Taff Ely Primary Care Cluster IMTP 2020-2023

Taff Ely
Primary Care Cluster

1. Executive Summary

Executive Summary from the Cluster leads

Welcome to our Taff Ely Cluster plan. This is very much a working document that will develop year on year as the Cluster continues to mature and as the collaborative working across all members improves further.

The cluster has achieved a number of projects, albeit some were stalled this year due to the COVID-19 pandemic, through working together to improve the health and wellbeing of its population. This will continue not only through targeting clinical services but also by considering projects to support social and community elements and needs of people living in its boundaries. Some of this work has been recognised with a shortlisted project at the NHS Wales Awards.

The COVID-19 pandemic has affected service delivery and development significantly at 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.

This cluster regularly reviewed the 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.

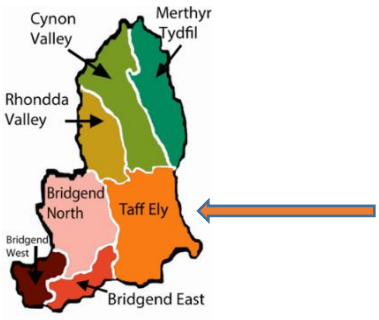
Weekly practice manager meetings and monthly practice clinical lead meetings through the second wave have allowed the dissemination of ideas and a strengthening of the cluster entity.

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

This plan has been developed by Taff Ely Cluster which includes:

- 7 GP practices
- 21 community pharmacies
- 13 Dentists
- 9 Opticians
- County Voluntary Council Interlink
- Local Authority – social care
- Public Health

Geographically Taff Ely is central to Cwm Taf Morgannwg Health Board area and is one of eight Clusters, with Taff Ely Cluster serving a GP practice population of 95,128.



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.

This IMTP has been informed by public health data showing key health needs within the area, information provided by Cwm Taf Morgannwg University Health Board, a cluster understanding of its localities, the services and identification of any potential unmet needs along with the development plans produced by GP practices, namely:

- Ashgrove Surgery
- Eglwysbach Surgery
- New Park Surgery
- Old School Surgery
- Parc Canol Surgery
- Taff Vale Surgery
- Taffs Well Surgery

The plan embraces key UHB priorities for the next three years, specifically focused on:

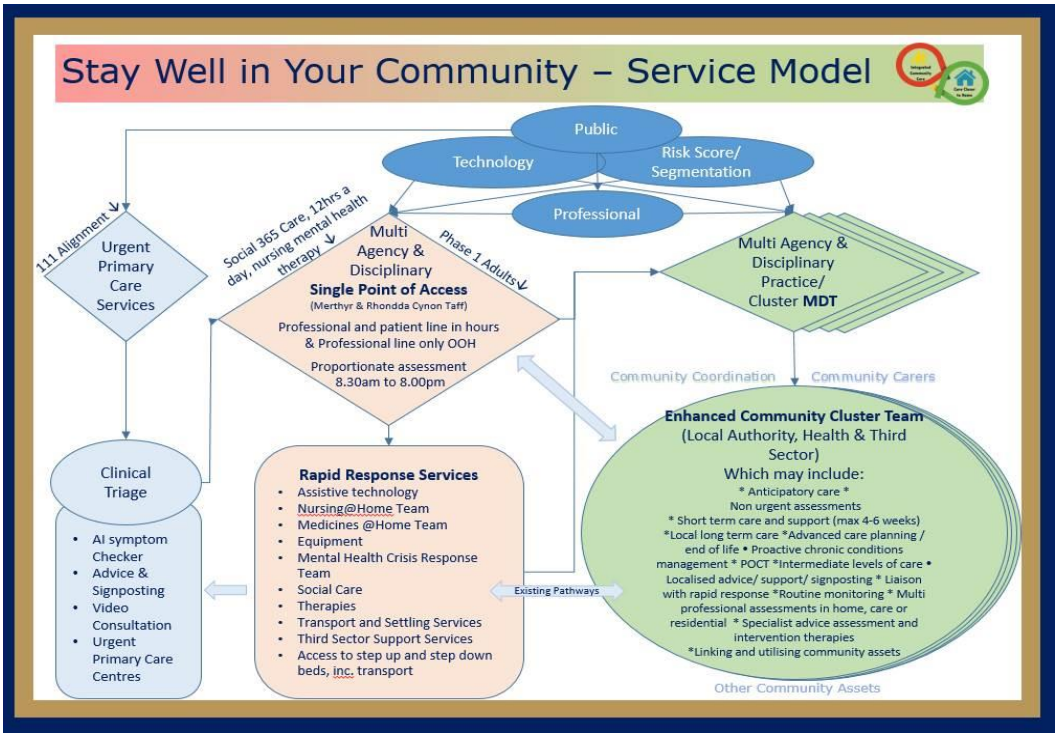
- Strengthening the sustainability of core services, referring to sustainability assessment frameworks completed by each practice
- Strengthening access to services, winter preparedness and emergency planning and improved service development
- Strengthening quality assurance in relation to clinical governance and assurance on specific QAIF indicators
- Developing more effective collaboration working with health & social care community services, including nursing, local authority and third sector to improve quality of care
- Encouraging the development of new models of care, including consideration of federations, practice mergers and shared practice support

Vision for cluster

Taff Ely Cluster share the ambition of Cwm Taf Morgannwg University Health Board (CTMUHB) and Welsh Government to deliver a high quality, sustainable and integrated primary and community care service for current and future generations. The current Welsh Government investment for Taff Ely Cluster of £564,000.00 along with the funding which has been released in 2020 to support transformational plans and development of multi-disciplinary teams across our primary, community and social care providers will allow us to focus our plans on integrated care to meet the individual and community needs.

The transformational model for primary and community care in Cwm Taf, which is a whole system approach to sustainable and accessible local health and wellbeing care, supports the vision set out in 'A Healthier Wales' and is now adopted as the Primary Care Model for Wales.

The Transformation Model is outlined in the diagram shown below. This is the service delivery model for all out of hospital services that will be developing and being implemented across Primary Care and Localities. The Cluster work closely with CTMUHB project leads to develop the Enhanced Community Cluster Team and delivery of anticipatory care based on the need of the population of Taff Ely. This will continue to develop during 2020/21 with the aim to this becoming a sustainable model for the future.



Key deliverables for 2020-2023

For the next three years the Cluster will continue to:

- Further develop the Multi-Disciplinary work to fully establish the 'Primary Care' Cluster working with Optometrist, Dental, Pharmacist colleagues and Local Authority.
- Provide appropriate education and signposting to ensure patients access the most suitable primary care and community services.
- Continue to support development of initiatives in the community to allow the population to improve their health & wellbeing, working collaboratively with community co-ordinators and 3rd sector organisations.
- Work with the Health Board to develop the Enhanced Cluster Team in line with Transformational plans
- Collaborative working with Rhondda and Taff Ely Integrated Locality Group
- Work within GP contract requirements for a multi-disciplinary basis with care homes and social care

2. Introduction to the 2020-2023 Plan

The Cluster are signed up to the values and principles set out in the Primary Care Model for Wales and will work towards actions in their cluster plan to support this. Objectives will be set to take into account the needs of the population and to work with both organisations and individuals to deliver services, projects and initiatives that matter to them in the right place at the right time and as close to their homes as possible.

This supports the model set out in the Welsh Government's plan for health and social care in Wales: 'A Healthier Wales', which focusses on:

- Service developments based on demand; planning and transformation is led through coordinated local care teams
- The promotion of healthy living by making well-being less of a medicalised term
- Service planning and delivery across local communities
- A more preventative, pro-active and coordinated care system which includes general practice and a range of services for communities
- A whole system approach that integrates health, local authority and voluntary sector services, and is facilitated by collaboration and consultation
- Care for people that incorporates physical, mental and emotional well-being, which is linked to healthy lifestyle choices
- Integrated and effective care on a 24/7 basis, with priority for the sickest people during the out-of-hours period.
- Creating stronger communities by empowering people and giving them access to a range of assets, ranging from access to debt and housing advice, to social prescriptions for gardening clubs and the leisure centre.
- Advice and support to help people remain healthy, with easy access to local services for care when it is needed
- Strong and professional leadership across sectors and agencies to drive quality improvement
- Technological solutions to improve access to information, advice and care, and to support self-care.

Governance

The Cluster have an approved Terms of Reference in place which provides governance and an accountability framework. This notes the

- membership
- leadership of the cluster, the
- decision making and financial arrangements
- reporting and monitoring arrangements.

There are five cluster meetings and two multi-disciplinary meetings held every year.
It also ensures that cluster plans and service developments meet a level of scrutiny, and will provide assurance to Cwm Taf Morgannwg University Health Board Executive Team and Board.
The Cluster plans for the next three years will align with the principles of the Primary Care Model for Wales and Welsh Governments plans for 'A Healthier Wales' to focus on:

- Service developments based on demand; planning and transformation
- Co-ordinated local care teams
- The promotion of healthy living by making well-being less of a medicalised term
- Service planning and delivery across local communities

The plan will also be developed, reviewed and monitored alongside the Cwm Taf Morgannwg Primary and Community IMTP and transformation plan.

The Cluster use a risk log to identify, record and manage any risks affecting the cluster plans and working. If there are any significant risks identified, a more detailed risk assessment will be carried out, supported by the Primary Care Development Manager, using the Cwm Taf Morgannwg Datix

Risk Management database. Any high risks will be reported to the Cluster meeting and also the Primary Care Quality, Safety, Risk and Governance meeting.

Outline of cluster population profile

Public Health Wales have provided the Cluster with a profile of their patient population (as shown at Appendix 1) with the following information providing a starting point. This will help the Cluster determine areas that require closer scrutiny and planning for projects based on the areas shown below:

- Demography- Population numbers, breakdown and projections
- Life expectancy and Healthy Life Expectancy
- Deprivation (WIMD – Welsh Index of Multiple Deprivation)
- Data related to households and families- poverty, unemployment, teenage pregnancy, low birth weight, carers etc.
- Chronic condition prevalence
- Mental health
- Clinical and behavioural risk factors
- Cancers and screening uptake
- Vaccination uptake

The estimated figures show that Taff Ely cluster has generally a similar or better prevalence of all chronic conditions than the welsh average with the exception of

- Diabetes and COPD in North Taff (Egwlysbach, Ashgrove and Taff Vale Practices)
- Asthma in South Taff (Parc Canol, Old School, Talbot Green and Taffs Well)

There are also some areas that Taff Ely have higher reported diagnosis, as compared to Cwm Taf, for Asthma in South Taff and Dementia in North Taff Ely. There will also be continued support for those presenting with mental health issues as RCT have higher reported mental health disorders than the welsh average.

