Integrated Medium Term Plan (IMTP)

2020 - 2023

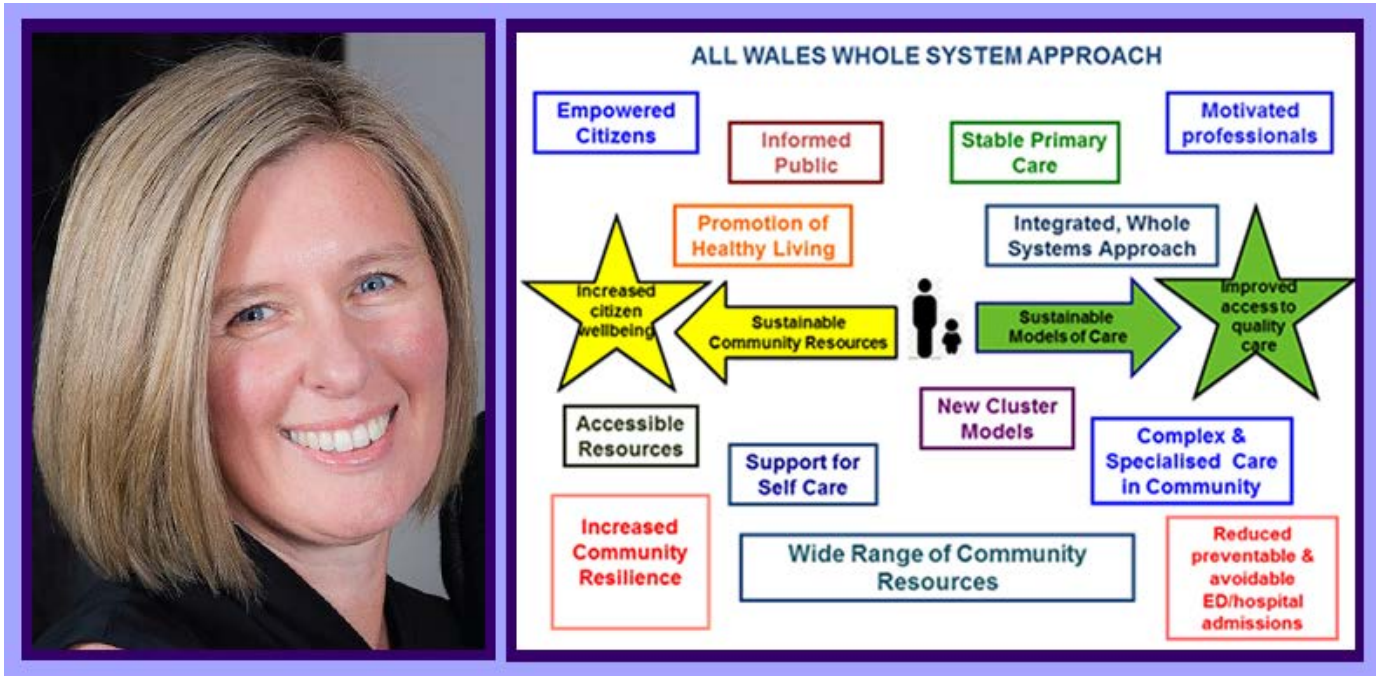
Welcome to the City Cluster IMTP 2020 – 2023

Section 1
Executive Summary

Welcome to the City Cluster Integrated Medium Term Plan 2020-2023. The Plan highlights our Cluster vision and priorities, detailing how we will look to achieve them over the next 3 years.

The City Cluster covers an area of Swansea with high levels of deprivation, homelessness, ethnic diversity and unplanned emergency inpatient admissions. Our Cluster Plan has developed over the last few years to adapt and meet the changing needs of our diverse and growing population. We have fostered new and innovative ways of working that support practice sustainability, ensuring we have the people in place to deliver pragmatic healthcare. This multidisciplinary approach has maximised the opportunities for cross-practice working and ensured better access for patients in conjunction with partner organisations. As we look to address the Quadruple Aims outlined in Welsh Government's A Healthier Wales, City Cluster will continue its work to build on this success.

Through the delivery of our Cluster Integrated Medium Term Plan we work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales and we will do this in the context of the Primary Care Model for Wales.



