PRIMARY CARE CLUSTER PLAN ON A PAGE

BAY HEALTH PRIMARY CARE CLUSTER

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Strategic Overview
Bay Cluster is dedicated to working together and improving patient care. We will work to deliver a Whole System Transformation programme. Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vison is to achieve a Cluster led transformed model of integrated health and social care for the Bay Cluster population. The programme will concentrate on implementing a range of projects to improve well-being across the age spectrum, co-ordinate services to maximise independence and bring care closer to home. Bay Cluster will endeavour to use this exciting opportunity to support the implementation of 'A Healthier Wales' and the new model of primary care. We look forward to working in partnership to deliver transformation providing services closer to home. Consideration has been given to Primary Care Cluster Governance 'A Good Practice Guide' in the development of this IMTP; our Cluster have undertaking a maturity assessment and will develop subsequent actions as a result to build on the work done to date. This will feed into the Health Board overarching Cluster Development Plan.
Vision
In 2018, Bay Cluster jointly agreed a Cluster Vision for the coming years. The Vision sets out how our Cluster sees its role in providing Health, Social Care and Wellbeing, with and for, the population of the Bay Cluster area and its practices. *"All Bay Cluster primary care services working together in partnership with patients, hospitals and the third sector to provide high quality services to meet patient's needs. We envisage a whole systems approach to transform services to meet the local needs of our patients."*
What We Will Do
In conjunction with our Partners, Bay Cluster will strive to deliver: • Timely, Equitable Access, and Service Sustainability: *access standards, choose pharmacy referrals* • A rebalancing of Care Closer To Home: *frailty framework, diabetes, mental health and heart failure* • Implementation of the Primary Care Model For Wales: *Making Every Contact Count, Health Literacy, CRP testing, My Health Online and Co-Production* • Workforce Development; expanding and upskilling Multi-Disciplinary Team, Custer education programme, succession planning. • Estates development: *ensuring safety, suitability and optimum use of premises* • Communication, Engagement and Co-production: *Patient Representative Group, Patient Reported Outcome Measures, Cluster website, and communication strategy*. • Improvements in Quality, Value and Patient Safety: *Quality Assurance Improvement Framework, risk register, enhanced services access, cancer* • Delivery of care closer to home of services that meet community health and wellbeing needs such as the Primary Care Child and Family Wellbeing Team and heart failure. • Building on known community asset and patient and citizen involvement in the development of peer support and community capacity, co-producing services and improving health literacy, and continuing to increase capacity for social prescribing and aligning with Transformation (Our Neighbourhood Approach)

- Extending the implementation of Cluster and Transformation communication strategies to both external and internal stakeholders, and using messages to maximise ability to address workforce recruitment issues.
- Develop and deliver a work programme, maximising support available to improve population health and wellbeing *through prevention and self-care,* with a focus on our priority areas of need for dementia, obesity (weight management, diabetes, pain management), mental health (social prescribing, access to new services, increased capacity in Cluster), flu, childhood immunisations and vaccinations and chronic pain.
- Ensuring that Cluster has suitable estates strategy and capacity to deliver required range of services
- Develop working relationship with associated Community Interest Company to establish a joint agenda for patient health and wellbeing
- Improving access to GMS services, enabled by delivery of further development of Cluster and practice based Multi-Disciplinary Team, together with use of IT and review of enhanced services.
- Develop agenda in partnerships with other 'blue light' services to improve local area knowledge and understand patient needs and improve services for vulnerable patients, including patients experiencing domestic abuse.

CITY HEALTH PRIMARY CARE CLUSTER

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Strategic Overview

City Cluster will work to deliver a Whole System Transformation programme. Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vison is to achieve a Cluster led transformed model of integrated health and social care for the City Cluster population. The programme will concentrate on implementing a range of projects to improve well-being across the age spectrum, co-ordinate services to maximise independence and delivery of care closer to home of services that meet community health and wellbeing needs, such as the Primary Care Child and Family Wellbeing Team and heart failure.
Consideration has been given to the Primary Care Cluster Governance Good Practice Guide in the development of this IMTP; our Cluster will be undertaking a maturity assessment and develop subsequent actions as a result to build on the work done to date. This will feed into the Health Board overarching Cluster Development Plan.
City Cluster will endeavour to use this exciting opportunity to support the implementation of A Healthier Wales and the new model of primary care.