Estimated % prevalence of chronic conditions (2018)				
	North Taf Ely (practice)	South Taf Ely (practice)	Cwm Taf	Wales
CHD	3.4	3.3	3.7%	3.7%
Heart Failure	0.9	0.7	0.9%	1.0%
Stroke +TIA	2.0	1.8	2.0%	2.1%
Diabetes	6.2	5.4	6.4%	6.0%
COPD	2.4	1.6	2.8%	2.3%
Asthma	7.0	7.4	7.1%	7.1%
Dementia	0.7	0.5	0.5%	0.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018				
Musculoskeletal disorder	17% in RCT (self-reported)			17%
Source: National Survey for Wales (NSW) 2017-19				

The population profile also reports lifestyle behaviours, using the National Survey for Wales and shows that although Taff Ely have more adults participating in healthy behaviours they have the highest number of adults reporting that they drink above the recommended weekly guidelines for alcohol intake.

Percentage of adults that report the following behaviours- National Survey for Wales (2016-18)					
	Smoke (%)	Eating 5 portions of fruit and veg a day (%)	Meet physical activity guidelines (%)	Drinking above guidelines for weekly alcohol consumption levels (%)	Working age adults of Healthy Weight (%)
North Taf Ely (USOA)	21.1	22.4	52.7	18.7	38.3
South Taf Ely USOA)	15.5	26.3	56.7	20.5	41.4
Cwm Taf Morgannwg	21.1	22.3	51.2	18.3	37.4
Wales	19.2	23.4	52.8	18.9	39.1
Source: Produced by Public Health Observatory (2019)					

Therefore key areas needing further analysis and planning are:

- Asthma
- Diabetes
- COPD
- Dementia
- Mental health & wellbeing
- Weight and obesity
- Alcohol

Achievements in 2020-21 demonstrate where some areas are starting to be addressed and the action plan and milestones will show continued approach to support health improvements for the patient population, including Healthy Lifestyles projects with Hapi, My Change My Life initiatives and 'Making Every Contact Count'. Investment in roles such as the pharmacy technician, frailty nurse will allow additional resource for pro-active management of chronic conditions and collaborative working and continued service development around diabetes, respiratory with the Integrated Locality Group and specialist services.

The Cluster could also consider GMS contract negotiations to review service provision in line with any priorities being highlighted to address health needs of its population.

Public Health Wales will also continue to support with inclusion of data for other primary care contractors to give a Cluster wide picture for the population rather than just concentrate on GP patient data. The Cluster have also made a decision to work with children and younger people to educate and support them to avoid risky lifestyle behaviours and adoption of healthy lifestyles for the future and therefore they would also want access to data on childhood health to support planning and initiatives to ensure they are targeting appropriately.

To improve population health status and therefore more positive public health data, the Cluster will continue to work closely with Public Health Wales (PHW) colleagues to ensure that data is captured for the population of Taff Ely. This will be done using the population needs assessment tool and also through involvement with the segmentation and risk stratification work which has been piloted in Rhondda. All practices in Taff Ely have signed the data sharing agreements with PHW.

3. Summary from the 2017-2020 three year cluster plan and Key Achievement 2020-2021

Cluster Pharmacists

The Cluster funded practice based pharmacists for 4 years. Included in the work is poly pharmacy / patient medication reviews, INR, asthma and hay fever reviews and chronic disease management. Polypharmacy is very topical with regard to ageing populations and increasing numbers of medications and the potential harm that can result from this. Five out of the seven practices now directly employ their own pharmacists, following a decision to no longer fund from the cluster allocation. which demonstrates the value felt in utilising this non-GP workforce and commitment to developing multi-disciplinary working.

Community Group development

The cluster wanted to support set up of groups and activities across Taff Ely that could be owned by the communities themselves and supported to become sustainable groups once Cluster funding ended. During 2018/19 information was gathered through questionnaires, engagement with participants to determine if the groups were achieving what was intended, and what the group wanted.

The Cluster will continue to support the groups with promotion of the activities to the population of Taff Ely. The Community Wellbeing Co-ordinator will act as a link worker for the groups to ensure that people are signposted to their activities.

Valley & Vale Arts based therapy sessions 'Breathing Space' is held once a week at a local community church. Sessions include topics such as art, relaxation, photography. The Cluster are currently working with Valley & Vale to support a funding bid to continue and develop further sustainable sessions in the community. This group continues to meet weekly with regular and new participants. Early feedback and reports indicated that *'all of the participants benefited from having somewhere to go, and something to do. Each group shared built up trust and discussed their feelings openly, being creative meant they did not dwell on the negative too long. They all appreciated this approach, and have felt an impact in their lives'.*

Mens Sheds/sustainable community development

The cluster have supported development of sustainable community groups. This has included walking rugby and football, garden initiatives, bowling club and canal group.

This was supported for a second year and was shortlisted for the NHS Wales Awards 2019.

There were 5 groups set up with a number of activities across all groups, which has ensured that the aim to set up 4 groups and 4 activities was achieved.

It was hoped to engage around 100 'shedders' – there were in the first year 70 participants. Sustainability of groups has been a mixed picture, some were able to take ownership and have the ability to support activities themselves. Some needed a little more support, adapting with just one group activity not continuing.

Follow up years have seen further development of a shed at Dewi Sant Health Park, which is bringing this group into a Health Board premises, working collaboratively to allow the group to meet, hold indoor activities with the plan to have gardening activities on site and at another Pontypridd site in 2021.

3C's (Companionship, Conversation and Creativity)

The Cluster have supported, through Drink Wise Age Well, community based sessions with an aim to boost the confidence of older people, encourage new friendships, and allow individuals to find out about hobbies to help to improve their well-being and creativity. The first cohort were asked for feedback and a report provided back to the cluster by the provider. Some of the feedback from participants is shown below:

- *A great fun session. Interesting learning the willow weaving and most enjoyable. Good instruction and company – Willow Weaving*
- *Wonderful scheme – desperately needed in the village. Very good and can be done at home – Nordic Walking*
- *The tutor had a good knowledge and helped us understand it. She was very interesting and lovely company too – General Nutrition*
- *Enjoyed everything. Good way of learning, really enjoyed coming and meeting people – only time I get out – Alcohol Awareness*
- *Good interaction between the group and general discussions. – Alcohol Awareness*
- *Helpful, interesting, really enjoyed, friendly atmosphere – Felting Craft*

Very good meeting. Very good information given, also with contacts. More please – Medical Screening

- *Enjoyed the session. Facilitators very good at their presentation. Such a shame the sessions are finishing as it has been excellent for the community – Exercise through Dance*

One of the original groups has continued to meet and participants are now running their sessions themselves.

Healthy Lifestyles - Hapi project (Newydd Housing Association) have an established relationship with the Taff Ely Cluster. They are, in partnership with Garth Olwg Lifelong Learning Centre, continuing to deliver sessions on nutrition, cooking skills, exercise, meditation and general health and wellbeing. A GP at Parc Canol GP was instrumental to this and engaged her patients through facebook and a closed group was set up to provide regular updates and health and wellbeing advice to participants.

A focus group were asked for their feedback and some of this information is included below:

What difference, if any has attending the programme made ?

- *More careful with what using to cook at home e.g. altering cooking methods and swapping for healthier ingredients*
- *Made aware of health impact of sugary food and now avoiding biscuits and cakes*
- *Generally making healthier food choices*
- *Weight loss*
- *Reduction of blood pressure medication*

What do you feel about making changes to lifestyle ?

- *Already making them*
- *Made more aware & happy to make choices*

Experience any challenges with making changes ?

- *Limitations with exercise*
- *It's good be able to keep attending as a reminder and keep motivated*

This initiative is now being run by the Hapi project and Garth Olwg Lifelong Learning Centre.

Care Navigation

The Cluster have invested in training for frontline staff to allow additional skills to actively signpost patients on choices and services available to them. The initiative has now moved into phase 2 where further providers are included to extend the choices being offered to patients.

Each practice have named 'Champions' who meet throughout the year to form a network and continued support for each other, share good practice –'hints and tips. There is also a care navigation newsletter which is produced when communication is needed to share across all the practices.

The Cluster have concentrated its efforts on some key areas to ensure patients get the right messages to allow them to 'choose well' and 'take care of their own health & wellbeing', these are:

- Promotional banners, posters
- Attendance at public events e.g. Big Bite event, Public Forum, 50+forum, Carers Conference.

Taff Ely Cluster website - provides a dynamic and up-to-date resource for the population of Taff Ely and information on services, support, classes and initiatives available in the area.

The Cluster have since developed facebook and twitter accounts, which are continually developing, linking with Health Board and GP practice sites.

Homeless Events

The Cluster have supported two morning events in a bid to reach out to those that are homeless in the area. The aim is to provide a 'one stop shop' in a Pontypridd town centre community church for advice from agencies such as Citizens Advice Bureau, Safe, Barod, the Job Centre, Mind, and Hapi Project during winter months. They also provided access to food, clean clothing, toiletries etc. The local police community officers also supported to engage those who had slept in the area to go along to the event.

Feedback from the events led to the cluster working in partnership with Health Board Primary Care to jointly fund a Specialist Nurse, as it was being identified that there were health needs that weren't always being addressed as individuals were not clear on access to health services. See key achievements for 2020/21 for further detail on the work undertaken.

A Service Level Agreement is in place with Merthyr & the Valleys Mind to continue with an Active Monitoring service across the seven GP practices in Taff Ely. This service allows support for those suffering with mild to moderate mental health issues e.g. dealing with bereavement.

e-consult – the cluster now have e-consult, a web based patient triage system for General Practice, available across all its Vision practices. This offers multiple benefits including triage, signposting and reducing the need for attendance to the surgery via its 24/7 portal and has supported practices and patients to have contact in a different way during the covid pandemic.

Community Wellbeing Co-ordinator - Taff Ely employed, via Interlink, a wellbeing co-ordinator to provide health & wellbeing information, advice and support in the community. Some of this will be targeted in line with national and local campaigns. This role has also become the screening champion for the Cluster working in areas to improve uptake of bowel, cervical, AAA and breast screening. This role has now become a substantive post in the Community Health & Wellbeing team alongside a second co-ordinator to support the cluster and its population.

Multi-Disciplinary Meetings and collaborative working

The Cluster continue to engage with the other Primary Care Contractors and partners to widen its membership. This includes community dental, optometrist and pharmacist colleagues, Social Care,

Public Health Wales and also community co-ordinators to ensure 3rd sector involvement. Multi-Disciplinary Meetings are held, outside of the main Cluster meeting, to allow a fuller discussion and support joint working and future initiatives.

Common Ailments Scheme – The scheme is available across Taff Ely. All Practices within the Clusters actively promote and sign post patients where appropriate, with the overall aim of ensuring patients access the most appropriate care provider in line with prudent healthcare.

Choose Well Campaign – work continues across the cluster to ensure that this is promoted in the best way to ensure patients are choosing the right primary care and community support services. This has included attending events such as the Local Authority run 'Big Bite event' and having a presence in the Health & Wellbeing Zone for the past three years.

Make Every Contact Count Training held by Public Health Wales was attended by all practices within the Cluster – this approach aims to empower staff working particularly in health services to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.

