y and over		Patients under 65y at risk		Children aged 2 & 3 years	
	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19
Cwmtawe cluster	67.3	65.5	42.9	38.5	43.4	38.0
Swansea	67.4	67.2	46.5	43.0	47.4	46.6
Wales	68.8	68.2	48.5	44.0	50.2	49.3

Cwmtawe Cluster figures for flu uptake has fallen over the past 2 years and is below the average figures of Neath Port Talbot (NPT); Swansea and Wales.

Teen pregnancy.

At a time when, across England and Wales, teenage conception rates are falling to record levels, the rates for the Swansea area are showing a worrying upward trend. Detailed below are referrals to the Young Parent schemes from Childrens and Young People Partnership, Swansea. The data for 2017 has recently been published and Swansea again sits at the top in Wales and within the top percentile across England/Wales. Within the Swansea are there are particular areas where Young parents are more prevalent. Within Cwmtawe these areas are Bonymaen and Mynddbach

Age	2016	2017
13	0	0
14	1	5
15	0	5
16	9	21
17	19	40
18	38	30
Total	67	101

Heart Disease

Diabetes

Cwmtawe has 2633 patients with diabetes. This is 6.16% of patients and is the highest % within the Swansea cluster areas.

Cwmtawe has the highest rate per 1000 of patients with Heart Disease within Swansea Clusters, at 1.16%. Two of the three practices within the cluster are above the local average	Within this Clydach (6.30%) and the former New Cross Surgery (7.2%) have the highest rates.
Accident and Emergency	**Out of Hours**
Cwmtawe Cluster patients attended A&E 12965 times. The rate per 1000 patients 152.14 times. This is the 3rd highest rate across the Swansea Bay University Health Board SBU HB) cluster between August 2018 and August 2019	Cwmtawe Cluster Patients rang out of hours at the rate of 77.86 per 1000 patients. This is the 3rd highest of the SBU HB Clusters between August 2018 and August 2019
Unscheduled Admissions from Care Homes	**Emergency Admissions**
number of admissions of patients living in Care Homes (SB UHB average number of unscheduled admissions is 187)	Cwmtawe Cluster rate of emergency admissions per 1000 patients is 25.09. This is the 2nd highest rate within SBU HB Clusters between August 2018 and August 2019
Admissions following Falls	
Lower than average rate of per 1,000 patients (SB UHB average rate per 1,000 patients 0.13)	

Data from Safer Swansea Partnership July 2019

Recorded Crime

34% of violent crime was Domestic Related.
49% of violent crime was Night Time Economy [6pm to 6am]
30% of violent crime occurred in Eastside and Morriston Sector

Domestic Abuse

Month	Penderi	Cwmtawe	Total Discussed
April	15	15	55
May	18	16	64
June	20	15	61
July	24	23	101

August	18	17	68
September	14	15	55
TOTAL	**109**	**101**	**404**

The following Swansea police beats recorded the highest rates of domestic abuse during July 2019:

- Townhill/Mayhill [53]
- Penlan [47]
- Clydach/Glais [44]

The table to the right details the number of MARAC cases within both Cwmtawe and Penderi, which between them have over half of the total cases monitored within the Swansea area. These are high risk cases of domestic abuse and any actions needed to ensure safety, creating a risk management plan involving all agencies. It should be noted that most victims experience 30-35 situations of abuse before seeking help - suggesting the full picture may be much higher.

(Recorded Incidents within 1000m of a GP Practice)

The table below is taken from the July Crime figures reported to Safer Swansea Panel and illustrates the recorded crime within Swansea for the period July 2018-June 2019 together with the impact that the night time economy has on crime.

Recorded Crime July 2018 - June 2019	City	East Side and Morriston	Gorseinon and Penlan	Gower and Townhill	Grand Total	%
Stalking and Harassment	355	866	658	511	**2390**	
Of which Domestic	97	274	223	187	**781**	33%
Of which Night Time Economy (NTE)	148	315	245	217	**925**	39%
Violence without injury	657	610	509	417	**2193**	
Of which Domestic	140	271	204	173	**788**	40%
Of which Night Time Economy (NTE)	405	306	256	194	**1161**	53%
Violence with injury	706	569	535	375	**2185**	
Of which Domestic	144	229	220	162	**755**	35%
Of which Night Time Economy (NTE)	465	280	279	208	**1232**	56%
Homicide	1	1	1	1	**4**	
Of which Domestic	0	1	0	1	**2**	50%
Of which Night Time Economy (NTE)	1	1	0	1	**3**	75%
Grand Total	**1719**	**2046**	**1703**	**1304**	**6772**	
Of which Domestic	381	775	647	523	2326	34%
Of which Night Time Economy (NTE	1019	902	780	620	3321	49%
% Domestic	22%	38%	38%	40%	34%	
% Night Time Economy (NTE)	59%	44%	46%	47%	49%	

Primary Care Measures – 2A. (ABMU reference point)

Description of Primary Care Measure	Category	Target (if available)	All Wales Average(Year)	ABMU Average(Year)
Bowel Screening	2A	60%	**53.4%** (2016/17)	**53.2%** (2016/17)
AAA Screening	2A	80%	**80.8%** (2016/17)	**81.9%** (2016/17)
Seasonal Influenza Immunisation in at risk groups	2A	55%	**48.5%** (2017/18)	**46.7%** (2017/18)
Overweight and Obesity in 4-5 year olds	2A		**26.2%** (2015/16)	**25.5%** (2015/16)
Breastfeeding Prevalence at 10 days	2A		**33.8%** (2016)	**31.3%** (2016)

Uptake of Scheduled Childhood Vaccinations at age 4	2A	95%	**85.2%** (2016/17)	**86.9%** (2016/17)
Smoking Cessation	2A		**20.4%** (2017/18)	**19.7%** (2017/18)
LARC	2A		N/A	N/A
Childhood Immunisation at age 16	2A	95%	**89.2%** (2016/17)	**87.5%** (2016/17)
Adults who accessed dental services at least once every 2 years	2A		**51.5%** (2016/17)	**58.0%** (2016/17)
Recording of Alcohol Intake	2A		**76.4%** (2017/18)	**76.6%** (2017/18)
Antibiotic Prescribing	2A		N/A	N/A
People with Dementia prescribed antipsychotic medication	2A		**1.8%** (2017/18)	**2.3%** (2017/18)
People with Diabetes who have received all 8 key care processes	2A		**45.2%** (2016/17)	**52.5%** (2016/17)
No. emergency admissions for ambulatory care sensitive conditions	2A		N/A	N/A
Diabetes lower extremity amputation and diagnosis code of diabetes	2A		N/A	N/A
Circulatory Disease Mortality Rate per 100 000 population <75 years • All Heart Disease • MI • Heart Failure • CVA (all ages)	2A		(2014-2016) **62.3** **18.3** **1.1** **70.6**	(2014-2016) **65.9** **20.5** **0.0** **70.5**
Percentage >65 years with dementia/memory impairment	2A		**2.95%** (2017/18)	**3.08%** (2017/18)
Children (0–17 years) who accessed dental services at least once a year	2A		**59.5%** (2016/17)	**68.8%** (2016/17)
Low Intensity Psychosocial Interventions	2A		N/A	N/A

