Rhondda GP Cluster Network Action Plan 2017-2020

RHONDDA NETWORK CLUSTER ACTION PLAN 2017-2020

This plan has been developed by the following **13** practices which operate in the Rhondda Cluster Area, through facilitated discussion with the Local Clinical Director and Primary care LHB Locality Management:-

- Cwm Gwyrdd Medical Practice
- Ferndale and Maerdy Surgery
- Forest View Surgery
- Llwynypia Surgery
- New Tynewydd Surgery
- Park Lane Surgery
- Penygraig Surgery
- Pontnewydd Surgery
- Porth Farm
- St Andrew's Surgery
- St David's Surgery
- De Winton Field Practice / Tonypandy Health Centre
- Tylorstown Surgery

The plan

The plan has been informed by the practice development plans produced by practices; public health information on key health needs within the area; information provided by Cwm Taf Morgannwg UHB re current activity/referral patterns; an understanding of our localities baseline services (current service provision) and identification of potential service provision unmet needs. The plan also embraces key UHB priorities for the next three years. The plan details cluster objectives for years 1-3 (2017/2020) that have been agreed by consensus across practices, providing where relevant background to current position, planned objectives and outcomes and actions required to deliver improvements. The plan is by its very nature fluid /flexible and evolving over the next 3 years the plan itself will be reviewed and updated in response to changes in cluster planning.

The RAG rating score indicates progress against planned action:

Red - future work

Amber - work in progress

Green - work completed.

A number of key principles underpin the plan:

- **Management of variation/reducing harm/sharing good practice:** in acknowledgement of the fact that healthcare must be delivered on the basis of safety, effectiveness and efficiency, the practices have considered and analysed variation in performance and where appropriate have considered steps by which to map standardise practice based on clinical guidelines.
- **Maximising use of local cluster resources**: practices have taken into account the capacity, capability and expertise that exists within primary care, community services and voluntary/third sector services to deliver more care closer to home and reduce unnecessary demands within the acute care services.
- **Promoting integration/better use of health, social care and third sector services to meet local needs:** practices have considered current arrangements/links with RCT Council and the voluntary sector and will also consider any action plans from stakeholders that evolve over the 3 year cycle of this plan.

- **Considering and embedding new approaches to delivering primary care**: this includes increased use of technology, new roles and service models considering an embedding new approaches to delivering primary care: this includes increased use of technology new roles

- **Maximising opportunities for patient participation**: this includes consideration of models of good practice that exist with within/locality/cluster and nationally and within the rest of the UK.

- **Maximising opportunities for more efficient and effective use of resources**: this includes consideration of current resources, opportunities to utilise and current and new services more efficiently and effectively

Additional contributors to the plan/potential evolving contributors to the plan subject to evolution of plan

- Health and social care facilitators.
- Primary care practice managers.
- Practice Nursing and allied health professions representatives.
- Local voluntary sector providers and third sector.
- Other Primary Care contractors.
- Public Health
- Acknowledgements Cynon cluster plan authors re layout.
- CHC

Strategic Aim 1: to understand the needs of the population served by the Cluster Network

Outline of cluster population profile

The Cwm Taf UHB population is 298, 116 with 238, 306 in the RCT locality (ONS, 2016, accessed via www.ourcwmtaf.wales). The UHB locality is the second smallest in Wales but the second most densely populated area. The Rhondda cluster has the highest concentration of the most deprived areas in Cwm Taf

The link between poor health and deprivation is well recognised. For our cluster this has implications for our populations such as; high rates of mental health issues, long term disability/morbidity, a high rate of poverty/benefits uptake and high rates of chronic illness from legacy heavy industry, particularly mining.