Further work is being undertaken with one of the GP practices as there is a plan to roll out the Making Every Contact Count (MECC) in line with recommendations of The Director of Public Health's Annual Report 'Stroke, A public health approach'. This involves scoping what this may mean in practice and how it could be achieved. As part of this work, we need to better understand the opportunities for health behaviour change conversations along the patient pathway.

MECC work around the COM- B model as it is recognised that for behaviour change conversations to take place, health care workers need to feel capable (through knowledge, skills and training) but also have the motivation and opportunity (potentially facilitated through processes and systems). PHW will continue to engage with the practice to follow up on this to ensure it can be implemented and that the systems work for them.

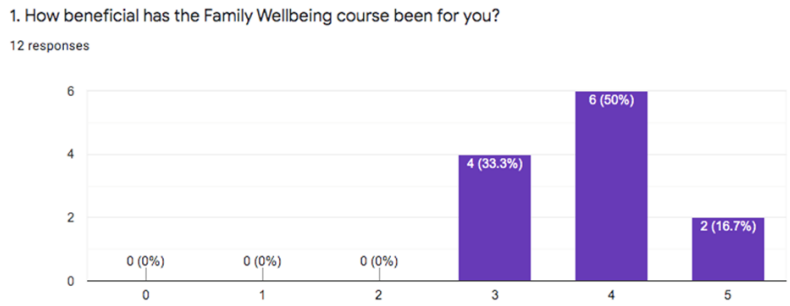
Key Achievements 2020-2021

Valleys Steps – Families 2gether 4 Wellbeing

The Cluster have worked with Valleys Steps following discussions around the younger population and how they are supported to improve their health & wellbeing, change future behaviours. The idea of giving young people a support mechanism and techniques to copy with day to day pressures was highlighted as a need. Through discussions with Valleys steps, who wanted to explore ways of working with young people, it was agreed to develop sessions that allowed a young person to attend with parent/guardian support. It was also agreed to support sessions for schools to raise awareness of the scheme and identifying those that may benefit from attendance.

The overall aim of the course is to raise awareness of ways to develop good mental health and provide solution focussed techniques/practices to reduce stress, anxiety and improve wellbeing using mindfulness, CBT and relaxation techniques

To date two face to face and two on line sessions have been held and those attending have reported benefits and improved mental wellbeing, techniques and support for improving mental wellbeing for the young people engaged. Indication from participants show this is a well received and valuable course, below is just one question, the scoring and the reason for their scores to help demonstrate this.



Narrative included to show reasons for score

- For me personally it has 'topped up' the mindfulness and stress control courses I have done in the past
- made me aware of anxiety and stress but didn't really focus on how to deal with depression
- I found the course very beneficial and I've taken a lot of useful tips. A possible option for future courses would be maybe to advise and provide parents with help on how to support a troubled teenager.
- I have meditation strategies for stress
- Found it easier controlling stress
- The course was interesting and I think I would use some of the techniques in the future if I needed to.

Valleys Steps, are also working directly with one secondary care school and will evaluate this model and feedback to the Cluster to decide on any potential roll out to other schools. The cluster are also reviewing delivery of weekly sessions to allow 'older' young people to attend on their own, as it has been recognised that they may not always want to attend with a parent/guardian.

Communications Officer and Cluster Communications Plan

The cluster discussed and agreed to fund one day communications officer time to support for practices and the cluster to develop their website, facebook and twitter accounts. The role would allow a dedicated resource to pro-actively promote activities, 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 inform our patients of key changes to services, as and when needed
- To engage with our patients and partner organisations when appropriate
- 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, social media pages

Pharmacy Technicians

Following on from the original Cluster project,and most practices employing clinical pharmacist, it was felt that an additional resource will be beneficial to support the development of the MDT team and skill mix within practice.

The role therefore adds additional capacity to the GP practices to help manage demand and improve access, allowing patients to be seen by most appropriate professional. It will also support the quality improvement project with the focus being on patient safety "Reducing medicines related harm through a multi-faceted intervention in primary care clusters".

The project aims to:

- Reduce medicine waste and avoidance, supporting reduced costs for the practice and Health Board.
- Support reduced demand for GP appointments and releasing GP practice time for more complex conditions
- Reduce some areas of work and demand for the clinical pharmacist to allow them to deal with higher complex cases and provide expert advice and support to other health professionals.
- 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 and Secondary care
- Support better communication with community pharmacies, dental practices and Optometrists.

First Contact Physiotherapy

The cluster approved funding, early in the year, to progress a first contact physiotherapy service. A service level agreement has been signed with the Health Board to deliver sessions in GP practices. 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 will allow patients to have access to the physiotherapist and effectively manage their condition without the need to see a GP. By presenting and having earlier intervention it will provide better outcomes for patients, reduce the need for repeat visits and also reduced referrals to secondary care, prescribing and unnecessary intervention.

Quarterly performance reports will be provided back to the Cluster to allow monitoring against targets.

Specialist Nurse – Homeless and Vulnerable Adults

The Cluster, in partnership with Cwm Taf Morgannwg Health Board Primary Care Team, agreed to employment of a specialist nurse role to support those that are homeless, at risk of becoming homeless and are in a vulnerable situation, as it was recognised that there was a growing need within Pontypridd and surrounding area. However it was noted that this was an issue that existed right across the health board area and the one year pilot would allow the Health Board to determine need for a sustained role and service with potential roll out across Cwm Taf Morgannwg.

This exciting initiative began in June 2020, adding this role to the Primary Care Team to work on development and access to services for those that are homeless. This role works closely with the Local Authority, Health Board services, GP practices and the new Enhanced Cluster Team. The nurse acts as a first point of contact for advice on matters related to health and homelessness for patients, other staff and external agencies. Providing high quality care and advice to patients with health problems as well as signposting individuals into appropriate service support.

The Nurse for Homeless & Vulnerable Adults aims to assist homeless and vulnerable people to access mainstream health services as appropriate. Working in a variety of venues including outreach, hostels, supported housing and day centres.

Dermoscopy training/equipment

This investment has allowed purchase of Dermoscopes and also training for two identified GPs in each practice. This will allow improved identifications and diagnosis of both benign and cancerous lesions. The Cluster will work with health board Macmillan GP leads to progress any joint working with secondary care.

To date the following has been achieved:

- Training completed by most of the 14 GPs across the Cluster
- New skills and equipment are being used on a daily basis
- helping with diagnoses of skin lesions and triage of patients to minor surgery clinic or to secondary care clinics if appropriate
- sharing photographs with a specialist hopefully meaning less removal of benign lesions unnecessarily.
- Saved appointments as patient not being asked to come back if trained GP is available to support other GPs whilst they are with the patient.
- Reports of GP feeling more confident in the referrals to dermatology and the priority

This will be reviewed again in 6 months, as there has been an impact to this project as some GPs needed to refer completion of the course, less patients coming into practice etc.

Development of a cluster covid contingency plan
The GP practices has worked together to develop contingency plans, put actions in place to allow them to revert to a network/cluster model if needed.

This is continually developing and is now seen as a plan that can be implemented at any time there are sustainability issues, impacts on service provision etc. to support the population of Taff Ely. Some of the actions undertaken include:

- IT system – development and access to other practice systems, shared appointments, Vision Anywhere.
- Weekly Practice Manager and monthly Clinical Management meetings
- Identification of central hub and service delivery sites for covid/non covid patients
- Liaising with Health Board to plan blood deliveries, communications

Dental and Optometry have also been liaising with the Health Board around service provision and working on a cluster basis.

4. **Cluster population area health and wellbeing needs assessment and evidence of what the population says it wants/needs**

In addition to the work being undertaken with Public Health Wales to analyse the population health profile for the Cluster, there are also other workstreams, although not funded directly by the cluster, will assess and have an impact on the health status of the patients.

Inverse Care Law (ICL) – Cwm Taf Health Checks
Cwm Taf Morgannwg University Health Board Cardiovascular Health Check Programme was rolled out in Taff Ely area and gave an opportunity for the team to target specific communities and individuals that were identified as high risk of Cardio-vascular disease (CVD) due to lifestyle factors.

All practices signed up, through a service level agreement, to the process. This has facilitated:

- Health Check+ software to be uploaded to allow their practice population data to be extracted
- the team to identify those in quintiles 4 & 5 (in most deprived communities and highest CVD mortality).
- The teams to be based in practices and deliver health checks, provide advice and support to those requiring it to make lifestyle changes.

From 1st April to 28th August - 1,311 were offered health checks and of these 473 took up the offer and completed a health check. The assessments established if people were smokers, overweight, had raised cholesterol or blood pressure and provided the Cluster with the following data:

Smoker – 83
Overweight (BMI 25-30) - 184
Obese (BMI OVER 30) - 156
High BP ≥140/90 - 164
Raised Cholesterol >=5mmols/L - 276
High Cholesterol >=7.5mmols/L - 7

High Cholesterol ratio≥6 - 51
Irregular pulse* - 12
Raised HbA1c - 68

On completion of the Health Check the practice is provided with a comprehensive electronic record of patients' modifiable cardiac risk factors e.g. BP and lipids, which will be read coded and reported in the Practice system. The practice then commit to follow up patients identified with raised 10yr CVD risk or individual risks i.e. high blood pressure

The team also provide information and advice to support individuals to make lifestyle changes and explain the impact this can have on their health.

Of those completed, the following actions were undertaken by the CVD team:
Referral to Stop Smoking Services - 83
Advised re activity levels - 311
Advised re weight management - 340
Referred to NERS - 4
Referred to alcohol services - 1
Diagnosis of hypertension within 3 months - 18
Diagnosis of diabetes within 3 months - 5
Diagnosis of atrial fibrillation within 3 months – 2

Community Development – based on areas identify through partner organisations and a scoping exercise the Cluster have linked with communities across Taff Ely and supported their requests for community group and activity development , namely:

- Pontypridd walking rugby
- Pontyclun rugby & football, gardening group & film club
- Tynant & Beddau community bowling
- Grow for it
- Pontypridd canal group
- 3C's in the community with Drink Wise Age Well
- Breathing space – arts based therapy sessions

Those that engaged in the projects were asked for feedback to allow the groups to determine if these were being organised and providing benefits as intended. The groups were supported to adapt if needed to ensure that they would continue based on what participants were saying they wanted.

Those involved in some of the activities reported that:

- Being more active
- Being fitter with weight loss
- Having healthier lifestyles and feeling better
- Having fun as well as exercise
- Improved fitness but thinks the best thing has been meeting people and the company
- Feeling better and making friends
- Keeping fit and feeling fitter
- Welcoming, good atmosphere and well run
- Physical and mental health benefits

Partnership working - Some of these projects would not have been as successful without the partnership working with Shednet, Pontypridd Rugby Club, Sports for Wales, WRU, Café 50, Hapi Project, Drink Wise Age Well, Valley & Vale Ltd, Garth Olwg learning centre.

In addition to the key areas being identified in the population health profile the Cluster will continue to encourage better and healthier behaviours. This will support development of sustainable projects linking directly with its communities to tackle loneliness and isolation and improve general wellbeing which has featured highly in cluster plans to date.