Enhanced Services undertaken by the cluster practices

Enhanced Services Type	Enhanced Service Name	Cwmtawe (3)
DES	Childhood Imms	3
DES	5 Years Boasters	3
DES	Asylum Seekers	3
DES	Care Homes	3
DES	Flu	3
DES	Learning Disabilities	3
DES	Mental Health	0
DES	Minor Surgery	3
DES	Warfarin (all)	2
DES	Diabetes Type 2 DES	3
SFE	HPV	1
SFE	Meningitis	3
SFE	Pertussis	3
SFE	Pneumo	3
SFE	Rota Virus	3
SFE	Shingles	3
NES	Drug Misuse	0
NES	Homeless	0
NES	Unscheduled (all)	2
LES	Depoprovera	3
LES	Nexplanon	3
LES	IUCD	3
LES	Gonadorelins	3
LES	Hep B	2
LES	INR	2
LES	Measles Outbreak	2
LES	Sexual Health	1
LES	Shared Care (All drugs)	2
LES	Student Registrations	0
LES	Syrian Refugee	0
LES	Uni Les	0
LES	Wound Care	3
SLA	Complex Wound	0
LES	DOACS	3

Community Pharmacy Enhanced Service Provision

Cluster	Address	Postcode	Contract	CAS	Seasnl Flu	Smokng L2	Smokng L3	MAR	Pall Care	Just In Case	EMS	Med Mgt	Suprvsd Consumptn	Syringe Needle	THNS	BBV	TB
Cwmtawe				**12**	**10**	**12**	**10**	**11**	**1**	**7**	**9**	**2**	**12**	**2**	**0**	**0**	**0**
Bonymaen Pharmacy (K.Th	145 Colwyn Avenue	SA1 7EN	605674B	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	x	x	x
Boots UK Limited	30 Woodfield Street	SA6 8BH	605818B	✓	✓	✓	✓	✓	x	✓	✓	x	✓	x	x	x	x
Hanford`s Chemist Ltd	1 Frederick Place	SA7 9RY	605143A	✓	x	✓	✓	✓	x	✓	✓	x	✓	x	x	x	x
Kevin Thomas Chemist	45 St Helens Road	SA1 4BB	605677C	✓	✓	✓	✓	✓	x	✓	✓	x	✓	x	x	x	x
KM Jones Pharmacy	3 Pentrepoeth Road	SA6 6AA	605429A	✓	x	✓	✓	✓	x	x	x	x	✓	x	x	x	x
Lloydspharmacy	50 Sway Road	SA6 6JA	605802E	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓	x	x	x
Lloydspharmacy	67 Sway Road	SA6 6JA	605802D	✓	✓	✓	✓	✓	x	x	✓	x	✓	x	x	x	x
Lloydspharmacy	2 Heol-Y-Nant	SA6 5HB	605804P	✓	✓	✓	✓	✓	x	x	x	x	✓	✓	x	x	x
Lloydspharmacy	New Health Centre	SA6 5LN	605801A	✓	✓	✓	x	x	x	x	✓	x	✓	x	x	x	x
Lloydspharmacy	4 Strawberry Place	SA6 7AG	605838D	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	x	x	x	x
Well	94 Rheidol Avenue	SA6 7JS	605854N	✓	✓	✓	✓	✓	x	x	x	x	✓	x	x	x	x
Well	103 Woodfield Street	SA6 8AS	605854D	✓	✓	✓	✓	✓	x	✓	✓	x	✓	x	x	x	x

