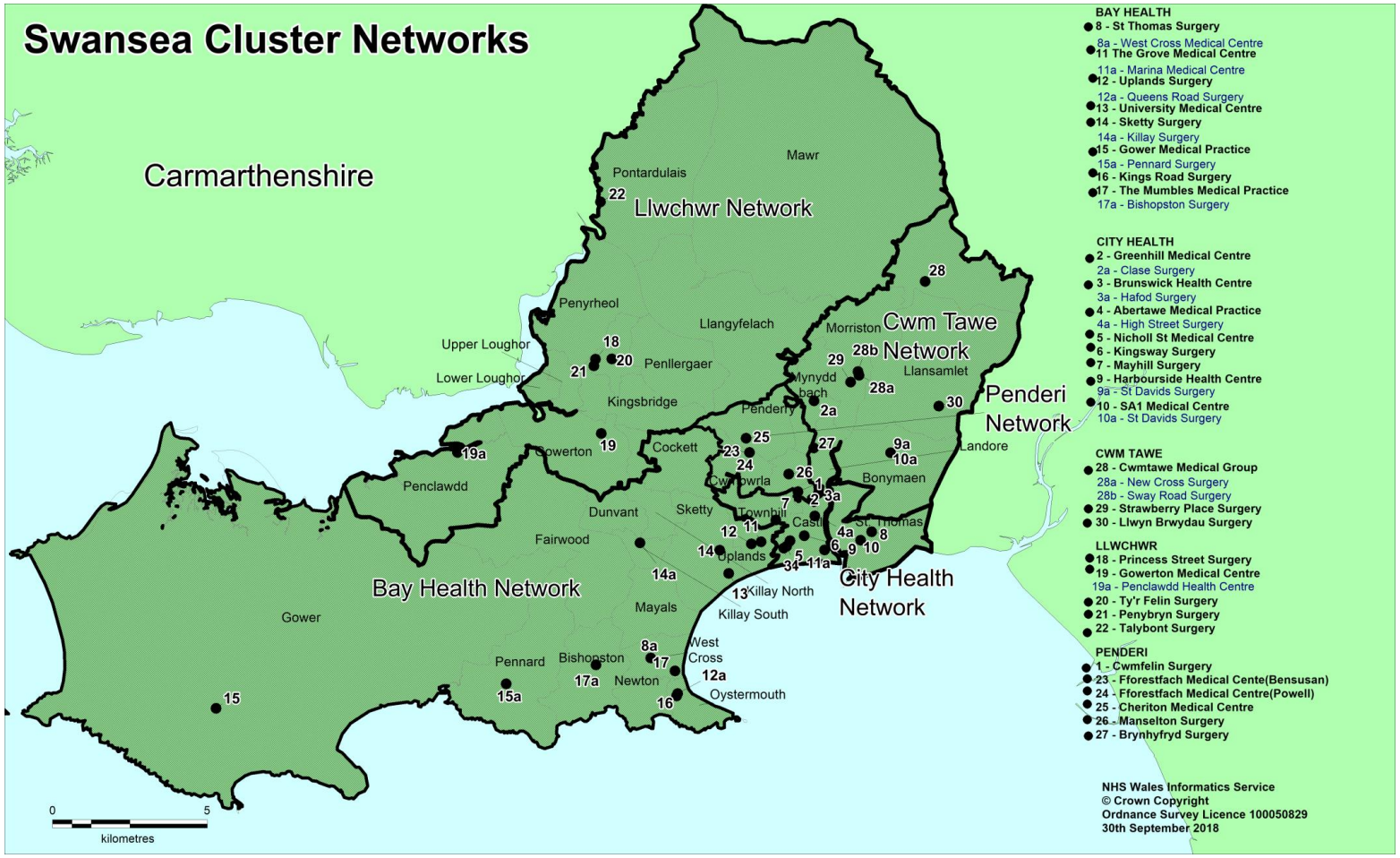
Three Year Cluster Action Plan 2018 - 2021

Cwmtawe Cluster

Welcome to the Cwmtawe Three Year Cluster plan, 2018 - 2021

1. Cwmtawe Cluster Overview

The Cwmtawe Cluster is one of 5 clusters in Swansea, geographically covering the area's of Bonymaen, Clydach, Landore, Llansamlet, Morriston and Mynyddbach.



