Bay Cluster

Integrated Medium Term Plan (IMTP)

2020 - 2023

Welcome to the Bay Cluster IMTP 2020 - 2023

Section 1
Executive Summary/Plan on a page

Bay Cluster is dedicated to working together and improving patient care. We have geographical challenges and different patient populations in which to provide efficient and equitable services for patients, with an ageing population. The cluster has already demonstrated its commitment to work with third sector services over the years collaborating with Action on Smoking and Health Wales, Restore Empower Accept Create Heal Western Bay Counselling and Action for Elders. We plan to continue to expand and strengthen links with all third sector services in Bay to work in partnership delivering more services. Our patient representative group helps to guide our decisions and recognise the value of our services. We wish to expand this input further over the next three years to ensure all patients in Bay Health feel included in decisions around their health.

Bay Cluster is due to start an 18 month Whole System Transformation programme on the 1st January 2020. Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vison is to achieve a transformed model of a Cluster led integrated health and social care system for the 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 care closer to home; and 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.

Dr Kirstie Truman
Bay Cluster Lead

Plan on a Page

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.

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.

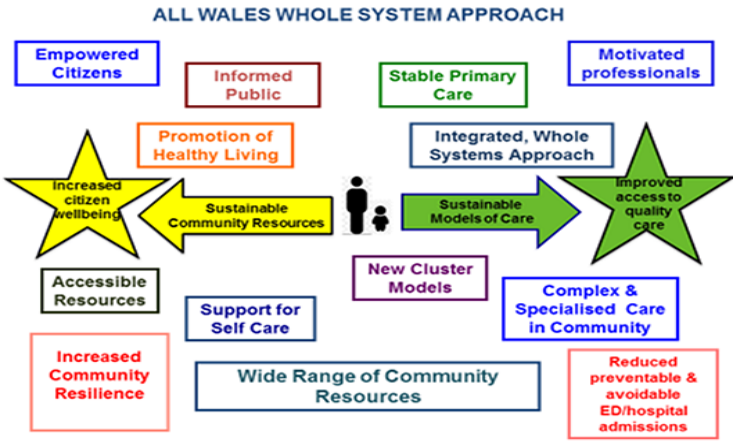
Our Vision

"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."

Our aims

Bay Cluster aims to promote healthy lifestyles ensuring engagement of patients and communities in supporting their own care and participating in shared decision making. We wish to expand our multi-professional team to improve access to those housebound and improve education for patients with chronic illness. Information technology is essential to improve access to health online and we wish to seek out programmes for our patients to utilise, working in conjunction with the local authority.

We will do this in the context of the Primary Care Model for Wales:



Section 2
Cluster profile:

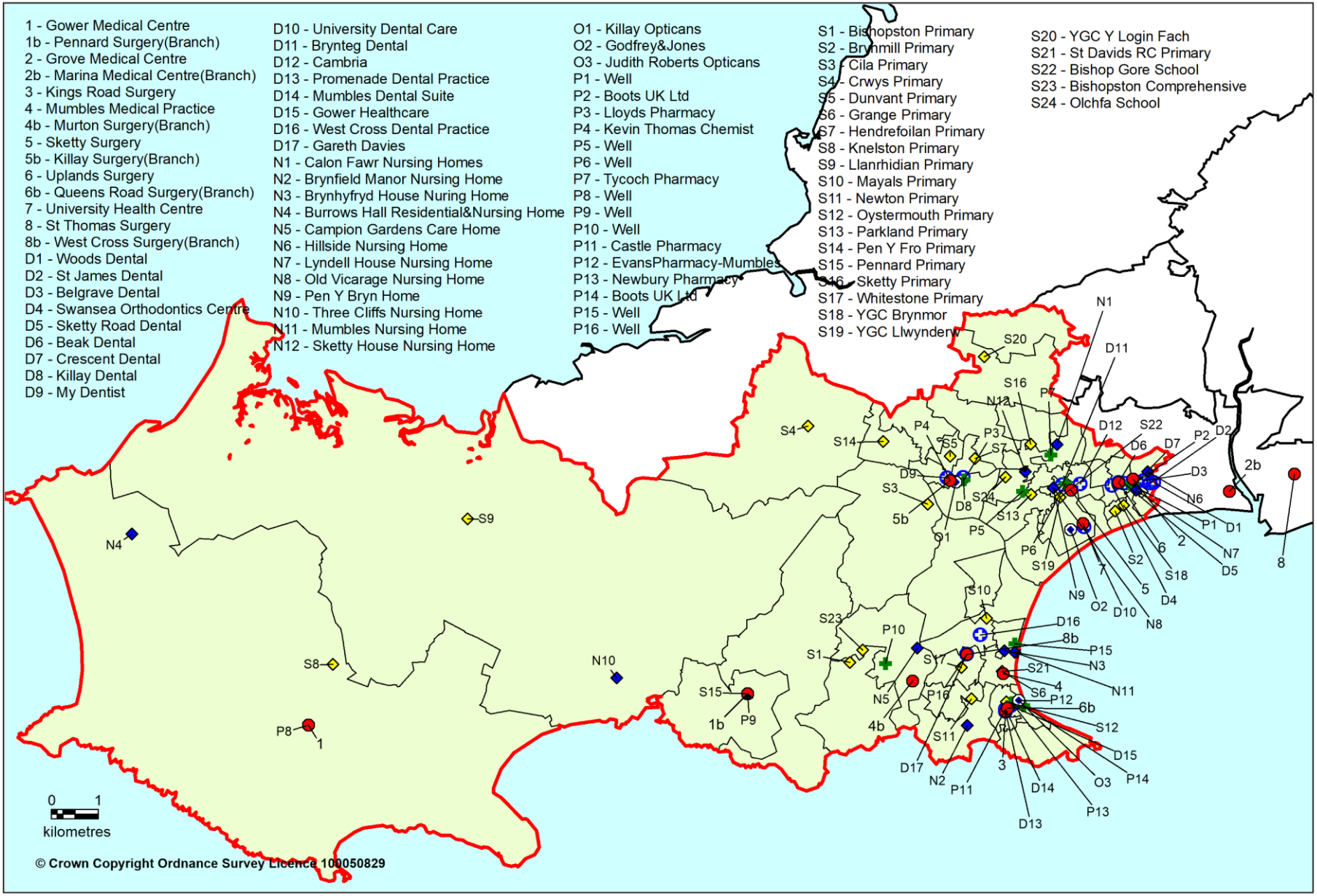
Members and Structure of Cluster

The Bay Cluster is one of eight Clusters in Swansea Bay University health Board and geographically covering Uplands, Sketty, West Cross, Mumbles, Killay, and Gower also serving students resident at Swansea University. Bay Cluster includes eight general practices, community pharmacies, dentists and optometrists, community and hospital services working together with partners from the local authority and the third sector. Clusters across the area have agreed that they aim to work together in order to:

- *Prevent ill health enabling people to keep themselves well and independent for as long as possible.*
- *Develop the range and quality of services that are provided in the community.*
- *Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.*
- *Improve communication and information sharing between different health, social care and voluntary sector professionals.*
- *Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.*

Key links are frequently forged with other partners such as Social Housing, Health of Homeless and Vulnerable Groups Forum, Supporting People, South Wales Police, Fire Service, and Schools and colleges.

Primary Community Services Bay Health Cluster



NHS Wales Informatics Service August 2019

Purpose and Values

The Swansea Bay UHB Clinical Services Plan sets out a list of key facets for the roles of Clusters:

- Delivery of primary, community and integrated services
- Planning and management of services best delivered at the Cluster level
- Delivery of Care Closer to Home where this is safe to do so and adds value to patient outcomes and experience
- Providing innovative alternatives to traditional outpatient or inpatient models of care
- Support whole populations to develop healthy lifestyles, through preventative programmes, self-care and out of hospital care.
- Integrating primary and community based services between health, social and voluntary sectors, physical and mental health services, with our partners
- Promoting University Research and Undergraduate and Postgraduate Education in a vibrant community setting

Governance Arrangements

The Cluster members meet 5 times a year at formal Cluster Board meetings, to plan and review progress and strategic direction related to the Cluster IMTP and to routinely address: Cluster Plan and associated planning actions, Cluster Spending Plan, Risk Register Update, Sustainability and Finance. Declarations of interest are addressed as standing items.

Welsh Government and Health Board allocated Cluster Funds are spent and allocated in accordance with Swansea Bay University Health Board's Standing Financial Instructions. Non-Welsh Government funds are administered on behalf of the Cluster in accordance with agreed Cluster and funding body policies and procedures.

The Cluster reports progress through its own agreed communications programme to a range of stakeholders. Cluster business is also reported through the 5 Cluster Leads Forum (bi-monthly), the 8 Cluster Leads Forum (bi-monthly) and through the Cluster Development Team formally to the Primary Care and Community Services Delivery Unit Management Board on a regular basis. Where Clusters are closely aligned with respective organisations such as Community Interest Companies, reporting arrangements are set out by mutual agreement and available separately.

The Bay Cluster is one of 5 Cluster in Swansea, geographically covering: Uplands, Sketty, West Cross, Mumbles, Killay, and Gower also serving students resident at Swansea University.

The Cluster area consists of 44 Lower Super Output Areas, comparatively low percentage of patients live within the most deprived areas. Bay has a large proportion of students, including those with multi-racial/cross cultural needs. A comparatively low percentage of patient in both Bay West (3.5%) and Bay East (4.1%) live with a long-term sickness or disability (Swansea 6.9%). The patient population is 70,800 (ranging from 3,737 patients registered at the smallest practice to 21,515 patients registered at the largest practice).

Demographic Profile
The Bay Cluster area features:

- Over 17,000 (21%) of patients aged 65+ (15.6% for Swansea)
- Over 8,500 (10.9%) of patients aged 75+ (9.2% for Swansea)
- Over 2,500 (3%) of patients aged 85+ (2.7% for Swansea)
- Large proportion of students, including those with multi-racial/cross cultural needs
- High numbers of 20-24 year olds; 22,521 (31.8%)
- Sketty 4 (the second most deprived Lower Super Output Areas in this area) is in the 10% most deprived Lower Super Output Areas in Wales in both the employment and income domains, but much less deprived in terms of physical environment, housing and access to services
- A comparatively low % of patients in both Bay West (3.5%) and Bay East (4.1%) live with a long-term sickness or disability (Swansea 6.9%)
- A comparatively low % of patients (7%) live within most deprived areas

Swansea wide “headline” information:

- Population: 242,400.
  High concentrations of population in and immediately around the City Centre, the adjacent wards of Cwmbwrla and Uplands (6,800 people per square km, the highest density in the county) and also in Townhill and Penderi
- Population has steadily grown between 2001 and 2015. Main driver of population growth in Swansea has been migration. Recorded live births has steadily risen since 2001 and number of deaths have fallen. Projected population Change: Welsh Government’s latest trend based population projections suggest that Swansea’s population will grow by 9% (21,600 people) between 2014 and 2039
- Life expectancy in Swansea is increasing: Average life expectancy for males is 78 (Wales 78.5) and 82.4 for females (Wales 82.3). This will impact significantly on the provision of health, social care and other public services in Swansea 2011 Census suggests that 14,326 people in Swansea were

from a non-white ethnic group: 6% of the total population and 20,368 (8.5%) of Swansea's Population were non-white British. (Above the Wales average of 6.8%. Census data (2011) suggests the largest non-white ethnic groups are: Chinese 2,052 (0.9%), Bangladeshi 1,944 (0.8%), Other Asian 1,739 (0.7%), Black African 1,707 (0.7%), Arab 1,694 (0.7%)

- Welsh Language: Proportion of people able to speak Welsh in Swansea decreased from 13.4% (28,938) in 2001 to 11.4% (26,332) in 2011. A fall of 9% despite an increase in population.