This will compliment work being undertaken to promote messages on available primary and community services and allow a better understanding of which services they can access. If people are 'choosing well' alongside improving their own health and wellbeing – there should be a noticeable reduced demand for inappropriate use of GP appointments.

Practices will continue to work with the patient participation groups to gain feedback on individual practice services, clinical performance and pathways to ensure engagement with their practice populations.

The Cluster will continue to engage with the population at specific events such as Big Bite, Carers Conference, RCT 50+ forum meeting and events and will continue to link with the Community Health Council to ensure community engagement.

5. Cluster Workforce profile

The Cluster will work closely with CTMUHB to support recruitment, training and placement of roles to implement an enhanced cluster team to deliver a primary care multidisciplinary workforce linked strongly to the Cluster network plans. The multidisciplinary team includes:

- A GP/ Clinical Lead
- Community Occupational Therapists
- Physiotherapists
- Mental Health CPN
- Clinical Pharmacists
- District Nurses
- Advance Care Planning Nurses

This will provide an approach to wrap assessment and services around people working collaboratively across community and primary care addressing issues of frailty, chronic ill health and mental health and wellbeing.

The Health Board will also employ a project lead and support, data performance analyst, IT Manager and administrator to support the Clusters with their transformational plans and Welsh Government reporting.

General Practitioners (GP's)

There are 7 GP practices in Taff Ely area, in which the following are employed:

- GP's
- Practice Nurses
- Healthcare Assistants
- Pharmacists
- Administrative staff

Urgent Primary Care 'Out of Hours' (OOH's) is commissioned and managed by the UHB and this now links with 111 service across the whole of Cwm Taf Morgannwg, which includes Taff Ely and supports the Strategic Programme 24/7 model.

General Dental Services (Dentists)

Across Taff Ely there are 13 dental practices. There is a community dental service delivered in Pontypridd. 'Out of hours' Emergency Dental Service (EDS) is commissioned locally by the UHB. Patients access urgent dental care services through the OOH service.

The Porth Dental Unit was the first of its kind in Wales and provides recently qualified dentists a fully equipped dental surgery while completing a two-year Dental Foundation Training Scheme

General Ophthalmic Service (Optometrists)

Taff Ely have 9 practices and 8 are accredited and provide the Wales Eye Health Scheme (EHEW) and 5 practices provide low vision services.

There are no primary care OOH optometry services in place across Cwm Taf Morgannwg but some practices operate over the weekend period, however for the first time in Wales, OOH eye care was provided on the Christmas Bank holiday.

The IPOS (independent prescribing scheme) has been introduced as a pilot across the Health Board area, with one IP practice in Taff Ely, a step in enhancing eye health care provision in Primary Care.

Community Pharmacy Service (Pharmacists)
The Community pharmacy service is managed by the Medicines Management Directorate and will therefore be described their IMTP document. There are 21 community pharmacies in Taff Ely and all deliver the Common Ailment Scheme.

Further work will be undertaken to establish a more detailed workforce profile and training needs across the cluster for all contractor professions and health/social care community services where this exists and key third sector providers

Interlink
Interlink is the County Voluntary Council (CVC) for Rhondda Cynon Taf, supporting individuals, communities and organisations to work together to make a positive impact on the life of people who live and work in Rhondda Cynon Taf and also in Merthyr Tydfil with Voluntary Action Merthyr Tydfil (VAMT).

They act as an umbrella body to support over 550 members, some small groups and others larger

charities, through helping plan and develop projects, activities and events as well as helping members plan and manage what they do.

Community Co-ordinators are employed by Interlink and work closely with the Clusters and GP practice, to offer social and community support for those age 18+ on behalf of the Cluster.

District Nursing
There are 6 District Nursing Teams, with 60+ staff, who work across the Taff Ely Cluster area, working alongside GP practices to provide care, follow up, reviews, vaccinations etc. to the GP housebound patients.

The Cluster also fund the following roles, as they recognise the need to integrate MDT staff working into their practices and across the cluster in venues that best support access and sustainability of services, with the following in place:

- 4 WTE Pharmacy Technicians working across the practices
- 15 sessions clinic time per week in practice of First Contact Physiotherapist
- 1 WTE Specialist Nurse – Homeless & Vulnerable Adults working outreach with hostels and in community
- 100 hours per week Active Monitoring Practitioner time – commissioned service from Cwm Taf Morgannwg Mind to support patients in practice.

The cluster will work with the Health Board Workforce and OD team to develop a formal workforce planning strategy and have started this work by 'defining their plan'. This plan can be used alongside the GP practice demand and capacity tool to help determine which roles are needed in the practice and across the cluster to meet their service delivery requirements. With the assistance of the Cluster Development Manager and Assistant Business Partner (Workforce Transformation and Modernisation) this can be developed further to include other Primary Care contractors, community health and social care staff and 3rd sector organisations to list current staffing, identify any gaps and whether new roles or enhanced skills are needing to deliver the right health and wellbeing support to their patient population. This sets a direction for:

- local MDT workforce planning

- strengthening Primary and Community Care to deliver care closer to home and support plans for 'A Healthier Wales'.
- Develop a model of working across Health & Social Care – nationally structured & co-ordinated
- Enhancing skill mix through the right training and development
- More sustainable recruitment and retention, through attracting the right people into the right roles

The Community Health & Wellbeing team, funded through transformation monies, are also key to the MDT working approach and have the following currently employed

- A GP/ Clinical Lead
- Community Occupational Therapists
- Physiotherapists
- Mental Health Practitioners
- Clinical Pharmacists (Advanced Pharmacists– Pain & Mental Health).
- District Nurses
- Advance Care Planning Nurses.

Training needs are also considered to enhance existing staff skills, such as

- Care Navigation training for receptionists and administrators
- Motivational training for Healthcare support workers
- Independent Prescribing for Frailty Nurses, Optometrists, Community Pharmacists

6. Cluster Financial Profile

The Cluster allocation was increased from April 2020 to £564,000 from £ 281,929.31.

Cluster Development Managers work in partnership with Health Board finance colleagues to ensure that any spend is aligned to this plan but also within the UHB's overall financial planning and Standing Financial Instructions (SFI's). The Cluster will continue to be supported by the finance department as the plan is progressed as their support is fundamental to ensure that the Cluster continue to work within allocated resources.

Delivery agreements are developed and are aligned to the Primary Care funding allocation and are reported to Welsh Government on an annual basis.

The following funding is not allocated directly to Clusters but do have impact and benefit for the population. Transformational allocation to Cwm Taf for the Enhanced Cluster team (Community Health & Wellbeing Team) is

- Year 1 £2.92m
- Year 2 £4.920m recurrent funding

We are awaiting confirmation of the Transformation funding allocation for the Community Health & Wellbeing team for 21/22.

Delivery agreement funding is also allocated to provide community clinics to establish care closer to home rather than in District General Hospitals. A COPD discharge clinic has recently started in the Cluster hub at Dewi Sant as part of roll out of the clinic following a pilot in Rhondda.

Pacesetter funding - nurse training hub and spoke
The initiative mirrors the very successful nurse training scheme that has been operating in England for a number of years; it is based on a model used in Yorkshire which has been running since 2009 and has recruited significant numbers of student nurses into primary care.

The hub is based at Pont Newydd Medical Centre and of the seven hubs successfully recruited to the scheme there are five in Taff Ely Cluster area, namely;
Eglwysbach Surgery, Old School Surgery, Ashgrove Surgery, Taffs Well Medical Centre and Taff Vale Surgery. Each practice has completed the mandatory Batchelor of Nursing Education Audit -

Practice Learning Environment. Spoke practices provide placements for three undergraduate nurses per year. As of January 2018, 23 pre-registration nurses have been placed in Cwm Taf Morgannwg within the hub or spoke practices, and there have been two students who have completed their consolidation in General Practice, with a third due to return to the practice in which they spent their 6 week placement for their consolidation in November this year. All three nurses have cited their positive experience within the GP practice during their 6 week placement as the reason for returning to complete their consolidation.

7. Gaps to address and cluster priorities for 2020-2023 – key work streams and enablers

Quality Assurance and Improvement Framework (QAIF) for the GMS Contract Wales
The GP practices in the cluster have now had sight of the QAIF which comes into force October 2019 and will work during the 12 month cycle to agree and implement quality improvement projects with the focus being on patient safety.

This will include the mandatory project – "Reducing medicines related harm through a multi-faceted intervention in primary care clusters (patient safety)" and a second QI project as agreed by the Cluster for implementation which will be "Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20"

The Cluster have agreed that each practice should provide reports to the April and September meetings. Reports will include information to demonstrate where changes have been made, any areas where practices have shown good practice etc. Antibiotic leads will also be identified in each practice. They will also discuss and report against the Demand and Capacity Audit by end of March 2021.

There will be a review of the clinical inactive indicators to ensure data is available for collection from GP clinical systems for the purposes of assurance of standards and this is to be reported back to the Cluster at its June meeting each year.

Roll out of 111 – Cluster will support roll out in line with the project plans and will welcome updates form project leads as information becomes available.

Patient Engagement, education and participation in health & wellbeing agenda
The Cluster will continue to link with the Community Health Council, link with 3rd sector organisations and Community Co-ordinators, existing groups such as 50+ forum to ensure that they are engaging in the right way. Any communications will also need to take into account the ability for a 2 way conversation so that it is not just about the Cluster informing the patients, but gives the opportunity for patients to also feed in their thoughts and responses.

There will be a number of ways they do this, for example

- Cluster leaflet to tell people about what's on offer - to compliment Taff Ely Cluster website information but be more available and on hand in practices, community pharmacies etc. to distribute to patients.
- Surveys, questionnaires
- Patient participation groups
- Community Health Council meetings with the Cluster and attendance at community and cluster events
- Referrals to Community Wellbeing Co-ordinators

Communication and engagement
The Cluster, through the support of the Primary Care Development Manager will work with PHW colleagues to extract further Cluster level qualitative data using the Primary Care Needs Assessment Tool. This will allow publicity, engagement, health & wellbeing campaigns to be targeted accordingly.

Attendance at public events such as 50+ forum, big bite event, carer's conference will allow the Cluster to promote their initiatives and engage with the population.

The cluster will continue to promote their initiatives and provide 'good news' stories by working closely with the Health Board communications team. This will also include promotion of #your local team.

Improved working, in partnership with Interlink, with 3rd sector organisations to deliver more robust and sustainable community development e.g. funding and collaborative working for initiatives with established organisations to allow the organisations to deliver on behalf of the Cluster.

The cluster have invested in one day a week communications officer support.

Welsh Language

The Cluster Primary Care services will work towards achievement of the 6 Welsh Language standards as set out by Welsh Government to achieve the following 'good practice'.

- Referrals to Secondary care – indicating where a welsh speaking patient/family would prefer a consultation through the medium of welsh
- Practice leaflet –include information about communication needs and ability to ask for a copy in Welsh.
- Identifying welsh speaking staff Bilingual element on the Cluster Website
- Consider an initial bilingual greeting as part of telephone message
- To work with the UHB to provide training for staff
- Bilingual signage and information available

Sensory Loss

The Cluster, with the support of the UHB sensory loss manager have introduced sensory loss equipment across the Cluster. This involved roll out of sonido hearing loop systems across primary care premises plus supporting posters, information and training to ensure patients can access the system when they attend for appointment should they wish.