- Recent CMO reports have indicated a low level of car ownership with an obvious impact on service planning.
- Birth weight is an important determinant of future health. Low birth weight babies (weighing less than 2500g) are at risk of problems with growth, cognitive development and the onset of chronic conditions later in life. In 2016 6.8% of babies born in North Rhondda were of low birth weight and in South Rhondda 7.1% (Public Health Wales Observatory (PHWO) Public Health Outcomes Framework (PHOF) Tool, 2017).
- Around a third of children (aged 0- 18) in Rhondda Cynon Taff live in poverty (29.9%) (PHWO PHOF Tool, 2017)
- Unemployment rates are available at a local authority level. Latest data shows that for the March 2017 quarter 6.5% of economically active people were unemployed in Rhondda Cynon Taf. This compares to (4.5%) at an all Wales level (ONS, 2017 accessed via www.ourcwmtaf.wales)
- Latest data shows that life expectancy at birth in North Rhondda is 76 years (males) and 80.5 years (females) and for South Rhondda; 75.4 years (males) and 79.3 years (females). This compares to the average across RCT of 76.9 years (males) and 80.6 years (females) (PHWO PHOF Tool, 2017). The lower life expectancy in the Rhondda cluster reflects the differences in life expectancy that exist across Wales between the most and the least deprived areas referred to as the 'inequality gap'. At a local authority level, the inequality gap for life expectancy at birth is 7.4 years (males) and 3.8 years (females)

Our locality has in recent years seen and will see several large scale residential developments with obvious impacts on primary care provision planning.

Public health presentations to our locality identify several top challenges to morbidity and mortality:

- Malignancy (Cancer survival levels in Cwm Taf are amongst the lowest in Wales)
- Cardiovascular disease/circulatory disease
- Smoking levels
- Obesity levels

Subsequent review of Welsh statistics highlighted further areas of concern (see next page)

- Chronic condition such as CHD, COPD and Diabetes are more prevalent in the Rhondda cluster compared to Cwm Taf as a whole (PHWO, General Practice Population Profiles, 2016). This is a reflection of the deprivation in the area and related health inequalities. Many of the risk factors for these conditions relate to lifestyle which is generally poor in the Rhondda Cluster. The long term health and social implications of engaging in harmful behaviours are wide ranging.
- Based on combined Welsh Health Survey data (2010-2015) the below table highlights the percentage of adults that engage in lifestyle related behaviours in the Rhondda Cluster.

Percentage of adults that smoke, eat 5 a day, meet physical activity guidelines and drink above guidelines for alcohol (2010-2015)				
	Smoke (%)	Eat 5 portions f&v a day (%)	Meet physical activity guidelines (%)	Drink above alcohol guidelines (%)
North Rhondda	29	28.7	23	46
South Rhondda	25.6	30.4	26.8	41.2

Source: Produced by Public Health Observatory (2017) using Welsh Health Survey data

Two thirds of adults in the Rhondda Cluster are above a healthy weight (overweight or obese) as the data shows that in North Rhondda: (32.1%) of working age adults (16-64 years) and South Rhondda: (31.2%) are a healthy weight (PHWO PHOF Tool, 2017). Around a third of children (age 5) are also above a healthy weight (PHWO PHOF Tool, 2017).

The Public Health Outcomes Framework (PHOF) Tool has been developed by the Public Health Wales Observatory to support the Public Health Outcomes Framework (PHOF) for Wales. The tool can be accessed here: http://www.publichealthwalesobservatory.wales.nhs.uk/phof2016

Our Cwm Taf brings together the partnership work of the Cwm Taf Public Services Board. Accessed via http://www.ourcwmtaf.wales/ the website contains a wealth of information about the region.

The areas of concern identified by the cluster through this analysis of our cluster populations health status and needs e.g. OBESITY/OVER WEIGHT STATUS, BINGE DRINKING/PROBLEMATIC ALCOHOL USAGE, HIGHER RATES OF CURRENT SMOKERS & its relationship to higher levels of cardiac and respiratory illness in our cluster, LOWER LEVELS OF PHYSICAL EXERTION will be areas that we will initially address in our action plan (detailed in later tabulated form)

No	Objective	Key partners	Completion by: -	Outcome for patients	Progress to Date	RAG Rating
1a	Review the needs of the population using available data.	Local Public Health Team	March 2018	To ensure that services are developed according to local need	Analysis complete and outlined in detail above, subsequently used by cluster to develop action planning on key priorities. See above text.	
			March 2018		Each practice has written a practice development plan identifying the needs of the patients that they provide services to. This information has been collated and used to inform the initiatives the cluster chooses to develop.	
			March 2018/19		Cluster representatives have worked with PHW to undertake a cluster wide population needs assessment. Initiatives are planned and prioritised to target those communities with the highest need.	
			March 2020		Use the PCNA Tool to access core data to support assessing population health.	
			March 2020		Use Population Health management (segmentation and risk stratification) data to review the needs of the population at cluster and practice level (linked to 2h).	
1b	Implement health promotion	GPs	March 2020	Health improvements	Cluster practices feel that buy-in from patients to improving their health / lifestyle will be increased through obtaining support	