Dr Ceri Todd – City Cluster Lead

Plan On A Page

Strategic Overview

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

Vision

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

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

What We Will Do

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

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

Section 2

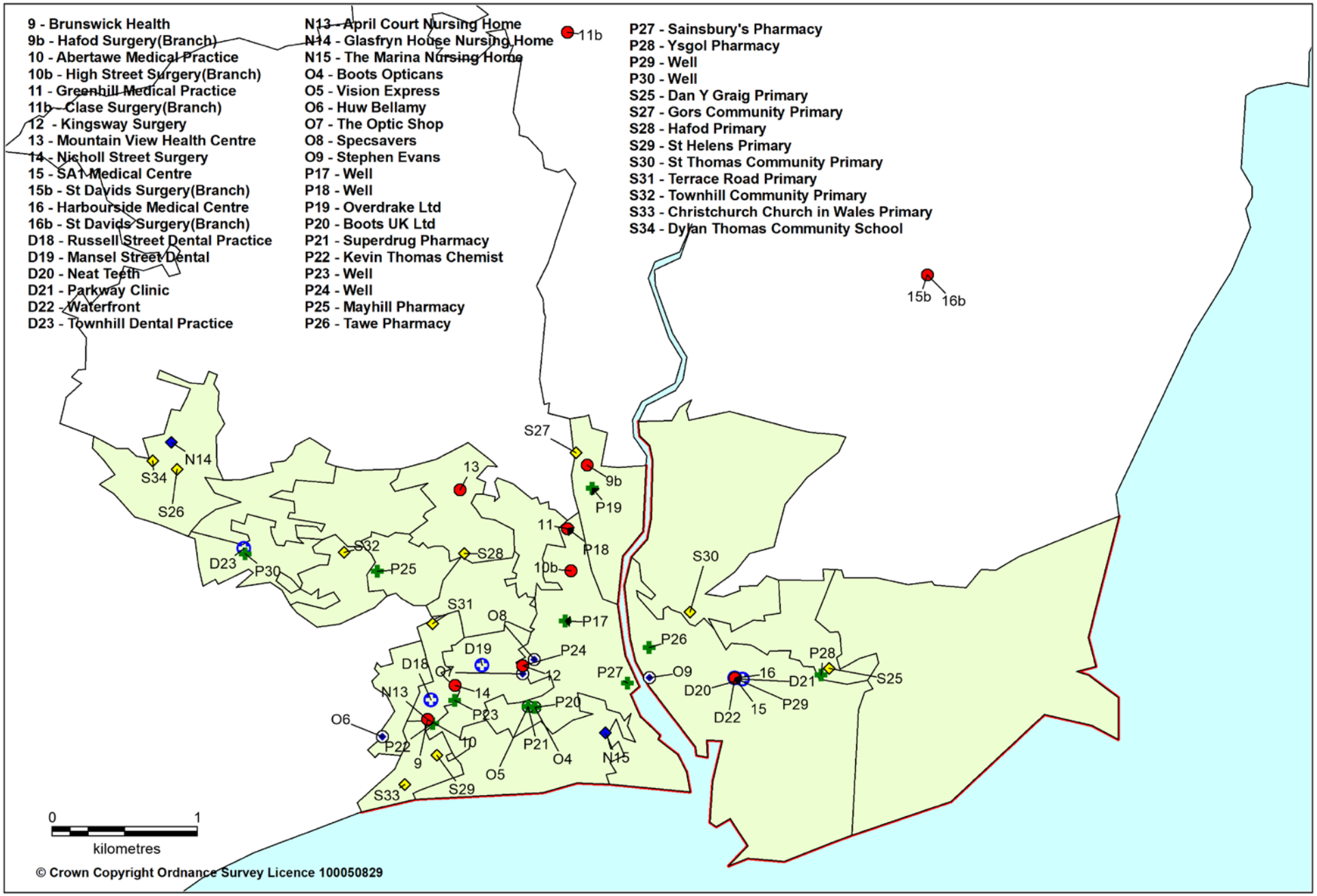
Cluster Profile:

Members and Structure of Cluster

The City Cluster is one of eight clusters in Swansea Bay University Health Board, geographically covering south east and central Swansea.
The Cluster is made up of eight general practices working together with partners from key Local Authority Departments such as Social Services and Poverty and Prevention, the Voluntary Sector, Community Pharmacies, Dentists and Optometrists and the wider Swansea Bay University Health Board 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.*

Primary Community Services City Health Cluster



NHS 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
- Supporting the transition of care out of hospital into the community
- 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, 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 by Swansea Council for Voluntary Services 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.

Demographic Profile

The City Cluster has practice registered populations ranging from 4,263 to 10,498, and a Cluster total of 50,809 (July 2019).

The Cluster area features:

High deprivation levels; with 24,833 (49%) residents living in the most deprived fifth of areas in Wales.

A high proportion of young people due to the large student population.

More than double the Swansea average of asylum seeker and multi-racial/multi-cultural groups.

There are slightly higher numbers in City Cluster (24.2%) than the Swansea average (23.3%) living with a disability.

12.4% are young parents. Swansea average 11.7%

29.2% of those living within City Cluster have no qualifications (Swansea 23.9%).