The Cwmtawe Cluster 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 ranging from 6759 to 25264, amounting to a cluster total of 42,865 (July 2018 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.*

Through the delivery of their plans they work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales:

- ✓ 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

2.1.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.

2.2 Our Local Health, Social Care and Wellbeing Needs and Priorities

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.

Key Population Features

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

Cluster Features

8 Dental Practices

10 Pharmacies

6 Nursing Homes

4 Opticians

26 Schools

3 Libraries

The Cwmtawe Network falls within 7 different electoral divisions (wards).

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

Major employers : City and COunty of Swansea; DWP; DVLA; HSBC; Land registry

Health Profile

Smoking: An estimated number of smokers of **7,390 = 18.1%** of the cluster population.

Bowel Screening - Cwmtawe has 3618 people eligible for screening, 1985 were screened. 54% of those eligible (2016) Target 60% PHW 2016/17

Breast screening- there are 5614 eligible for screening, with a 73.5% uptake.(2016) Target 70% PHW 2016/17

AAA screening – there are 174 people eligible for screening with a 79.3% uptake.(2016) Target 80% PHW 2016/17

Cervical screening – uptake has decreased annually for four consecutive years - there are 10712 eligible for cervical screening with a 78.1% uptake.(2016) Target 80% PHW 2016/17.

Obesity: The cluster has the highest levels of obesity within Swansea at 11.7% compared to the lowest cluster figure at 6.1%.

Flu: Cwmtawe is in line with Swansea for patients 65yand over but below the Swansea figure for patients under 65y at risk; and children aged 2& 3years, all of which are below the Public Health target.

Service demands

Some areas have limited transport links to the city centre and across the cluster.

Pockets of deprivation across the cluster result in higher demands for care due to anxiety and stress. (Swansea Wellbeing plan 2017)

Cwmtawe is third in relation to the proportion of patients attending A&E out of all the Swansea Clusters. Between 1st Sept 2017 and 31st Aug 201, 13,157 patients attended A&E (153.95 per 1000).

Cwmtawe has the third lowest rate of attendances (77.74/1000) in Swansea for Out of Hours GP services.

Other Key Influencing Factors

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.

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).

Public Service Board, Local Wellbeing Plan Focus:

Early years: Making sure children have the best start in life.

Live Well. Age Well – making Swansea a place to live and age well.

Working with nature- improving health, supporting biodiversity and reducing our carbon footprint

Strong communities- supporting communities to promote pride and belonging.

PSB aims to make all services work together by sharing resources, assets and knowledge

2.3 GP Disease Register data

Disease Register	Cwmtawe Register Total 2018 (%)	Swansea %	ABMU %	Trends/Highlights
Atrial Fibrillation	933 (2.2%)	2.2%	2.3%	
Cancer	1121 (2.6%)	2.7%	2.9%	3rd highest % cluster in Swansea
Dementia	266 (0.61%)	0.7%	0.7%	Joint second lowest % cluster in Swansea.
Mental Health	397 (0.9%)	1.1%	1.1%	Lowest % cluster in Swansea and ABMU
Obesity	5034(11.7%)	9.0%	10%	Highest % cluster in Swansea. 4th highest % in ABMU.
Diabetes	2676(6.2%)	5.6%	6.2%	Joint 2nd highest % cluster in Swansea
Hypertension	6326 (14.81%)	13.1%	15.3%	2nd Highest % cluster in Swansea
Heart Failure	499 (1.2%)	1.0%	1.1%	Highest % cluster in Swansea
Epilepsy	933 (2.2%)	0.8%	0.8%	Joint highest % cluster in Swansea
Stroke/TIA	920 (2.1)	2.1%	2.3%	Joint 2nd highest % cluster in Swansea. 2nd lowest across ABMU
Chronic Kidney Disease	1551 (3.6%)	3.0%	3.9%	2nd highest % in Swansea

