Taff Ely Cluster Annual Delivery Plan 2021/2022

Taff Ely
Primary Care Cluster

1. Executive Summary

As new Cluster leads in 2020 it is good to reflect on the year and appreciate what the cluster have achieved, albeit the COVID-19 pandemic and the challenges that has brought about this year.

The cluster has progressed in some areas of their plans, through continuing to work together to improve the health and wellbeing of its population.

1. Continued funding of MIND Active Monitoring to support patients with mental health difficulties to make positive changes to manage their own health.
2. Establishment of Physiotherapists in the cluster to provide early treatment for patients with acute musculoskeletal problems aiming to reduce time away from work and risk of chronicity.
3. Establishment of Pharmacy Technicians within the cluster to assist practices in streamlining medicines management and improving quality of reviews including de-prescribing.
4. Establishment of Frailty Nurse service to work with frail, housebound patients to reduce frailty, plan future care, anticipate deterioration in symptoms and reduce unnecessary admissions.
5. Ongoing support for Homelessness Nurse to support homeless persons in the locality to access health, local authority and third sector organisations for care and support.
6. Further development of the 'MyChange' project to address inequalities in health and the contribution lifestyle factors such as exercise, smoking, diet and obesity to poor health, through a nurse led motivational interviewing programme. The benefits would be to improve the rates in these areas and, in time, the health problems associated.

The cluster are aware of the need to consider their plans against national and local targets being set, particularly taking into account the:

- Need to align with the Health Board and Locality IMTPs
- local regional partnership board plans particularly the thriving communities and healthy people objectives
- Primary Care Model for Wales, which features strongly in the Cluster IMTP
- Strategic Programme for Primary Care as the different elements are key priorities that impact on service delivery, access and the health and wellbeing of our population.

The Cluster regularly review its IMTP and ensure that all members have sight of and given the opportunity to comment and provide information specific to their service area. All members are actively encouraged to put proposals to the cluster meetings for consideration to allow collaborative working and projects across Primary, Community and Social Care.

Through 2020, we have seen the establishment of the ILG with cluster representation contributing to the decisions made by the health board affecting service delivery through the pandemic and building the ILG team for collaborative integrated working in the future.

Cwm Taf Morgannwg University Health Board

Taff Ely Cluster Annual Plan on a Page 2021/2022

Our Vision is to deliver a high quality, sustainable and integrated primary and community care service for current and future generations. To support transformational plans and development of multi-disciplinary teams across our primary, community and social care providers to focus plans on integrated care to meet the individual and community needs.

Cluster Aims – to work together in order to:

Provide more services closer to home and in community settings

Support the population with assessment of their health and wellbeing to allow people to stay well, lead healthier lifestyles and live independently

Developing more effective collaboration working with health & social care community services

Support the sustainability of Primary Care and access to core services

Strategic alignment

Health Board IMTP alignment - Work with Rhondda and Taff Ely ILG to develop services closer to the community e.g. diabetes clinics

Primary Care Model for Wales

Strategic Programme for Primary Care

Planned Cluster Actions:

Continue delivery of essential services, whilst dealing with complexities and responding to the Covid pandemic.

Implementing a new Frailty service to work collaboratively with Community Health & Wellbeing Team, @home service, District Nurses and care homes.

Provide physiotherapy and mental health services locally to improve access.

Continue to navigate patients to the most appropriate care and advice in their community.

Review of health promotion campaigns to allow targeted, proactive messaging.

Improve medicines management, patient safety through newly appointed pharmacy technicians.

Defining its plans for workforce development.

Collaborative working with the R&TE ILG to develop services, review pathways to support access to services for its patient population in Primary Care and Community Settings.

Key Achievements 2020 – 2021:

Valleys Steps – Families 2gether 4 Wellbeing to support Mental health and wellbeing of young people.

Recruitment of Pharmacy Technicians to support the development of the MDT team and skill mix within practice.

Commissioned First Contact Physiotherapy sessions to improve early access and intervention.

Joint funded Specialist Nurse to support Homeless and Vulnerable Adults.

GP Dermoscopy training and purchase of equipment in each practice.

Development of a cluster covid contingency plan.

Integration into R&TE ILG arrangements and regular attendance of cluster leads at meetings, which is allowing a Primary Care and Cluster partnership approach to be develop.

3. Reflections of 2020 Covid-19 service delivery and impact on Cluster working and cluster planning

The COVID-19 pandemic has affected service delivery and development significantly as individual practice and cluster level.