	signposting and support mechanisms, which will help to address: • Obesity • Smoking • Alcohol dependence Ensure that healthcare staff maximise opportunities to provide health care advice	Health Board Primary Care 3rd sector partners Public Health Lead GP – Dr Karen Pascoe Dr Westley Saunders (from 2018)		Improved take-up by patients in funded services Increased collaboration between practices and 3rd sector Increased engagement by practices in public health promotion	on a one-to-one basis from an individual (rather than being handed a leaflet / information from a GP). Practices within the cluster have arranged and attended a meeting on Brief Intervention training as well as receiving updated information about what is available in the cluster to refer to for: smoking cessation services, drugs and alcohol services, weight management services, etc. The cluster appointed a journalist to work in partnership with the Rhondda practices to produce health promotion articles in the local media to educate patients on relevant health issues. This post is no longer funded by the Cluster but a Communications & Engagement Officer is now funded by CTMUHB across Primary Care. The cluster entered into an SLA with Interlink for a Wellbeing Coordinator service to promote social prescribing which involves signposting patients to services within the community that impact upon health and well-being. Every practice has a Numed Envisage or Jayex screen to display healthcare educational information which is tailored to the population that the practice serves.	   

			Ongoing		The Rhondda Cluster will continue to have a presence at a number of local events and will use this opportunity to deliver health promotion messages as well as “choose well” signposting.	
1c	To identify additional information requirements to support service development	Local Public Health Team NWIS	March 2020	Improved support for service development	For example, High premature cardiovascular mortality – need local Dashboard to understand consistency of prevention and risk management. *Action:- for development with UHB.* The cluster have been working with the Local Public Health Team on a Population Health Management project to improve intelligence to support service development.	
1d	To consider learning from previous analyses to identify any outstanding service development needs	GP Practices UHB	March 2020	Investing manpower in areas with proven outcomes	Action 1: Through UHB IMTP planning process identify areas of shift from secondary to community/primary (UHB). Action 2: Ensure all project/ new developments have written in evaluation process to inform future service developments (UHB). The cluster are using Logic models where appropriate in the project planning process. The cluster has commissioned services for an IT support to ensure that the information required to evaluate the projects is collected consistently across the cluster	 

1e	Training to develop Flu champions in the practices throughout the Rhondda.	GP Lead- Dr. Rekha Shroff. GP Practice Nurses Receptionist HCSW	March 2020	Improve the flu vaccination uptake in patients throughout Rhondda.	Two training sessions have been held in conjunction with the Vaccination Lead Nurse for CTUHB, with the aim of educating flu champions to work within practices to share best practice with peers and provide patients with up to date, evidence based information. The sessions encouraged practices to think about actions they can take to improve uptake, including myth busting promotion. *Action: Ongoing annual refresher training to be undertaken dependant on flu vaccination uptake.*	 

Strategic Aim 2: To ensure Sustainability of Core GP Services and Access Arrangements that Meet Reasonable Need (including new approaches to Delivering Primary Care)

Cluster practice members have considered this area already in their individual Practice Development Plans, with a range of access and sustainability issues considered including: number of GP appointments provided, hours of services, inappropriate use of A+E, unscheduled admissions +GP Out of Hours services by patients, DNA rates, Promoting use of technology such as My Health on Line/Texts messaging etc.

Further WAG briefing on primary care clusters also advocates use of new technology including ultimately via My Health patient access to their records online repeat prescription ordering, online appointment booking as well as new technologies for consultation, practices are at various stages with these developments within the cluster. In addition to practices individual development plans in this area those areas of common interest across the Cluster are identified in this section.

No	Objective	Key partners	For completion by:-	Outcome for patients	Progress to Date	RAG Rating
2a	Work with the health board on devising solutions for the current issue of GP recruitment and succession planning	Health board Dr David Miller – lead GPs as required	March 2017	Improve upon recruitment and retention of healthcare professionals to ensure delivery of sustainable services to patients.	Dr David Miller has volunteered to act as lead for the cluster on a health board committee to review this issue. A scoping exercise to identify sustainability issues for the Rhondda practices has been undertaken. The report has been finalised and there are key actions that have been identified to support the recruitment and retention of GP's. A number of the actions are at Health Board and Welsh Government levels and these actions will be fed back to the appropriate people.	