2.4 Antibiotic Prescribing: Detailed below are the most current figures for antibiotic prescribing within the Swansea Cluster area. Nationally there was a 2.2% reduction in antibiotic prescribing levels for the same period. Cwmtawe has reduced prescribing at a substantially higher rate than other Swansea Clusters. *With regard to antibiotic prescribing levels nationally there was a 2.2% reduction for the period noted.*

Items Apr 17 - Mar 18	Items Apr 16 - Mar 17	Items % Variation	Items Difference
29,794	31,643	-5.84%	-1,849

2. ***Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis: Cwmtawe***

Cluster SWOT Analysis

Strengths

Monthly practice Managers meetings are held to discuss need and feed into and drive the action plan Strong collaborative working relationship between the practice managers

Developing Infrasructure within the cluster

Willingness to look past traditional primary care models

Beginning to undertake decisions and actions for the good of the cluster not just the practice

Strong leadership by the Cluster Lead

Weaknesses

Varying rates of adoption of change by key stakeholders

Consistency in ensuring that the cluster message is relayed back to GP's within the practice 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 for cluster work due to demands of the practice

Opportunities

To increase closer working with secondary care and CAHMS

To futher 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

External funding sources

To consider the sharing of back office functions in order to provide resources to the cluster within existing budgets

Threats

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

Practice sustainability

Increase in list sizes due to housing developments

3. Cluster Vision

In July 2018, Cwmtawe 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 Cwmtawe area and its practices.

"Cwmtawe Cluster aims to be a vanguard within Wales for 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"

Our Cluster Plan

Strategic Aim 1: To understand and highlight actions to meet the needs of the population served by the Cluster Network with a preventative approach

Our three year focus:

- Developing and delivering a preventative work programme focusing action on reducing rates of obesity, diabetes and CKD.
- Supporting preventative work by increasing health literacy levels, working together with public and patients

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?	Current position	RAG Rating
1.1	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	C&D Manager	Ongoing to March 2021	A 5% reduction in those patients classed as obese within the target area.	Questionnaire currently being developed to identify patient needs. Funding bid currently being developed.	
1.2	Work in partnership with 'HWB Abertawe' a Lottery Funded project to deliver Health and Well being programmes to cluster patients	C&D Manager	March 2019	To have delivered 3 HWB Health and Well being programmes and to have identified patients in need of more intensive support.		
1.3	To deliver 3 patient questionnaires each year, in partnership with SCVS to inform the work of the cluster	Cluster SCVS CDSM	March 2019 and ongoing to March 20121	To have obtained the views of patients on 3 cluster priorities to inform service delivery	2nd questionnaire in respect of physical activity is currently being developed –outcomes to assist in indentifying needs and in support of external funding bid. Proposal for the 3rd questionnaire to be taken to PM meeting 10/10/18 –proposal –something around mental health	

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?	Current position	RAG Rating
1.4	To develop a calendar of funding opportunities	C&D Manager ABMU	Ongoing to March 20121	Funding opportunities are maximised		
1.5	To evaluate outputs from issues identified by the social prescribing link worker to identify gaps in service	SCVS Cluster CDSM	Ongoing to March 2021	The cluster provides services responsive to patient health and wellbeing needs		
1.6	Provision of communications tool for professionals to enable productive conversations about physical activity, diet and weight/BMI	Public Health Cluster ABMU	September 2019	Professionals have been trained in how to provide brief interventions about physical activity, diet and weight/BMI		

Strategic Aim 2:
To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements.

Our three year focus

- Expand MDT team to meet the workforce needs of the Cluster by 2021
- Enable practice teams to work prudently by enabling all staff access to and capacity for undertaking relevant training programmes, expanding their skills and supporting them to meet the needs of the practice.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
2.1	Develop a training programme suitable for front line practice staff.	C&D Manager	January 2019	To have a workforce training plan ready for implementation in April 2019	The C&D manager has made contact to request their demo list to be considered at PM meeting 10/10/18 and a training list compiled.	
2.2	Consider the provision of the Social Prescribing Link Worker role and how it will evolve moving forward	C&D Manager HB Cluster Lead Cluster	January 2019	Funding is obtained to extend the post of the Link Worker to 2x 0.5 wte	Link Worker currently 0.4wte	

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
2.3	Develop 3 year plan to identify and implement, the most appropriate and effective MDT for the Cluster	Cluster	Ongoing 2021	Sustainable and stable cluster wide workforce with MDT as key component in delivery of services Patients able to access most appropriate services in a timely fashion.		