The handover period between cluster clinical and non-clinical leads from March – June 2020 ensured a smooth handover and additional resource for developing the cluster contingency plan.

The cluster regularly reviewed this plan throughout 2020, which facilitated collaborative planning for the challenges of managing staff sickness absence, remote working, remote consultations and service delivery in accordance with government guidelines.

Weekly practice manager meetings and monthly practice clinical lead meetings through the second wave have allowed the dissemination of ideas and a strengthening of the cluster entity.

The move to developing online presence for the Cluster through funding for a communications officer and eConsult was timely in supporting GP practices to move to remote consulting and communicate with the wider community.

Some cluster plans were stalled by the pandemic. However, we have succeeded in starting a First Contact Physiotherapy service to manage musculoskeletal problems at the point of primary care contact. Evaluation of this project is needed to ascertain achievement of the intended outcomes.

We have appointed 4 pharmacy technicians to support the medicines management in the practices. These roles are just starting in January 2021 and ongoing evaluation will measure the success of this initiative.

The cluster have approved funding for 2 frailty nurses to work independently alongside practices and the Community Health and Wellbeing team.

In spite of lockdowns and moves to remote working, we have maintained our support for MIND active monitoring.

We have supported practices in maintaining services through the pandemic through provision of additional hardware and software for remote consultations and home working, screens for the protection of staff and patients at receptions, funding for additional staffing requirements to deal with additional work caused by the pandemic.

We have funded dermoscopy courses and dermatoscopes for each surgery, which were completed by GPs leading to improved knowledge and aiming for increased appropriateness of referral

In line with agreements to suspend aspects of Cluster working there has been a need to continue to provide evidence against the indicator CND015W and bullet four of indicator CND016W: Active participation as evidence of operating an effective system of clinical governance (quality assurance) in the practice e.g., through completion of CGSAT and IG toolkit) retained to support Cluster IMTPs.

The GP practices will continue to provide services, building on relationships with other community services and MDT members of the cluster. This will include access to urgent care, working in a mutually supportive way with clinical colleagues.

4. One year in reflections on the 2020/23 Cluster Plan content and ongoing relevance to direct future cluster working

The cluster have continued to work on a delivery some projects through working together this to improve the health and wellbeing of its population, albeit the covid pandemic and restrictions that have been presented this year. There have been delays to some new initiatives which were agreed early in 2020 and also a need to put some projects on hold, namely:

- My Change, My life
- Community Development Support
- First Contact Physiotherapists
- Additional pharmacy roles in practice

This year has however given an opportunity to consider the way we deliver primary care services and presented a need to adapt. It has strengthened primary care contactors working together with evidence of GP practices, Dentists, Optometrists and Community Pharmacies considering Cluster contingency plans for their service areas and provision of essential services to their population.

The Cluster leads will continue to liaise with the Rhondda and Taff Ely Integrated Locality Group clinical and managerial leads to develop and improve access for the population.

Delivery

- **First Contact Phyisotherapy -** This service began in September 2020, during the covid pandemic so it was agreed to begin with a process to triage, contact by phone, video consultation or provide face to face if deemed necessary.

  This would provide more timely access and more effective management of patients condition as they no longer need to wait to see a GP or for a referral into without the need to see a GP. Research shows where physiotherapists are present in primary care as first contact practitioners appropriate early management of MSK conditions helps to reduce onward referral to secondary care, reduce prescribing and unnecessary investigations. Quarterly performance reports will be provided to the Cluster to allow monitoring and review of the service provision and impact in Primary Care settings for patients.

- **Pharmacy Technician** - The cluster have employed 4 pharmacy technicians, for 2 years, to work across the 7 GP practices and provide additional capacity to help manage demand and improve access, allowing patients to be seen by most appropriate professional. It will also support the mandatory quality improvement project with the focus being on patient safety "Reducing medicines related harm through a multi-faceted intervention in primary care clusters".
  Some specific aims of the project are to:
  - Reduce medicine waste and avoidance, supporting reduced costs for the practice and Health Board.
  - Improve patient care, safety and experience
  - Improve discharge information
  - Support better communication and quality of information between Primary and Secondary care, including community pharmacies, dental practices and Optometrists.