Key Community Assets

There are 8 GP Practices, 17 Dentists, 3 Opticians, 16 Community Pharmacies, 12 Care Homes, 4 Libraries and 24 schools in the area (21 Primary Schools and 3 Secondary School).

Major employers in the Cluster are: schools, Swansea Bay Health Board (Singleton Hospital), Swansea University, University of Wales Trinity St Davids, Gower College Swansea, Welsh Ambulance Service NHS, Swansea West Industrial Estate (part of), Parc Fforestfach Retail Park, tourism and agriculture.

- Swansea University
- Singleton Hospital
- Gower College
- Libraries
- Extensive countryside
- Uplands Wellbeing Centre
- Volunteer capacity
- Leisure Centers
- Development of continuous cycle routes along the bay
- Schools

Swansea Council have agreed to seek re designation for Phase 7 for the World Health Organisation's 'Healthy Cities'. Cluster examples will be used from across Swansea Bay University Health Board in the case study submission to showcase Cluster work at an international level

Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis: Bay Cluster

Strengths	**Weaknesses**
Multi Disciplinary Team complement Well established leadership and shared common purpose Comparatively lower levels of GP practice sustainablity issues Bay Patient Representative Group in place Dedicated Cluster Implementation/ Business Development Capacity (part time) Strong Working Relationships with the Third Sector Ensuring that patients are directed to the most appropriate professional. Explore external funding	Capacity within Cluster to implement /deliver programmes including Cluster Lead time No legal entity with which to draw in additional funding, no ability to expand/rollout Wide geographical area to cover 'Head-space' for innovation
Opportunities Establish formal legal entitity Development of business plans based on evaluation working with other Clusters Enhancing practice level engagement to implement and develop Cluster agenda Seeking areas of collaboration between GP practices and our partners	**Threats** Programmes largely dependant on WG annual funding Risks to practices/staff regarding employment law for Cluster based staff Workload and sustainability pressures. SBUHB organisational changes

Section 3
Key achievements from 2018-21 plan

Enhancing the multidisciplinary team – developing and expanding the role of both the Cluster Pharmacists and Cluster Specialist Nurse with Minor illness and Independent prescribing

Our initial project of enhancing the multidisciplinary team demonstrated immediate success with two Cluster pharmacists in post seeing patients and undertaking GP day to day work in this area. An initial review of the service indicated that there was a £80,000 annual saving made on medication changes and GP consultations saved.

A specialist nurse in chronic disease and Minor Illness has demonstrated reduced home visits for GPs, decreased admissions and enhanced care for those patients housebound with a chronic disease such as diabetes or Chronic Obstructive Pulmonary Disease.

Bay Cluster successfully achieved target for flu immunisation uptake in all 2 and 3 year olds during the 2018-19 Flu season. We were the only Cluster to achieve this across the Health Board.

Bay Cluster have an active **Patient Representative Group**, the purpose of which is to act as an advocate for patients and help to make sure the patient and public voice is heard. An element of the representative group is to make informed decision around cluster investment and ensure that these services meet the health needs of the local population. The group embrace the 'no decision about me without me' promise and actively promote Bay Health Cluster priorities.

Patient Representative Group – An advocate for all Bay Cluster patients.

ash wales cymru
action on smoking and health

We are working with Action on Smoking and Health Wales to help GPs and practice staff increase the number of would-be quitters getting the right support and nicotine replacement for them.

Action on Smoking and Health Wales have provided GP surgeries with 'smoke' breath monitors; hand-held devices to show a patient the current level of carbon monoxide – poisonous smoke – in their body; acting as a powerful motivator to think about acting to conquer their habit.

Strengthening Third Sector Links – Collaborative projects such as Action for Elders, REACH and Carers Desks

Collaborative projects with Third Sector organisations such as Action for Elders and Swansea Council for Voluntary Service have been key in our success stories. We have secured funding for 2 projects addressing social isolation in our Cluster, totalling in circa £320,000

Cronfa Iach ac Egnïol
Healthy & Active Fund

As part of this, we were pleased to receive Health Foundation funding to deliver the Better Together project. It aims to improve the health of older people by tackling social isolation and loneliness. The project will focus on the role of social connections and community in shaping health and wellbeing.

The Healthy and Active fund have also agreed to invest in our ideas to introduce a programme called Balanced Lives into 5 care homes in Bay Health. It will cater for the needs of residents and local older people by incorporating gentle exercise with a range of social activities. The programme will develop a unique understanding of those communities and individuals, with the aim of improving residents' physical, mental and social wellbeing.

Section 4
Health and Wellbeing Needs Assessment

Information has been collated on a wide range of health needs within the Bay Cluster area in order to develop the priorities for this plan. Agreement on the objectives and actions within the plan has been reached through a combination of analysis of Practice profile data, a review of Public Health Priorities, Disease Register data, audit reports and a series of Cluster meetings.

The development of the plan has presented an opportunity for Clusters to build on the progress made in 2017-19 and has involved partners from Public Health Wales, other Health Board teams and directorates, the Third Sector and Social Services.

Between 2020 and 2023, Bay Cluster will continue to explore areas for development and in the first year will focus on the following priorities:

Obesity	**Diabetes**
Lowest rate in SB UHB at 6.1% obesity rate, 4583 patients (SB UHB average is 9%)	Lowest rate in SB UHB – 4.3% (SB UHB average is 6.1%)
Smoking / Lung Cancer	**Mental Health**
15.7% of smokers across the Cluster population. Welsh Government have set a target of 16% by 2020. The Cluster has a rate of lung cancer per 100,000 at 62.8	Around 32,200 people aged 16 or over in Swansea may have one Common Mental Disorder e.g. anxiety depression and OCD. Bay Cluster has a lower than average rate in Swansea of 1% for those registered as having a mental health condition. 4 of the 8 practices reporting the higher than average rate are within Bay Cluster.

Influenza Vaccination

Bay	Influenza immunisation uptake (%) 2017/18 and 2018/19					
	Patients 65y and over		Patients under 65y at risk		Children aged 2 & 3 years	
	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19
Bay	69.3	70.7	48.5	46.8	48.5	55.3
Swansea	67.4	67.2	46.5	43.0	47.4	46.6
Wales	68.8	68.2	48.5	44.0	50.2	49.3

Screening

Highest uptake in Swansea for Bowel screening 59.4%. Target 60%

Second highest uptake in Swansea for Cervical Screening 76.9%. Target 80%

Highest uptake in Swansea for Breast screening 76.3%.Target 70%

Uptake on AAA screening 79.8%. Target 80%.

Atrial Fibrillation

Joint highest in SB UHB for AF with a rate of 2.3% (SB UHB rate 2%)

Chronic Obstructive Pulmonary Disease

Lowest rate in SB UHB - 1.3% (SB UHB rate 2.2%)

Cancer

Joint highest in SB UHB with a rate of 3% (SB UHB rate 2.3%)

Stroke

Lowest in SB UHB with a rate of 1.9% (SB UHB rate 2.1%)

Asthma

Lowest in SB UHB with a rate of 6.5% (SB UHB rate 7.3%)

Unscheduled Admissions from Care Homes

Highest number of admissions of 289 patients living in Care Homes (SB UHB average number of unscheduled admissions is 187)

Admissions following Falls

Lower than average rate of 0.12 per 1,000 patients (SB UHB average rate per 1,000 patients 0.13)

Unless stated otherwise, all data taken from Swansea Bay UHB Information Portal 2017-19

Emergency Admissions		
Cluster	**No of Admissions**	**R (1k) all ages**
City	2,727.00	26.68
Neath	2,709.00	23.99
Bay	2,319.00	15.56
Afan	2,315.00	22.70
Cwmtawe	2,138.00	25.09
Llwchwr	1,883.00	19.72
Penderi	1,870.00	24.49
U Valleys	1,337.00	21.21
Average	**2,162**	**22.43**

Emergency Attendances		
Cluster	**No of Admissions**	**R (1k) all ages**
Afan	19,657.00	192.77
Neath	18,084.00	160.12
City	14,920.00	145.96
Bay	13,299.00	89.22
Cwmtawe	12,965.00	152.14
Penderi	11,360.00	148.78
Llwchwr	10,065.00	105.42
U Valleys	8,417.00	133.50
Average	**13,596**	**141.00**

Out Of Hours Contact		
Cluster	**No of Admissions**	**R (1k) all ages**
Afan	8,644.00	84.77
Neath	8,242.00	72.98
City	7,706.00	75.38
Bay	6,782.00	45.5
Cwmtawe	6,620.00	77.68
Llwchwr	6,326.00	69.83
Penderi	6,316.00	82.72
U Valleys	3,781.00	59.97
Average	**6,802**	**71.1**

Data from Safer Swansea Partnership July 2019

Recorded Crime

34% of violent crime was Domestic Related.
49% of violent crime was Night Time Economy [6pm to 6am]
30% of violent crime occurred in Eastside and Morriston Sector

Domestic Abuse

The following police beats recorded the highest rates of domestic abuse during July 2019:

- Townhill/Mayhill [53]
- Penlan [47]
- Clydach/Glais [44]

The table below is taken from the July Crime figures reported to Safer Swansea Panel and illustrates the recorded crime within Swansea for the period July 2018-June 2019 together with the impact that the night time economy has on crime.

Recorded Crime July 2018 - June 2019	City	East Side and Morriston	Gorseinon and Penlan	Gower and Townhill	Grand Total	%
Stalking and Harassment	355	866	658	511	**2390**	
Of which Domestic	97	274	223	187	**781**	33%
Of which Night Time Economy (NTE)	148	315	245	217	**925**	39%
Violence without injury	657	610	509	417	**2193**	
Of which Domestic	140	271	204	173	**788**	40%
Of which Night Time Economy (NTE)	405	306	256	194	**1161**	53%
Violence with injury	706	569	535	375	**2185**	
Of which Domestic	144	229	220	162	**755**	35%
Of which Night Time Economy (NTE)	465	280	279	208	**1232**	56%
Homicide	1	1	1	1	**4**	
Of which Domestic	0	1	0	1	**2**	50%
Of which Night Time Economy (NTE)	1	1	0	1	**3**	75%
Grand Total	**1719**	**2046**	**1703**	**1304**	**6772**	
Of which Domestic	381	775	647	523	2326	34%
Of which Night Time Economy (NTE	1019	902	780	620	3321	49%
% Domestic	22%	38%	38%	40%	34%	
% Night Time Economy (NTE)	59%	44%	46%	47%	49%	

Primary Care Measures (2A)

Description of Primary Care Measure	Category	Target (if available)	All Wales Average (Year)	ABMU Average (Year)
Bowel Screening	2A	60%	53.4% (2016/17)	53.2% (2016/17)
AAA Screening	2A	80%	80.8% (2016/17)	81.9% (2016/17)
Seasonal Influenza Immunisation in at risk groups	2A	55%	48.5% (2017/18)	46.7% (2017/18)
Overweight and Obesity in 4-5 year olds	2A		**26.2%** (2015/16)	**25.5%** (2015/16)
Breastfeeding Prevalence at 10 days	2A		**33.8%** (2016)	**31.3%** (2016)
Uptake of Scheduled Childhood Vaccinations at age 4	2A	95%	**85.2%** (2016/17)	**86.9%** (2016/17)
Smoking Cessation	2A		**20.4%** (2017/18)	**19.7%** (2017/18)
LARC	2A		N/A	N/A
Childhood Immunisation at age 16	2A	95%	**89.2%** (2016/17)	**87.5%** (2016/17)
Adults who accessed dental services at least once every 2 years	2A		**51.5%** (2016/17)	**58.0%** (2016/17)
Recording of Alcohol Intake	2A		**76.4%** (2017/18)	**76.6%** (2017/18)
Antibiotic Prescribing	2A		N/A	N/A
People with Dementia prescribed antipsychotic medication	2A		**1.8%** (2017/18)	**2.3%** (2017/18)
People with Diabetes who have received all 8 key care processes	2A		**45.2%** (2016/17)	**52.5%** (2016/17)
No. emergency admissions for ambulatory care sensitive conditions	2A		N/A	N/A