Vision

In 2018, City Cluster jointly agreed a Cluster Vision for the coming years. The Vision sets out how our Cluster sees its role in providing Health, Social Care and Wellbeing, with and for, the population of the City Cluster area and its practices.

"City Health Cluster has a vision to improve its patient's health and wellbeing outcomes alongside focusing on the future sustainability of General Practice. We will achieve this by embracing and encouraging multi-agency and peer collaborative working, participating in and promoting education; sharing our skills and resources across our Cluster efficiently and effectively."

What We Will Do

In conjunction with our Partners, City Cluster will strive to focus on and deliver over the next three years:

- Prevention, Wellbeing and Self Care: *diabetes, obesity, smoking, COPD, bowel screening, substance misuse, influenza*
- Timely, Equitable Access, and Service Sustainability: *meeting and improving access standards, care closer to home, demand and capacity*
- A rebalancing of Care Closer To Home: *transfer of services to the community (memory, diabetes, heart failure), improving patient health literacy*
- Implementation of the Primary Care Model For Wales: *collaboration between primary care providers and other Cluster partners*
- Developments in digital, data and technology: *improving systems of clinical governance*
- Workforce Development; including skill mix, capacity, training, and leadership: *development of comprehensive workforce strategy*
- Estates development: *ensuring safety, suitability and optimum use of premises*
- Communication, Engagement and Co-production: *Nothing about us, without us, is for us.*
- Improvements in Quality, Value and Patient Safety: *Quality Assurance Improvement Framework (QAIF), risk register, enhanced services access*

CWMTAWE PRIMARY CARE CLUSTER

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

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

LLWCHWR PRIMARY CARE CLUSTER

Llwchwr Cluster Priority Areas
Work with partners to deliver programme of Transformation of Clusters with the aims of: • Increased social referral activities • Expanded MDT – Speech and Language, Physiotherapy, Mental Health, Phlebotomy • Medical records storage • Outpatient Clinics • Acute Clinical Outreach in Clusters • Pro-active management of Chronic Conditions
Ensure all Cluster work undertaken with a co-productive approach, making every contact count, and working to develop levels of health literacy amongst our population and assessing implementation/improvements on an annual basis.
Maximise the use and development of all available estates/estates activities within the Cluster.
Improving Quality, Value and Patient Safety, Quality Assurance and Improvement Framework Consider the requirements under QAIF with a focus on: • Patient Safety Programme - Reducing medicines related harm • Reducing stroke risk • Ceilings of care / Advanced Care planning. • Urinary tract infection - Antimicrobial Stewardship
Develop the maturity of the Cluster in line with the Good Practice Guide for Cluster Governance.
Improve Flu Vaccination uptake rates for children, people with chronic conditions, people over 65, pregnant women and staff through Flu immunisation campaign.
Map current and discuss future enhanced service provision at individual Cluster level to ensure universal services available to patients.
Development of a Cluster workforce strategy using analysis of IMTP workforce data collation.

Work with partners to deliver Neighbourhood Approach.
Cancer: increase screening uptake rates, with an initial focus on Bowel Screening.
Tackle problem of increasing levels of diabetes by participating in Pre Diabetes Project.
Progress links with community pharmacy to manage patients with common ailments in the community and integrate with Cluster Communications Strategy.
Engage with patients to understand their experience of services and to identify their needs.

PENDERI PRIMARY CARE CLUSTER

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Strategic Overview

Over the next 3 years, we will continue to strengthen our links with the local community and explore alternate methods of engagement to further develop a co productive approach to health and wellbeing. We will continue to enhance our Multi Disciplinary Team and develop valuable shared resources across the cluster. We will adopt a preventative, holistic approach through partnership, collaboration, use of local assets and co production. Some of the Key issues for us to progress over the next 3 years include Diabetes, Mental Health and Sustainability. We look forward to developing new innovative projects and ways of working that will support the local community and enhance patient wellbeing across the Cluster.

Consideration has been given to the Primary Care Cluster Governance – A Good Practice Guide, in the development of this IMTP; our Cluster will be undertaking a maturity assessment and develop subsequent actions as a result to build on the work done to date. This will feed into the Health Board overarching Cluster Development Plan.