  Improving communication - In 2020, the cluster approved funding for one day per week of communications officer time to support practices and the cluster to develop their website,

facebook and twitter accounts. This provides a dedicated resource to promote, pro-actively, activities and services available to the population. A communications plan has now been developed to structure activity across the year, with objectives being:

- To effectively communicate with patients and other key stakeholders using the most appropriate tools
- To work proactively with partners, third sector organisations and the local community to maximise coverage and reach of our messages to support engagement
- To inform our patients of key changes to services, as and when needed
- To ensure any information we provide for patients is easy to understand and accessible to all patients
- To protect and enhance the reputation of the Taff Ely Primary Care Cluster
- To ensure clear links are in place between GP Practices and Cluster website and social media

Accelerated

- **IT infrastructure** – GP practices have worked together to ensure that their IT provision is adequate to allow them to work remotely, carry out video consultations and continue to connect with patients across their population. All these measures support their contingency planning for the Cluster and include
  - additional monitors, cameras and headsets in each consultation room
  - desktop access across practices to allow network and cluster working
  - Vision Anywhere implementation and shared appointments
  - remote access and working – supported by additional laptops

- **E-consult**
  All GP practices using Vision have now implemented the use of eConsult, an online consultation tool that catches clinical symptoms early and offers effective, time-saving, remote triage and consultation. Although the Cluster had already purchased the e-consult package, due to COVID-19 restrictions and inability to see patients for face-to-face appointments, use of the tool at a pace from March 2020 supported remote consultations and triage and modernisation in the way they provide patient care.

  One practice decided not to continue using the E-consult tool as it did not integrate well and was not very user friendly with EMIS web. They have still adapted to new ways of using technology and are currently using AccuRx platform to contact and consult with patients.

  Consultant Connect
  GPs now have the ability to directly connect with consultants. This can dramatically reduce numbers of hospital referrals. Taff Ely Cluster have specialist advice available locally to them with consultant lines being covered by CTM based consultants for Cardiology, COTE, Gastroenterology, Paediatrics, Respiratory, Acute Medicine, Pharmacy and @home.

Delayed

- **Frailty Service** – this however is due to start April 2021, as 2 Frailty Nurses now recruited and plans underway.

- **My Change My life** – this initiative, started early in 2020, has not rolled out any further across the practices. This will be revisited in 2021 to allow Healthcare support workers to work with patients to improve their own health & wellbeing, through motivational techniques, signposting, advice and support.

- **Dermoscopy Training** - Some GPs have deferred due to the impact of covid on ability to complete the course, but rescheduled for March 2021. For those that did complete and pass the course, they are reporting that they are using the new skills on a daily basis.

5. Key Cluster Actions for 2021/22							
Strategic Alignment / Priority Area	**Objectives**	**Planned Action** 2021/22	**Expected Outcome** Mar-22	**Possible Constraints/ Key Risks**	**Workforce Implications**	**Financial Implications**	**Monitoring process**
Covid-19 Resilience 2021/22							
Primary Care Model For Wales NHS Wales Operating Framework - Maintaining Essential Health Services during the COVID 19 Pandemic – summary of services deemed essential	Primary Care Contractors to continue to deliver essential services to their population whilst taking into account covid restrictions Individual GP practices continue to deliver essential services, whilst also taking into consideration ability to deliver enhanced services based on access, workforce. Cluster to ensure that patients are continually updated on service availability and using campaigns to actively encourage contact should they have a health concern – urgent or routine need.	Practices to ensure access to health advice support and interventions using multiple routes e.g. telephone, e-consult, video consultation. Decisions about individual care to be based on need and clinical decision. To continue to work with Health Board Primary Care Team, ILG to ensure plans to work jointly across teams are identified as needed e.g. to provide timely care of frail/elderly at home, to manage long covid conditions. To continue to use social media, national and local campaign messages to explain that services are 'open' for business and target particular groups due to health condition e.g. cancer, children.	Access to services to continue in most appropriate way. Increase in contacts around conditions that have reduced during covid Timely delivery and completion of covid and flu vaccination programmes Improved and targeted communications with patient population	Lockdown measures and need to manage access, need for social distancing, control measures which does impact on number of patients that can be seen at premises at any one time Ability to access referrals on to other specialist services.	Impact of covid on available workforce cohort/specific skills which could impact on ability to deliver a particular service area.	Adjustments to premises, additional costs of social distancing measures, cleaning regimes etc. Additional staff costs to allow normal service delivery against any other requirements e.g. covid vaccination priorities,	Cluster will work with the Health Board, who will use a monthly reporting mechanism to monitor activity