Diabetes lower extremity amputation and diagnosis code of diabetes	2A		N/A	N/A
Circulatory Disease Mortality Rate per 100 000 population <75 years • All Heart Disease • MI • Heart Failure • CVA (all ages)	2A		(2014-2016) **62.3** **18.3** **1.1** **70.6**	(2014-2016) **65.9** **20.5** **0.0** **70.5**
Percentage >65 years with dementia/memory impairment	2A		**2.95%** (2017/18)	**3.08%** (2017/18)
Children (0–17 years) who accessed dental services at least once a year	2A		**59.5%** (2016/17)	**68.8%** (2016/17)
Low Intensity Psychosocial Interventions	2A		N/A	N/A

Enhanced Services undertaken by the cluster practices

Enhanced Services Type	Enhanced Service Name	Bay (8)	Enhanced Services Type	Enhanced Service Name	Bay (8)
DES	Childhood Imms	7	LES	Depoprovera	8
DES	5 Years Boasters	7	LES	Nexplanon	5
DES	Asylum Seekers	4	LES	IUCD	3
DES	Care Homes	6	LES	Gonadorelins	7
DES	Flu	8	LES	Hep B	4
DES	Learning Disabilities	5	LES	INR	8
DES	Mental Health	7	LES	Measles Outbreak	8
DES	Minor Surgery	7	LES	Sexual Health	1
DES	Warfarin (all)	3	LES	Shared Care (All drugs)	7
DES	Diabetes Type 2 DES	6	LES	Student Registrations	1
SFE	HPV	3	LES	Syrian Refugee	3
SFE	Meningitis	8	LES	Uni Les	1
SFE	Pertussis	8	LES	Wound Care	8
SFE	Pneumo	8	SLA	Complex Wound	0
SFE	Rota Virus	8	LES	DOACS	7
SFE	Shingles	8			
			NES	Drug Misuse	1
			NES	Homeless	0
			NES	Unscheduled (all)	3

Enhanced services provided by Community Pharmacies

Cluster	Address	Postcode	Contract	CAS	Seasnl Flu	Smokng L2	Smokng L3	MAR	Pall Care	Just In Case	EMS	Med Mgt	Suprvsd Consumptn	Syringe Needle	THNS	BBV	TB
Bay Health				**16**	**13**	**14**	**8**	**16**	**3**	**12**	**14**	**1**	**11**	**5**	**0**	**0**	**0**
Boots UK Limited	133 Mumbles Road	SA3 4DN	605818C	✓	✓	✓	x	✓	x	✓	✓	x	✓	✓	x	x	x
Boots UK Limited	51 Uplands Crescent	SA2 0NP	605810B	✓	✓	✓	✓	✓	x	x	✓	x	✓	✓	x	x	x
Castle Pharmacy	44 Queens Road	SA3 4AN	605006B	✓	x	✓	x	✓	x	✓	✓	x	x	x	x	x	x
Kevin Thomas Chemist	12 Newton Road	SA3 4AU	605677D	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	x	x	x	x
Kevin Thomas Chemist	Killay Medical Centre	SA2 7QP	605674D	✓	✓	✓	✓	✓	x	✓	✓	x	x	x	x	x	x
Lloydspharmacy	The Precinct	SA2 7BA	605802F	✓	✓	✓	✓	✓	x	x	✓	x	✓	✓	x	x	x
Newbury Pharmacy	35-37 Newton Road	SA3 4BD	605145B	✓	✓	✓	x	✓	✓	✓	✓	x	✓	✓	x	x	x
Tycoch Pharmacy	36 Carnglas Road	SA2 9BW	605521B	✓	x	x	x	✓	x	x	x	x	✓	x	x	x	x
Well	2 Park Way	SA2 8JJ	605854P	✓	✓	x	✓	✓	x	x	✓	x	✓	x	x	x	x
Well	82 West Cross Lane	SA3 5NG	605854I	✓	✓	✓	x	✓	x	✓	x	x	x	x	x	x	x
Well	5 Dillwyn Road	SA2 9AQ	605854K	✓	✓	✓	✓	✓	x	✓	✓	x	✓	x	x	x	x
Well	Pennard Surgery	SA3 2AD	605855B	✓	x	✓	x	✓	x	✓	✓	x	✓	x	x	x	x
Well	8A Alderwood Road	SA3 5JD	605854E	✓	✓	✓	✓	✓	x	✓	✓	x	✓	✓	x	x	x
Well	Manselfield Road	SA3 3AR	605854L	✓	✓	✓	x	✓	x	✓	✓	x	✓	x	x	x	x
Well	Monksland Road	SA3 1AY	605855C	✓	✓	✓	x	✓	x	✓	✓	x	x	x	x	x	x
Well	55 Uplands Crescent	SA2 0EZ	605854F	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	x	x	x

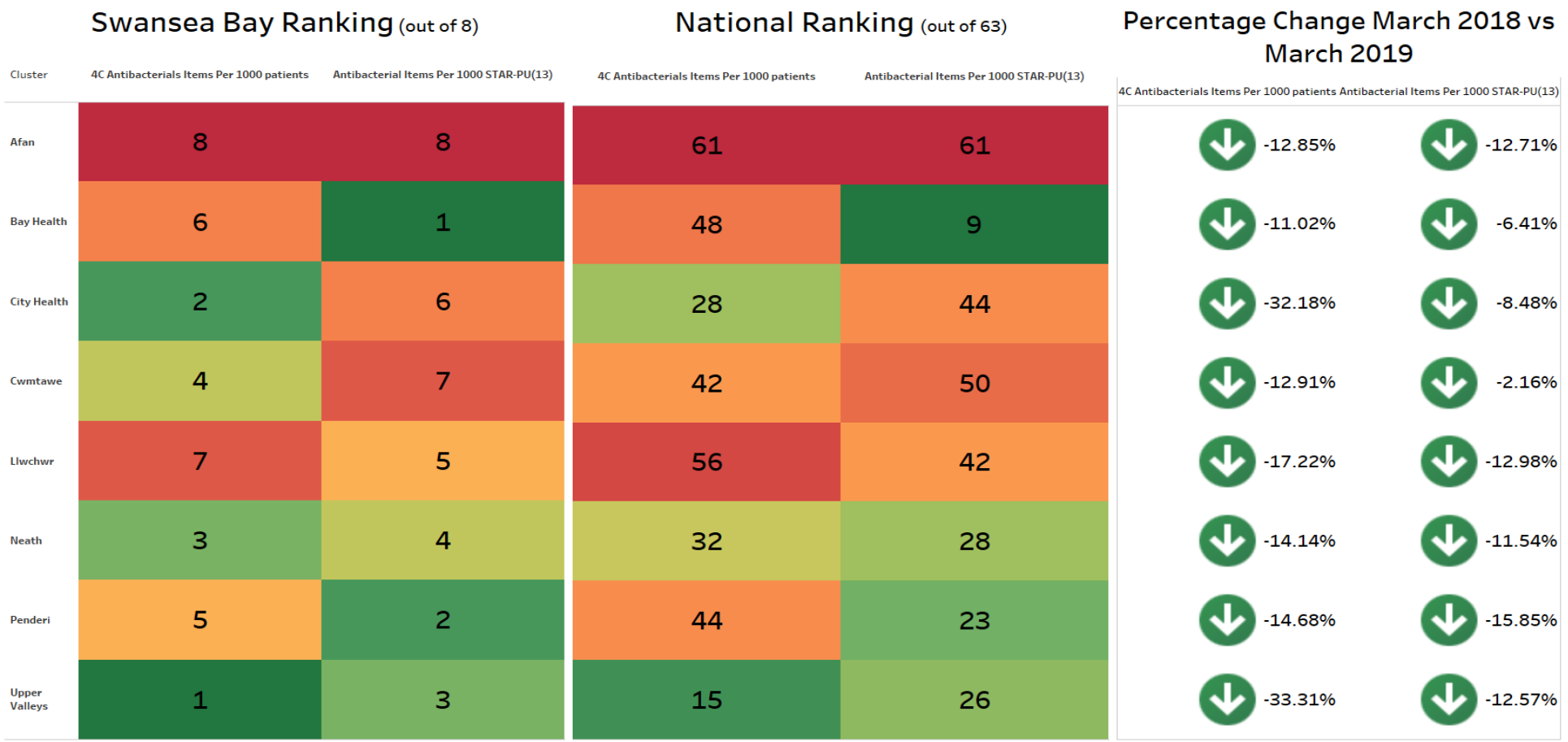
Antibiotic Prescribing

In January 2019 the UK 5 year AMR National Action Plan 2019-2024 was published, which underpins the UK AMR Strategy 20 year vision. Building on achievements seen in 2018/19 improvement goals are set for Heath Care Acquired Infection and Antimicrobial Resistance, which will be reported at a National level. The Primary Care goals in relation to prescribing are:

- All prescribers should document indications for all antimicrobial prescriptions; it is expected that an appropriate read code will be entered whenever antimicrobials are prescribed. Primary Care Clusters should ensure urgent dental cases are seen by dental services rather than by GMS.

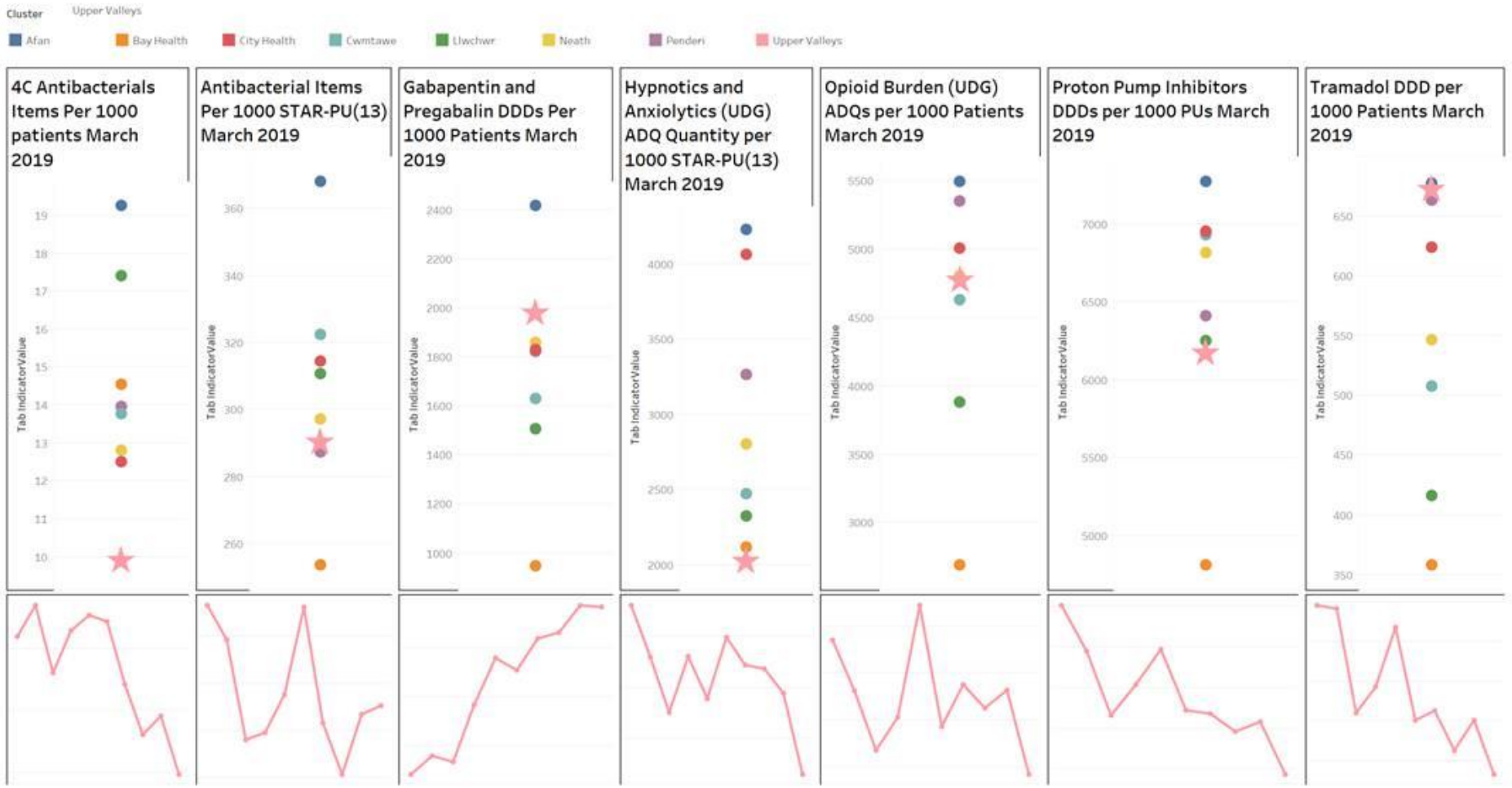
- Wales Quality Improvement: Antimicrobial Stewardship – Supporting measures to improve UTI prevention, multidisciplinary diagnosis and management of UTI, making use of ‘UTI 9’ standards. Materials are available to support GPs and Clusters to review Multi-Disciplinary Team diagnosis and management of adults with UTI. Further information on numerous resources, audits, leaflets etc available here
- To continue to reduce overall antimicrobial consumption by 25% from baseline year of 2013 by 2024. Nationally a 12% reduction has been seen between 2013 to 2017.