			Ongoing		The cluster will continue to do all it can at local level to promote working in the Rhondda.	
2b	To review current demand and capacity Specific Emphasis on DNA rates	Patient participation groups if in place CHC	March 2018	Services developed to reflect local need	The UHB currently has data available which shows: • GP face to face contact • GP telephone contact • Practice Nurse face to face contact • Practice Nurse telephone contact • All collected on a weekly basis The cluster has engaged the services of the Primary Care Foundation in analysing the workload within the GP practices to identify peaks and troughs in workload with the aim of allocating appropriate resources. This will also help look at the current workforce and identify what other health care professionals could be utilised to provide services to patients. Practices have undertaken a data collection exercise. Each practice has received a report detailing how the workload within their practice is distributed and how they can utilise their staff and systems more effectively to cope with patient demand. Part of this work also includes identifying avoidable appointments and documenting	

					which health professional would have been better suited to consult with the patient depending upon their presenting complaint. The aim of this work is to identify how the Primary Care Team could be supported by alternative clinicians to deliver services and improve upon access. The data should be regularly reviewed to inform service needs. Review of DNA rates across locality.	
2c	Establish local data collection systems to monitor trend	NWIS UHB GP Practices		Capacity more effectively matched to local demand	UHB reviewing our own data to determine how this could be presented and used to inform service development Action via national DQS group – for national development	
2d	To develop local workforce development plans	Welsh government Deanery UHB GP Practice	March 2020	Ensure high quality sustainability of local services	Actions: • Establish data collection to monitor scale of difficulty and trend. Practices to complete the Data Capture Template with practice workforce data as part of the Wales National Workforce Reporting System. • Issue added to UHB Risk Register	 

					• Utilise appropriate resources such as PCSU for development • Recruitment campaign 'Positive working opportunities in the valleys has been done. • Rhondda Docs website has been developed and launched to promote working throughout the Rhondda Valleys. The cluster is using social media to advertise the website and target professionals. • UHB have produced a promotional video to advertise the benefits of working in the Rhondda Valleys and Cwm Taf. • Cluster appointed Journalist / Health Board Comms officer produces promotional material to advertise good work throughout the Rhondda. Articles have been published locally and nationally promoting the work of the cluster • The cluster has canvassed those doctors who have worked within practices in the Rhondda and this information has been fed back to the cluster. • Target schools, colleges etc. to promote primary care roles as attractive career choice.	

					The cluster has been involved in Year 10 taster days with Treorchy Comprehensive School to promote Primary Care roles as attractive career choices. • Have training practices in locality we may then be in a better place to recruit • Influence Deanery to review options for alternative models to increase training practice numbers/ spaces • Survey study questioning final year students/FY1/junior doctors relating to career choices • The cluster has implemented the “marginal gains” approach and has invested in up-skilling staff both medical and clerical and reviewing the current processes within practices. • There are now pharmacists working in every practice throughout the Rhondda cluster. • A pilot was undertaken with a physiotherapist working out of two practices seeing those patients who present with an acute MSK problem. As a result a number of practices have entered into an SLA with private physiotherapy providers.	

					• An active monitoring practitioner was attached to every practice. Patients who present with a first episode of depression, anxiety and other related mental health issues were referred into this service for early intervention. The cluster decided to discontinue this service in 2018. • The cluster engaged in an SLA with Interlink to provide a GP Cluster well- being co-ordinator to sign post patients to services available to support them within their communities. The Wellbeing Co-ordinator role is being funded by CTMUHB for 2019/20. • To promote the other Primary care contractors, optometrist, dentists and community pharmacists and sign post patients to the most appropriate health care provider. Messages have been developed that are displayed on the electronic message screens within each practice, promoting the service of other primary care professions.	   