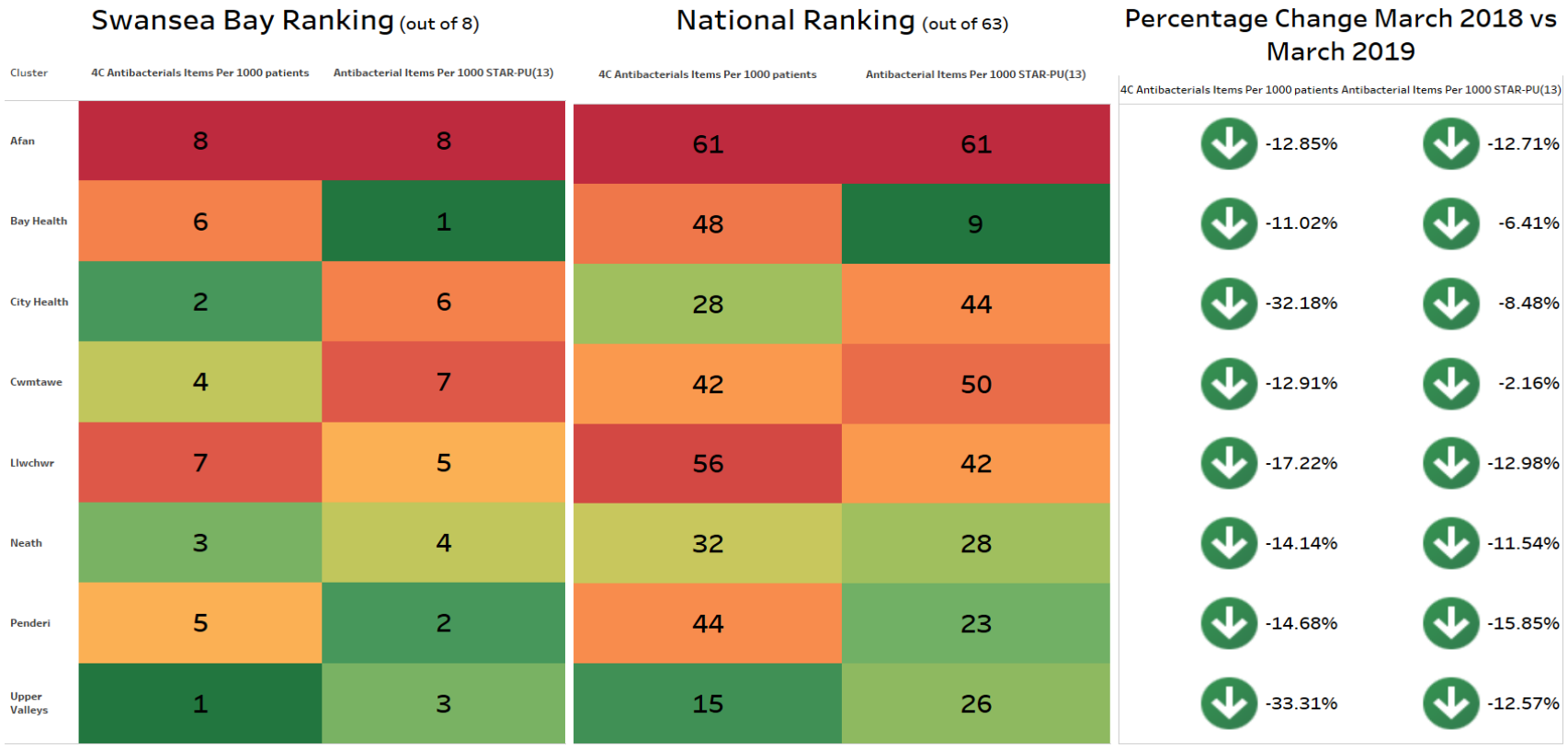
Antibiotic Prescribing

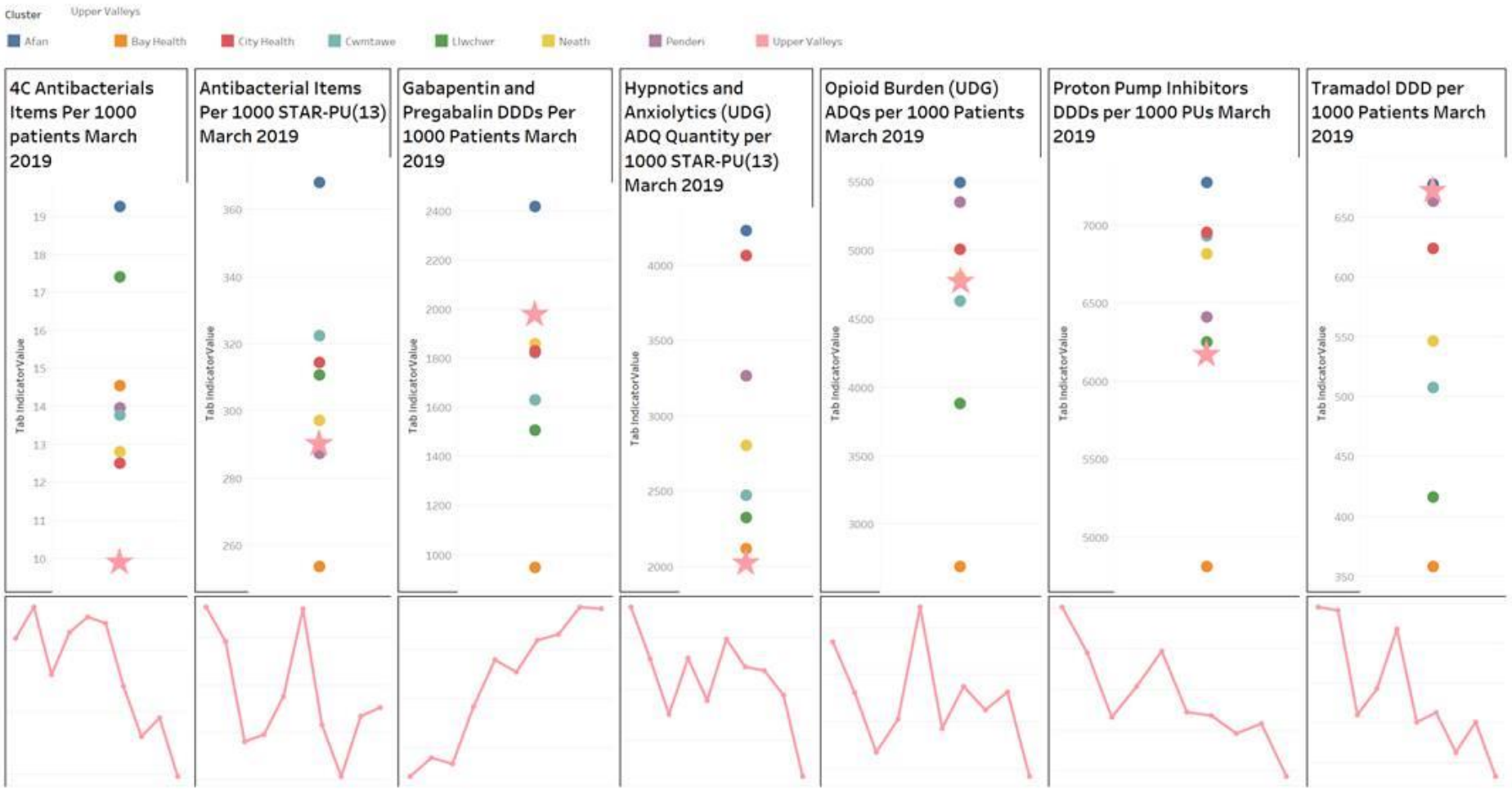
In January 2019 the UK 5 year AMR National Action Plan 2019-2024 was published, which underpins the UK AMR Strategy 20 year vision. Building on achievements seen in 2018/19 improvement goals are set for Heath Care Acquired Infection and Antimicrobial Resistance, which will be reported at a National level. 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. Further information on numerous resources, audits, leaflets etc. available here
- 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. However when reviewing the 8 clusters within the context of the 64 Welsh clusters then it can be seen that significant improvements are still required in the fight against overall antimicrobial use and '4C' antibacterials.




Cluster
Upper Valleys
Afan
Bay Health
City Health
Cwmtawe
Llwchwr
Neath
Penderi
Upper Valleys
4C Antibacterials Items Per 1000 patients March 2019
Antibacterial Items Per 1000 STAR-PU(13) March 2019
Gabapentin and Pregabalin DDDs Per 1000 Patients March 2019
Hypnotics and Anxiolytics (UDG) ADQ Quantity per 1000 STAR-PU(13) March 2019
Opioid Burden (UDG) ADQs per 1000 Patients March 2019
Proton Pump Inhibitors DDDs per 1000 PUs March 2019
Tramadol DDD per 1000 Patients March 2019
Tab IndicatorValue

Section 5 - Cluster Workforce Profile

We have strengthened our multi-disciplinary team with a clinical pharmacist now in place for the fourth year, undertaking medication, polypharmacy and new patient reviews; along with any medication related queries from all staff in primary care.

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.

Swansea Bay community pharmacists

	Employed Headcount	**Employed FTE**
Bay Health	18	15.4
City Health	25	19.5
Cwmtawe	18	12.6
Llwchwr	13	9.7
Penderi	11	9.2
Totals	85	66.4

Total pharmacist FTE	85.0
Total pharmacist Headcount	130

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.

Wider Support from other partners:

Our Cluster has a consistent and long approach to involvement of partners in addition to working alongside other health service areas. This has informed the priorities of the Cluster as well as delivering action against those to improve the health and wellbeing of the population and in turn reducing impact on primary and secondary care health services.

For our Cluster these have included:
Local Area Co-ordination
Swansea Council for Voluntary Services
Children's Services in Swansea Council
Poverty and Prevention
National Exercise Referral
A range of Third Sector providers such as Citizens' Advice Bureau
Regional (West Glamorgan) Carers Partnership
Multi-agency input via a range of partnership forums such as Safer Swansea Partnership, the Health of Homeless and Vulnerable Groups etc.

DOCTORS

Head Count	Whole Time Equivalent	GP / Patient Ratio
24	18.8	2,271

NURSES – *Nurses employed directly by the Practice*

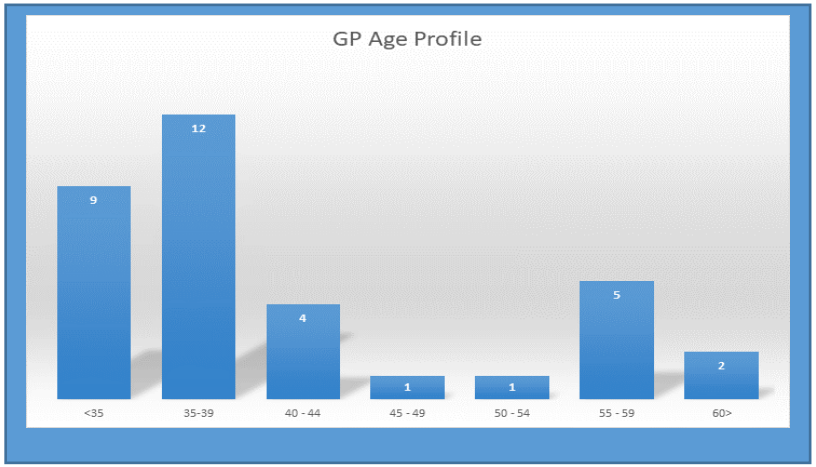
Head Count	Whole Time Equivalent	Nurse / Patient Ratio
20	14.2	2,999

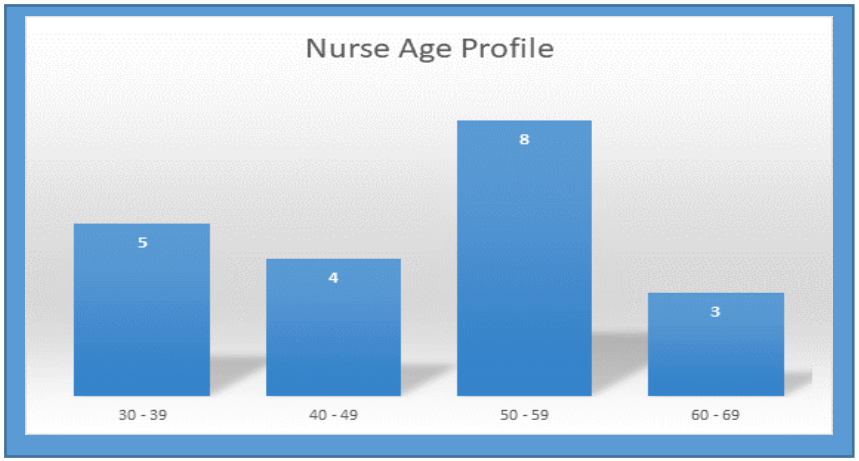
DIRECT PATIENT CARE – *Health Care Assistants, chiropodists, therapists, etc*.