From the graphs and data, all based on National Prescribing Indicators, it can be seen that Swansea Bay Clusters have made good improvements over the last year. However when reviewing the 8 Clusters within the context of the 64 Welsh Clusters then it can be seen that significant improvements are still required in the fight against overall antimicrobial use and ‘4C’ antibacterials.


Swansea Bay Ranking (out of 8)
National Ranking (out of 63)
Percentage Change March 2018 vs March 2019
Cluster
4C Antibacterials Items Per 1000 patients
Antibacterial Items Per 1000 STAR-PU(13)
4C Antibacterials Items Per 1000 patients
Antibacterial Items Per 1000 STAR-PU(13)
4C Antibacterials Items Per 1000 patients
Antibacterial Items Per 1000 STAR-PU(13)
Afan 8 8 61 61 -12.85% -12.71%
Bay Health 6 1 48 9 -11.02% -6.41%
City Health 2 6 28 44 -32.18% -8.48%
Cwmtawe 4 7 42 50 -12.91% -2.16%
Llwchwr 7 5 56 42 -17.22% -12.98%
Neath 3 4 32 28 -14.14% -11.54%
Penderi 5 2 44 23 -14.68% -15.85%
Upper Valleys 1 3 15 26 -33.31% -12.57%

Prescribing Management Savings+ Scheme

The data below relates to the Prescribing Management Savings+ part of the incentive scheme, where practices made prescribing improvements in areas such as inhalers, home blood glucose monitoring, low value medicines etc and not linked to NPIs



Section 5
Cluster Workforce Profile

To ensure practice sustainability, we have agreed to develop a Cluster workforce plan in 2020, ensuring we have the people in place to deliver pragmatic healthcare. This should maximise the opportunities for cross-practice working and ensure better access for patients in conjunction with partner organisations.

Across our 8 practices, the Cluster has:

DOCTORS

Head Count	Whole Time Equivalent	GP / Patient Ratio
63	43	1,724

NURSES – *Nurses employed directly by the Practice*

Head Count	Whole Time Equivalent	Nurse / Patient Ratio
27	15.5	4,781

DIRECT PATIENT CARE – *Health Care Assistants, chiropodists, therapists, etc*.

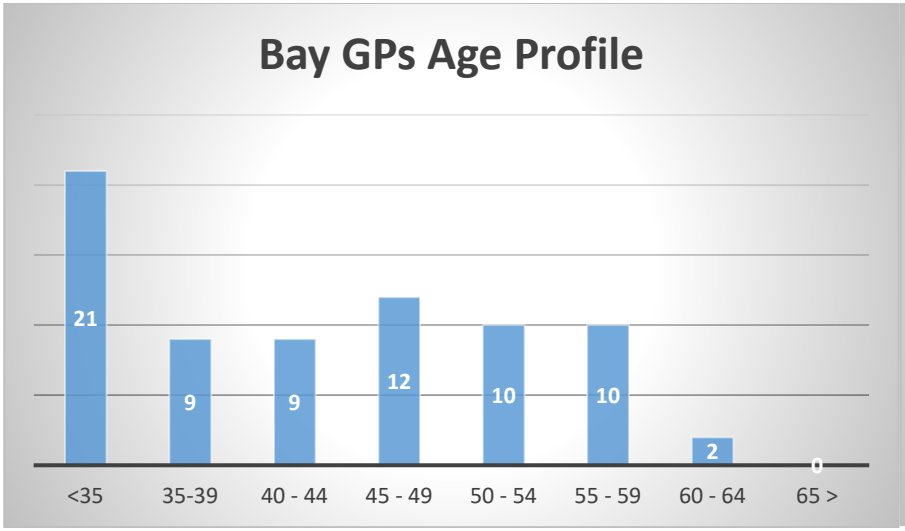
Head Count	Whole Time Equivalent	DPC / Patient Ratio
18	7.2	10,335

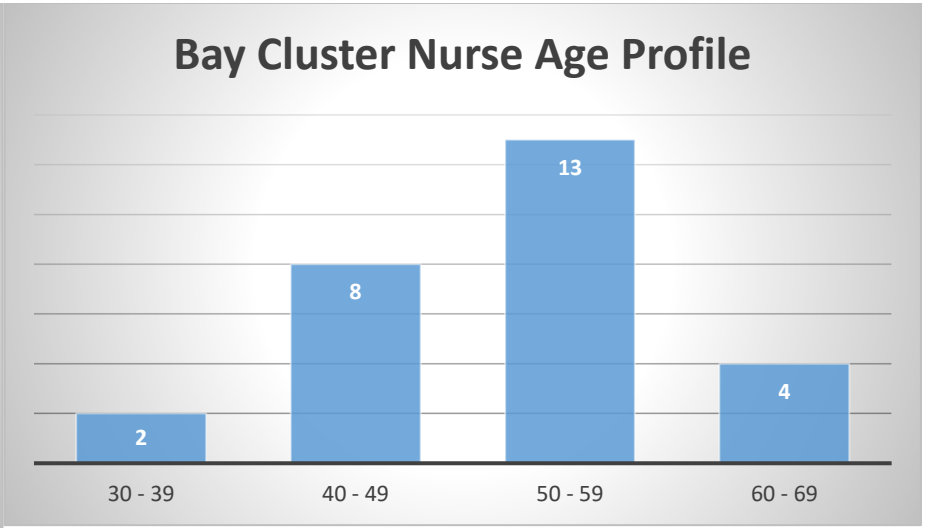
ADMINISTRATIVE STAFF – *Practice Managers, receptionists, secretaries, etc.*

Head Count	Whole Time Equivalent	Admin / Patient Ratio
104	72.8	1,018

In February 2017 we employed a Chronic Conditions Nurse who has become integral to the wider Cluster multi-disciplinary team. Recruited to address potential health inequalities amongst housebound patients living in the Cluster area, through improving access to nurse-led coordination, management and monitoring for chronic disease patients with long-term chronic illness. **98%** of housebound patients are dealt with at their homes, with a large majority avoiding admissions as a result (includes telephone consultation or a home visit). Our Chronic Conditions Nurse is providing enhanced monitoring systems and improving links with colleagues in secondary care, i.e. Singleton hospital Respiratory Team. It has also improved the referral to other professionals, such as Physiotherapist, Dieticians, and Occupational Therapy. Continual professional development is underway, with the completion of Minor Illness course and enrolment in Independent Prescribing course.

Our initial age profiling exercise shows 2 GPs retiring in the next 12 to 18 months and indicates a future potential shortage of practice nurses.


Bay GPs Age Profile
21
9
9
12
10
10
2
0
<35
35-39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 >


Bay Cluster Nurse Age Profile
2
8
13
4
30 - 39
40 - 49
50 - 59
60 - 69

Pharmacy:

We have strengthened our multi-disciplinary team with a clinical pharmacist now in place for the fourth year, undertaking medication, polypharmacy and new patient reviews; along with any medication related queries from all staff in primary care.

Independent Prescribers:
All clusters have worked collaboratively with Health Education Wales [HEIW] and Swansea University to increase the number of Independent Prescribers working within community pharmacies across the Swansea Bay University Health Board footprint.

Independent Prescribers will be able to provide an enhanced Common Ailments Service enabling independent prescribers to diagnose, assess and manage acute conditions within the Pharmacy. This will relieve pressure on GP practices and increase accessibility for patients seeking condition specific appointments.

Swansea Bay community pharmacists

	Employed Headcount	**Employed FTE**
Bay Health	18	15.4
City Health	25	19.5
Cwmtawe	18	12.6
Llwchwr	13	9.7
Penderi	11	9.2
Totals	85	66.4

Total pharmacist FTE	85.0
Total pharmacist Headcount	130

Dental:

Contract Reform:

The General Dental Service Contract Reform programme has been rolled out to every cluster across SBU HB. The dental reform programme was established based on the learning from the Welsh Dental Pilots (2011-2015) and dental prototype practices in Swansea. The current General Dental Service (GDS) model is based on delivery of Units of Dental Activity (UDAs), a proxy for counting dental treatments. The system does little to encourage utilisation of skill-mix and delivery of risk and need-based preventive dental care. Patient outcomes are also not monitored. Many people who need and want to access dental services cannot access dental services while many apparently 'healthy' patients attend every 6 months.

The programme is a positive change to the way dental services are currently provided, moving away from dental practices trying to achieve annual targets and replacing this with a service focused on preventative care and active engagement with patients to look after and improve their oral health. The objectives of the dental reform programme are to reducing oral health inequities, delivering improved patient experience and outcomes by implementation of Prudent Healthcare Principles, evidence based prevention and to development of culture of continuous improvement, are key in ensuring NHS dental services are sustainable.

Wider Support from Other Partners

Our Cluster has a consistent and long approach to involvement of partners in addition to working alongside other health service areas. This has informed the priorities of the Cluster as well as delivering action against those to improve the health and wellbeing of the population and in turn reducing impact on primary and secondary care health services.

For our Cluster these have included:
Local Area Co-ordination
Swansea Council for Voluntary Services
Children's Services in Swansea Council
Poverty and Prevention
National Exercise Referral
A range of Third Sector providers such as Citizens' Advice Bureau, EYST (Ethnic Youth Support Team),
Regional (West Glamorgan) Carers Partnership
Multi-agency input via a range of partnership forums such as Safer Swansea Partnership, the Health of Homeless and Vulnerable Groups et
Local Schools.