					The Cluster are in the planning phase of a Care Navigation project so that practice staff develop skills to signpost patients to the most appropriate service and patients are given consistent messaging. GP practices refer patient presenting with eye complaints to WECS. The common ailments scheme has now been rolled out across Rhondda and patients can obtain treatment after a consultation with the pharmacist for certain conditions without needing to present to the GP for a prescription.	  
2e	Develop further GPs with Special Interests (GPwSIs)	Health board GPs	March 2020	Develop an improved range of services available to patients within cluster practices	Practices have already submitted data to the health board on current GP and nurse specialist interests as part of their practice development plans. The next stages are: • Health board to identify gaps in skill sets across the cluster • Health board to identify GPs, who would be interested in developing as GwPSI for gap specialist areas • Health board to review and increase GPwSI rate and share revised pay	

					scale with practices, as current rate does not cover backfill requirement • Health board to identify GPs, who can provide training for the gap specialist areas and facilitate training. This could be through health board funded training sessions in practice, via formal observation or by backfilling. • GPwSI in Dementia identified and has been working alongside secondary care colleagues. • A practice has provided INR services to another so that patients can continue to be monitored in Primary Care.	
2f	Improve upon quality and timeliness of recording of patient data for consultation away from the practice	GP's	March 2020	Use Vision Anywhere to access and update patients records at the time of consultation whilst out of the practice	Hand held devices have been purchased by the cluster and Vision Anywhere software downloaded but usage has been low due to issues with the software. The cluster is committed to using the software in the future but this project is on hold whilst until issues are resolved and until clinical system migration is completed.	
2g	Include other primary Care providers,	GP's Practice Managers	March 2018	Develop cross sector work initiatives that benefit patients	Identify services where collaborative working with others could improve upon access and service provision to patients.	

	third sector, CHC and local authority in Cluster Meetings	Optometry Lead Community Pharmacy Lead Community Dental Lead CHC representative Local Authority Representative			There has been representation from Optometry, Dentistry, community Pharmacy and third sector at most cluster meetings. The CHC has attended a planning workshop to set cluster priorities. The Cwm Taf RCGP advocate has also attended some cluster meetings. Work is ongoing to find the most effective way of including other primary care providers, local authority and CHC in cluster meetings. Review TOR on at least an annual basis to ensure membership reflects the wider cluster and that a robust governance framework/ decision making process is in place. Close working relationships have been developed between the cluster and local third sector organisations and are collaborating on a number of projects.	  
2h	Use evidence based and targeted methods to implement interventions based on	PHW GP's Practice Managers Optometry Lead	March 2020	Interventions tailored around population need Improve patient activation and self-management capacity.	• The Cluster is taking part in a pilot which uses Population Health Management (Population Segmentation and Risk Stratification) to group the Rhondda population by what kind of care they need and how often they might need it. And then risk stratified to	

	the need of the population.	Community Pharmacy Lead Community Dental Lead CHC representative Local Authority / Social Services District nursing team 3rd sector organisations.			understand who has the greatest risk of having a significant health event or at most risk of deterioration. • Primary and secondary care data has been extracted and combined to create a single integrated dataset for the Rhondda Cluster population of nearly 80,000 people. • Ten distinct, mutually exclusive segments have been identified for the pilot population based on their healthcare utilisation. These segments have been further broken down to identify low, medium and high risk patients. • GP practices in the Cluster have received cluster level summaries and practice level summaries. • The project has completed phase 1, the pilot stage, and is progressing to phase 2 which will include: o Targeting current interventions at individuals based on their current and future need and identifying gaps in interventions. o Implementing new interventions based on gaps in services.	

Strategic Aim 3: Winter preparedness and emergency planning

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
3a	To ensure each nursing home has a quality service provided by a dedicated GP resource which should in turn free up some much needed capacity Equalisation of patients between practices. Development of new LES Restructure and differentiate EMI/Residential	GP Practices UHB Nursing Homes	December 2017	• Continuity of care • More dedicated access • Improved quality	Action: Develop proposal and engage with all GP's and Nursing homes. Current LES does not facilitate the change of current working practices. Under review by UHB. The Rhondda Cluster has purchased Vision Anywhere to allow access to patients' medical records away from the practice premises to provide the GP with access to the patients' complete medical history to support them in making decisions whilst consulting with the patient. Every Nursing and residential home has been visited and their views canvassed. Feedback about the proposal has been very positive .Each home has now been allocated a practice. Residents within the homes have been informed and given information about the proposed change and patients have now started to be registered with the	