Head Count	Whole Time Equivalent	DPC / Patient Ratio
43	9.9	4,298

ADMINISTRATIVE STAFF – *Practice Managers, receptionists, secretaries, etc.*

Head Count	Whole Time Equivalent	Admin / Patient Ratio
59	48.5	878





Role	Bay Cluster	City Cluster	Penderi Cluster	Llwchwr Cluster	Cwmtawe Cluster
	West Hub	Central Hub		North Hub	
District Nurse	22.3	36		15.3	11.4
Health Care Support Worker (HCSW)	9.4	8.9		5.4	3.1
Out Of Hours Nursing Team	N/A	10.2		N/A	
Physiotherapy/Occupational Therapy (OT)	7.6	13.2		9.7 (P) / 8 (OT)	
Single Point Of Access	3.6	7.5		1	
Palliative Care (HCSW)	8.6	N/A		N/A	
Palliative Care Nurses	1.4	N/A		N/A	

Continuing Health Care inc NB Team (HCSW)	31.5	N/A	N/A
CHC Nurses inc NB Team	5.6	N/A	N/A
Administration	4.4	3.29	3.1
Swansea Council (Social Workers, Homecare, OTs)	31.5	36	41.1

Issues reported for Swansea Bay University Health Board

Escalation is reviewed on weekly basis in order to identity sickness absence, SL or leave to identify capacity within the Hubs and resources available for district nursing and mobilise staff in order to provide equitable service for all service users across Swansea.
Vacancies within the Hubs are fast moving and recur frequently.

Current OT provision in the community is primarily provided through the Integrated Community Health and Social Care teams. Access to OT provision is through the Community Resource Team, and GP access for outpatient services e.g. fibromyalgia. There is also capacity within Mental Health Services. Cluster based OT provision is currently being provided as two pilots in Llwchwr and Cwmtawe with a focus on mental health and Frailty respectively. A robust evaluation is being undertaken in relation to assessing benefits and feasibility of the pilots

Audiology in Primary Care	**Number of staff per cluster**								**Total *(if not available by cluster)***
Staff Title	**Bay Health Cluster**	**City Health Cluster**	**Cwmtawe Cluster**	**Llwchwr Cluster**	**Penderi Cluster**	**Afan Cluster**	**Neath Cluster**	**Upper Valleys Cluster**	
Audiologist/Clinical Scientist Band 8A			***0.5***			***0.5***	***0.5***		***1.5***
Audiologist/ Clinical Scientist Band 7			**0.7**			**0.7**	**0.7**		**2.1**
Associate Audiologist			**0.7**			**0.7**	**0.7**		**2.1**
Please describe any issues; insufficient capacity, recruitment, vacancies, sickness, age profile	Audiology services are available across Swansea, from Singleton Hospital. A transformation programme is underway to deliver community based services being trialled in Cwmtawe Cluster.								

School Nurses	Number of staff per cluster								Total *(if not available by cluster)*
Staff Title	**Bay Health Cluster**	**City Health Cluster**	**Cwmtawe Cluster**	**Llwchwr Cluster**	**Penderi Cluster**	**Afan Cluster**	**Neath Cluster**	**Upper Valleys Cluster**	
School Nursing Service									**41**
Looked After Children Service									**11**

Acute Clinical Outreach Service	
ACO: 3 x GPs (sessional basis working one day each a week covering all of Swansea clusters Monday, Wednesday and Fridays)	

	Number of staff per cluster								**Total *(if not available by cluster)***
Staff Title	**Bay Health Cluster**	**City Health Cluster**	**Cwmtawe Cluster**	**Llwchwr Cluster**	**Penderi Cluster**	**Afan Cluster**	**Neath Cluster**	**Upper Valleys Cluster**	
Speech and Language Therapist	***1***	***1***	***1***	***1***	***1***	***1***	***1***	***1***	***n/a***
Description of other resources pertinent to Cluster discussions	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	

Health Visitors	
• 3 whole time equivalents (WTE) , 1x 0.9 WTE and 1x 0.6 WTE in the Clydach group . • 2 WTE based in Clydach , who are practice teachers and have Health Visiting Students., • 1WTE , 0.9 WTE and 0.6 WTE based in Sway Road Health Centre .	

• Frederick Place HV are 2WTE and 0.5 WTE based in Sway Road Health Centre. • Strawberry Place 1WTE HV who is also a Practice Teacher and has Health Visiting Students . • They have 1WTE HCSW who is supporting them with clinics and administrative work, which is equivalent of 2WTE Community Nursery Nurses who support the team	
Please describe any issues; insufficient capacity, recruitment, vacancies, sickness, age profile	We all support the delivery of the Healthy Child Wales Programme to families with children under the age of 5 years old. Which comprises of core contacts at antenatal period for targeted population such as first time mums and families in need of extra support. Birth visit at 10- 14 days , follow up contacts , clinic contacts , 6 month , 12-13 months,15 months, 27 month,42 months and continue to support until 5 years old. The contacts are meaningful to the time of delivery such as the antenatal and birth visit and post-natal period we discuss safe sleeping to reduce SID, we carry out a demonstration of basic life support and chocking with a baby Annie to all parents unless declined. Presently we are the only Health Visiting service that deliver this, but due to the positive feedback from parents other Health Boards are hoping to train their workforce .The public health advice is given throughout these contacts with the overall outcome of the school ready child. This is a child with healthy lifestyle, fully immunised, toilet trained and development to be within normal limits, deviations from these outcomes result in more intensive work with the family, signposting to other services and supporting the families. As well as delivery the Healthy Child Wales programme we deliver a number of community support programmes presently we have Mother and Baby group delivering baby massage and early week support and advice for parents in Clydach Health Centre and Tesco community room Llansamlet. Support a mother and baby group in the Morriston . We have just commenced 2 walking group one in Clydach and Llansamlet.

Transformation

Integral to Cwmtawe Cluster is the willingness to embrace new ways of working to adopt the new model of primary care. In real terms this means whole system remodelling with over 20 projects and services to deliver improved health and wellbeing and care closer to home. Delivery has included additional pharmacists; advanced nurse practitioners; physiotherapists; phlebotomists; audiologist and a speech and language service based within practices as funded through the Transformation Project.

To ensure practice sustainability, we have agreed to develop a Cluster workforce plan, ensuring we have the people in place to deliver pragmatic healthcare. This should maximise the opportunities for cross-practice working and ensure better access for patients in conjunction with partner organisations.