Community Health and Social Care Teams					
Role	**Bay Cluster**	**City Cluster**	**Penderi Cluster**	**Llwchwr Cluster**	**Cwmtawe Cluster**
	West Hub	**Central Hub**		**North Hub**	
District Nurse	22.3	36		15.3	11.4
HCSW	9.4	8.9		5.4	3.1
OOH Nursing Team	N/A	10.2		N/A	
Physiotherapy/Occupational Therapist	7.6	13.2		9.7 (P) / 8 (OT)	
Single Point Of Access	3.6	7.5		1	
Palliative Care (HCSW)	8.6	N/A		N/A	
Palliative Care Nurses	1.4	N/A		N/A	
CHC inc NB Team (HCSW)	31.5	N/A		N/A	
CHC Nurses inc NB Team	5.6	N/A		N/A	
Administration	4.4	3.29		3.1	
Swansea Council (Social Workers, Homecare, Occupational Therapists)	31.5	36		41.1	
Issues reported for Swansea Bay University Health Board Escalation is reviewed on weekly basis in order to identity sickness absence, SL or leave to identify capacity within the Hubs and resources available for district nursing and mobilise staff in order to provide equitable service for all service users across Swansea. Vacancies within the Hubs are fast moving and recur frequently.					
Acute Clinical Outreach Service					
Role	**Bay Cluster**	**City Cluster**	**Penderi Cluster**	**Llwchwr Cluster**	**Cwmtawe Cluster**
ACO: 3 x GPs	sessional basis working one day each a week covering all of Swansea Clusters Monday, Wednesday and Fridays				
Speech and Language					
Role	**Bay Cluster**	**City Cluster**	**Penderi Cluster**	**Llwchwr Cluster**	**Cwmtawe Cluster**
Speech and Language Therapist	1	1	1	1	1
School Nursing					
	Bay Cluster	**City Cluster**	**Penderi Cluster**	**Llwchwr Cluster**	**Cwmtawe Cluster**

School Nursing Service	41 members of staff				
Looked After Children Service	11 members of staff				
Audiology					
Audiology services are available across Swansea, from Singleton Hospital. A transformation programme is underway to deliver community based services being trialled in Cwmtawe Cluster.					
Local Area Coordinator					
	Bay Cluster	**City Cluster**	**Penderi Cluster**	**Llwchwr Cluster**	**Cwmtawe Cluster**
Local Area Coordinator (all F/T)	4	2	2	2	1
Description of other resources available or required, pertinent to Cluster discussions, e.g IT, skill mix			Only part of Cluster covered	Only part of Cluster covered	Only part of Cluster covered
Occupational Therapy					
Current Occupational Therapy provision in the community is primarily provided through the Integrated Community Health and Social Care teams. Access to Occupational Therapy provision is through the Community Resource Team, and GP access for outpatient services e.g. fibromyalgia. There is also capacity within Mental Health Services. Cluster based Occupational Therapy provision is currently being provided as two pilots in Llwchwr and Cwmtawe, with a focus on Mental Health and Frailty respectively. A robust evaluation is being undertaken in relation to assessing benefits and feasibility of the pilots.					

We have strengthened our multi-disciplinary team with a clinical pharmacist now in place for the fourth year, undertaking medication, polypharmacy and new patient reviews; along with any medication related queries from all staff in primary care.

Section 6

Cluster Financial Profile

The Bay Cluster has a financial allocation from the Welsh Government of £217,516. In addition, the Heath Board have secured significant addition resource for the use in Bay Cluster - over £1.416m to undertake an 18 month Transformation Programme which will formally commence in January 2020 (Whole System – New Model of Primary Care).

Bay Cluster Funding 2019-20	
Welsh Government allocation	£217,561
Total available	**£217,561**

PLANNED SPEND	
Project	**Spend allocated**
Clinical Pharmacist (1.6WTE)	£68,094
Cluster Specialist Nurse (1WTE)	£41,601
Business Manager (0.2WTE)	£13,940
Mentoring	£2,000
Multi-Disciplinary Team Expenses	£1,907
PCC Training	£1,000
Wifi Costs ongoing	£5,000
PLTS	£750
Reducing Social Isolation	£7,927
CYP Counselling	£13,060
Patient Engagement	£7,100
Patient Representative Group	£500
Cluster Development and Staff training	£5,607
Shadow leadership board	£4,000
Total spend	**£172,486**
Planned spend balance to be allocated to further Cluster schemes	**£45,075**
Additional Resource 2019-20	
Prescribing Management Savings+ Monies	£42,687
Health Foundation	£59,200
Action for Elders (over 3 years)	£260,000
Total available	**£260,248**

Welsh Government Allocation per theme	
Older People	£5,224,000
Learning Disabilities/Mental Health /Complex Needs/Carers	£2,590,000
Edge of Care	£1,942,000
Total	**£9,756,000**

Section 7 Our Cluster Three Year Action Plan

The development of the plan has presented an opportunity for Clusters to build on the progress made in 2017-19 and has involved partners from Public Health Wales, other Health Board teams and directorates, the Third Sector and Social Services.

Following the Health and Wellbeing Needs Assessment, it has highlighted areas in which Bay Cluster will continue to explore and develop to bridge those health inequalities. For example a high number of unscheduled admissions for residents of care homes within the Bay Cluster foot print. Although, Bay Cluster are proactively screening patients, there are opportunities to achieve targets. Similarly, improved management of Atrial Fibrillation and the detection and diagnosis of cancer.

The Cluster has expressed a range of areas which are a priority for them in delivering a sustainable and effective Health service. Among these are included:

- Reduce frailty
- Promotion of self-care
- Improved access
- Increased use of co-production

In addition, as stated earlier, from January 2020 Bay Cluster is please to become part of the national Transformation Programme for an 18 month period. Actions agreed through the programme will become part of the Cluster action plan through regular updates.

Prevention, Wellbeing and Self Care

Our three year focus:
To promote self-care, health and wellbeing amongst the Cluster population and increase referrals to relevant prevention service with a focus on smoking, exercise and nutrition, flu vaccinations and social isolation.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
1.1	Reduce the level of obesity in pre diabetes and patients with a BMI 40+ through a tailored programme. Increased recording of BMI on patient records. Increased referral to Fitbit 6 weeks rolling programme. Development of a successful 'Walk with my GP' programme Increase referrals to WW weight loss sessions	All GPs Lifelong Learning Digital Communities Wales National Exercise Referral Scheme	March 2020	Reduction of obesity prevalence. Better understanding of scale of issue. Better data. Improved access to a variety of support organisations available to patients.	Funding Venue National Exercise Referral Scheme Lifelong Learning Digital Communities Wales Equipment	Working with Lifelong Learning, Digital Communities Wales and National Exercise Referral Scheme to facilitate a 6 week rolling Fitbit programme. Aim to commence Oct 2019
1.2	To contribute to the obesity pathway delivery review: • Completion of baseline survey by practices • Participation in qualitative interviews	Practices Swansea Bay public health team Cluster leads Cluster Development managers	March 2020	Obesity pathway delivery review completed Greater understanding of level 2 provision in primary care, in order to improve and deliver a consistent and coherent patient centred obesity pathway	Staff time	Obesity Pathway delivery review commenced in Swansea Bay March 2019. Level 2 insight with primary care to commence September 2019

1.3	Increase flu uptake for housebound patients using a streamlined approach which will allow the Multi-Disciplinary Team to vaccinate a larger number of housebound patients.	All GPs Cluster Multi-Disciplinary Team	March 2020	Achieving 75% uptake in 65 years and older and/or housebound patients. 2018/19 uptake of 70.7% Central collection point for Cluster Multi-Disciplinary Team to collect vaccinations to reduce time collecting vaccinations from each individual practice.	Flu Vaccinations Development of a flu proforma Staffing Resource	Agreed to have a central point of collection for all housebound patients
1.4	Improve access to expert smoking cessation counselling and treatment by: Targeting Bay Cluster smoking population. Promoting 'Bay Cluster Stop Smoking Month' Developing promotional material to be sent to all patients recorded as smokers	All Practice Staff Cluster Multi-Disciplinary Team Third Sector	March 2021	Reduction in Smoking prevalence.	Funding Promotional material Administrative staff Accurate Help Me Quit smoking cessation location details	All practices have been provided CO monitors in order to accurately record patients smoking status.
1.5	Increase referrals to National Exercise Referral Scheme and physical exercise	All GPs Lifelong Learning Digital Communities Wales	March 2020	Increased referrals to National Exercise Referral Scheme via streamlined pathway Increased referral to Fitbit 6 weeks rolling programme. Development of a successful 'Walk with my GP' programme	Funding National Exercise Referral Scheme Lifelong Learning	Working with Lifelong Learning, Digital Communities Wales and National Exercise Referral Scheme to facilitate a 6 week rolling Fitbit programme. Aim to commence Oct 2019

		National Exercise Referral Scheme		Development of activities database/ quick reference guide to available activities.	Digital Communities Wales Equipment	
1.6	Reduce social isolation and improve mental health and wellbeing commissioning Action for Elders	All GPs Third Sector	March 2022	Addressing mobility movements, mental health issues and cognitive thinking, life style adaption, health promotion, social interaction and peer group stimulation.	Funding	Action for Elders has been commissioned via third sector grant scheme
1.7	Further develop opportunities to increase social prescribing and to make full use of the assets available within the local community by: Using social prescribing pads Placing Activators in practices to signpost patients Making carers desks available in practices	Cluster Dev Team Swansea Council for voluntary Services Cluster Development Manager	March 2020 and Ongoing	Increased opportunities for patients to participate in non-medical opportunities that will increase their wellbeing	Time Funds	Both Action for Elders and Restore Empower Accept Create Heal counselling services have been commissioned via third sector grant scheme

Timely, equitable access, and service sustainability

Our three year focus:

Improving access to primary care services and delivering at or close to home through achieving Access Standards and increased referrals to Choose Pharmacy

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position

2.1	Access to In-Hours GMS Service Standards: Improved access to services, delivered closer to home. Informing Cluster population of wider options available.	All Practices	March 2021	Achieving Access Standards and measures (Group 1 and Group 2)	Funding Telephone infrastructure Signposting materials Communication and Engagement	All Practices offer good in-hours access, however practice access position will be reviewed to reflect the new GMS contract reform
2.2	Increase referrals to Choose Pharmacy/Common Ailment Scheme	All Practice staff Cluster Multi-Disciplinary Team	March 2022	Greater confidence in non-clinical referral to Community Pharmacy services. Increased referrals to Community Pharmacy services. Improved relationships between all practices and Community Pharmacy	Task and finish group to design a workflow guide to support non clinical members of staff. The group will include representatives from practices, Pharmacy Team and the Primary Care Team	Bay Cluster has the lowest rate of referrals to Choose Pharmacy/Common Ailments scheme in Swansea Bay UHB

Rebalancing Care Closer to Home

Our three year focus:

Working in partnership to provide care closer to home. Developing and improving services in the community, such as early identification of patient at risk of frailty and heart failure.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position

3.1	Support delivery of Frailty Framework for the identification and management of frailty through *'one system' of* care - by ensuring that Bay Health Cluster can be a basis for much of the care and services for older people across agencies.	Cluster Community Nursing Team	March 2021	A multidisciplinary approach to Frailty in the community Increased identification of patients at risk of frailty Patients will remain at home for longer Early intervention with referral to mobility classes	Identify and fund venue Commission on frailty nurse Consultant Rhodri Edwards	Initial discussion has taken place to scope delivery of frailty framework.
3.2	Encourage Practices to sign up to the Diabetes National Enhanced Service	Cluster Lead GPs	October 2019	Improved outcomes for patients with Diabetes.		X-Pert Diabetes Sessions are taking place in practices The Cluster has participated in Pre Diabetes initiative and key staff have received training in Food Wise sessions ensuring that appropriate advice and guidance regarding healthy lifestyles is given to patients
3.3	Improve access to mental health services for adolescents aged 14-25 years by commissioning counselling services.	Cluster REACH	March 2023	Improved access to services delivered in the community with clinics in OPD	Funding Venue	Restore Empower Accept Create Heal commissioned to provide services via a grant.
3.4	Improve community care of patients with heart failure by ensuring:- Patients with heart failure have a flu vaccination Creating a self-management educational programme is created	Cluster Community Heart Failure Team	March 2023	Improve identification of patients with heart failure. Optimise treatments in the community to maximal tolerated doses. Undertaking 6 monthly reviews of patient diagnosed with chronic heart failure	Funding Venue	Primary care target framework awaited. Whole systems approach business plan being created with the Health Board

3.5	Improve community care of patients with Chronic Obstructive Pulmonary Disease by ensuring patients with Chronic Obstructive Pulmonary Disease have a flu / Pneumoccocal vaccination and creating self-management educational programmes with patients	Cluster Pulmonary Rehab Team	March 2023	Improve identification of patients with Chronic Obstructive Pulmonary Disease using Spirometry Optimise treatments in the community with appropriate inhalers/ Referrals to Pulmonary Rehabilitation Undertaking annual reviews of patient diagnosed with Chronic Obstructive Pulmonary Disease	Funding Venue	Primary care target framework awaited. Whole systems approach business plan being created with the Health Board

Implementing the Primary Care Model for Wales

Our three year focus:

Clusters remain at the heart of the Primary Care Model for Wales, bringing together all local services involved in health and care across the Cluster geographical footprint.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
4.1	Deliver a comprehensive Multi-Disciplinary Team, in 4 distinct population groupings in Bay Cluster. Progress rollout of Primary Care Child and Family Wellbeing Service (Early Years) across all Clusters.	Cluster Community Nursing Team	March 2023	Services will be integrated and seamless within neighbourhoods Early years: Making sure children have the best start in life.	An increase of 3 community physiotherapists Increasing Occupational Therapists Early Years Worker	Initial discussion has taken place to scope delivery of care in a population grouping approach.