16.8% of patients are aged 65+ (19.2% across Swansea) and 7.8% of patients are 75+ (8.9% across Swansea).

The area consists of 22 LSOAs in the city centre area and adjacent urban areas to the north, west and east; across both sides of the River Tawe.

Many of the men released from HMP Swansea are provided housing within the City Cluster.

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. The main driver of population growth in Swansea has been migration.

Recorded live births has steadily risen since 2001 and number of deaths have fallen.

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.

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.

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

Active Community and Voluntary Organisations.
Leisure centres
Entertainment venues
Libraries
Community Hubs
Beach access
Football and Rugby stadiums
University
Kilvey Country Park
Access to the River Tawe and the Marina
City regeneration, together with the development of continuous cycle routes along the bay and road improvements to reduce congestion along Fabian Way have facilitated easier and safer access to the city.

Swansea Council have agreed to apply for 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: City Cluster

Strengths	Weaknesses
• Recognising Cluster population needs and working to support • Building on relationships with Secondary Care, Third Sector, Local Authority and other partners • Self-assessing and acknowledging gaps in provision and acting to fill i.e. Paramedic , Pharmacist • Strong, committed leadership from Cluster Lead • Health Foundation funding secured - Innovative Project • Implementation and Business Development Manager • Access external funding sources	• Lack of time to develop initiatives • Staff working at full capacity • Difficulty regarding recruitment and retention of GPs • Lack of/Increasing cost of locums • Need to have drive – Participation from all partners • Consistency in ensuring that the Cluster message is relayed back to GP's within the practice and that their thoughts are fed into the Cluster
Opportunities	**Threats**
• Tailor Protected Learning Time Sessions to attract and inform staff in order for primary care teams to engage with new ways of working and direction of travel for the Cluster • Strengthen links with Secondary Care, Third Sector, Local Authority and other partners • Digitalisation/Modernisation • Links established with two neighbouring Clusters for mutual benefit • Tailor the IMTP further to the needs of the Network population • Transformation funding	• Demand greater than capacity • SBUHB organisational changes • Contractual changes with commissioned services • GP retirement/ recruitment issues • Staff shortages in other areas • Staff morale/wellbeing • Practice sustainability • Finance beyond the Transformation Fund • Reduced allocation of budget by Welsh Government • Change in Government policy regarding Clusters • Mainstreaming of Cluster Innovative Roles / Projects

Section 3

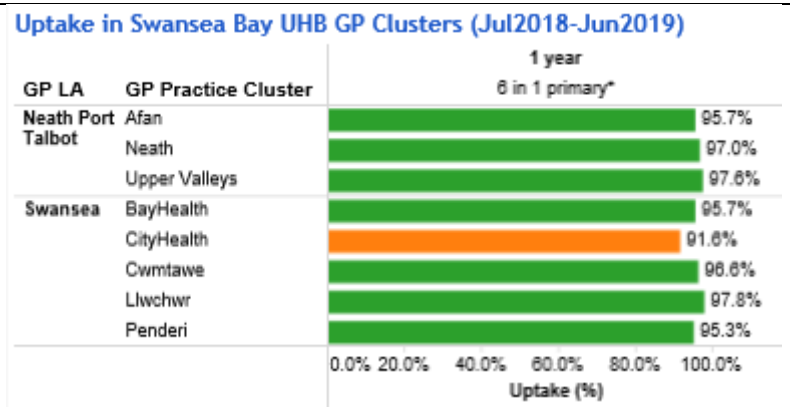
Key achievements from 2018-21 plan:

- Developed Multidisciplinary Team
- Provided dermoscopy training and equipment for all Cluster practices
- Liaison with Local Area Coordinator to develop community skills
- Undertook patient satisfaction survey in conjunction with Swansea Council for Voluntary Services
- Progressed the “Choose Well” patient education campaign
- Engaging with toolkit to increase uptake for bowel screening
- Donated defibrillators and training to community settings
- Adopted CRP Point of Care Testing to support clinical decisions for patients with respiratory tract infections
- Ensuring practice sustainability with Cluster workforce exercise
- Developed “Fit For Life” programme to compliment National Exercise Referral Scheme
- Increased smoking cessation service uptake in collaboration with Public Health Wales and Action for Smoking and Health
- Increased uptake of flu vaccinations in hard to reach and targeted patient groups
- Expanded practice team skills with Blue Stream training package
- Developed closer liaison with Macmillan leads and undertaken Red Whale training
- Signed up for pre-diabetes scheme
- Successfully obtained £75,000 Health Foundation funding to deliver preventative MDT care in community settings
- Employed Business Implementation and Development Manager to bid for and secure further funding streams
- QR Boards at all Cluster practices to provide patients with up to date information
- Developing further links with public sector staff working with vulnerable people within the Cluster

Section 4
Health and Wellbeing Needs Assessment

Information has been collated on a wide range of health needs within the City 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 individual practice profile data, a review of Public Health Priorities, disease register data, audit reports and a series of Cluster meetings.