Training Needs

- IRIS (Identification and Referral to Improve Safety)- Programme based within General Practice that provides training and referral support where domestic Violence and Abuse have been identified
- Cluster Development Team- Leadership /Project Management and Bid Writing Training

- ACE's (Adverse Childhood Experiences)- Important to raise awareness of impact and ongoing issues
- Complex Needs Training- Dual Diagnosis/Vulnerable Patients
- Health Literacy Training- Following on from Health Literacy Consutation undertaken in 2019. There is a need to progress this cluster wide and raise awareness of what actions can be taken
- Ensuring Mandatory Training Sessions are all up to date eg: Safeguarding

Section 6 - Cluster Financial Profile

Cwmtawe Cluster Funding 2019-20	
WG	**£130,020**

Planned Spend	
Project	**Spend Allocated**
Pharmacist	£56000
Comm and Dev Manager	£12000
YP counselling	£18500
QR info pods licence	£400
Early Years Worker	£25000
Link Worker	£20320
Link worker project fund	£1339
Carp Evaluations	£3500
PLTS locum cover	£750
Total Spend	137309
Planned spend remaining	(£7289)

Other funding obtained by the Cluster

Integrated Care Fund (ICF) & Changing for the Better Grant.- Young People's wellbeing activities	£2,530
ICF Revenue Grant- dementia	£38,593
PMS+	£5,815
Total	**£30,094**

Welsh Government Allocation per theme

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

In addition, as stated earlier, from November 2018 Cwmtawe Cluster become part of the national Transformation Programme for an 18 month period. Cwmtawe have been awarded £1.7million and actions agreed through the programme will become part of the Cluster action plan through regular updates

£3.6m has been awarded through Transformation Funds to Swansea's Our Neighbourhood Approach, delivered across Llwchwr and Cwmtawe Clusters:

Early Help Hubs & Transition- providing family support services from a range of different partnerships integrating local authority services with multi-disciplinary working with colleagues from Health, Police, Education and the third sector. Alongside the Early Help Hub initiative will be Transition workers focused upon linking with Education, Child and Family services and Health provision to establish the level and type of future needs of children aged from 15 years - 17 yrs. In addition, mental Health staff with specific focus on substance misuse will work with partners to support Two Mental Health staff would be placed in each of the CMHT's with a focus on better linking with substance misuse services for those identified with such issues

Building Community Assets: The Hubs will also include space for meetings, direct work and communal areas that can be accessed by families. Third sector organisations and wider partners would also be able to run group work and offer access to information and advice from these Hubs. Local Area co-ordination (LAC) resource will be increased in the area.

With a strong emphasis on a co-productive approach and community 'owned' assets the third sector specific element includes Community Development Workers and sector specific funding which is easily accessible for identified costs including the training and expenses of volunteers.

Community Based Care & Review: enabling individuals to remain within their own community, homes and as independent as possible for as long as possible through Adult Services community based Care and Review. The team will build upon the integrated model in place with health and community services of a reablement focused resource linked with timely, regular engagement with individuals and their support network.

Section 7: Our Cluster Three Year Action Plan

The development of the plan has presented an opportunity for Clusters to build on the progress made in 2017-19 and has involved partners from Public Health Wales, other Health Board teams and directorates, the Third Sector and Social Services.

Prevention, Wellbeing and Self Care

Our three year focus:

The development of the plan has presented an opportunity for Cluster Practices to build on the progress made in 2017-19 and has involved partners from Public Health Wales, other Health Board teams and directorates, the Third Sector and Social Services. Between 2020 and 2023, Cwmtawe Cluster will continue to explore areas for development

To develop and deliver a work programme, listening to the needs of the community and practitioners; to help patients by maximising support available to improve their health and wellbeing. With a focus on dementia; mental health; perinatal health and chronic pain and ensuring that cluster has the estate suitable to deliver those services

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
1.1	To improve service provided to new mothers to increase their health and wellbeing by appointing a perinatal Band 7 nurse.	Health visitors.	April 2021	Reduction in post-natal anxiety and depression.	1 x WTE £48K	None in place
1.2	To develop condition specific peer support groups in partnership with SCVS.	SCVS Patient groups Community Developme nt Worker	Jan 2020	3 condition specific peer support groups in operation by December 2020. Evidence collated to detail the impact on appointments	TBC	Community Developme nt worker now in post.

		Practice Managers		from the condition specific cohort of patients		
1.3	To evaluate outputs from issues identified by the social prescribing link worker to identify gaps in service	SCVS Link Worker Commissioning and Development Manager (CDM) Health Board	Ongoing	Gaps in service are identified	To be decided once evaluation is completed	Currently seeing a large number of domestic abuse victims. Work group established to scope potential project
1.4	Provide specialist mental health resources with an emphasis on recovery, work and educational opportunities ,working with Swansea Social Services 'Crest Recovery College'	Health Board CDM SCVS Crest Practices	Ongoing	To develop a referral pathway to Crest to provide recovery opportunity for patients with complex mental health conditions via primary care. Providing improved outcomes for those with mental health issues. Improved practice sustainability	TBC	Gap in service for primary care patients. Referrals currently only taken from secondary care.
1.5	Continue to develop and deliver a preventative work programme focusing on improving diagnosis of dementia and ongoing support for patients, families and carers.	SCVS CDM Llwchwr cluster Health Board Practices	ongoing	Dementia awareness training provided to 50 front line staff. Establishment of 15 peer support volunteers An additional 5 community groups making their activities accessible to	Funding obtained until March 2020	Dementia support worker in place. Training has begun with staff and partner agencies

				dementia patients and their carers.		
1.6	For each of the practices within the cluster to become Dementia Friendly Practices.	Practices and their staff SCVS Dementia support worker	May 2020	For all the practices to become Dementia Friendly Practices Improved recognition, treatment and support for patients with denemtia	Funding obtained until March 2020	Dementia support worker in place
1. 7	Improve uptake of childhood immunisations, particularly for those in areas of high deprivation, in conjunction with the childhood immunisation group.	Health Visitors Practices	Ongoing	An increase in the number of children immunised	**TBC**	Practices developing plans
1.8	Development health champion volunteer role within the cluster	SCVS Community Development worker Practices	March 2020	Flu champion volunteer in place and an increase in the number in people receiving flu vacs.	**TBC**	Community Development worker in place
1.9	Improve Flu Vaccination uptake rates for children, people with chronic conditions, people over 65 and staff through Flu immunisation campaign and Flu Action Plan through Flu steering group	Practices Flu champion volunteer CDM	Sept/Oct 2019 Annually	An increase in the number in people receiving flu vacs.	**TBC**	Practices developing plans
1.10	To explore the potential benefits of social prescribing with respect to chronic pain	SCVS Link Worker CDM Health Board	November 2020	A reduction in the number of patients with chronic pain presenting at GP surgeries	**TBC**	

1.11	To ensure that all staff receive the Corporate Safeguarding training	Practice Managers	Dec 2020	All staff are fully aware of safeguarding issues	Staff Time	
1.12	Developing and delivering a preventative work programme focusing on reducing the rates of obesity. Identify additional funding to allow the cluster to commission a lifestyle coach/physical trainer to develop a series of exercise programmes to be delivered to cluster patients, though group sessions within the community, targeting weight management, pain management, diabetes, hypertension	SCVS Cwmtawe Clusters Llwchwr Cluster Swansea Council YMCA Bike Ability Plus other partners	TBC	Appointment of a lifestyle coach Increase in physical activity in patients. Reduction in patient hypertension Development of a peer support volunteers	Lifestyle coach Funding	Currently looking for funding

Timely, equitable access, and service sustainability

Our three year focus:

To work with partners to improve access to Health and Wellbeing services by adopting a joined up approach to service delivery.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
2.1	Maximise opportunities to improve patient and citizen health and wellbeing, through working in partnership with Cwm Alliance (CIC)	Health Board CDM SCVS Community Development Worker	Nov 2020 ongoing	An increase in opportunities for the community to improve health and wellbeing via Cwm Alliance	TF funds Community/Directors time Community development officers time	Company established Work on going to get policies in place .support boing provided by the Comm Dev worker
2.2	Work with partners to deliver programme of Transformation for Our Neighbourhood Approach including the implementation of the ONA Community Development Role	CSVS HB CDM	Oct 2019 onwards for a period of 18months	Community working closely with the clusters. A picture of the services provided within the community	Community Development worker	CDW now in post and mapping exercise has commenced
2.3	Access to In-Hours GMS Services Standards: Cluster practices should ensure improved access to services delivered closer to home as set out in the guidance and,	All Practices	March 2021	Achieving Access Standards and measures (Group 1 and Group 2)	Funding Telephone infrastructure Signposting materials	Assessment being undertaken