8. Planned Cluster Actions and intended measurable outputs and outcomes 2020-2023

The Cluster have developed a monitoring report which is attached at Appendix 2 to provide a working document to allow regular updates and reports against the planned cluster actions plus will highlight any key risks associated with initiatives.

The monitoring report is structured to align to the HB IMTP, the Primary Care Model for Wales and Strategic Programme for Primary Care and will consider the following areas:

- Prevention, well-being and self-care
- Timely, equitable access, and service sustainability
- Rebalancing care closer to home
- Digital, data, and technology developments
- Workforce development including skill mix, capacity,
- capability, training needs, and leadership
- Estates developments
- Communications, engagement and coproduction
- Improving quality, value, and patient safety

Cluster actions and projects being considered for 2020 -2023

- To develop an enhanced cluster team to support the transformational plans for Primary and community care and delivery of anticipatory care for their patient population and those most at risk to ensure their conditions are being managed and they are able to stay well at home.

- **Community Development and working more collaboratively with 3rd sector organisations**

The Cluster have previously supported community development through financial and project support. They will not continue to do this in the same way, and will review any opportunities as they are presented to them.

- **Prescribing Quality Improvement Programme (PQIP)**
  - Antimicrobial stewardship
  - CRP Point of Care testing

- **Healthy lifestyles scheme** – particularly focussing on healthy eating, cooking skills, food choices, physical exercise, this project will focus on healthy families and chronic condition intervention e.g. pre-diabietes.

  The plan is for a nurse led service, with trained individuals, who will provide support to groups and individuals to implement lifestyles changes.

  The project is being fully supported by GPs and Public Health Wales and will be planned to ensure that there are support mechanisms in place to help individuals bring about small behavioural change. This will include
- Motivational training for 2 healthcare professionals within each practice
- Identified staff to become practice champions
- Investment in time for practice staff to work on this proposal
- Healthy lifestyle roadshows – suggested name 'My change, my health, my life'
- Link with EPP programme
- Use reports from Cardio-vascular team to help identify individuals and make contact
- Make Every Contact Count (MECC) principles and work towards encouraging small changes and improve patient choices, focussing on:
  - Exercise
  - Diet
  - Smoking
  - Alcohol
  - Obesity

Frailty Nursing Service
The Cluster have approved funding for nursing roles to support their frail, elderly population in their homes. The recruitment process has begun, with an aim to have nurses in post for start of April 2021. Project evaluation will be key to ensure any impact is being measured in the following key areas:

- Improved quality of care provided.
- 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.
- Identified and known link for housebound and care home patients into services.
- Improved knowledge and understanding across the Primary Care workforce and care homes staff, as knowledge and information, skills will be shared.

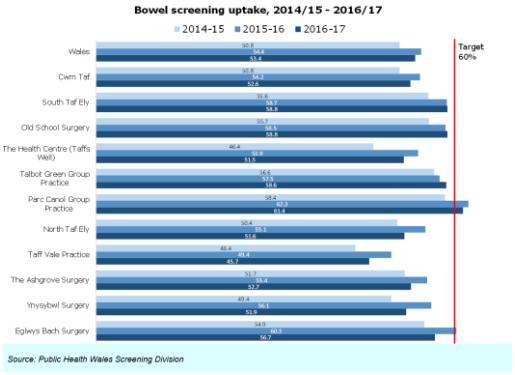
To continue to develop the following initiatives, monitor and evaluate to ensure that these are bringing the intended benefits. Any outcomes will be reported back to the Cluster, through the IMTP into the Health Board and Welsh Government.

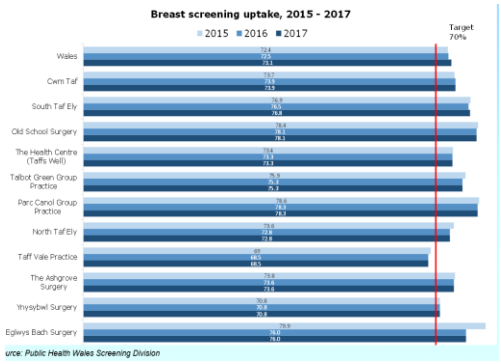
- Dermoscopy training/equipment
- Physiotherapy
- Pharmacy technician roles
- Mental Health Service Provision
  - For Adults – continuing with Cwm Taf Morgannwg Mind 2021/22 Active Monitoring Service with an aim to exploring opportunities to review the service and reflect on needs of the patient population. This will consider incorporating 1:1 counselling into

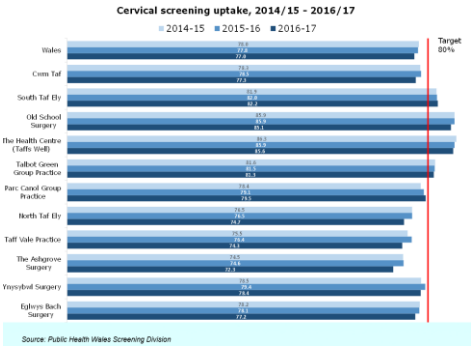
the service delivery. Evaluation of a model currently being provided in Rhondda will be considered.

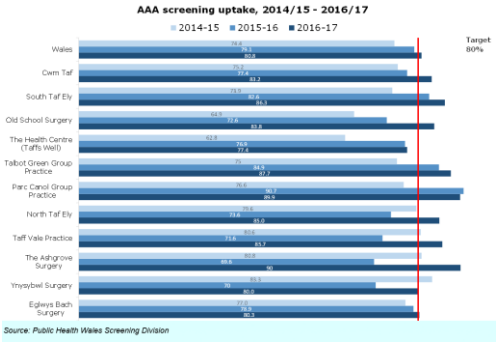
- For Young People – continuing to work with Valleys Steps to deliver Families2gether programme and have further discussions and develop to project further to ensure that any provision is providing pro-active support and is meeting the needs of young people.

- **Health Screening**
  Increase health screening uptake based on the data received from Public Health Wales with particular support to the following screening for life campaigns
  - Bowel
  - Breast
  - Cervical
  - Abdominal Aortic Aneurysm









This graph is specific to cancers and therefore covers only bowel, breast and cervical screening

Uptake of screening % (2017/18)						
	National targets	**North Taf Ely (practice)**	**South Taf Ely(practice)**	**Cwm Taf**	**Wales**	
Bowel	60%	56.1	60.5	64.8	55.7	
Breast	70%	72.1	77.2	73.6	72.8	
Cervical	80%	73.3	81.7	76.4	76.1	
Source: Produced by Public Care Hub using QOF (Primary Care Needs Assessment tool, 2019)						

Digital, data and technology developments

Continued use of digital technology to provide information on services, support patient choices and support sustainability and access through

- e-consult
- website development
- use of social media to promote projects, services and community groups
- video consultations
- Vision Anywhere

Cluster have approved funding to support IT equipment within the practices to support effective and efficient use of e-consult and video consultations which were introduced during the covid pandemic but to also ensure that this way of working can continue when services return to normal – as it has been recognised that patient consultations will continue through these mediums into the future.

The cluster have also employed, via the Health Board, a Communications officer to support the development of the website, social media and to also ensure that messages are being produced and promoted as and when necessary, which will allow continuity across the cluster and further developments.

There are a number of factors that the Cluster need to consider when planning services, projects and initiatives, this includes the following:

Estates developments
There are significant housing developments planned over the next 10 years which impact mainly on Llanharan and Llanharry, Talbot Green and Church Village. Many of the current main surgery premises are used to maximum and therefore some are exploring opportunities for improvements and new builds. The Health board will continue with the Local Authority planning officers to identify timelines for housing developments and link with GP surgeries and other primary care services in line with any potential impact.

Dewi Sant Health Park Development
Dewi Sant is being developed as a Health Park, through a capital funding programme of the Health Board to support a wide range of community and primary care services. This includes an area which is specifically allocated as a Cluster hub to allow services to be delivered from the site on Cluster network basis. It is also available for use by 3rd sector organisations and links directly with one of the GP practices as they have re-located one of their branches to the site.

Covid-19
COVID-19 has had a significant impact on the delivery of Primary Care Services, on the Cluster's current services and intended actions for 2020. In order to enable primary care services to concentrate on delivering core services during the pandemic, and to ensure the safety of staff and the community, many cluster services have been suspended, delayed or delivered in different ways.

Impact of the cluster on dental, pharmacy, optometry and GMS contract reform and plans for delivering extended range of enhanced services.

Contract changes for community pharmacies
Welsh Government considers the community pharmacy sector to be a fundamental part of a strong primary care service and has therefore made commitment to:

- investing in community pharmacies to take pressure off GP services, reducing unnecessary appointments and making sure people are able to see the right professional in the right setting at the right time
- encourage community pharmacies in Wales to engage with primary care cluster and develop and improve collaborative working relationships with GPs and other healthcare professionals

New contract demonstrates the need to work, not only with their fellow GP practices, but also in collaboration with the wider cluster partners. The Taff Ely Cluster invite the cluster partners to Cluster meeting and encourage submission of initiatives based on the population needs and Cluster plans.

Engagement of other health professionals is varied and attendance at Cluster meetings continues to be a challenge particularly for Optometrists and Dentists. The Cluster will continue to invite them

and engage with the Health Board advisors to disseminate information and encourage attendance at meetings and opportunities for collaborative working.

9. Health Board actions and those of other cluster partners to support cluster working and maturity.

- Primary Care Development Manager employed to support Taff Ely Cluster
- Terms of Reference in place and reviewed and updated when necessary
- Standing Financial Instructions – regular meetings with Finance colleagues and budget reports and spend to Cluster
- Workforce and planning support
- Cluster reports to Primary Care Committee to provide assurances through to Executive Director and Board level
- Dental and Optometry Advisors and Pharmacy leads support developments of the Cluster and liaise with the Development Manager and attend Cluster meetings to update on services, contract changes and offer advice on collaborative working.
- Interlink in their role as umbrella organisation for 3rd sector organisations are active members of the cluster and support the health & wellbeing agenda and community development

The Cluster will continue work in partnership achieve the aims within the plan and will ensure that any partnership working and support continues to be included throughout, as applicable.

Taf Ely Cluster Population Profile

Appendix 1

This summary provides an overview of the population served by the Taf Ely Cluster. This consists of patients registered with:

North Taf Ely Practices: Eglwysbach Surgery, Ashgrove Surgery, Taff Vale Practice.