4.2	Improve access to CRP testing by utilising the CRP testing machines.	All GPs	March 2022	To reduce antibiotic prescribing across all Practices.	Machines and testing strips for practices	Currently at the procurement stage of equipment.
4.3	Provide training for Cluster members and service teams on: - Co-production - Making Every Contact Count - Health Literacy	Cluster Public Health Wales	March 2023 Other tbc	Ill health and disease will be at the heart of every appropriate contact and patients will become more engaged. Measurement of the number of brief advice conversations undertaken by staff and self-reported behaviour change in patients. Improved patient experience, shared decision making, Self-management support, and improved staff health Most Cluster teams trained appropriately	Public Health Wales capacity to deliver training.	To be confirmed
4.4	Increase use of My Health Online in all Practices in Bay Cluster. (also refer to 5.2)	Practice administration staff Health Board Digital Communities Wales Library	March 2021	Reduce impact on Practices Better access for Patients All Practices increasing the number of patients in Bay Cluster using My Health Online	Training Venue Software Demonstration	An event will take place in Oct 19 to raise awareness of My Health Online
4.5	Work with partners to deliver programme of Transformation of Clusters, robustly evaluated, underpinned with training, support, clinical time and workforce	Cluster Lead GP Leads	Ongoing	To achieve a transformed, sustainable, model of cluster led integrated health and social care.	Staff resource Funding	Bay Cluster is due to start an 18 month Whole System Transformation programme on the 1st January 2020.

	development and resulting development	Cluster Development Manager Transformation project Manager		Improving health and wellbeing across the age spectrum, including a key focus on facilitating self-care and building community resilience Coordinating services to maximise wellbeing, independence and care closer to home including flexibility to coproduce, design and implement services in partnership with the community.		

Digital, data and technology developments

Our three year focus:

Improving access to information and introducing new ways of engaging and delivering care with digital technologies.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
5.1	Rollout Vision 360 software to all Vision practices	All Practice Staff Cluster Multi-Disciplinary Team	March 2022	All practices to install Vision 360 software. All Cluster members of staff delivering services cross the whole Cluster with IT infrastructure support.	Software Demonstration Funding Software	No infrastructure in place
5.2	Increase use of My Health Online in all practices in Bay Cluster. Refer to 4.5					
5.3	Introduce the use of digital technology to improve access via Skype consultations and email booking system	All Practice Staff Cluster Multi-	March 2023	Reduce impact on practices Better access for patients	Software Demonstration Funding Software	No infrastructure in place

		Disciplinary Team				

Workforce development including skill mix, capacity, capability, training needs, and leadership

Our three year focus:

To build on current Cluster workforce to meet the needs of the populations and deliver a comprehensive training programme which supports staff and clinicians to work in the most effective way possible.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
6.1	Upskill Multi-Disciplinary Team through undertaking independent prescribing module for CSNCD	Cluster Specialist Nurse	March 2020	Cluster specialist nurse in chronic disease and Minor Illness to complete independent prescribing module to enable working autonomously for patients.	Funding Mentoring	Cluster Specialist Nurse has begun the Independent prescribing module
6.2	Expanding Multi-Disciplinary Team by employing an additional Cluster Nurse.	GP Lead Business Manager	March 2022	To employ an additional Cluster Nurse with a view to upskill and undertake minor illness and Independent Prescribing modules.	Funding Mentoring HR CIC	Scoping solutions to Cluster employment challenges
6.3	Employ a Business Development Manager	GP Lead	March 2020	Business Development Manager employed to drive forward the Cluster agenda. Additional funding brought to Cluster.	Funding HR CIC	Scoping solutions to Cluster employment challenges
6.4	Develop a Cluster education programme to support and supervise trainee volunteer counsellors	Restore Empower Accept Create	March 2020	Trainee counsellor to undertake training hours in Bay Health practices supervised by Restore	Venue Mentoring funded in Grant scheme Trainee identified	Trainee identified

		Heal counselling		Empower Accept Create Heal counselling		
6.5	Increase access to CBT pain management programme by providing services closer to home	All GPs	March 2022	Reduction of opioids prescribing Increased access to persistent pain management programme	Funding GPs Administration	Due to commence
6.6	Develop Cluster workforce and succession plan/strategy.	All GPs Cluster	March 2023	Robust succession plan to reduce impact of high number of future workforce retirement and meet population health needs.	Planning session	Session dates to be agreed

Estates developments

Our three year focus:

To maximise the use and development of all available estates/estates activities within the Cluster to deliver Cluster programmes and services and to improve the population health and wellbeing

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
7.1	The Cluster will map with Health Board, Local Authority and other partners the availability of estates on a Cluster basis for the delivery of services	Cluster Development Support Manager (Health Board)	May 2023	Clear understanding of available estates. Clear understanding of relevant organisational estates strategies impacting the Cluster The Cluster able to influence estates' strategies	Cluster Lead for Estates Capacity to map and collate information Capacity to attend high level estates meetings and individual schemes project meetings	Information is disparate, held in silos and not considered at Cluster level other than by exception

				More prudent use of estates for better patient access to services at lower cost to providers.		
7.2	The Cluster will work closely with partners including Social Housing providers in the development of estates strategies, development plans for the benefit of population health	Cluster Lead, Public Health Wales Cluster Development Support Manager	Opportunistically	Social Housing providers invited to relevant Cluster forums New developments better informed by the Health and Wellbeing agenda and local health and care needs.	Capacity to scope out providers and attend respective forums.	Occasional involvement not widely tested.

Communications, Engagement and co-production

Our three year focus:

To improve communication, engagement and co-production between the Cluster, Stakeholders and Patients to strengthen relationships. This will assist service development and improvement, providing patient education of the services and support available close to home.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
8.1	Scoping solutions to Cluster employment challenges by forming a Community Interest Company.	Cluster	March 2022	Forming a Community Interest Company (CIC) and successfully employing Cluster staff	Staff resource Specialist advice Funding	Initial discussions have taken place
8.2	Co-produce services with increased patient input and feedback - Set out a clear programme of patient engagement to build on the Patient Representative Group	GP Lead Business Development Manager	Quarterly	The Patient representative group will increase input into Bay Health.	Venue Staff resource	Meetings are scheduled to take place prior to Cluster meetings.

8.3	Annual assessment to be undertake to evaluate of the role that co-production play in the development and implementation of services and programmes within the Cluster; lessons learnt to be fed back to Cluster Board	Cluster	Annually	Annual assessment will highlight area of improvement and development.	Cluster Health Board	Annual assessment date to be agreed.
8.4	Empowering patients through the Patient Representative Group	Patient representatives GP Lead Cluster Development Manager	Quarterly	Active Patient Representative Group. Act as an advocate for patients and help to make sure the patient and public voice is heard. Make informed decision around Cluster investment and ensure that these services meet the health needs of the local population Cascade appropriate and relevant information to fellow patients.	Increase membership of group Venue	Next meeting scheduled for Nov 2019
8.5	Improve Third Sector engagement by undertaking a workshop and developing robust communication plan between Bay Cluster and Third Sector.	All Practice Staff Third Sector Cluster Development Manager	March 2021	Improved service deliver and increased opportunities to work together	Venue Staff resource	Swansea Council for voluntary Services attend Cluster meetings.
8.6	Raise awareness of Community Dementia service amongst practices	All GPs	March 2022	Increase referrals to the Dementia workers first point of contact service Dementia patients can be escalated as necessary if there are any memory concerns	Staff resource	Some referrals made to Dementia workers.

				Patients can be seen closer to home. Working with social care professionals and have quick access to services and onward referrals for more in-depth assessment if necessary.		
8.7	Assess if services have improved patients' health and wellbeing through the use of Patient Reported Outcome Measures	Cluster	March 2023	Patient will be able to feedback to Bay Health practices about the value they perceive in the services delivered utilising Patient Reported Outcome Measures	Staff resource Patient Engagement	No current survey in place
8.8	Improve communications and recourses for all members of the Cluster and patients by an improved, and relaunch of Cluster website	Cluster Development Manager	March 2022	To improve access to Cluster website for all members of the Cluster and patients Improve marketing/advertising of local services available to patients	Business Development Manager Funding	Current Cluster website to be updated/upgraded
8.9	Develop Cluster communication strategy, aligning with Transformation communications and strategy programme for Primary Care	Cluster	March 2023	To develop and implement a robust communication strategy, ensure clear messages are cascaded appropriately	Cluster input/ development	No current communication strategy in place.

Improving Quality, Value and Patient Safety

Our three year focus:

To undertake quality improvements of services and consider requirements of Quality Assurance and Improvement Framework to reduce the prevalence of risk factors and to minimise harm.

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position
9.1	Quality Assurance and Improvement Framework: Consider the requirements under Quality Assurance Improvement Framework with a focus on patient safety and identified workstreams from the basket of priority areas. Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the Cluster population. b. Reducing stroke risk through improved management of Atrial Fibrillation in for the Cluster population. c. Ceilings of care / Advanced Care planning. d. Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20	Cluster	1st Oct 2019 - 30 Sep 2020	All Bay Health practices will ensure that all patients with lone AF should no longer be anticoagulated with Aspirin. All Bay Health practices will ensure that all patients with CHADSVASc Score greater than 2 will be anticoagulated appropriately with Warfarin or a DOAC if not contraindicated Review all patients on prophylatic antibiotics and stop if appropriate in keeping with recent national guidance	GP and administration resource	Practices to commence work once document disseminated
9.2	Map current and discuss future enhanced service provision at	Cluster	March 2021	Universal services delivered across the Cluster	GPs	Initial discussions to take place

	individual Cluster level to ensure universal services available to patients				Practice Manager Business Development Manager	
9.3	Work together with partners to ensuring that delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond. We recognise the importance of involving the Multi-Disciplinary Team in supporting people affected by cancer, and integrating cancer care into holistic chronic disease management in Primary Care. As clinical pathways are shared through the Single Cancer Pathway programme we will review local experience to inform implementation. Practices will work to embedding anticipatory care planning as routine practice	Practices	Ongoing Ongoing	Integrating cancer care into holistic chronic disease management in Primary Care. Ensuring that the multidisciplinary primary care team has the necessary skills and knowledge to support the SCP and detection and diagnosis of cancer. Improved end of life experience	Timescale/ workforce	Cancer diagnosis rates issues

Communications and Engagement

The plan below demonstrates how Cluster related issues and developments are shared and communicated with the Cluster, its partner organisations and the wider community.