Strategic Aim 3: Planned Care - to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface.

Our three year focus:

- Dementia: ensuring that patients are fully supported in the management of their condition and diagnosed early wherever possible
- Diabetes: transforming care for patients with Type 2 Diabetes, ensuring comprehensive care in place as a cluster, with a focus on delivering the early implementation of the National Enhanced Service for the ABMU Health Board.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
3.1	Continued participation in the National Diabetes Audit Providing diabetes care closer to home Uptake of the DES – Gateway module	GP practices/MDT		Reduction in ED attendances for Hypoglycaemia Reduction in Amputations Reduction in hospital length of stay/bed days Reduced duplication across primary & secondary care	Business case submitted for approval to Investment Benefit Group	

				Improved self-management by patients		
3.2	In partnership with SCVS, HB and Cluster develop support for people living with dementia and their carers, including - employing a dementia specialist social prescribing worker. - developing a peer support group of volunteers who have had experience of being a carer. - Provide training/awareness raising to potential groups which those living with dementia could access to improve their wellbeing. - Provide training to primary care staff to enable them to become a dementia friendly general practice	SCVS HB CDSM		Individuals understand the steps they can take to reduce their risk or delay the onset of dementia Staff within primary care have the skills to help them identify people with dementia and to feel confident and competent in supporting individuals needs post diagnosis The third sector groups have the skills to identify people with dementia and to feel confident and competent in supporting individuals needs post diagnosis Individuals affected by dementia and their carers report an improvement in their health and well being.	Dementia support worker out to advert.	

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management. To address winter preparedness and emergency planning

Our three year focus:

- To identify the causes resulting in Cwmtawe patients having lower rate of OOH contacts in Swansea; understanding variation and sharing learning with peers.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
4.1	Undertake baseline assessment of key cluster features impacting on OOH attendances - Identify data which could support changes from implementation - compare with other clusters - Share findings	Cluster, practices	May 2019	Reduction in unscheduled care attendances within Cluster		
4.2	Review OOH usage, and identify good practice . Work to educate patients, and/or implement new processes to reduce usage	C&D Manager HB	March 2019	A 5% reduction in calls from Cwmtawe patients to OOH service. Improved patient knowledge		

Strategic Aim 5: To develop the Cluster as a structure for delivery of identified priorities.

Our three year focus:

- Identify cluster specific benefits and further develop the cluster as a formal collaboration by 2021
- Enable Cluster to reach full maturity against recognised criteria which have not yet been achieved

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating

5.1	Develop a Community Interest Company to deliver wellbeing for the cluster area. Establish a working group to develop and implement a collaborative model.	Cluster Lead C&D Manager Health Board Cluster	March 2019 Ongoing	The development a community interest company to provide health and wellbeing service to the patients of Cwmtawe Cluster Regular meetings and a delivery /action plan established and agreed by the cluster	A planning group has been developed to progress establishing a community interest company. Initial meeting has taken place. 2nd meeting planned for Oct 18	
5.2	To capture the cluster Vision, Purpose, Functions and Strategy by; Developing and adopting agreed cluster standards for probity Ensuring there is clarity on the cluster constitution, structure, operational processes and functions That the cluster strategy/plan reflects the vision, principles, purpose and functions of the cluster.	P.M ABMU	December 2019	A clear sense of direction is agreed and understood and able to be used in communicating cluster work.	To be raised at practice managers meeting May 2019	
5.3	Ensure that the cluster has a robust communication and engagement strategy.	P.M Cluster	December 2019	Cluster engagement and communication strategy identified stakeholders fully informed of cluster strategic direction, action and outcomes. Patients and citizens feel better able to contribute towards delivery of health and wellbeing in their area and work towards co-production of health and social care wellbeing services.	To be raised at practice managers meeting November 2018	