Strategic Alignment / Priority Area	Objectives	Planned Action	Expected Outcome	Possible Constraints/ Key Risks	Workforce Implications	Financial Implications	Monitoring process
Rehabilitation: A Framework for Continuity and Recovery 2020-21' Health and social care services rehabilitation framework 2020 to 2021 Allied Health Professional Framework: Looking Forward Together Primary Care Model for Wales	To consider the guidance and framework to allow access to services to support rehabilitation of patients in the 4 identified groups • People post Covid-19: those recovering from extended time in critical care and hospital and those with prolonged symptoms of Covid-19 recovering in the community • People awaiting paused urgent and routine planned care who have further deterioration in their function • People avoiding accessing services during the pandemic who are now at risk of harm e.g. disability and ill-health • Socially isolated/shielded groups where the lockdown is leading to decreased levels of activity and social connectivity, altered consumption of	To work jointly with the Health Board, R/TE ILG and Community Health & Wellbeing Team to ensure adequate resources can be provided across services and health professionals to support those recovering from covid. GPs to ensure medical investigations prior to referrals to Covid Rehabilitation Hub to ensure patient is 'rehab ready' To communicate service provision and support to the patient population through effective campaigns.	Support improved outcomes for those requiring post covid rehabilitation. MDT support available in rehab hub for individuals with post covid syndrome to work towards symptom resolution within 12 weeks. Improved knowledge, understanding of services available to people and how to access following recommendations of the self-management resources available to them.		Use of Rehab hub, Primary Care and secondary care teams where needed to allow appropriate support care, intervention and access to services. Use of cluster funded roles where appropriate e.g. physiotherapy to provide early access to services. Community Health & Wellbeing Team to allow an MDT assessment		R&TE ILG and Cluster lead meetings. GP reports Rehab hub reports to Health Board

	food, substance misuse, the loss of physical and mental wellbeing and thus increased health risk						
Cluster vaccination delivery 2021 - Seasonal Flu +/- Covid-19 vaccine	To target and vaccinate eligible groups with Flu and Covid-19 vaccinations	Covid-19 roll out from January 2021 Flu planning – as early as possible in line with communications and ordering processes	All priority groups, as indicated by Welsh Government, offered vaccinations. Plans for 2nd covid vaccination.	Timely deliveries of vaccinations to practices to ensure they can plan covid vaccination clinics. Impact on delivery of first vaccination when 2nd vaccination for priority groups begins	Increased workload across General practice. Increased visits for GP/Practice Nurses, District Nursing and Community Teams for housebound patients.	Additional resource costs	Practices progress monitored via WIS. Continued contact with HB.
Covid-19 Cluster Hub delivery	To move to network/cluster delivery if needed.	To continue to communicate and work with Health Board and Local Authority should a cluster vaccination centre be required.	Delivery at scale/pace	Impact of staff availability to support on rota basis due to absences etc. Access to adequate covid vaccination supply	Increased workload across Primary Care	Cost of venues and set up/infrastructure Additional staffing, consumables	Vaccination programme reporting / WIS
Strategic Alignment / Priority Area	**Objectives**	**Planned Action**	**Expected Outcome**	**Possible Constraints/ Key Risks**	**Workforce Implications**	**Financial Implications**	**Monitoring process**
Ministerial Delivery Milestones 2020/21 relating to the Primary Care Model for Wales							
Primary Care Model for Wales Strategic Programme for Primary Care	To assess care home service across the Cluster	Cluster to review care home service provision across Taff Ely. GP practices sign up to DES. Work with Health Board to ensure	Consistent provision and delivery of care across the cluster for care homes.	All GP practices signed up to Care Home DES.	Clinician time for delivery of DES e.g. ward round. Frailty Nurses time	DES Funding – Frailty Nurse roles	Those signed up to the Care Homes DES will provide reports and claims to UHB and WG in line with contract requirements.

		plans are in place to provide enhanced services across the cluster. Cluster will consider impact on Frailty Nurse roles to ensure care provision to patients in care homes as well as in own homes.					Primary Care GMS Team reports
2020/23 3 year Cluster IMTP Priority							
Strategic Programme for Primary Care Prevention and Wellbeing – providing care closer to home to support Frail elderly patient population in their own home/care home to stay safe and well, avoid A&E attendances, hospital admissions	Development and delivery of a Frailty Service working in partnership with Community Health & Wellbeing Team and Rhondda/Taff Ely Integrated Locality Group – community services	Recruitment of 2 x Frailty Nurse roles Reviews carried out across all GP practices to identify patients to be held on caseload. Pro-active contact and review of Frail Elderly. Close liaison with Community Health & Wellbeing Team – MDT to ensure access to allied health professionals, social worker and community support.	Evaluation of first year in collaboration with HB ILG to determine any proven need and sustainable service provision. Reviews aim to show: •Improved quality of care. •Reduction in complex care needs through pro-active, comprehensive and effective care provision through multi-agency liaison and early identification and crisis resolution. •Reduced need for urgent GP responses, A&E attendances, hospital admissions.	Funding approved for 2 years so risks to these current roles within this IMTP timescale not applicable to Cluster. Discussions already underway with HB ILG to determine need for inclusion in IMTP as necessary to highlight any potential future need for roles based on evaluation, any benefits and outcomes	Two year funded post on secondment basis or fixed term.	Nurse roles funded for 2 years by Cluster. Collaboration with ILG to help determine future need and funding of sustainable roles, best fit within current service provision.	Six monthly reviews to measure outcomes identified in evaluation plans Reporting to cluster and R&TE ILG