Communications Matrix	Cluster Meetings	Cluster Spend Plan	Cluster IMTP	Grant Scheme Updates	Newsletter	Media Releases
Cluster Lead	✓	✓	✓	✓	✓	✓
Cluster GPs	✓	✓	✓	✓	✓	✓
Cluster Practice Staff / Employees	✓	✓	✓	✓	✓	✓
Patients/Citizens			✓		✓	✓
Patient Representative Group	✓	✓	✓	✓	✓	✓
Swansea Council for Voluntary Services	✓	✓	✓	✓	✓	✓
Service Providers – Grant Schemes			✓		✓	✓
Non GMS Contractors	✓		✓	✓	✓	✓
Primary Care Team	✓	✓	✓	✓	✓	✓
Health Board Community Team	✓		✓	✓	✓	✓
Public Health Team	✓		✓	✓	✓	✓
Local Authority Team	✓		✓	✓	✓	✓
Local Medical Committee	✓		✓	✓	✓	✓
South Wales Police			✓		✓	✓
Welsh Ambulance Service Trust			✓		✓	✓
Citizens Advice Bureau			✓		✓	✓
Community Health Council			✓		✓	✓
Local AMs / MPs			✓		✓	✓
Media			✓		✓	✓
Heads Of Clinical Services	✓		✓		✓	✓
Out Of Hours			✓		✓	✓

SBUHB Patient Feedback Team			✓		✓	✓
Shared Services Partnership			✓		✓	✓
NWIS			✓		✓	✓

Bay Cluster have an active Patient Representative Group, the purpose of which is to act as an advocate for patients and help to make sure the patient and public voice is heard. An element of the representative group is to make informed decision around cluster investment and ensure that these services meet the health needs of the local population. The group embrace the 'no decision about me without me' promise and actively promote Bay Health Cluster priorities. The group have been forthcoming with suggestions and areas they believe Bay Health Cluster can improve on or focus, such as the provision of GPs with specialist interest for a range of areas. These suggestions have been taking into consideration when progressing areas of priority. The group have established a task and finish group to develop a patient survey to engage with the wider Cluster community.

There are plans to engage further will our community and hold an event during National Libraries Week event at Killay Library celebrating Libraries in a digital world. Through this event the local community will be able to speak to representatives from Bay Cluster, Digital Communities Wales and Swansea Libraries to learn more about health care support and advice available via your tablet, phone or computer online.

Section 8

Strategic Background

'A Healthier Wales' was published by Welsh Government in June 2018 and set out a clear long term strategy and future vision for Health and Social Care in Wales that everyone in Wales **'should have longer, healthier and happier lives, able to remain active and independent in their own homes for as long as possible.'** The strategy describes a **whole system approach to health and social care,** in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives, a "wellness system" which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

This future ambition is underpinned by the ongoing philosophy of prudent healthcare alongside a quadruple aim:

- ✓ Improved population health and wellbeing
- ✓ better quality and more accessible health and social care services
- ✓ higher value health and social care
- ✓ a motivated and sustainable health and social care workforce;

and ten design principles.

Primary Care response to 'A Healthier Wales' is outlined in the **Strategic Programme for Primary Care,** published in November 2018. Specifically, the whole systems approach to health and social care. This programme of work focuses on 'Clusters remaining at the heart of this model'. The document outlines the six key work streams:

I. *Prevention and wellbeing*
II. *24/7 Model*
III. *Data & Digital Technology*
IV. *Workforce & Organisational Development*
V. *Communication, Engagement*
VI. *Transformation Programme and the Vision for Clusters*

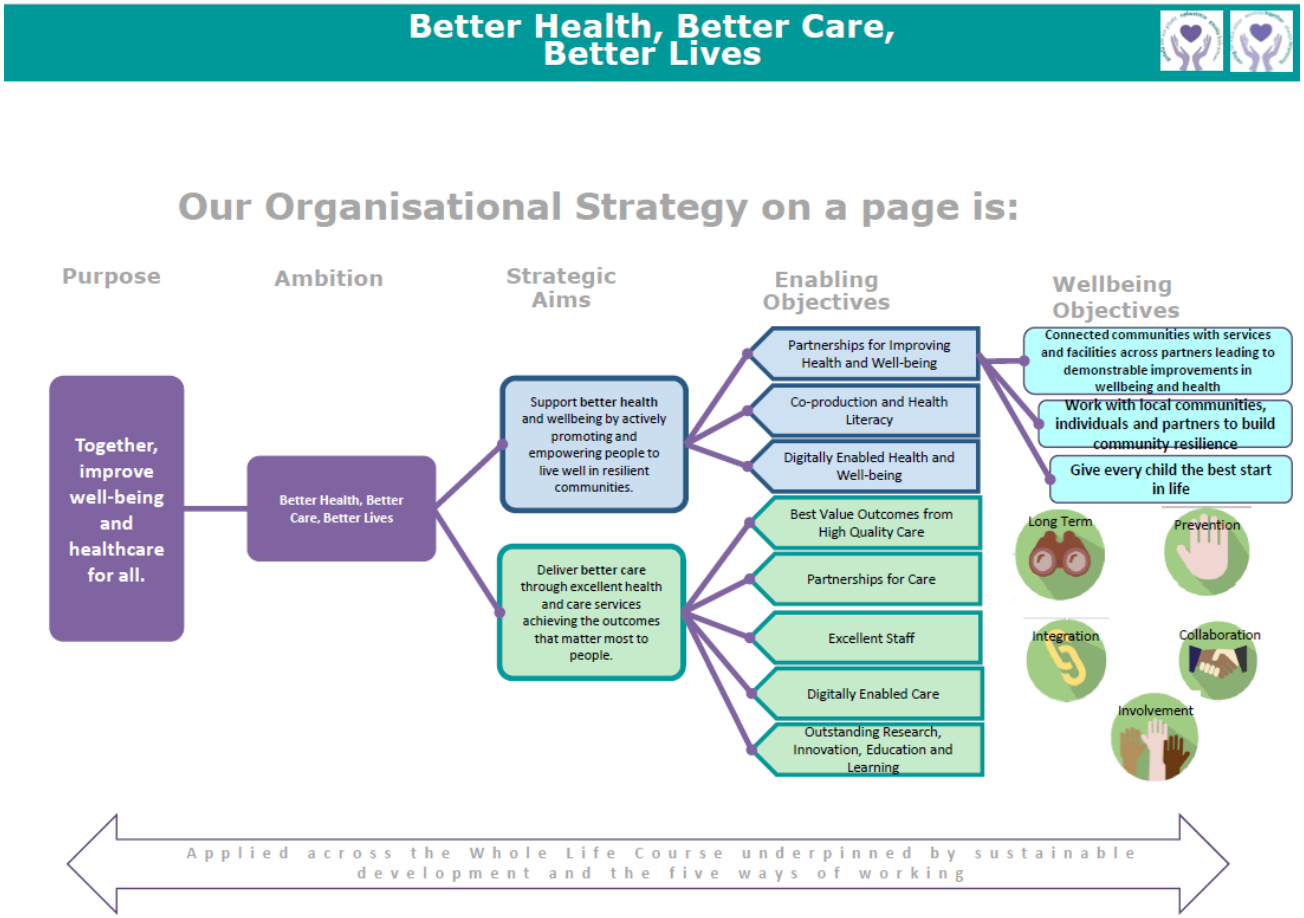
Throughout this document there are key messages:

- Get better at measuring what really matters to people
- Greater emphasis on wellbeing
- Health and Social Care will work together
- Work as a single system, everyone working together
- Invest in new technologies
- Shift services out of hospitals into the community
- Implement the Primary Care Model for Wales

The cluster will work under the context of the delivery of the strategic programme of work for primary care, developed following the publication of A Healthier Wales, increasing pace and scale and addressing new priority areas. Our Cluster will take a whole system approach to health and social care, (a 'wellness' system), which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health and inequality. This will further enable us to work closely with partners, shifting the focus to a social model of care, ensuring timely access to primary care services when required and working seamlessly across the whole system.

In addition, there are a number of Health Board interrelated supporting strategies, specifically within Swansea Bay University Health Board, the **Primary and Community Strategy 2017 – 2022**. The overarching Health Board framework, the **Clinical Services Plan** is central to the organisation's ambition to provide Better Health and Better Care to enable Better Lives for all our communities. The key principles are:

The Health Board Organisational Strategy is set out below in summary:



There are a number of key regional, partnership and organisational strategies and priorities including:
Swansea Wellbeing Plan:

- Early Years: To ensure that children have the best start in life to be the best they can be
- Live Well, Age Well: To make Swansea a great place to live and age well
- Working with Nature: To improve health, enhance biodiversity and reduce our carbon footprint
- Strong Communities: Live well, age well, to make Swansea a great place to live and age well

Neath Port Talbot Wellbeing Plan:

- Children in their Early Years, especially those at risk of Adverse Childhood Experiences
- Safe, confident and resilient communities, focussing on vulnerable people
- Ageing Well
- Wellbeing through work and in the Workplace

(Green Infrastructure and Digital Inclusion runs through all areas)

The West Glamorgan Regional Partnership now focuses on three areas of 'transformation', all with associated projects and work streams being delivered in the context of the Social Services and Wellbeing (Wales) Act 2014.

- **The Adult's Transformation Board** (the key priorities of which include Older Adults, the Commissioning for Complex Needs Programme, Dementia, the Mental Health Strategic Framework, the Learning Disability Strategic Framework).
- **The Children and Young Adults' Transformation Board** (key priorities of which include the Multi Agency Placement Support Service, Children with Complex Needs and the Regional Strategic Development Plan).
- **The Integrated Transformation Board** (the key priorities of which include Carers, Digital Transformation, Transformation in Networks and the Welsh Community Care Information System).

Transformation (Clusters – A Whole System Approach) - a programme which aims to test out the components set out in 'A Healthier Wales', and provide learning to be shared across Wales, using the individual Clusters in our region as a basis for delivery at local level, thus making significant progress toward achieving the future vision as laid out. The overarching vision of the programme is **to achieve a transformed, sustainable, model of Cluster led integrated health and social care,** across all eight Cluster populations in the West Glamorgan Partnership area**,** with the main aims of:

- Improving health and wellbeing across the age spectrum, including a key focus on **facilitating self-care and building community resilience,** and with targeted population groups dependent on Cluster demographics.

- Coordinating services **to maximise wellbeing, independence and care closer to home** including flexibility to coproduce, design and implement services in partnership with the community.

- **Testing out the vision and aims described with 'A Healthier Wales'** and implement components of the overall model, demonstrating proof of concept and an ability to evaluate and redesign.

In addition the Clusters: A Whole System Approach Programme must be viewed in the context and as part of a wider health and social care regional transformation process and it will dovetail to both 'Our Neighbourhood Approach' and the 'Hospital to Home' Programmes, embedding the prevention and early intervention agenda, improving community resilience to achieve a much greater focus on self-care, the integration of health and social care systems and at a local level the delivery of care closer to home.

Section 9
Health Board and Cluster actions to support Cluster Working and Maturity

The Primary and Community Services Unit, supported by other departments, together with Cluster members will act as partners to continue to develop and provide/access wide ranging support to Clusters.