			March 2020		practice that has been allocated to the home. Continue to monitor the implementation of this project to ensure patient satisfaction and quality of service provision.	
3b	Promote the other Primary Care Contractor services to support patients in making decisions on which health care provider is the most appropriate to access depending on their symptoms. Support the role out of the Common Ailments service provided by community pharmacists	GP practices Optometrist Community Dentist Community Pharmacist Cluster Comms GP Practices UHB pharmacist NWIS	March 2017 January 2017 March 2020	• Timely access to appropriate healthcare provider. • Improve GP access	Develop promotional material for patients to educate them on accessing Services appropriately. WECS and Dental information now being displayed in all practices who have NUMED or Jayex screens. Information about the common ailments scheme is also now displayed on the screens in every practice. The Common Ailments service has been rolled out across Cwm Taf and practices refer to the scheme as appropriate. The Cluster are in the planning phase of a Care Navigation project so that practice staff develop skills to signpost patients to the most appropriate service and patients are given consistent messaging.	  

	throughout Rhondda Valleys					
3c	Promotion of Flu vaccination	GP Practices Community Pharmacy District Nursing	Ongoing	Prevent patients from developing health complications through Flu	Practices to continue to promote the benefits of the flu vaccine. Use social media to disseminate information and advertise flu clinics Continue to utilise the flu champion within the practices	

Strategic Aim 4: Access to services, including patient flows, models of GP access, engagement with wider community stakeholders to improve capacity and patient communication.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
4a	Open responsive access to diagnostics, especially Echo cardiograms	UHB Primary Care and Secondary Care GP practices	March 2020	Faster access to information to aid diagnostics and treatment Reduced anxiety due to shorter waiting period to diagnosis	Actions: Explore purchase of 'cluster' ECG as part of developing localised diagnostic services Or Work with Acute UHB Dept to consider alternative pathway to achieve objective.	
4b	Physiotherapist	GP Practice Physio Provider	April 2017	Improved access to GP appointments Quick access to Physiotherapist for acute MSK problem.	Two practices piloted having a physiotherapist within their practice to see patients who present with an acute MSK problem instead of seeing a GP. In both practices having a physiotherapist in the practice freed up 5% of GP appointments to see other patients. 5 of the 13 practices have now entered into an SLA with a Physiotherapist provider.	
4c	Active Monitoring	MIND GP Practices	March 2018	To provide timely intervention for all adults who are experiencing a	Active Monitoring (AM) is a self-directed psycho-educational programme. The service is offered to people presenting to GPs with a range of symptoms	

				first episode of mental health problems.	associated with common mental health problems. This service will increase their wellbeing, self-esteem and confidence and reduce their likelihood of needing to access further primary and secondary mental health services. Due to limited cluster funding and based on the evaluation of this and other projects, it was decided not to continue with this project past March 2018.	
4d	Wellbeing Co-ordinator	Interlink GP Practices	March 2019	Signposting service for patients to access that informs them of services and activities within their local community to support their Health and wellbeing needs.	The aim of the service is to work with individuals to address their needs through identifying their interests and supporting them to self-manage, access community activities, facilities and services to improve their health and well-being, self-esteem and confidence and lead to a reduction in their use of GP practice resources. This service is currently available to any patient registered with a practice within the Rhondda Cluster. Patients can self-refer to this service. The Wellbeing Co-ordinator is funded by CTMUHB for 2019/20. The cluster continue to support the service.	

4e	Pharmacist	Cwm Taf UHB GP Practices	March 2020	To improve upon access for patients by undertaking tasks within the practice associated with medication which would usually be done by the GP.	The number of pharmacists allocated to the practices has been increased in 2018/19 to 5FTE. Each practice has defined a work plan for the pharmacist allocated to their practice which will free up time for the GP with the aim of improving access. *Action: Practices to continue to feedback to evaluate the project to help decide whether to continue to cluster fund in 2020/21.*	 
4f	Slimming World on referral	Slimming World GP Practices	March 2020	Patients identified according to criteria will be provided with 12 weeks attendance at slimming world which has been funded by the cluster	A referral criteria was agreed between the cluster and Slimming World. The cluster receive quarterly account performance evaluation reports and each practice receive results from their referred patients. Patients are “followed-up” by Slimming World 6 and 12 months after their 12 week attendance. This project is ongoing due to positive evaluation of the first 12 months. The Rhondda Slimming World project is being presented at the Wales Public Health conference in 2019.	