Dr Daniel Sartori, Cluster Lead

Vision

The Penderi Cluster aims to care for the unique health and wellbeing needs of patients and citizens in the most effective way possible.
In recognition of our particular population needs we will work together to create an innovative culture of enabling long term change by taking a preventative approach to tackling ill health and its contributing factors

What We Will Do

- Develop a comprehensive Cluster Training Programme to meet Cluster and Community needs
- Focus on Quality Improvement through QAIF,GP Carers Accreditation Scheme, cancer
- Development of a Cluster Workforce plan
- Develop and implement the Cluster Health Literacy Plan
- Continue to develop links with key partners including Social Housing, Community Groups, SCVS, Local Schools and the Local Authority
- Expand portfolio of social prescribing schemes
- Maximise use of community assets
- Participate in 'Penderry Regeneration' programme to ensure that health and wellbeing remains a focus and primary care sustainability factors are considered
- Enhance and develop shared resources including estates, MDT and collaborative working arrangements that meet patient needs
- Continue to strengthen links with community pharmacies to ensure patients are utilising services effectively
- Empower patients to take responsibility for their own health and wellbeing-develop a 'self care' culture
- Actively promote screening opportunities
- Reduce smoking rates
- Reduce antibiotic prescribing and use of prophylactics
- Increase flu vaccination uptake and develop a comprehensive approach to winter preparedness
- Co produce initiatives that impact positively on mental health
- Support children and families to improve wellbeing outcomes and reduce health inequalities
- Continue to support business case development for Primary Care Child and Family Wellbeing Service and Cluster Pharmacists
- Improve local knowledge and partnerships to improve services for vulnerable patients including victims of domestic abuse
- Undertake a rigorous programme of Quality Improvement in key nationally identified areas
- Delivery of care closer to home that meet community health and wellbeing needs such as the Primary Care Child and Family Wellbeing Service, Heart Failure etc
- Consider the Future Generation Act; the seven wellbeing goals and five ways of working.

AFAN VALLEY PRIMARY CARE CLUSTER

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Strategic Overview

The transformation programme offers the cluster the opportunity to develop further ideas at pace. We shall over the next 3 years to embed successful projects, strengthen our engagement and involvement of patients and partners and continue the drive to improve primary care sustainability and the wellbeing of our patients. ***Dr Mark Goodwin***

Vision

To enable communication between the right people at the right time, leading to cohesive working for the betterment of the population with provision of equitable services across the Network that are safe, timely and accessible.

What We Will Do

We will prioritise the following:

- *Prevention, wellbeing and self-care:* Diabetes prevention, supporting the 'Safe & Resilient Communities' Programme, weight management, patient education, uptake of the influenza vaccine and the MMR vaccine in patients 16-24
- *Timely, equitable access and service sustainability*: Implementing the Access to In-Hours GMS Services Standards and exploring areas of collaboration with community pharmacies
- *Rebalancing Care Closer to Home:* Supporting the development of a community phlebotomy service, delivering flu vaccinations to housebound patients, supporting further development of an Afan Primary Care Hub
- *Implementing the Primary Care Model for Wales*: Engaging with the transformation programme, Increasing collaboration between primary care, social services and other Cluster partners, supporting the rollout of Primary Care Child and Family Early Years Wellbeing Service
- *Digital, Data and Technology Developments*: Promoting the use of My Health on line and of 3rd sector services through information platforms such as DEWIS and infoengine,
- *Workforce Development including Skill Mix, Capacity, Capability, Training Needs and Development:* Identifying learning needs of practice staff and developing cluster based MDTs.
- *Estates Development;* Exploring options for improvement grants, and mapping current estates to identify available space to accommodate new services
- *Communications, Engagement and Co-production*: Engaging with patients to understand their experience of services and to identify their needs, working with 3rd sector to increase presence in primary care and community settings, improving health literacy and signposting to Third Sector services
- *Improving Quality, Value and Patient Safety:* Engaging with patients to understand their experience of services and to identify their needs, working with 3rd sector to increase presence in primary care and community settings, improving health literacy and signposting to Third Sector services

NEATH PRIMARY CARE CLUSTER

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Strategic Overview

The transformation programme offers the cluster the opportunity to develop further ideas at pace. We shall over the next 3 years to embed successful projects, strengthen our engagement and involvement of patients and partners and continue the drive to improve primary care sustainability and the wellbeing of our patients. *Dr Deborah Burge Jones*.