			•Dedicated link for housebound and care home patients				
Service developments based on demand Pro-active care provision in practice to support prevention and early intervention.	First Contact Physiotherapy (FCP) Service. To support more timely access to Physiotherapy appointment, which will support patients with effective management of their condition, ensuring early intervention, GP repeat visits, referrals to secondary care services.	Continue with and fully implement FCP	Reduce inequalities and improve outcomes for patients with musculoskeletal conditions through the additional cluster funded service. Work with Health Board service to evaluate and plan next steps.	Ability for service to run as fully and effectively as needed due to covid restrictions.	First Contact Physiotherapist employed by CTM UHB.	Continue the FCP Service into 2021/22 – with funding for 15 sessions per week.	Service provider reports to the Cluster to help monitor and evaluate the impact that this additional resource is providing. Use of evaluation plan to review against expected outcomes.
Strategic Alignment / Priority Area	**Objectives**	**Planned Action**	**Expected Outcome**	**Possible Constraints/ Key Risks**	**Workforce Implications**	**Financial Implications**	**Monitoring process**
Workforce & Organisational Development of the multi-disciplinary team. GMS contract Quality Assurance and Improvement Framework	To develop the workforce further through employment of Pharmacy Technicians to support practice based pharmacists and support the Quality Improvement (QAIF) project with the focus being on patient safety "Reducing medicines related harm through a multi-faceted intervention in primary care clusters".	4 x pharmacy technicians employed to support pharmacists and practices. Fund clinical pharmacist time to provide clinical supervision and mentor support. Develop standard operating procedures for the practice, the cluster – working with the Health Board when as necessary.	Reduce medicine waste and avoidance, supporting reduced costs for the practice and Health Board. Prudent healthcare – Assist with some areas of work and demand for the clinical pharmacist to allow them to deal with higher complex cases.		Practice Pharmacist time to train, support and supervise, particularly in initial months.	Cluster funding for pharmacy technicians approved for 2 years. Clinical pharmacist supervision/mentor time approved for all practices.	Reports - provided by practices and health board on a 6 monthly basis to allow the cluster to review and report against any impact.

			Improve patient care, safety and experience Improve discharge information Assist with reduction of hospital admissions /A&E attendances due to better management of conditions Improve communication and quality of information between Primary care (community pharmacies, dental practices and Optometrists) and Secondary care.				
Development of new models of care Prevention and Wellbeing PHW Population Health Needs Assessment - Mental Health & Wellbeing - adults	To gain a clear understanding of MH service access in PC and impact of different levels of service – through collaborative working To provide access and early intervention to Mental Health and wellbeing support for those presenting at GP	Cluster Development Managers and Cluster Leads to work with Mental Health team leaders from PCMHT, CH&WT and MIND. To continue to commission Active Monitoring Service and access to sessions in GP	Patients able to access the ”right service at the right time”. Improved understanding for referrers Reduction in repeat GP appointments	Currently lack of clarification of how all the services interact, exact level of provision and support for patients, causing some confusion for referrers into MH services and support.	GP clinical assessment for referral into most appropriate service. Active Monitoring practitioners based in all GP practices.	Cluster funding for • CTM MIND contract for Active Monitoring Service • Valleys Steps to support developmen t and	Work with PCMHT and CH&WT team leaders to determine any impact on referrals into service-reductions, more appropriate & timely, better outcomes.