4g	Grow Rhondda	Men's Sheds Treorchy Ysbyty George Thomas GP Practices	March 2020	Gardening activities on referral to promote the benefits of active living and social engagement within the community to patients. Additional social activity offering for Rhondda community.	A gardening on referral 8 week programme in collaboration with Men's Sheds Treorchy and using the gardens in Ysbyty George Thomas. The service commenced in January 2018. The service is being "relaunched" to increase referrals and positive outcomes for the community The project continues to be evaluated and developed.	
4h	Care Navigation	GP Practices Pharmacists Dentists Optometrists Wellbeing Coordinator Local 3rd sector services.	March 2020	Patients/ service users able to contact the right person first time.	Care Navigation training is being planned to encourage frontline staff to signpost patients appropriately.	

4i	Waun Wen Lindsay Leg Club	Wound Care Service District Nursing Service	March 2020	Patients able to access leg advice and treatment in a friendly environment and in a timely manner with no appointment needed.	The Leg Club opened on the 3rd October 2018. The cluster have supported the roll out of the Lindsay Leg Club in Waun Wen, Trebanog through promoting the service to patients who are suitable to attend.	

Strategic Aim 5: Service development and liaising with secondary care leads as appropriate

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
5a	COPD	Secondary Care Consultant Secondary Care respiratory Nurses Primary Care Respiratory Nurses.	March 2018	A post discharge service to provide disease management support and prevent further admissions	The service has been in place since August 2016 and has been evaluated positively leading to roll out across other CTMUHB clusters. The service has piloted extending the service to providing support to a small number of GP practices who identify patients who are at risk of hospital admission because of their COPD.	
5b	Dementia		January 2017	Work collaboratively with Cwm Taf UHB mental health directorate to address demand and capacity issues and ensure access to timely diagnosis across Cwm Taf	To appoint a GPwSPI in Dementia to deliver the required follow up clinics within their practice or at a local Health Park with support from a pharmacist and a CNS from Memory Service. Rhondda GP identified and work completed.	

Strategic Aim 6: Review of quality assurance of clinical governance practice self- assessment Toolkit (CGPSAT) and inactive QOF indicator peer review.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
6a	Peer Review inactive QOF indicators	Cwm Taf UHB GP Practices	End March 2018	Assurance that chronic disease monitoring and quality care continues despite changes to QOF	Data has been circulated to the whole of the cluster 1st Peer Review took place September 6th 2017. 1st peer review has been completed second was due to take place in March 2018 but has been postponed due to QOF relaxation.	
6b	CGPSAT	GP Practices	End March 2018	A systematic, comprehensive review of practice systems to ensure that all contractual and statutory obligations are satisfied	Practices will consider key issues from the CGSAT for discussion at Primary Care cluster meetings where there may be potential to identify common themes that might be addressed through agreed actions once the toolkit is completed. On track to complete however postponed due to QOF relaxation.	

Strategic Aim 7: General Practice national priority area – Liver disease

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
7a	To facilitate appropriate management of abnormal ALT tests and, thereby, more timely diagnosis of patients with liver disease	Secondary Care Gastroenterologist Biochemistry Department GP Practices	March 2019	Improved management of patients with liver disease.	The cluster lead has met with the Gastroenterologist. A pathway has been agreed. Discussions have been had with the biochemistry department with regard to practices requesting the additional test and a process has been agreed. A steering group consisting of both Primary and Secondary care professionals has been set up. The pathway is in place and a template has been designed to assist with data capture so that patients can be audited and outcomes measured.	Suspended 

Strategic Aim 8: General practice national priority area - COPD

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
8a	Improve COPD care within the context of the framework embedded within QOF	GP Practices	March 2019	Higher percentage of accurate coding and recording of COPD consultations, and more appropriate prescribing and referrals.	Practices undertook first baseline audit	Suspended 

Strategic Aim 9: General practice national priority area - Dementia

No	Objective	Key partners	For completion by:-	Outcome for patients	Progress to Date	RAG Rating
9a	To improve recognition, assessment and referral for suspected early dementia.	GP Practices	March 2019	To improve practice systems and ensure that patients who present with possible dementia are referred for assessment	Practices undertook an initial audit and have reviewed their practice systems in line with the outcomes. As a result of the audit feedback, a template has been developed and is now in place at each GP practice in Rhondda. The aim of the template is to improve the recording of history for patients who present with possible dementia and to prompt GP's to undertake the recommended tests prior to referral and also to refer where appropriate. The audit will be redone to evaluate if the use of the Template has had a positive impact on the number of patients being referred for assessment. In 2019/20 the Cluster have been working with 1000 Lives on a project to improve rates of patients on Dementia registers.	Suspended 

					Early results show that there has been an increase in patients on dementia registers which is partly due to consistent recording of read code information by MAS on all GP correspondence. Some Rhondda practices have undertaken Dementia Friends Training.	