5.4	To ensure practices within the cluster have appropriate employment and training arrangements in place, including -clarity on indemnity issues for all professional groups - Robust processes for cluster workforce planning and OD. .	PM	March 2020	All practice staff feel supported and able to safely deliver services to patients	Data protection officer support offered by the LMC. Practices need to sign up. To be discussed at PM meeting October 2018.	
5.5	To ensure the cluster has appropriate infrastructure, support and leadership. Including;- Appropriate consistent Information Governance and technical security policies and procedures in place. All cluster staff are clear on identity, responsibilities and contractual arrangements of Data Protection Officer. Review estates, IT systems, communication channels to deliver vision and purpose Clarity on cluster financial skills needed to effectively engage in financial debate discussion and challenge That the cluster leadership team has appropriate financial skills and expertise	PM ABMU	Ongoing		-Individual -1st practice management subscribed to by practice - Staff informed via posters and training once officer is in post.	
5.6	Addressing population needs -Current care and support available to cluster population, assess any gaps and duplication -To ensure that accurate, timely data is easily accessible to identify local and social priorities for the cluster. - Cluster project outcomes are shared with stakeholders	HB CDM	Ongoing	Cluster has a clear and timely understanding of pertinent issues across cluster and within practices. Patients receive more appropriate services and better access	3 questionnaires are commissioned to inform direction of cluster activity. Work has begun to develop activities and bench maker with Llwchwr regarding obesity/ physical activity.	

	-Continuous benchmarking used between cluster practices to address variation					
5.7	Integration and partnerships -draw up a code of conduct between cluster partners and organisation. -MDTs held at least monthly within the cluster - Community team, Public health community pharmacies, dentists and optromitry and medicines management regularly attend cluster meetings Team working with all health and care stakeholders; active links between primary and secondary care.	Cluster PM	Ongoing	All partners engaged fully with a sense of ownership	Monthly MDT palliative care meetings are held. Quarterly child protection meetings held.	
5.8	Quality Assurance -Peer review of activities to identify cluster variation and learning opportunities - Each stakeholder group leads on one or more cluster projects -Protected time is allocated for clinical audit and research	PM Cluster		To ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms	Cluster has already considered flu. Now 3 year focus on obesity, diabetics, CPD and unscheduled care.	
5.9	To develop a network of wellbeing services across the cluster that cross refer and sign post to the other services both within the network and beyond to improve prevention and self referral into services	SCVS Cluster Commissioning and development manager. HB	March 2019	A vibrant and active wellbeing network that is working towards improving patient wellbeing, and patient confidence to self refer to these services.	Initial meeting arranged with current wellbeing providers for 19th September 2018	

Strategic Aim 6: Other Cluster and area specific issues

Our three year focus:

- Improving screening uptake particularly bowel screening
- Learning from good practice for flu vacs delivery
- Sponsoring the strategic direction to maintain a new model of primary care

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	To ensure that a Bowel screening pathway is established and shared across the cluster	PM and Public Health	January 2019	An increase in the uptake of bowel screening	C&D manager in the process of obtaining the pathway from Public Health.	
2	To adopt good practice followed by Llansamlet practice in the delivery of flu vaccinations	Practice Managers	March 2019	An increase in the uptake of flu vaccinations across the cluster	An initial letter has been issued by the practices	
3	Support the mainstreaming of services via the business case application process through 'Balancing the System – shifting resources from secondary to primary care' for: Mental Health Services for Tier 0 Pharmacist Provision Physiotherapy on a Cluster basis	Cluster Development Managers, Cluster Lead	Oct/Nov 2018	Services mainstreamed and Cluster funds released where relevant	Pharmacy outline case summarised for consideration by ABMU Strategy and Finance Depts. Physiotherapist preferred option model being costed Mental Health.	

5. Cluster Finance Statement

Cwmtawe Cluster has a financial allocation from the Welsh Government of £130,020. In addition Clusters have access to other funding streams such as through the Health Board delivered PMS+ scheme.