	Inform cluster population of wider communication/access options available. Cluster to discuss and develop action plan on finding from all Wales patient survey and share with Health Board Cluster to consider demand and capacity analysis				Communication and Engagement	

Rebalancing Care Closer to Home

Our three year focus:

To identify the most appropriate service that can be delivered within the cluster, and work to deliver those services which matter most to the community.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
3.1	Diabetes: care closer to home for patients with Type 2 Diabetes, ensuring comprehensive care in place as a cluster, delivery of the three National Enhanced Services	Practice Managers	Ongoing	**Safer patient care closer to home**	Part of NES	Practices to increase provision
3.2	Clinics in the community e.g glaucoma, audiology, CAMHS	Practices Secondary care	Ongoing	Care closer to home	TF Staff time	Projects boards established and operational

3.3	Mental Health Treatment and Support provided within the Cluster See section 1.4	Mental Health services Practice	February 2020	Care closer to home	TF Staff time	Job to be advertised
3.4	To hold sexual health clinics for young people within the cluster.	Practice Managers Nurses CDM Health Board	March 2021	To address a gap in services and potentially reduce the number of teenage pregnancies	Funding Venues Training	
3.5	Improve community care of patients with heart failure by ensuring patients with heart failure have a flu vaccination and creating self-management educational programmes with patients	Cluster Community Heart Failure Team	March 2023	Improve identification of patients with heart failure. Optimise treatments in the community to maximal tolerated doses. Undertaking 6 monthly reviews of patient diagnosed with chronic heart failure	Funding Venue	Primary care target framework awaited. Whole systems approach business plan being created with HB
3.6	To contribute to the obesity pathway delivery review: • Completion of baseline survey by practices • Participation in qualitative interviews	Practices Swansea Bay public health team Cluster leads cluster development managers	March 2020	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	Staff time	Obesity Pathway delivery review commenced in Swansea Bay March 2019. Level 2 insight with primary care to commence

						September 2019
3.7	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

Implementing the Health Model for Wales

Our three year focus:

To develop whole system approaches to improving the health and wellbeing of people through aligned and seamless services delivered by the most appropriate healthcare professional.

No #	**What action will be taken**	**Who**	**When**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
4.1	Understand needs and improve services for vulnerable patients by developing partnership aims and objectives with other 'blue light' services, through improving local area knowledge	Police Fire and Rescue CDM HB Housing Providers	Oct 2019	Improved community resilience. Increase in partnership working. Identification of previously unidentified vulnerable patients.	Staff time	Initial meeting has been held

4.2	Work with partners to deliver programme of Transformation of Clusters, robustly evaluated, underpinned with training, support, clinical time and workforce development and resulting development	Cluster Lead GP Leads CDM TF project Manager	Ongoing	The cluster adopts the new model of primary care	TF Staff time	Extended MDT in place. Community Developme nt working in place
4.3	CIC cross ref 2:1					
4.4	Work with partners to deliver programme of Transformation of Clusters, robustly evaluated, underpinned with training, support, clinical time and workforce development and resulting development	HB Practices	Start July 19 for 18 months	Successful Transformation of services for patients	Transformation funds	Llwchwr went live July 2019. Leadership group in place and meeting monthly

Digital, data and technology developments

Our three year focus:

To improve cluster value, efficiency and development by maximising opportunities for digital transformation and making evidence led decisions

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
5.1	Digital consultations/triage –use of My Health on Line	Practices CDM Volunteers Comms Manager	Ongoing	Increase usage of My Health on line –reduction telephone contacts	Practices Comms Manager	All GP practices using a triage system

5.2	To identify mechanisms to improve access for Health Visitors to be able to access patient notes	Health Visitors Practice Managers CDM	May 2020	Direct input of health visitors notes on to the GP patient notes. Efficient service for patients	IT system	Not yet commenced
5.3	To develop a more formal and technological method of data collection for projects	CDM SCVS	November 2020	Improved data for decision and evaluation purposes	Practice Managers IT system Cluster Funds	Not yet commenced

Workforce development including skill mix, capacity, capability, training needs, and leadership

Our three year focus:

Build on the work commenced through Transformation, to continually review and strengthen the cluster workforce to support new and evolving service models, and create a sustainable, motivated and engaged workforce.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
6.1	Continue to utilise Blue Stream E Learning package for front line staff	Practice Managers	ongoing	A developed and motivated workforce able to provide patients An effective service for patients	Cluster funds	Package purchased
6.2	Identify suitable topics for shared learning with other partners. E.g. domestic violence,	Practice Mangers SCVS Partners e.g Police Fire and Rescue service	Ongoing	Stronger working relationships with partners. Gaps in service provision filled for patient needs	TBC	Initial meeting and joint issues identified.
6.3	Consider the provision of the Social Prescribing Link Worker	SCVS Cluster Lead	October 2020	That the role is mainstreamed.	Cluster Funding	Awaiting final report

	Role and how it will evolve moving forward.	Practice Mangers		Patients will have continued support for health and wellbeing issues		
6.4	Continue to develop 3 year plan to identify and implement the most appropriate and effective MDT for the Cluster	Practice Managers Health Board GP Leads	April Annually	That the Cluster continues to developed in accordance with the changing role of health care	TF Cluster funding	Projects established
6.5	Development of workforce strategy	Practice Managers	April Annually	That the Cluster continues to developed in accordance with the changing role of health care	Practice time	Discussions ongoing
6.6	Delivery and mainstreaming of Early Years Worker Scheme delivered in Cwmtawe building on pilot	CDM Cluster Lead Health Board Swansea Council	Jan 2020	That the patients continue to receive early years support and see the most appropriate person for their concerns	Funding	Discussions ongoing regarding mainstreaming
6.7	Explore the need for a domestic abuse/complex needs nurse in partnership with other clusters	CDM SCVS Health Board Penderi Cluster Swansea Council	April 2020	That the gaps identified by the Link Worker evaluation regarding patient needs are filled That the cluster responds to issues identified by the Police as a community issue.	Funding Staff time	TBC

Estates developments

Our three year focus:

To review the cluster estate to ensure it reflects the needs established within the New Model of Health Care and provides the necessary premises within which to deliver those changes and maximise to support improvements in health and wellbeing of the population.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
7.1	Facilitate and support the upgrade of practice premises where needed, including hot desking / agile capability within specifications to support greater partnership working	Estates Manager Health Board Practice Managers Cluster Lead	April 2020	Premises that can provide patients and staff with the appropriate accommodation to reflect the changing model of health care	Funding	Links made with HB Estate manager
7.2	Maximise the use and development of all available estates/estate activities within the Cluster to deliver Cluster programmes and services and to improve the population health and wellbeing, mapping Health Board, Local Authority and other partners estates for the delivery of services and improvement of health and wellbeing. Work closely with partners including Social Housing providers in the development of health and wellbeing. Work closely with partners including Social Housing providers in the development of estates strategies, development plans for the benefit of population health	Estates Manager Health Board Practice Managers Cluster Lead Stakeholder partners	April 2020 and ongoing	Premises that can provide patients and staff with the appropriate accommodation to reflect the changing model of health care and enhance partnership working within the Cluster	Funding	Information not collected and matched against needs on a cluster footprint/ across organisations
7.3	To scope requirement for a 'community clinic' facility shaped to facilitate the delivery of increased clinics as more services are delivered in the community and reduce duplication of existing clinics	Estates Manager Health Board Practice Managers	2020-2023	Improved value and coordination of services for patients and increase opportunities to more care closer to home	Funding/building	As above

		Cluster Lead Stakeholder partners				
7.4	Improve IT connections available within the practices where necessary.	Estates Manager Health Board Practice Managers Cluster Lead Stakeholder partners	2020-2023	Improved options for digital connectivity	Funding	Not yet commenced