Vision

To develop links within our community that will enable timely & appropriate care to those who require our services.
To work together to ensure those services are sustainable & of the highest quality possible, and provided from within the community wherever possible

What We Will Do

We will prioritise the following:

- *Prevention, wellbeing and self-care:* Diabetes pprevention, supporting the 'Safe & Resilient Communities' Programme, weight management, patient education, uptake of the influenza vaccine and the MMR vaccine in patients 16-24
- *Timely, equitable access and service sustainability*: Implementing the Access to In-Hours GMS Services Standards and exploring areas of collaboration with community pharmacies,
- *Rebalancing Care Closer to Home:* Supporting the development of a community phlebotomy service, delivering flu vaccinations to housebound patients, supporting further development of the Neath Primary Care Hub
- *Implementing the Primary Care Model for Wales*: Engaging with the transformation programme, Increasing collaboration between primary care, social services and other Cluster partners, supporting the rollout of Primary Care Child and Family Early Years Wellbeing Service
- *Digital, Data and Technology Developments*: Promoting the use of My Health on line and of 3rd sector services through information platforms such as DEWIS and infoengine,
- *Workforce Development including Skill Mix, Capacity, Capability, Training Needs and Development:* Identifying learning needs of practice staff and developing cluster based MDTs.
- *Estates Development:* Exploring options for improvement grants, and mapping current estates to identify available space to accommodate new services
- *Communications, Engagement and Co-production*: Engaging with patients to understand their experience of services and to identify their needs, working with 3rd sector to increase presence in primary care and community settings, improving health literacy and signposting to Third Sector services
- *Improving Quality, Value and Patient Safety:* Engaging with patients to understand their experience of services and to identify their needs, working with 3rd sector to increase presence in primary care and community settings, improving health literacy and signposting to Third Sector services .

UPPER VALLEYS PRIMARY CARE CLUSTER

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Strategic Overview
The next 3 years promise to be exciting. We look forward to engaging with the Transformation programme, which will provide much-needed support to develop the range of services offered in the Upper Valleys Cluster Primary and Community Setting – *Dr Rebecca Jones*.
Vision
To work collaboratively with partners and patients to improve the health and wellbeing of our local communities. To provide good, safe standards of care in the community, closer to our patients
What We Will Do **We will prioritise the following:** • *Prevention, wellbeing and self-care:* Childhood immunisations, influenza vaccination uptake, weight management, diabetes prevention • *Timely, equitable access and service sustainability:* Further development of the Upper Valleys Multidisciplinary Hub, implementation of the Access to In-Hours GMS Services Standards, exploration of areas of collaboration with community pharmacies • *Rebalancing Care Closer to Home:* Introduction of Trail without Catheter (TWOC) in patients own homes, improvement of EOL care and care of frail elderly patients • *Implementing the Primary Care Model for Wales*: Signposting to the most appropriate professional, engaging with the transformation programme, Improving links with Dementia support services, supporting the rollout of Child and Family Wellbeing Early Years' Service • *Digital, Data and Technology Developments*: Promoting the use of My Health on line and continuing to work towards standard utilisation of guidelines for practice data entry and collection • *Workforce Development including Skill Mix, Capacity, Capability, Training Needs and Development:* Improving back office workflow, identifying learning needs of practice staff and reviewing staff profile and competencies • *Estates Development;* Exploring options for improvement grants, mapping current estates to identify available space to accommodate new services and working with 3rd sector to increase presence in primary care and community settings • *Communications, Engagement and Co-production*: Increasing awareness of local services, engaging with the 3rd sector to increase presence in primary care and community settings and with patients to understand their experience of services and to identify their needs and facilitate their participation in the development and evaluation of service, developing Cluster website, QR Pods and other resources • *Improving Quality, Value and Patient Safety:* Engaging in prescribing management schemes, agreed cluster Quality Improvement projects and robust clinical governance and information governance processes.