	practices with Low to moderate MH issues.	practices for adults (16+). To review provision in 2021 and deliver future model based on need e.g. 1:1 counselling. To work with Primary Care Mental Health Team and Community Health & Wellbeing Team CH&HT) to ensure collaborative working and clear pathways to avoid 'missed' opportunities and avoid duplication. Through the Community Health & Wellbeing Team MH practitioner - delivery of additional clinical sessions in practice and cluster hub and MDT support for patients.	Improved awareness of the different services and how they fit together and best pathway for patient Improved collaborative working with Health Board services and 3rd sector organisations to ensure any gaps in provision identified and developments based on need.		MH practitioners aligned to Cluster based in CH&WT. Wellbeing Co-ordinators in CH&WT to provide MH& Wellbeing support in the community	delivery of sessions in the community and secondary schools	Quarterly reports from MIND. Reports from Valleys Steps
Prevention and Wellbeing PHW Population Health Needs Assessment - Mental Health & Wellbeing – young people		To continue to work with Valleys Steps on service provision and support for Young People, through delivery of the Families 2gether 4 Wellbeing sessions and direct links with Secondary School and local college.	Pro-active support provision through working with schools. Raised awareness of families 2gether sessions to ensure pupils are signposted if needed.				

		Delivery of eye to eye counselling sessions and CAMHS clinics at Dewi Sant Health Park/Cluster hub	Direct links to other services e.g. eye to eye				
Strategic Alignment / Priority Area	**Objectives**	**Planned Action**	**Expected Outcome**	**Possible Constraints/ Key Risks**	**Workforce Implications**	**Financial Implications**	**Monitoring process**
Prevention & Wellbeing	Implementation of My Change My life project	Work with PH Specialist. Use of MECC Motivational training for Healthcare assistants across practices. GP project leads to support development Consider options available for delivery of Foodwise sessions	Improved knowledge, skills and confidence of HCAs to encourage, advise and support patients. Better understanding and support for patients on identifying achievable and beneficial changes to improve their lifestyle and wellbeing.	Timely access to ongoing support and services for individuals who have identified a need. Training of staff – covid pandemic impact on resource, availability of Motivational interviewing course.	HCA time for training and development of initiatives GP project lead time	Costs to support project – training, staff time	Use of patient records. Reports back to cluster on any impact.
Communications and Engagement	To have a more structured approach to communicating with the patient population to ensure they have information on available services – for Primary Care Health Services, local authority, community support, groups and activities. Development of information for website, social media and local	Dedicated Communications Officer – 1 day per week. Development of Communications Strategy. Engagement from all Cluster members to target Health & Wellbeing and service delivery	Implementation of the communications plan. Regular campaigns to support cluster projects, PC services More targeted messages	Involvement needed from all services to provide up to date information. Potential of not reaching the right people in the right way. Changes in population habit, IT	Communication Officer – only 1 day per week. Practice manager/administration time needed	Cluster funding for: • Communication officer • Advertising/ campaigns	Review of social media and website activity. Consideration of feedback being included in adverts/campaign

	press to allow 24/7 access to information.	messages to the patient population of Taff Ely		and media of choice Willingness and confidence of individuals to be part of campaigns and messaging.			
Contract Reform, Health Board IMTP, RPB Area Plans, Strategic Programme, Primary Care Model for Wales Priorities not referenced above							
Strategic Alignment / Priority Area	**Objectives**	**Planned Action**	**Expected Outcome**	**Possible Constraints/ Key Risks**	**Workforce Implications**	**Financial Implications**	**Monitoring process**
Work with communities and partners to reduce inequality, promote well-being and prevent ill- health;	Support ongoing developments of Dewi Sant Cluster hub linking with Rhondda Taff Ely Integrated Locality Group IMTP – to provide activities, services and clinics at a community site.	Continue to support the development of services at the Health Park, engaging community groups, running clinics.	Working with ILG to ensure equitable, timely provision close to home. Support provision of local community services for the cluster area in aim to improving access of health and well-being support	Covid restrictions and ability to re-start some face to face clinics, and 3rd sector organisation sessions and community groups and activities.			Cluster to continue to work alongside the ILG on developments and review as necessary through meetings with cluster leads and Cluster Development Manager.
Strategic Programme for Primary Care – Workforce and Organisational Development Workstream Expanding and Strengthening Primary and Community Care	Development of a workforce strategy for Primary Care across Health and social care, ensuring the right roles, skill mix and delivery of MDT working across the Cluster. Introduce a model for future workforce	All practices to complete the national workforce reporting toolkit. To define the plan for the cluster. To review Nursing & Healthcare support worker roles and skills, training needs	A plan developed to demonstrate workforce across the whole cluster MDT. Identification of any training, skills development or need for new roles, based on current service	Data being available for all Health & Social care staff. Active involvement of all cluster members	Managers, Workforce & OD Business Manager, Cluster Development Manager. Wider workforce implications to	To be determined	Reviews of plan and feedback to Cluster.