Communications, Engagement and co-production

Our three year focus:

To actively encourage the community to be engaged in designing and supporting their own health and wellbeing, by working with the Cluster to create the health care services that are important to them, and to communicate cluster messages to key stakeholders

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
8.1	Promote the work and brand of Cwmtawe Cluster both with the public and partners.	Comms Manager Practice Managers Cluster Lead Health Board	Ongoing	Increased public awareness of the cluster and an understanding of the changing face of health care Increased working with key partners to design and deliver services on a cluster basis	Staff time TF funding	Attendance at community events has begun together with the purchase of promotional material

8.2	Develop the establishment of peer support groups with service users.	SCVS Practice Managers Health Board Community Development manager	Ongoing	Patients will receive additional support for their condition. The practice has a specific point of contact to dissemination disease specific information, potential for a reduction in GP appointments	Staff time Cluster funding	Currently dementia peer support group established
8.3	Delivery of training programmes/self-assessment for all Cluster staff on co-production, making every contact count, health literacy - Cluster Communications assessment and strategy development	Public health Practice Managers Health Board	Ongoing	Better trained staff and more informed patients	Staff time TF funding	Yet to commence
8.4	Map the existing services available within Cwmtawe with a view to promoting them with the community and reducing duplication of services	CDM Health Board Cluster	Jan 2020	Improved value and access to services. Effective use of resources	StaTF fundingff time	Yet to commence
8.5	Promote the work of DN via the intranet and to try to reduce the number of vacancies	Comms Manager District Nursing	Oct 2019	Improved access to district nurses. Improved partnership relationships	Comms Manager's capacity	District nurse levels are low and having difficulty in recruiting
8.6	Escalate to Cluster Leads meeting the 'need to work with the University to include (by rotation) experience of the various types of community nursing available as part of the course'	Cluster Lead Health Board University	Jan 2020	Improved nurse training. Reduction in the number of District Nurse vacancies	Cluster Leads time	Community nursing levels low, difficult to recruit

Improving Quality, Value and Patient Safety

Our three year focus:

To provide high value, evidenced based care for the patients. Integrating improvement into everyday working to achieve better outcomes and a better experience for patients.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
9.1	QAIF –consider the requirement with a focus on -reducing medicines related harm Reducing stroke risk Ceiling of care/advance care planning Urinary tract infection – antimicrobial stewardship	Practice Managers Health Board	September 2019	Improved patient care	Staff time	Cluster to decide on priority areas
9.2	Improve screening uptake rates, particularly bowel screening to reduce late diagnosis of cancer	Practice Managers Nurses GP's	March 2020	Improved recovery rates	Promotion material	Lower than target levels in Cwmtawe
9.3	To evaluate outputs from issues identified by the social prescribing link worker to identify any gaps in provision	CDM Cluster Lead SCVS Health Board	October 2019	Improved patient care for issues that are important to the patients	Cluster time	Issues raised at cluster meetings for consideration –currently considering complex needs nurse

9.4	Work together with partners to ensuring that delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond. We recognise the importance of involving the MDT in supporting people affected by cancer, and integrating cancer care into holistic chronic disease management in health care. As clinical pathways are shared through the Single Cancer Pathway programme we will review local experience to inform implementation. Practices will work to embedding anticipatory care planning as routine practice	Practices – other?	Ongoing Ongoing	integrating cancer care into holistic chronic disease management in health Care. Ensuring that the multidisciplinary health care team has the necessary skills and knowledge to support the SCP and detection and diagnosis of cancer. Improved end of life experience		Issues around cancer diagnosis rates

Communications and Engagement

The plan 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	Grant Scheme Updates	Newsletter	Media Releases
Cluster Lead	□	□	□	□	□	□
Cluster GPs	□	□	□	□	□	□
Cluster Practice Staff / Employees	□	□	□	□	□	□
Patients/Citizens			□		□	□

Swansea Council for Voluntary Services	□	□	□	□	□	□
Service Providers – Grant Schemes			□		□	□
Non GMS Contractors	□		□	□	□	□
Primary Care Team	□	□	□	□	□	□
Integrated community Health and social care team	□		□	□	□	□
Public Health Team	□		□	□	□	□
Local Medical Committee representative	□		□	□	□	□
South Wales Police			□		□	□
Welsh Ambulance Service Trust			□		□	□
Fire and Rescue Service			□		□	□
Community Health Council			□		□	□
Citizens Advice Bureau					□	□
Welsh Government		□	□		□	□
Local AMs / MPs					□	□
Media					□	□
Chairman / Executive Team			□		□	□
Other Unit.e.g. mental health and learning disability, corporate strategy			□		□	□
Out Of Hours					□	□
SBUHB Patient Feedback Team						□
Shared Services Partnership						□
NWIS						□

Following on from the development of the questionnaire programme and CIC community engagement event, together with the above assessment, the Cluster recognises that there is a need to develop a Communications Strategy. The Transformation programme in Cwmtawe has developed a communications strategy, which covers many areas pertinent to the Cluster IMTP and vision. Learning and outputs will be drawn from this to develop a Cluster strategy toward the end of the 18 mth Transformation programme.

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 and ten design principles.

Primary Care response to 'A Healthier Wales' is outlined in the **Strategic Programme for Priamry Care,** published in November 2018. Specifically, the whole systems approach to health and social care. This programme of work focuses on 'Clusters remaining at the heart of this model'. The document outlines the six key work streams:

I. *Prevention and wellbeing*
II. *24/7 Model*
III. *Data & Digital Technology*
IV. *Workforce & Organisational Development*
V. *Communication, Engagement*
VI. *Transformation Programme and the Vision for Clusters*

Throughout this document there are key messages:

- Get better at measuring what really matters to people
- Greater emphasis on wellbeing
- Health and Social Care will work together
- Work as a single system, everyone working together
- Invest in new technologies
- Shift services out of hospitals into the community
- Implement the Primary Care Model for Wales

The cluster will work under the context of the delivery of the strategic programme of work for primary care, developed following the publication of A Healthier Wales, increasing pace and scale and addressing new priority areas. Our Cluster will take a whole system approach to health and social care, (a 'wellness' system), which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health and inequality. This will further enable us to work closely with partners, shifting the focus to a social model of care, ensuring timely access to primary care services when required and working seamlessly across the whole system.

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:

1. One System of Care

Clinical pathway processes that cross specialities, departments & delivery units

2. My Home First

Pathways which enhance care delivery in or closer to the patients home where clinically safe