Action plan

Objective no.	Date	Action	Responsible	Status
1a	March 2020	Use the PCNA Tool to access core data to support assessing population health. Use Population Health management (segmentation and risk stratification) data to better understand the needs of the population at cluster and practice level.	GP Practices Public Health	Ongoing
1b	March 2020	Have a presence at a number of local events to deliver health promotion messages as well as "choose well" signposting.	GPs Health Board Primary Care 3rd sector partners Public Health	Ongoing
1c	March 2020	Improved support for service development	NWIS Public Health	Ongoing
1d	March 2020	Consider learning from previous analyses to identify any outstanding service development needs Through UHB IMTP planning process identify areas of shift from secondary to community/primary (UHB).	GP Practices UHB	Ongoing
1e	March 2020	Update practice flu champion	UHB GP	Ongoing

		Undertake annual refresher training dependant on flu vaccination uptake.		
2b	March 2018	Review Demand and Capacity in practices	Primary Care Foundation GP practices UHB	Ongoing
2c	March 2020	Establish local data collection systems to monitor trend	NWIS UHB GP Practices	Ongoing
2d	March 2020	Develop local workforce development plans Target schools, colleges etc. as career choice. Survey final year students/FY1/junior doctors relating to career choices Care navigation training	Welsh government Deanery UHB GP Practice Pharmacy Optometry Dentistry 3rd sector	Ongoing
2e	March 2020	Develop an improved range of services available to patients within cluster practices	UHB GP Practices	Ongoing
2f	March 2020	Improve access to patient records Roll out Vision Anywhere to access and update patients records at the time of consultation whilst out of the practice	UHB Vision GP practices	Ongoing
2g	March 2020	Develop cross sector work initiatives that benefit patients.	Community Pharmacy Optometry Dentistry	Ongoing

		Continue to find the most effective ways of including other primary care providers, local authority and CHC in cluster meetings. Review TOR on at least an annual basis to ensure membership reflects the wider cluster and that a robust governance framework/ decision making process is in place.	CHC Third sector	
2h	March 2020	Use Population Health Management (Population Segmentation and Risk Stratification) to target interventions.	PHW, GP's Practice Managers, Optometry, Community Pharmacy, Community Dental, Local Authority / Social Services, District nursing team.	Ongoing
3a	March 2020	Continue to monitor the implementation of this project to ensure patient satisfaction and quality of service provision.	Managers in Nursing/Residential homes GP	Ongoing
3b	March 2020	Continue to actively promote other services available to patients. Implement Care Navigation training to ensure front line staff signpost to the most appropriate service.	GP practices Optometrist Community Dentist Community Pharmacist Cluster Comms	Ongoing

4a	March 2020	Explore purchase of 'cluster' ECG as part of developing localised diagnostic services Or Work with Acute UHB Dept to consider alternative pathway to achieve objective.	UHB Primary Care and Secondary Care GP practices	Ongoing
4e	March 2018	Evaluate service and cluster to decide if they wish to re-commission in 2020/21 based on outcomes.	UHB pharmacy Cluster	Ongoing
4g	March 2020	Promote service to increase referrals. Collect data to measure outcomes	Interlink Mens Shed's Treorchy Cluster	Ongoing
6a	March 2018	1st peer review completed	Cwm Taf UHB GP Practices	Suspended
6b	March 2018	GP practices completing	GP Practices	Suspended
7a	March 2019	Steering group to meet. Template to be utilised within the practices	UHB Cluster	Suspended
8a	March 2019	Practices undertaking review of patients records to identify patients who need review	GP practices	Suspended
9a	March 2019	Guideline has been issued to every practice. Re-audit to be done	GP Practices	Suspended