– A Healthier Wales Regional Partnership Board – wellbeing plan	development to ensure the right: ✓ Recruitment and retention ✓ Education and training ✓ Skill mix	To work with Health Board Workforce and OD to develop a more formal strategy. Identifying learning needs of practice staff and MDT and cluster members	provision, population health needs and delivery of sustainable and accessible services.		be determined by plan.		

6. Cluster workforce Implications for 2021/22

The cluster have new roles that will provide an impact in 2021/22. Members of staff will work in GP practices and across the cluster to ensure a multi-skilled workforce is available to provide support and care for their patients. This increases the MDT working within the practices and across the cluster and offers specialist links into other services.

Physiotherapists - This service was commissioned in 2020, although this has been impacted by covid restrictions. The aim is to develop the service provision further, with

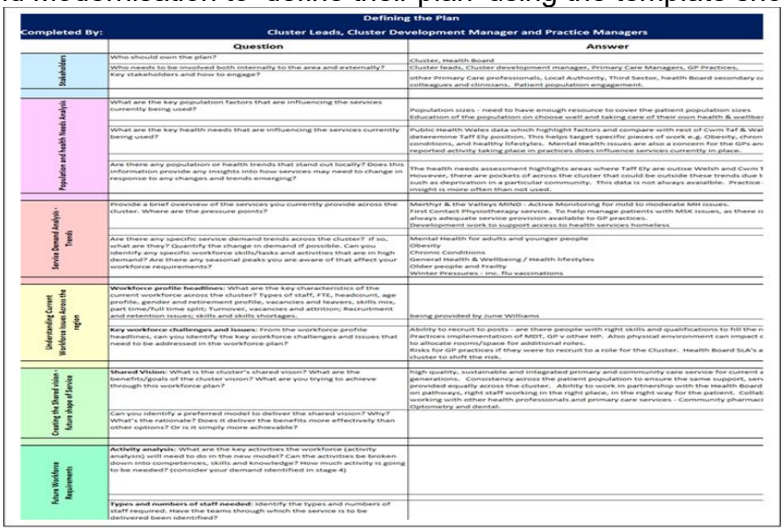
- Raised awareness in GP practices as physiotherapists on site allow for direct conversations around patients conditions and most appropriate advice, support and intervention
- Care navigators booking patients directly into appointment
- Increased use of capacity available in all practices
- Provision of more face to face consultations and direct interventions
- Reduction in referrals and signposting into primary care and secondary care services

Pharmacy Technicians – 4 whole time equivalent technicians are working across the 7 GP practices in Taff Ely. They will work closely with clinical pharmacists to develop their knowledge, skills and understanding of primary care.

Frailty Nurse Service – 2 x frailty nurses will commence their roles in April 2021. These individuals will work closely with the GP practices to identify patients who would benefit from pro-active reviews, visits, health and social care support. They will link with other services such as Community Health & Wellbeing Team, District Nurses, @home etc. to ensure care and support is provided in the best way for patients on their caseload. It is hoped the pro-active approach will prevent repeat contact with GP practices, A&E attendances, hospital admissions, more appropriate use of District Nurse visits etc.

Workforce Development

In a bid to work towards a more formal workforce strategy the cluster will work with their Cluster Development Manager and Health Board Assistant Business Partner for Workforce Transformation and Modernisation to 'define their plan' using the template shown below.