This may include;

- building on external relationships with the Primary Care Hub for delivery of national programmes such as Confident Leaders, Governance Frameworks, Compendium of Multi-Disciplinary Team roles, and Primary Care Health Needs Assessment Tool, councils for Voluntary Services, Public Health Wales, Local Authorities and internally with pertinent Health Board functions and delivery units.
- provision of general guidance for Cluster development
- performance management, financial reporting, general cross-cluster reporting
- development of Cluster IMTPs
- developing internal Cluster training
- acting as key links for national Transformation programmes
- provide capacity to support key stages of the Transformation programme where required
- development of business cases
- identification of and flagging new funding or research opportunities
- providing Clinical Leadership for Cluster Development
- providing opportunity for common discussion points through clearly set out governance arrangements such as the Cluster 8 Leads Meeting
- accessing strategic documentation/programmes to support articulation of Cluster strategy development

Welsh Language

Through the 6 Welsh language duties placed on independent primary care contractors (including our general practice, community pharmacy, dental, and optometry services), our Cluster will aim to deliver improved access to services and improved healthcare outcomes, including wherever possible to deliver the 'Active Offer'.

1. Where the contractor provides services, or any part of a service, under the contract through the medium of Welsh, it must notify the Local Health Board in writing.
2. The contractor must make available to its patients and members of the public a Welsh language version of any document or form provided to it by the Local Health Board.
3. Where the contractor displays a new sign or notice in connection with services, or any part of a service, provided under the contract, the text on the sign or notice must be in English and in Welsh, and the contractor may utilise the translation service offered by the Local Health Board for this purpose.
4. Where the contractor provides services, or any part of a service, under the contract through the medium of Welsh, it must encourage its staff to wear a badge to convey that they are able to speak Welsh.
5. The contractor must encourage and assist its staff to utilise information and/or attend training courses or events provided by the Local Health Board, so that it can develop:
    - an awareness of the Welsh language (including awareness of its history and its role in Welsh culture); and
    - an understanding of how the Welsh language can be used when delivering services, or any part of a service, under the contract.
6. When delivering services, or any part of a service, under the contract, the contractor is encouraged to:
    - establish the language preference of a patient; and
    - record any language preference expressed by or on behalf of a patient

What is the 'Active Offer'?
The duties placed on independent primary care contractors came into force on 30th May 2019.
The Welsh Language Standards are set out in Regulations approved by the National Assembly and bodies subject to the Regulations are issued with compliance notices from the Welsh Language Commissioner. Compliance with the standards is monitored by the Welsh Language Commissioner and complaints in relation to bodies not meeting the standards set in their compliance notices are investigated by the Commissioner.
The duties placed on independent primary care contractors are included within the National Health Services (Welsh Language in Primary Care Services) (Miscellaneous Amendments) (Wales) Regulations 2019. The duties sit within the primary care contracts/terms of service of independent primary care contractors. The contracts are managed and monitored by Local Health Boards and complaints on not meeting the duties would be investigated by the relevant health board.
The duties apply to the Primary Care Sector in Wales which includes general practice, community pharmacy, dental, and optometry services.
A key component of More than just words is the concept of the 'Active Offer'. The 'Active Offer' simply means providing a service in Welsh without someone having to ask for it. It places the responsibility of asking the question on you, the service provider, not the service user. Offering services in Welsh without the need for the end user to request them is an intrinsic part of a good service.

Following on from Cluster discussions which undertook a further self-assessment exercise, the Cluster identified that there is now a need to work on achieving higher levels as follows; the Health Board and Cluster will work jointly to support the Cluster Lead to develop the programme achieve the following objectives:

Component and Current Positon	Areas to develop
Informed Public **LEVEL 2**	**To achieve Level 3**: Clear understanding by public of case for change, new systems of care how to access local information, advice support and care

Empowered Citizens **LEVEL 1**	**To achieve Level 2:** Systems for promoting and receiving feedback Active engagement and involvement of service user representatives in design of Cluster services and assets All team members trained in behavioural change **To achieve Level 3:** New and redesigned local services and assets developed through co-production with user. Service feedback actively used in redesign of Cluster services
Support for Wellbeing, Disease Prevention and Self Care **LEVEL 2**	**To achieve Level 3:** SMART technologies in widespread use to support self-monitoring and self-care, especially for long term conditions Widespread information advice and support are available to promote ownership of health and wellbeing Need Cluster signposting /navigation system
Community Services **LEVEL 1**	**To achieve Level 2:** Robust evaluation of initiatives to ensure value for money Cluster services with direct access /self referral routes eg community pharmacy, audiology **To achieve Level 3:** Comprehensive up to date directory of Cluster services published Systems are in place to empower people with differing level of health literacy and sensory impairments to access advice care treatment.
Cluster Working **LEVEL 1**	**To achieve Level 2:** Cluster governance framework in place with robust processed for Cluster decision making, risk management and accountability for all partner organisations. Primary care training placements are established for Cluster staff.

Call-handling, Signposting, Clinical Triage / Telephone First Systems **LEVEL 0**	**To achieve Level 1:** Gain a clear understanding of systems in place.- List required for each practice procedure and each community based service. Service users designed in feedback systems to evaluate call handling, signposting and triage systems. To achieve level 2 Training and refresher courses attended by all staff involved in Cluster call handling and triage systems/ processes Regular risk assessments and audits of Cluster call handling and triage systems
111 and Out-of-Hours Care **LEVEL 2**	**To achieve Level 3:** Use of digital technology to improve patient experience and efficient service delivery
People with Complex Care Needs **LEVEL 1**	**To achieve Level 2:** Specialist care closer to home – utilising transformation monies to bring frailty clinics closer to home. Practices to consider tailoring appointment times to complex needs patients
Infrastructure to support Transformation **LEVEL 1**	**To achieve Level 2:** Need to identify and address deficiencies in a more effective manner. To achieve level 3 Multi-professional team working and training. Need vision 360 to be able to have staff covering all practices and other digital technology. More direct access diagnostic services required.

WHOLE SYSTEM PLANS MATRICES

The Clinical Services Plan sets out a number of ambitions (below), which have been translated into Whole System Plans. The Cluster IMTPs have considered the Clinical Services Plan priorities, and in addition have mapped out below the actions within those Whole System plans which the Cluster Plan is supporting to address.

	UNSCHEDULED CARE

REF	ACTION
USC_1_1	Actively promote to all staff and patients at higher risk from influenza
USC_1_2	Adopt a tobacco control approach to smokefree health board premises
USC_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
USC_1_4	Adopting approaches that develop health literacy
USC_1_5	Taking action aimed at obesity
USC_1_6	Implement the Neighbourhood Model
USC_2_1	Implement risk stratification approaches to cohorts of vulnerable people to remain at home with the appropriate levels of care and support, implemented through the Cluster Transformation Model
USC_2_2	Implement new pathways for Respiratory Health through the New Cluster Model
USC_2_3	Implement new pathways for Heart Failure through the New Cluster Model
USC_2_4	Implement new pathways for Diabetes through the New Cluster Model
USC_2_6	Review of Acute Clinical Teams and opportunity for improved pathways from community and front door through Keep Me at Home Workstream of OP programme including right size capacity for rapid response.
USC_2_8	Ensure best practice in caring for patients with dementia across all settings by implementing the actions of the All Wales Dementia Plan
USC_2_12	Improve diagnostic access within the community to prevent admission within existing resources
USC_2_14	Continue multi-agency approach to manage frequent attenders
USC_3_1	Continue remodelling of multi disciplinary primary care out of hour services
USC_3_3	Continue to maximise use of 111
USC_3_8	Improve rapid access to assessment for CAMHs patient through commissioning approaches
USC_3_9	In line with the CSP, standardise the front door Frailty Model, standards of care and ways of working on all sites
USC_4_12	Develop a Swansea Bay Acute Care Model through the Clinical Services Plan
USC_5_4	Implement the Neighbourhood approach

	MENTAL HEALTH / LEARNING DISABILITIES
REF	ACTION
MHLD_1_1	Implement actions for delivery of Nieghbourhood approach as per the Neighbourhood approach implementation plan
MHLD_1_2	Support the Cluster transofrmation actions around social prescribing as per the CSP
MHLD_3_3	Development of cluster based Primary Mental Health care
MHLD_4_3	Commisisoning of Mental Health Sanctuary service as per the CSP
	PLANNED CARE
Ref	ACTION
PLAN_1_1	Actively promote to all staff and patients at higher risk from influenza

PLAN_1_2	Adopt a tobacco control approach to smokefree health board premises
PLAN_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
PLAN_1_4	Adopting approaches that develop health literacy
PLAN_1_5	Taking action aimed at obesity
PLAN_1_6	Implement the Neighbourhood Model
PLAN_2_1	Implement solutions including digital based on pathways of care which provides:- information on services available / ability to book appointments / information on my position on the pathway (tracking) / who to contact for advice who is currently responsible for my care / information on my condition and how to maintain wellbeing / information on triggers for seeking additional care or treatment
PLAN_2_4	Ensure all clusters are operating a multi disciplinary team model
PLAN_3_1	Explore within resources the potential for clinical interface using digital solutions and access to timely specialist advice (telephone, telemed, email advice)
PLAN_3_2	Explore within resources increased direct access to diagnostics
PLAN_3_3	Undertake demand and capacity modelling of idagnostic services aross clinical pathways to ensure services are sustainably "right-sized"
PLAN_3_4	Implement solutions including digital based on pathways of care which provides:- information on services available / ability to book appointments / information on my position on the pathway (tracking) / who to contact for advice who is currently responsible for my care / information on my condition and how to maintain wellbeing / information on triggers for seeking additional care or treatment
PLAN_4_3	Explore digital solution for optimising booking of patient into available capacity
PLAN_4_8	Undertake demand and capacity modelling across clinical pathways to include bed modelling, workforce, theatre efficiency to ensure services are sustainably "right-sized"
PLAN_4_22	Implement digital technology, telemed, telephone and self care approaches.
PLAN_4_27	Roll out PROMS to prioritiy specialities
PLAN_5_1	Examples could include •telemed •SOS •email and phone advice •rapid access clinics
	STROKE
REF	ACTION

STK_1_1	Actively promote to all staff and patients at higher risk from influenza
STK_1_2	Adopt a tobacco control approach to smokefree health board premises
STK_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
STK_1_4	Adopting approaches that develop health literacy
STK_1_5	Taking action aimed at obesity
STK_1_6	Implement the Neighbourhood Model
STK_2_1	Delivery of MECC in particular to those at risk of a stroke
STK_2_6	Shared education and training on stroke pathways for Paramedics, hospital staff, GPs and call handlers so tht taff (call handlers/GP receptionists etc.) are fully trained at recognising the symptoms of a stroke
STK_2_9	Effective triage protocols and training in place
STK_3_7	Ensure early access to diagnostics
STK_4_2	MDT in community services
STK_4_11	Local areas coordinators / services

	CHILDREN
Ref	ACTION
CHI_1_2	MECC (School nurses, Health visitors, Midwives)
CHI_1_3	MECC - Midwives and health visitors
CHI_1_5	Smoking cessation services - Help me Quit Programme
CHI_1_6	Healthy eating/Physical activity (NERS)
CHI_1_7	Vaccination programme
CHI_2_8	Promotion of healthy eating and increasing physical activity for children and young people to encourage a healthy weight and reduce obesity.
CHI_6_5	Improve accessibility to CAMHS and specialist advice and support
CHI_7_1	Review opportunities with 111 to support emergency pathway for CYP
	CANCER
REF	ACTION
CAN_1_1	Help me quit campaign
CAN_1_2	Smoking cessation services widely available
CAN_1_3	No smoking culture on sites
CAN_1_4	MECC is embedded across all tumour sites
CAN_1_10	Focus on early years healthy behaviours
CAN_2_11	Demand and capacity modelling
CAN_3_4	Demand and Capacity modelling for treatment

CAN_3_12	Implement optimal pathways through QI approaches for all tumour sites in line with the National programme: - Lung - Breast - Gastroenterology - Head and Neck
CAN_3_24	Improve nutritional screening within MDTs and earlier in the pathway within resources
CAN_6_1	Move as soon as possible to national platforms, including WCP, and the national picture archiving and communications system PACS

	CANCER
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