South Taf Ely Practices: Parc Canol Surgery, Old School Surgery, Talbot Green Group Practice, Taffs Well Medical Centre

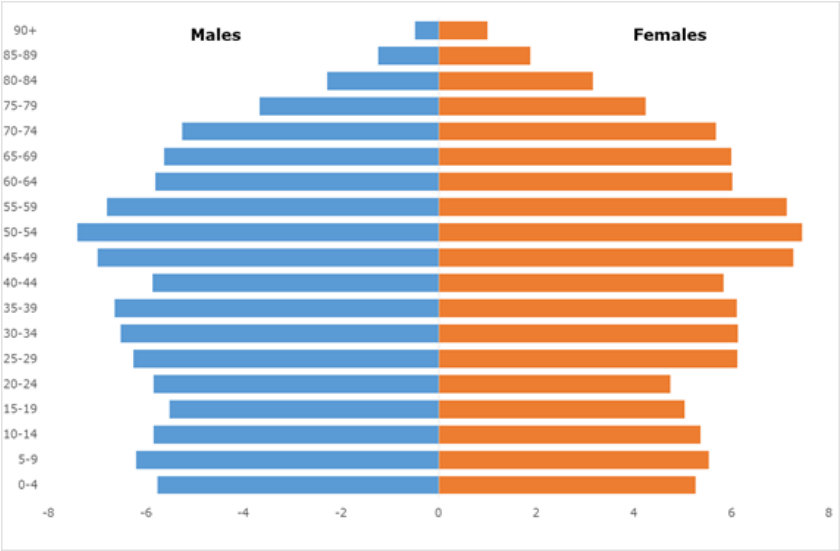
This cluster profile uses two main sources of population data: (i) data captured by registered practice and collated into North and South Clusters; (ii) data that is captured by area of residence. Note: Some data is only available at local authority level and in places data may only be available as part of the old Cwm Taf UHB area as opposed to the new Cwm Taf Morgannwg footprint

Demography

Population

- Resident population (2018 estimates): Cwm Taf Morgannwg University Health Board: 445,190, Rhondda Cynon Taf (RCT): 240,131 (Source: ONS)
- **Practice population (2019)**: North Taf Ely 46,634, South Taf Ely 48,742 (Source: shared services)

Percentage of population by age and sex, Rhondda Cynon Taf local authority, 2018



Population projections up to 2039 will be reviewed by the Public Health Wales Observatory later this year and forwarded when available.

Life expectancy / Healthy life expectancy

	Life expectancy at birth for males and females (2015-2017)			
	Wales	South Taf Ely (USOA)	North Taf Ely (USOA)	South Cynon/North Taf (USOA)
Males	78.3 years	78.9	77.7	77.2
Females	82.3 years	82.4	80.4	80.4

Source: Produced by Pubic Health Wales Observatory using ONS data (PHOF Tool, 2019)

- **Healthy life expectancy** (the number of years a person can expect to live in good health) is only available at a local authority level. For RCT it is 56.5 years for males and 60.2 years for females. For Wales, HLE is 61.4 years for men and 62 years for women.
- The differences in healthy life expectancy that exist across an area between the most and least deprived areas is referred to as the 'inequality gap'.
- The inequality gap for healthy life expectancy in RCT: 6.7 years (males) and 4.3 years (females) (Source: Public Health Wales Observatory PHOF Tool (2017) using ONS and WG data)

Social deprivation

Welsh Index of Multiple Deprivation

Estimated percentage of patients living in the most deprived 40% of areas in Wales (2015)		
Cwm Taf Morgannwg	North Taf Ely(practice)	South Taf Ely (practice)
57.1%	49.9%	26.3%

Source: Produced by Public Health Wales Observatory using WDS (NWIS) and WIMD 2004 (WG) data

- The link between deprivation and poor health is well recognised. Overall the concentration of the "most deprived" areas in Wales is comparably lower in the Taf Ely cluster (particularly South Taf Ely) compared to rest of the Health Board area. However, at a lower geography, pockets of deprivation exist where the population are likely to be experiencing poorest health.

measure of deprivation for small areas designed to identify those small areas with the highest concentrations of several types of deprivation based on a range of domains including income and employment

Children, families and households

- **Children living in poverty** in RCT: 28.0% children (aged 0-18) live in poverty. Welsh average 24%
  (Source: Public Health Wales Observatory PHOF Tool (2019) using WG and ONS data)

- **Low birth weight babies** (born less than 2500g in 2017): North Taf Ely (7.2%); South Taf Ely (5.6%); South Cynon/North Taf Ely (7.1%). RCT (7.4%) Birth weight is an important determinant of future health. Low birth weight babies are at risk of problems with; growth, cognitive development and the onset of chronic conditions later in life.
  (Source: Public Health Wales Observatory PHOF Tool (2019) using WCCHD (NWIS) data)

- **Teenage pregnancy-** RCT has the 2nd highest rate of teenage pregnancy in Wales

- **Unemployment rates** for RCT (March 2019) indicated that 7.4% of economically active people were unemployed; Wales: 4.6%
  In RCT, 20.9% of households, (where at least one person aged 16-64 years were living) were classified as a workless household; Wales: (17.5%) (Source: ONS)

- **Carers –** 13% of the population in Cwm Taf self-reported that they are a carer for a family member or friend. The 2011 census reported that there are 29,640 carers in RCT. 32% provide over 50 hours of care a week.

Chronic disease

Chronic conditions

Estimated % prevalence of chronic conditions (2018)				
	North Taf Ely (practice)	South Taf Ely (practice)	Cwm Taf	Wales
CHD	3.4	3.3	3.7%	3.7%
Heart Failure	0.9	0.7	0.9%	1.0%
Stroke +TIA	2.0	1.8	2.0%	2.1%
Diabetes	6.2	5.4	6.4%	6.0%
COPD	2.4	1.6	2.8%	2.3%
Asthma	7.0	7.4	7.1%	7.1%
Dementia	0.7	0.5	0.5%	0.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018				
Musculoskeletal disorder	17% in RCT (self-reported)			17%
Source: National Survey for Wales (NSW) 2017-19				

The Taf Ely clusters have generally a similar or better estimated prevalence of all chronic conditions than the Welsh average with the exception of diabetes in the North and asthma in the South which are higher.
Prevalence data is estimated from Audit + and as such, only captures conditions which have been diagnosed and coded. This may therefore be an underestimate of 'true' prevalence.

Mental Health

11% of adults in RCT report as having a mental health disorder, higher than the Welsh average of 9% (Source NSW 2017-19)

Mental wellbeing is an important factor in individual's overall health.

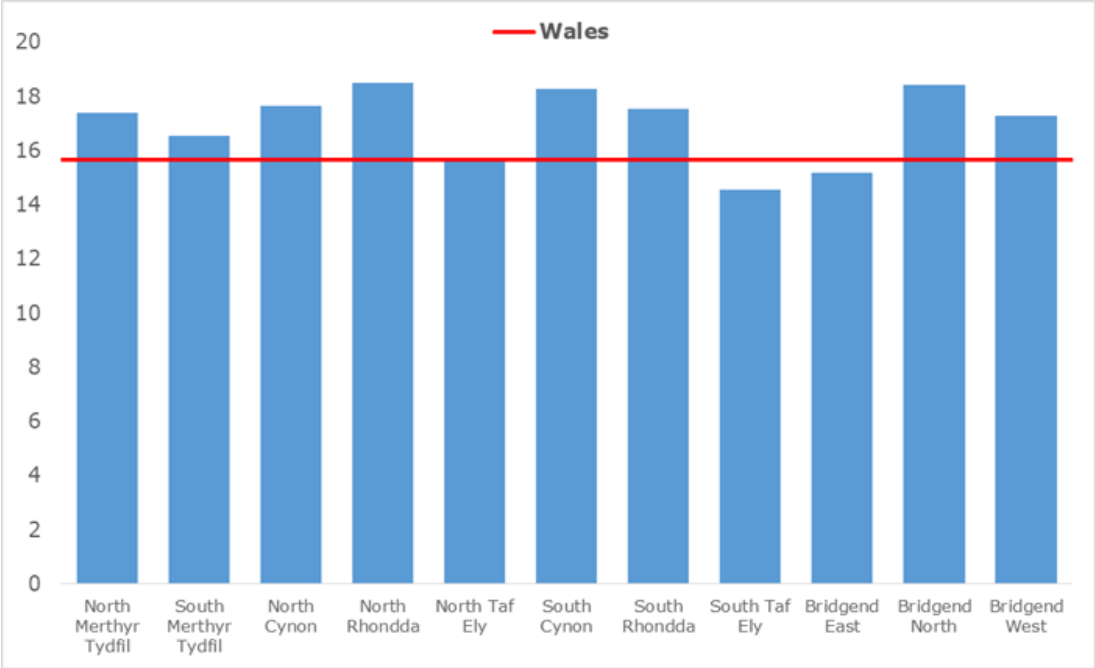
17.5% of adults in RCT report feeling lonely. 28% of adults in RCT do not report a high level of general happiness. (Source ONS 2018)

Risk Factors

Clinical Risk Factors

Estimated % prevalence of risk factors (2017/18)				
	North Taf Ely (practice)	South Taf Ely (practice)	Cwm Taf	Wales
Hypertension	15.6%	14.5%	16.8%	15.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018				
Atrial Fibrillation	2%	2.1%		2.2%
Source: QOF data 2018				
High Cholesterol	Not currently available			
Raised blood glucose	Not currently available			

South Taf Ely has the lowest estimated prevalence of hypertension in the CTMUHB area. North Taf Ely is the third lowest.



Prevalence data is estimated from Audit + and as such, only captures conditions which have been diagnosed and coded. This may therefore be an underestimate of 'true' prevalence.

Achieving optimum management is key in tackling clinical risk factors. A previous review of QOF data for 2016/17 found that almost 1 in 5 patients on registers in the old Cwm Taf UHB area did not achieve even the upper level of 150/90mmHg or less as a desired blood pressure reading.

Data regarding the management of Atrial fibrillation at a cluster and with consent, practice basis is available via the Primary Care Portal -Stop a Stroke tool.

Adult Lifestyle behaviours

Percentage of adults that report the following behaviours- National Survey for Wales (2016-18)					
	Smoke (%)	Eating 5 portions of fruit and veg a day (%)	Meet physical activity guidelines (%)	Drinking above guidelines for weekly alcohol consumption levels (%)	Working age adults of Healthy Weight (%)
North Taf Ely (USOA)	21.1	22.4	52.7	18.7	38.3
South Taf Ely USOA)	15.5	26.3	56.7	20.5	41.4
Cwm Taf Morgannwg	21.1	22.3	51.2	18.3	37.4
Wales	19.2	23.4	52.8	18.9	39.1
Source: Produced by Public Health Observatory (2019)					

- South Taf Ely generally has more adults participating in healthy behaviours than other clusters in CTM UHB apart from having the highest number of adults reporting drinking above the recommended weekly guidelines for alcohol intake. North Taf Ely has a similar profile to the Health Board average apart from lower levels of overweight and obese individuals.
- There is still a significant proportion of adults in Taf Ely engaging in harmful behaviours for which the long term health and social implications are wide ranging.