Defining the Plan		
Completed By:	Cluster Leads, Cluster Development Manager and Practice Managers	
	Question	Answer
Stakeholders	Who should own the plan?	Cluster, Health Board
	Who needs to be involved both internally to the area and externally?	Cluster leads, Cluster development manager, Primary Care Managers, GP Practices,
	Key stakeholders and how to engage?	other Primary Care professionals, Local Authority, Third Sector, health Board secondary c colleagues and clinicians. Patient population engagement.
Population and Health Needs Analysis	What are the key population factors that are influencing the services currently being used?	Population sizes - need to have enough resource to cover the patient population sizes Education of the population on choose well and taking care of their own health & wellbei
	What are the key health needs that are influencing the services currently being used?	Public Health Wales data which highlight factors and compare with rest of Cwm Taf & Wal determine Taff Ely position. This helps target specific pieces of work e.g. Obesity, chron conditions, and healthy lifestyles. Mental health issues are also a concern for the GPs an reported activity taking place in practices does influence services currently in place.
	Are there any population or health trends that stand out locally? Does this information provide any insights into how services may need to change in response to any changes and trends emerging?	The health needs assessment highlights areas where Taff Ely are outsie Welsh and Cwm T However, there are pockets of across the cluster that could be outside these trends due t such as deprivation in a particular community. This data is not always available. Practice insight is more often than not used.
Service Demand Analysis - Trends	Provide a brief overview of the services you currently provide across the cluster. Where are the pressure points?	Merthyr & the Valleys MIND - Active Monitoring for mild to moderate MH issues. First Contact Physiotherapy service. To help manage patients with MSK issues, as there is always adequate service provision available to GP practices. Development work to support access to health services homeless
	Are there any specific service demand trends across the cluster? If so, what are they? Quantify the change in demand if possible. Can you identify any specific workforce skills/tasks and activities that are in high demand? Are there any seasonal peaks you are aware of that affect your workforce requirements?	Mental Health for adults and younger people Obesity Chronic Conditions General Health & Wellbeing / Health lifestyles Older people and Frailty Winter Pressures - inc. flu vaccinations
Understanding Current Workforce Issues Across the region	**Workforce profile headlines:** What are the key characteristics of the current workforce across the cluster? Types of staff, FTE, headcount, age profile, gender and retirement profile, vacancies and leavers, skills mix, part time/full time split; Turnover, vacancies and attrition; Recruitment and retention issues; skills and skills shortages.	being provided by June Williams
	Key workforce challenges and issues: From the workforce profile headlines, can you identify the key workforce challenges and issues that need to be addressed in the workforce plan?	Ability to recruit to posts - are there people with right skills and qualifications to fill the r Practices implementation of MDT, GP v other HP. Also physical environment can impact c to allocate rooms/space for additional roles. Risks for GP practices if they were to recruit to a role for the Cluster. Health Board SLA's a cluster to shift the risk.
Creating the Shared vision - Future Model of Service	**Shared Vision:** What is the cluster's shared vision? What are the benefits/goals of the cluster vision? What are you trying to achieve through this workforce plan?	high quality, sustainable and integrated primary and community care service for current a generations. Consistency across the patient population to ensure the same support, ser provided equally across the cluster. Ability to work in partnership with the Health Board on pathways, right staff working in the right place, in the right way for the patient. Collab working with other health professionals and primary care services - Community pharmac Optometry and dental.
	Can you identify a preferred model to deliver the shared vision? Why? What's the rationale? Does it deliver the benefits more effectively than other options? Or is it simply more achievable?	
Future Workforce Requirements	**Activity analysis:** What are the key activities the workforce (activity analysis) will need to do in the new model? Can the activities be broken down into competences, skills and knowledge? How much activity is going to be needed? (consider your demand identified in stage 4)	
	Types and numbers of staff needed: Identify the types and numbers of staff required. Have the teams through which the service is to be delivered been identified?	

This will identify current roles already in place across the GP practices and wider cluster, the current demand and any gaps in provision or skill mix.

The GP practices will also use data from their demand and capacity reports and the workforce development plans and access information in the NHS National Workforce Reporting System.

7. Cluster financial implications for 2021/22
Although some projects have been delayed in 2020/21 the Cluster have continued to progress their ideas which have resulted in a number of new investments and their funding almost fully committed for 2021/22. The increase in cluster allocations from Welsh Government and the indication of this being recurrent funding has allowed cluster to commit to longer term projects and provided more attractive employment opportunities, as they have not needing to make year on year decisions. It also gives the ability to consider other initiatives. The cluster will continue to work closely with the Health Board on spend and will ensure that any funded projects are evaluated, in collaboration with service provider and R&TE ILG to determine any impact across services, potential of longer term funding opportunities and sustainability. Cluster plans will be reviewed accordingly and reports provided to demonstrate any benefits and requests for shift in resource, mainstreaming of projects, to allow clusters to focus on new project developments.
8. Strategic influence / links / alignment with Health Board Annual Plan 2021/22
The cluster will continue to review their IMTP and actions, taking into consideration the Population Health Needs and the strategic direction of the Rhondda & Taff Ely ILG, Health Board and Welsh Government. • Primary Care Model for Wales • Ministerial Delivery milestones 2020/21 • Strategic Programme for Primary Care • Transformational Plans for Primary Care • Primary Care IMTP • Rhondda & Taff Ely IMTP Some cluster plans are determined by the GMS contract and GP services that will continue in line with QAIF delivery and reporting requirements.