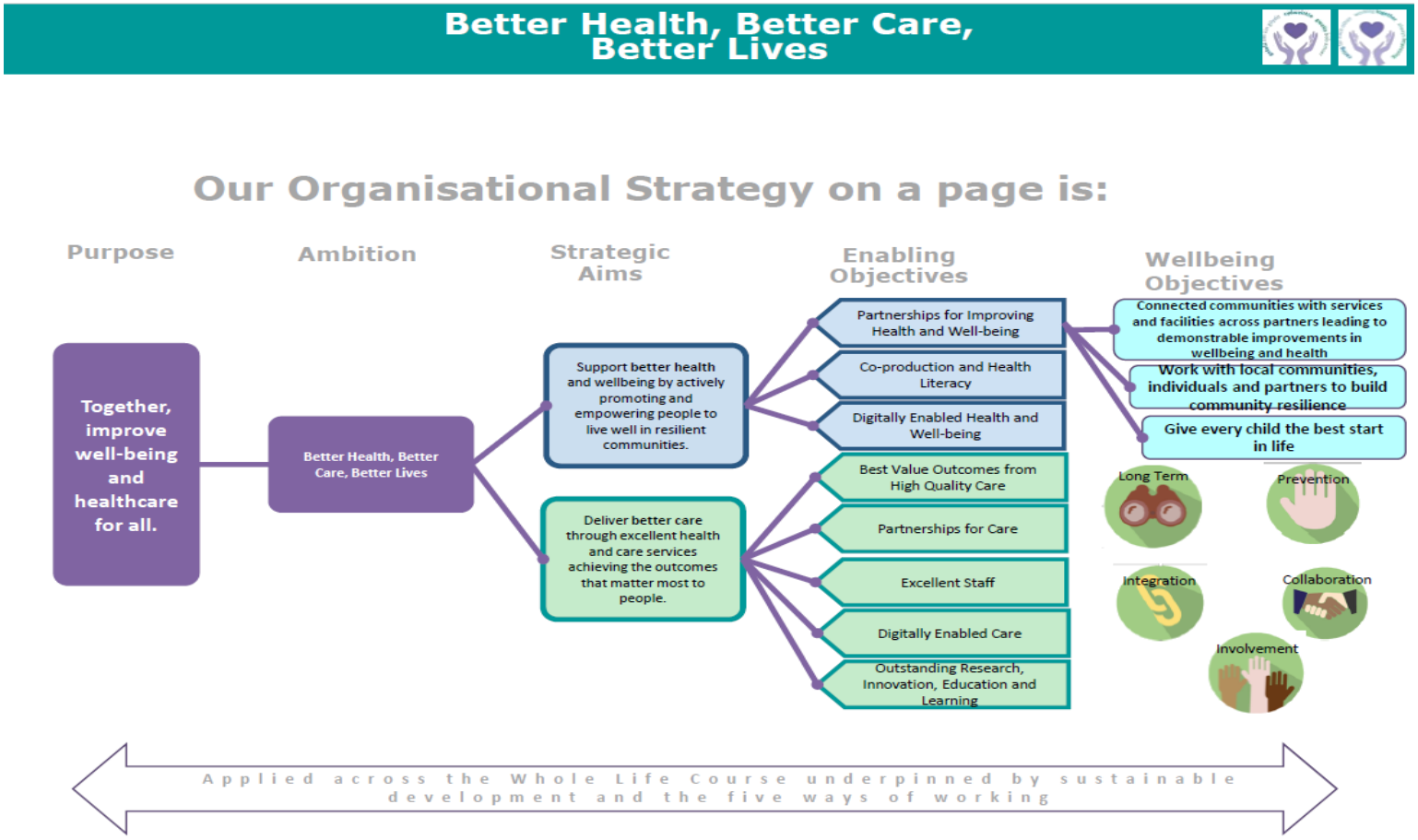
3. Right Place, Right Person, Right Time

Workforce, estates, equipment, digitalisation

4. Better Together

Regional and local collaboration on networks of services that meet the care needs of patients

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 Cluster's 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 Clusters: A Whole System Approach Programme must be viewed in the context and as part of a wider health and social care

regional transformation process and it will dovetail to 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 Health 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
- development of Cluster IMTPs
- developing internal cluster training
- acting as key links for national Transformation programmes
- provide capacity to support key stages of the Transformation programme where required
- development of 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

Welsh Language

Through the 6 Welsh language duties placed on independent primary care contractors (including our general practice, community pharmacy, dental, and optometry services), our Cluster will aim to delivery improved access to services and improved healthcare outcomes, including wherever possible to deliver the ‘Active Offer’

1. Where the contractor provides services, or any part of a service, under the contract through the medium of Welsh, it must notify the Local Health Board in writing.

2. The contractor must make available to its patients and members of the public a Welsh language version of any document or form provided to it by the Local Health Board.

3. Where the contractor displays a new sign or notice in connection with services, or any part of a service, provided under the contract, the text on the sign or notice must be in English and in Welsh, and the contractor may utilise the translation service offered by the Local Health Board for this purpose.

4. Where the contractor provides services, or any part of a service, under the contract through the medium of Welsh, it must encourage its staff to wear a badge to convey that they are able to speak Welsh.

5. The contractor must encourage and assist its staff to utilise information and/or attend training courses or events provided by the Local Health Board, so that it can develop:

(a) an awareness of the Welsh language (including awareness of its history and its role in Welsh culture); and

(b) an understanding of how the Welsh language can be used when delivering services, or any part of a service, under the contract.

6. When delivering services, or any part of a service, under the contract, the contractor is encouraged to:

(a) establish the language preference of a patient; and

(b) record any language preference expressed by or on behalf of a patient

What is the 'Active Offer'?

The duties placed on independent primary care contractors came into force on 30th May 2019.

The Welsh Language Standards are set out in Regulations approved by the National Assembly and bodies subject to the Regulations are issued with compliance notices from the Welsh Language Commissioner. Compliance with the standards is monitored by the Welsh Language Commissioner and complaints in relation to bodies not meeting the standards set in their compliance notices are investigated by the Commissioner.

The duties placed on independent primary care contractors are included within the National Health Services (Welsh Language in Primary Care Services) (Miscellaneous Amendments) (Wales) Regulations 2019. The duties sit within the primary care contracts/terms of service of independent primary care contractors. The contracts are managed and monitored by Local Health Boards and complaints on not meeting the duties would be investigated by the relevant health board.

The duties apply to the Primary Care Sector in Wales which includes general practice, community pharmacy, dental, and optometry services.

A key component of More than just words is the concept of the 'Active Offer'. The 'Active Offer' simply means providing a service in Welsh without someone having to ask for it. It places the responsibility of asking the question on you, the service provider, not the service user. Offering services in Welsh without the need for the end user to request them is an intrinsic part of a good service.

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

	UNSCHEDULED CARE
REF	ACTION
USC_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
USC_1_5	Taking action aimed at obesity
USC_1_6	Implement the Neighbourhood Model
USC_2_4	Implement new pathways for Diabetes through the New Cluster Model
USC_2_8	Ensure best practice in caring for patients with dementia across all settings by implementing the actions of the All Wales Dementia Plan
USC_3_8	Improve rapid access to assessment for CAMHs patient through commissioning approaches
	PLANNED CARE
Ref	ACTION
PLAN_1_1	Actively promote to all staff and patients at higher risk from influenza
PLAN_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
PLAN_1_4	Adopting approaches that develop health literacy
PLAN_1_5	Taking action aimed at obesity
PLAN_1_6	Implement the Neighbourhood Model
PLAN_1_7	Establish Wellness Centres
PLAN_2_2	Implement Multi Disciplinary Cluster triage model
PLAN_2_4	Ensure all clusters are operating a multi disciplinary team model

	MENTAL HEALTH / LEARNING DISABILITIES
REF	ACTION
MHLD_1_1	Implement actions for delivery of Neighbourhood approach as per the Neighbourhood approach implementation plan
MHLD_1_2	Support the Cluster transfrmation actions around social prescribing as per the CSP
MHLD_3_3	Development of cluster based Primary Mental Health care
MHLD_7_2	Development of Perinatal Mental health Network

	STROKE
REF	ACTION
STK_1_1	Actively promote to all staff and patients at higher risk from influenza
STK_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
STK_1_4	Adopting approaches that develop health literacy
STK_1_5	Taking action aimed at obesity
STK_1_6	Implement the Neighbourhood Model
STK_1_7	Establish Wellness Centres
STK_4_11	Local areas coordinators / services
STK_4_17	Self-management /peer support groups

	CANCER
REF	ACTION
CAN_1_2	Smoking cessation services widely available
CAN_1_3	No smoking culture on sites
CAN_1_6	Vaccination programme for HPV
CAN_2_2	Understand screening processes/management
	CHILDREN
Ref	ACTION
CHI_1_3	MECC - Midwives and health visitors
CHI_1_7	Vaccination programme
CHI_1_8	Robust Sexual Health services