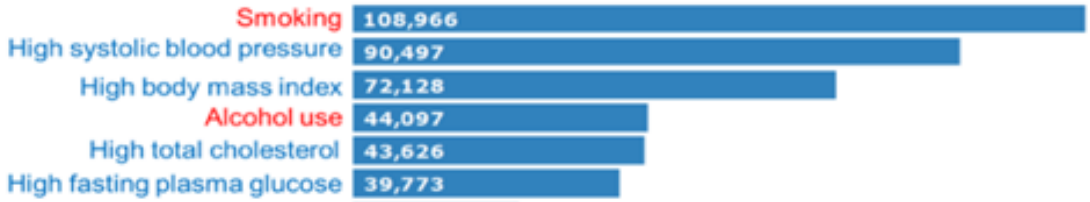
Chronic disease is often preventable. Previous work in Cwm Taf indicated the following: -

The Global Burden of Disease Study is a comprehensive research study of disease burden that assesses mortality and disability from major diseases, injuries, and risk factors. http://www.healthdata.org/gbd Welsh data from the study was used to estimate the burden associated with disability-adjusted life years (**DALYs**) These are a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

Almost half of all years lost are attributable to 3 conditions: cancers, cardiovascular disease and musculoskeletal disorders with mental and substance misuse disorders in 4th place.

A large proportion of these health conditions are caused by adjustable risk factors

DALYs lost by risk factor, Wales 2016 Source PHWO USING Global Health Data Exchange (IHME)



Cancers and Screening

Cancer incidence and prevalence

- The most common cancers for men in RCT (2014 -2016) were: prostate, lung and colorectal. For women: breast, lung and colorectal. (Source: WCISU, 2019)
- Cwm Taf has the highest lung cancer incidence rate of all health boards for both men and women (Source: WCISU, 2019). Lung cancer has the strongest link to deprivation of all the most common cancers, mainly due to the link with smoking.

Screening

Uptake of screening % (2017/18)					
	National targets	North Taf Ely (practice)	South Taf Ely(practice)	Cwm Taf	Wales
Bowel	60%	56.1	60.5	64.8	55.7
Breast	70%	72.1	77.2	73.6	72.8
Cervical	80%	73.3	81.7	76.4	76.1
Source: Produced by Public Care Hub using QOF (Primary Care Needs Assessment tool, 2019)					

Bowel screening has the lowest uptake rate of the national screening programmes across CTMUHB. South Taf Ely is the only cluster to meet the programme target. However, the largest inequalities in take up are found in Bowel Screening. There is a difference of 14.9% in uptake between the least and most deprived areas of RCT so that is a need to be mindful there may be pockets of poor uptake throughout the area.

In line with Wales as a whole, there has been a decline in young women attending their first cervical smear across Cwm Taf Morgannwg although again South Taf Ely is the only cluster to meet the national target.

Prevention of infectious diseases

Flu vaccination uptake

% Uptake (2017/18)					
	National targets	North Taf Ely (practice)	South Taf Ely (practice)	Cwm Taf	Wales
At risk aged 6 months to 64 years	**55%**	46.2%	43.6%	46.8%	48.5%
2 and 3 year olds	No specific Targets yet	47.0%	72.2%	53.0%	50.2%
65+ years	75%	68.2%	65.6%	67.7%	68.6%
Source: Primary Care Needs Assessment tool, 2019 using IVOR data					

Apart from 2-3 year olds in South Taf Ely Flu vaccination uptake is at a lower rate for all groups in both the Taf Ely clusters than the Welsh average.
Vaccination levels do not yet meet any of the targets set for the influenza vaccination programme.

Data for 2018/19 at a Health Board and LA level is available at http://nww.immunisation.wales.nhs.uk/ct-ivor . Also given is the breakdown for different at risk groups.

Childhood Vaccination Uptake

% uptake (2018/19)					
	Targets	North Taf Ely (practice)	South Taf Ely (practice)	Cwm Taf	Wales
Uptake of 5 in 1 at 1 year old	95%	98%	98%	97.4%	95.9%
Up to date by age 4	95%	87.9%	94.1%	88.2%	84.9%
MMR2 at age 5	95%	92.8%	94.6%	90.6%	89.5%
MMR2 at age 16	95%	88.0%	92.1%		
Source: COVER data accessed via http://nww.immunisation.wales.nhs.uk/cover					

Childhood vaccination uptake is at a higher rate in both the Taf Ely clusters than the Welsh average. However, it has not yet met any of the 95% targets set for the immunisation programme to achieve 'herd immunity', except for immunisation uptake of childhood vaccinations in children aged 1 year.

Cluster Summary

The Taf Ely area generally has a lower level of deprivation and poverty than the Welsh average. However, at a lower geography, pockets of deprivation exist where the population are likely to be experiencing poorest health.

Data indicates a generally better or comparative profile of behavioural and clinical risk than the Welsh average, but the importance of these risk factors in relation to disease means that action to tackle these areas remains a priority. Using the evidence related to the disease burden associated with that risk would indicate a focus on smoking, obesity, alcohol misuse and detection and optimum management of hypertension and atrial fibrillation.

North Taf Ely has a higher estimated prevalence of diabetes and COPD than the Welsh average, while the South has a higher prevalence of asthma. Despite the lower level of chronic disease in this area compared to some of the other CTMUHB clusters the level of multi-morbidity is likely to still be of concern. This generates the need to review how services are delivered and develop more patient centred approaches. Support for mental health also needs to be a key component of care for this cohort.

The plan details cluster objectives for the years 2020-2023 that have been agreed by consensus across practices and the wider cluster providing where relevant background to current position, planned objectives and year on year milestones 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

	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
a.	Prevention, well-being and self care					
1.	Implement health promotion signposting and support mechanisms, which will help to address: • Asthma • Diabetes • COPD • Dementia • Mental health & wellbeing • Weight and obesity • Alcohol	Increased engagement by practices in public health promotion Increased awareness & education for patients on 'choices' available to them for other health, social care & voluntary sector services Communication Officer input to work on national campaigns alongside promotion of local groups, services to support health promotion	Work to communication plan and target national and local campaign messages. Signposting and Care navigation processes to continue Healthy lifestyles – HCSW champions to motivate and signpost and engage patients in self-management and/or organised programmes	Continue to promote public health messages and campaigns – developing ability to target population Continue to engage with Public Health, to ensure initiatives are planned and prioritised Healthy lifestyles – HCSW champions to motivate and signpost and engage patients in self-management and/or organised programmes	Dependency on public health data at cluster and local community level External factor impact on ability to develop engagement opportunities e.g. due to covid	 Cluster development manager and cluster leads work closely with public health colleagues to determine local need and target initiatives accordingly. Using population health needs assessment tool to determine suitable action to address priorities set by the cluster.

	Development of Healthy Lifestyle project to allow dedicated support and access for individuals	Identification of HCP in practices to be 'champions' MECC & Motivational training for all champions	Set up of healthy lifestyle support groups across the Cluster			
2.	Community Development and increased collaboration between cluster and 3rd sector organisations Tackle loneliness and isolation Increased social and community developments based on identified need to support improved health & wellbeing	Development of community groups, and activities based on need Partnership working and funding provision to allow 3rd sector organisations to be lead on develop sustainable community projects	Continue to promote groups, activities on social media, cluster website	Continue to promote groups, activities on social media, cluster website	Ability for 3rd sector organisations to support and continue with projects once Cluster funding ends	
3.	Support for those that are homeless to allow them access to advice, support, treatment	To recruit a specialist nurse to support development and partnerships to identify need of vulnerable individuals. Work with Local Authority and Health Board services to ensure access to health services is available e.g. drop in podiatry clinics.	Sign up of GP practices to the 'homeless' enhanced service for the Cluster. Links with secondary care services to improve pathways, processes and promotion of 'how to access'	To develop a sustainable service across Taff Ely and other areas across Cwm Taf Morgannwg with support of UHB Primary Care Services.	Need to work with RCTCBC to determine need and areas with most need and target accordingly. Ability of Cluster to influence all service providers required to support the needs of this patient population.	 Year 1 complete. Nurse in post. Partnership working now in place with Local Authority in RCT and links with Merthyr.

	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
4.	Healthy lifestyles – My change, my health, my life.	GP leads identified Healthy lifestyle champions identified in each practice. Motivational training undertaken. Champions network development	Motivational training for all champions. Patients receiving advice, support from HCSW champions. Consideration to foodwise sessions for HCSW Patient sessions to be developed & delivered by HCSW	Evaluate impact and work with PHW to gain evidence. through PH data and practice reports that demonstrate decrease in levels of obesity, chronic health conditions such as diabetes in patient population through monitoring in GP record of weight loss, improved health conditions.	Impact of covid on ability to continue with staff training. This will be revisited once staffing back to normal and restrictions around access to premises and consultations lifted	 A number of practices have trained champions.
5.	To support social prescribing and education of population to access services that are appropriate to their need and avoid them seeing a GP for social issues.	Community Wellbeing Co-ordinators employed via transformational funds, will work in the community and with GP practices to support on social needs	Joined up working of wellbeing co-ordinators, Merthyr & the Valleys Mind and other agencies to ensure people are supported to receive the right support, in the right way, by the right organisation. Improved communications plan to regularly target information to the population	Improved patient information of other services available in their communities to support their health & wellbeing. Evaluation of campaigns to determine any improved knowledge and also impact of communications plan to allow adjustments where necessary.		

	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
6.	To work jointly with Merthyr & the Valleys MIND to support their social prescribing research project - help determine the value and most suitable way to deliver and access social prescribing support	Continue to support the research and development project Project leads identified – to work with Mind and attend National Steering Group	Research element of project suspended due to covid. Social prescribers still based in Taff Ely	N/A – 2 year project		 .
7.	Increased screening uptake across Taff Ely by patients particularly targeting • Bowel screening • Breast screening • AAA Screening • Cervical Screening In support of PHW 'Screening for Life' Campaign.	Increase in reported figures across all practices to work towards meeting national targets. Community wellbeing co-ordinators fully engaged in community groups and at all primary care premises Reported improved awareness of need for health screening captured through quarterly reports of Wellbeing co-ordinator and also PHW data.	To work towards meeting national targets across the whole of the population – which will be demonstrated through shared practice and public health data. Calendar of campaigns and ways to target population included in Comms plan. Regular and timely campaign promotion	Reported PHW data to demonstrate increased update of screening opportunities.		

	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
8.	Protection against flu for elderly and medically vulnerable patients Delivery of flu vaccination programme to population of Taff Ely in line with government guidelines and Health Board advice	Increased level of uptake across the Cluster, reported increase in PHW data. Promotion, with support of wellbeing co-ordinator in • primary care – GP practices, dentists, optometrists, • local authority buildings • community premises/groups Cluster to work with Community Pharmacy representatives to agree joint working Adapt to delivery vaccine to patients in line with WG guidance e.g. 50+	Work with UHB pharmacy directorate/ Community Pharmacy Wales /Community Pharmacies to optimise take up by patients of seasonal flu	Increased level of uptake across the Cluster, reported increase in PHW data. Promotion, with support of wellbeing co-ordinator in • primary care – GP practices, dentists, optometrists, • local authority buildings • community premises/groups		

	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
b. Timely, equitable access and service sustainability						
9	Care Navigation training, information and support	Continue to support training and development of existing care navigators. Continue 'champions' network. Care Navigator newsletter	Roll out to other health, social care and community partners to ensure consistent signposting and messages to the population. Additional providers to be added to system.	Fully embedded care navigation process.	Engagement of other primary care contractors and partners	
10	To provide mental health & wellbeing support for those presenting to GPs	To continue with established active monitoring service GP practice business for those attending with early presentation mild to moderate anxiety, stress and depression. To explore option of CPN role in Primary Care with Health Board leads To provide specific support for young people to build resilience and ability	To work with Primary Care Mental Health Team to make clear and simple pathways into the services being provided. To continue with Cwm Taf Morgannwg Mind Active Monitoring Services. Utilise the Community H&Wbeing team MH practitioners through referrals into the service, clinic delivered at GP practices Further development of support for young people. Valleys Steps delivery of sessions in	To have a joined up service across primary, community, secondary care and 3rd sector organisation. One point of access to MH & wellbeing support. Further develop offer, through Valleys steps and links with other services,	Year 3 milestones dependent on clusters ability to influence change in HB services and development of joined up services and one point of access. Ability to recruit to roles dependent on Health Board and availability of staffing across the services.	 Meeting held with PCMHT Team leader. Draft Decision guide developed. Offer of PCMHT to meet with practice staff to gain understanding of services, issues to support GP decisions and most appropriate referrals.

		to manage day to day stressors and anxieties by funding sessions to be developed and delivered by Valleys Steps	the community and schools. Consider need, consult with young people and schools – develop support as necessary e.g. group, 1:1	organisations and local schools and colleges		
11	Delivery of First Contact Physiotherapy (FCP) Services in GP practices to allow ease of access and earlier contact due to increased demand on existing services	Recruitment and implementation of Physiotherapists, employed by HB and funded by Cluster for 2 years. Implementation of FCP across all Taff Ely practices Purchase of Vision Shared Appointments. Introduction of IT system to support clinic lists, shared access to appointments to best suit service and practices and ensure improved access for patients.	Evaluate service provision and quality in collaboration with primary care physiotherapy service leads to establish any • Released GP time • Earlier assessment, advice, interventions and diagnosis • Improved outcomes for patients • Easier access – closer to home • Reduced referrals to Primary Care service and Secondary Care orthopaedics, CMATs services	Evaluation to determine any continuation of cluster funding, need for shift in resources/mainstream funding.	Lack of evidence or funding to establish investment needed across Primary Care Physiotherapy service provision Impact of covid on ability to start service earlier in the year.	
	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating

12	Delivery of Covid vaccination programme for Primary Care	Sign up of Enhanced service to deliver covid vaccinations to 80+ and housebound patients. Develop cluster working plan to deliver mass vaccination programme if needed. Funding for additional activity, protection to support sustainability, access for patients whilst restrictions in place and staffing issues are affecting delivery of services.	unknown	unknown		
c. Rebalancing care closer to home						
13	Cluster hub development at Dewi Sant Health Park and delivery of network services and community clinics for the population in a central location	Sign up of community groups, 3rd sector organisations and use of resource hub rooms. Advertising of activity in hub and ways of	Accommodating Cluster wide approaches, initiatives in hub where needed. Working collaboratively with Rhondda/Taff Ely Integrated Locality to support local service provision.	Continuing support for cluster hub and community development.		

		engaging to general population				
14	Frailty Nursing Service	Explore options and services being delivered across Wales to determine best fit. Approval by Cluster to fund nursing roles	Establish process for identifying patients to ensure consistent across cluster. Partnership working with Community H&Wbeing team, @home, District Nursing Service etc. to ensure full history of patients. Develop case load. Continually review and evaluation of service provision	Review and evaluation of roles to determine benefits, sustainability and best fit of service provision. Business case to be developed and presented to Health Board Integrated Locality Group		
	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
d. Implementing the Primary Care Model for Wales						
15	To continue to develop Cluster initiatives and partnership working taking into consideration principles of the Primary Care Model for Wales and Strategic Programme for Primary Care	Consider refreshed programme of work for 2020-21 (Strategic Programme for Primary Care)	Continue to develop cluster initiatives, working collaborative across health and social care. Working closely with R/TE Integrated Locality Group	Continue to develop cluster initiatives, working collaborative across health and social care.		
e. Digital, data and technology developments						
16	Cluster wide signposting, use of website, facebook and twitter.	To continue to develop the information further	Development of targetted campaigns in	Improved communications,		

		and links to other sites and services. Dedicated communications officer resource.	line with cluster communications plan.	more targeted campaigns		
17	e-consult	Introduce use of e-consult across all practices. Improving use of e-consult by patients. Further developments – e.g. for clinical consultation and signposting options to appropriate services.	Evaluate practice data to establish effectiveness and benefits to patients and practices. Also to establish any good practice, effectiveness, need for review. Continue to communicate benefits to patient population. Increase use of Care navigators to ease demand on GPs	Evaluate practice data to establish effectiveness and benefits to patients and practices. Also to establish any good practice, effectiveness, need for reviews/developments.	EMIS practice suitability an issue.	
18	Vision Anywhere					
19	Video consultation • Attend Anywhere • AccuRX					
f. Workforce development						
20	Cluster to support the transformational plans for Primary and community care and delivery of anticipatory care for their patient population	Cluster leads to support process and recruitment of identified roles to form multi-disciplinary team	Embedded MDT working to agreed processes and protocols. Increased referrals to weekly MDT meeting			

			and directly to services where needed.			
21	Employment of Pharmacy Technician role to work in GP practices. This supports patient safety, improved medicines management alongside practice pharmacists.	Recruitment of pharmacy technicians through Health board. Agree processes for management, clinical supervision of technician roles	Evaluation of roles to demonstrate any benefits for patients, improved patient safely and impact on GP practices, and other Primary Care providers.	Continued evaluation of roles to demonstrate any benefits for patients, improved patient safely and impact on GP practices, and other Primary Care providers. Decision needed to extend roles within practices, either cluster or practice funded.		
22	Support IP training for community pharmacies to allow OOH prescribing and direct access from other services e.g. Welsh Eye Care Service	Proposal to be explored for consideration by the Cluster as part of collaborative working				
	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
23	To develop a workforce strategy for the cluster taking into consideration Health Board plans, Regional Board Wellbeing plans, Strategic programme for Primary Care and the Primary and Community Care Training and Education Framework.	Define the cluster plan. To work with Health Board to consider the four overarching themes set out in the Workforce and Organisational Development	Development of formal workforce strategy template. Work with the ILG, Primary, community care providers, social care and 3rd sector organisations to determine workforce across the cluster – with support of Assistant Business	Introduce a model for future workforce development to ensure the right: ✓ Recruitment and retention ✓ Education and training ✓ Skill mix This will support	Availability of data Engagement from all service providers Cluster needing support and guidance at a strategic level	

		To review Nursing & Healthcare support worker roles and skills, training needs	Manager Workforce and OD and Cluster Development Manager. Consider opportunities brought about through the development of the Primary and Community Care Training and Education Framework.	• Establishment and development of an integrated health and social care workforce; identifying what is already available within the Cluster where gaps are		
g. Estates development						
24	Dewi Sant Health Park & Cluster hub developments	Continue to support development, use, range of services available in the Cluster Resource Hub and Dewi Sant Health park to support community site ethos	Continue to support development, use, range of services available in the Cluster Resource Hub and Dewi Sant Health park to support community site ethos	Continue to support development, use, range of services available in the Cluster Resource Hub and Dewi Sant Health park to support community Site ethos		
	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
h. Communications, engagement and coproduction						
25	Cluster to fund a dedicated communications officer resource.	To continue to fund for full year. To develop existing website, social media information further and links to other sites and services.	Development of communications plan, incl • Target audience strategy • Practice support • Calendar of campaigns for year • Better use of local media Allocation of advertising budget	Improved communications strategy More targeted campaigns Better patient population awarenesss		

			To determine need for continuation of dedicated communications officer role			
26	Development of Cluster patient participation group	To be agreed and developed for Cluster. Set up Cluster PPG in liaison with Community Health Council (CHC) Regular cluster updates to be provided to CHC by Development Manager	To work with Cluster PPG to ensure co-production and assessment of cluster plans			
27	Develop resources to provide leaflets for patients and information source e.g coaster for primary care practitioners to advertise services	To be agreed and developed for Cluster				
	Key Priority	Year 1 milestones	Year 2 milestones	Year 3 milestone	Risks	RAG Rating
28	Population surveys, engagement.	To be agreed and developed for Cluster. Practice patient survey	Practice patient survey, Access and Demand Audit – and development of Cluster action plan	Practice patient survey, Access and Demand Audit – and development of Cluster action plan.	Changes to GMS contract e.g suspension of QAIF requirements to carry out audit due to covid pressures.	

				Continued engagement in public forums and events		
29	Primary Care to introduce the use of welsh language and provide an active offer for their patient population to conform with Welsh Language Standards	To work jointly to implement welsh language standards across primary care contractors	To continue to apply welsh language standards	To continue to apply welsh language standards		
i. Improving quality, value and patient safety						
30	GMC Contract – The Quality Assurance and Improvement Framework (QAIF) has been introduced as part of the contract reform in 2019 – the practices will need to work to deadlines to ensure evidence is provided to the Health Board and Welsh Government as described in the contract. The cluster will support practices and ensure reports are provided at a cluster level as necessary.	Choose and set cluster projects in line with framework. Discuss QAIF requirements at Cluster meeting. Liaise with Primary Care Managers as necessary. Set timescales and processes using tools and reporting methods developed to Cluster, Health Board and Welsh Government level.	Implement any additional Quality Improvement projects as required. Evaluate projects and action plans at cluster level to ensure improvements are being made where necessary	Implement any additional Quality Improvement projects as required. Evaluate projects and action plans at cluster level to ensure improvements are being made where necessary	Impact on covid and relaxation and reintroduction of contract requirements, QAIF project requirements.	
31	CRP POCT	To be agreed by cluster for funding equipment and implementation				

32	Prescribing Quality Improvement Programme (PQIP)	Proposal to be developed and considered by Cluster				
33	Dermoscopy	Training, purchase of equipment	Improved early diagnosis and appropriate referrals. Working with Rhondda & Taff Ely ILG to improve communication and links to specialist advice and support.	Working with R&TE ILG and secondary care consultants, planning colleagues to develop services and support patients in Primary Care		
34	To achieve Dementia Friendly status for Practices, the Cluster and it's communities	All GP practices to undertake Dementia Friends training for identified staff. Other primary care contractors to start training for their staff. To support Shednet in development and production of a manual for Shed Management Teams to be more 'Dementia Friendly	All GP practices to undertake an environmental assessment Improvement of patient/carer experience and management of patients with Dementia across the Cluster To work with Memory Assessment Team OTs	All primary care contractors to undertake environmental assessment To achieve Dementia Friendly status for the Cluster To have consistent pathways and support services across cluster