Obesity	**Bowel Screening**
7.6% obesity rate, 3992 patients (Swansea average is 9%)	Of patients eligible for bowel screening in 2017-18, only 47.5% were screened. Target 60% (PHW screening data 2017-18)
Smoking / Lung Cancer	**Mental Health**
25.3% of smokers across the Cluster population. Welsh Government have set a target of 16% by 2020. The Cluster has a high rate of lung cancer per 100,000 at 82.5 (Lung Cancer profile 2015)	Around 32,200 people aged 16 or over in Swansea may have one Common Mental Disorder e.g. anxiety depression and OCD. City Cluster has the highest rate in Swansea of 1.5% for those registered as having a mental health condition. 6 of the 7 practices reporting the highest burden are within City Cluster.
Asthma	**COPD**
Second highest rate in Swansea - 7.3% (Swansea average is 7%)	Highest rate in Swansea – 2.6% (Swansea average is 1.9%)
Influenza Vaccination	**Out Of Hours Contact**
Uptake of 67.4% in those 65 years and older (Target 75%), 47.8% in those under 65 years at clinical risk (Target 55%) and 41.9% for 2 & 3 year olds. (Influenza Vaccine Online Reporting April 2019)	OOH contact between 1st August 2018 and 31st July 2019, rate per 1000 was 75.38. This is the third highest within Swansea.
Diabetes	**Outpatient Referrals**
Third highest rate in Swansea – 5.9% (Swansea average is 6.1%)	Second highest number of referrals in Swansea (4,142) - 84.54 per 1000.
Childhood Immunisations	**Other Screening**
City Cluster is the lowest in Swansea Bay UHB for the uptake of childhood immunisations by the age of 4yrs at 91.6% (COVER Data)	- 11,857 eligible for cervical screening, 8216 were tested (69.3%). Target 80% - 219 eligible for AAA screening, 161 people were tested (73.5%). Target 80% - 5,763 eligible for breast screening, 3787 were tested (65.7%). Target 70% (PHW screening data 2017-18)



GP Practice Cluster	Wcode	1 year 6 in 1 primary* Immunised (n)	Records (n)	Uptake (%)
CityHealth	W98608	50	54	92.6%
	W98057	82	89	92.1%
	W98056	51	55	92.7%
	W98039	37	38	97.4%
	W98027	85	97	87.6%
	W98024	29	32	90.6%
	W98020	20	21	95.2%
	W98015	74	81	91.4%
	All GPs in cluster	428	467	91.6%

Accident & Emergency	Substance Misuse
Highest number of emergency admissions of any cluster in Swansea at 26.68 per thousand. The highest rate in Swansea Bay UHB of emergency inpatient admissions.	The highest rate of prescription of anxiolytics and hypnotics, antidepressants, opioid analgesics, Tramadol and NSAIDs in Swansea

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
BayHealth	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
BayHealth	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
BayHealth	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**

Safer Swansea Performance Report

South Wales Police – July 2018 – June 2019

Violent 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 Violence
The following beats recorded the highest rates of domestic abuse:
Townhill/Mayhill [53]
Penlan [47]
Clydach/Glais [44]

Substance Misuse
Recorded Drug Crime Breakdown (Last 3 Months)

Swansea Area - 1/04/2019 – 30/06/2019
Hotspot – **City** [134]
Penlan [23]
Morriston [21]

231 offences [74 Trafficking, 157 Possession]

Cannabis [112], Cocaine [32], Heroin [25], Amphetamine [11], Crack [8], Methadone [2], MDMA [1], Other Class A [24], Other Class B [6], Other Class C [5], Class Unspecified [3]

The City sector has the highest recorded level of reported hate crime. The top 3 beats are Marina, Townhill/Mayhill and Blaenymaes.

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%	

Community Cohesion

Sector Name	Racial	Religion	Sexual Orientation	Transgender	Disability	Grand Total
City	63	2	19	10	5	99
East Side and Morriston	55	0	10	0	8	73
Gorseinon and Penlan	47	4	10	0	4	65
Gower and Townhill	50	2	5	0	4	61
Grand Total	215	8	44	10	21	298

Primary Care Measures – 2A. (ABMU reference point)

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)
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)
Children (0–17 years) who accessed dental services at least once a year	2A		59.5% (2016/17)	68.8% (2016/17)
Recording of Alcohol Intake	2A		76.4% (2017/18)	76.6% (2017/18)
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)
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)

Enhanced Services

City Cluster practices offer a number of enhanced services, as detailed below.

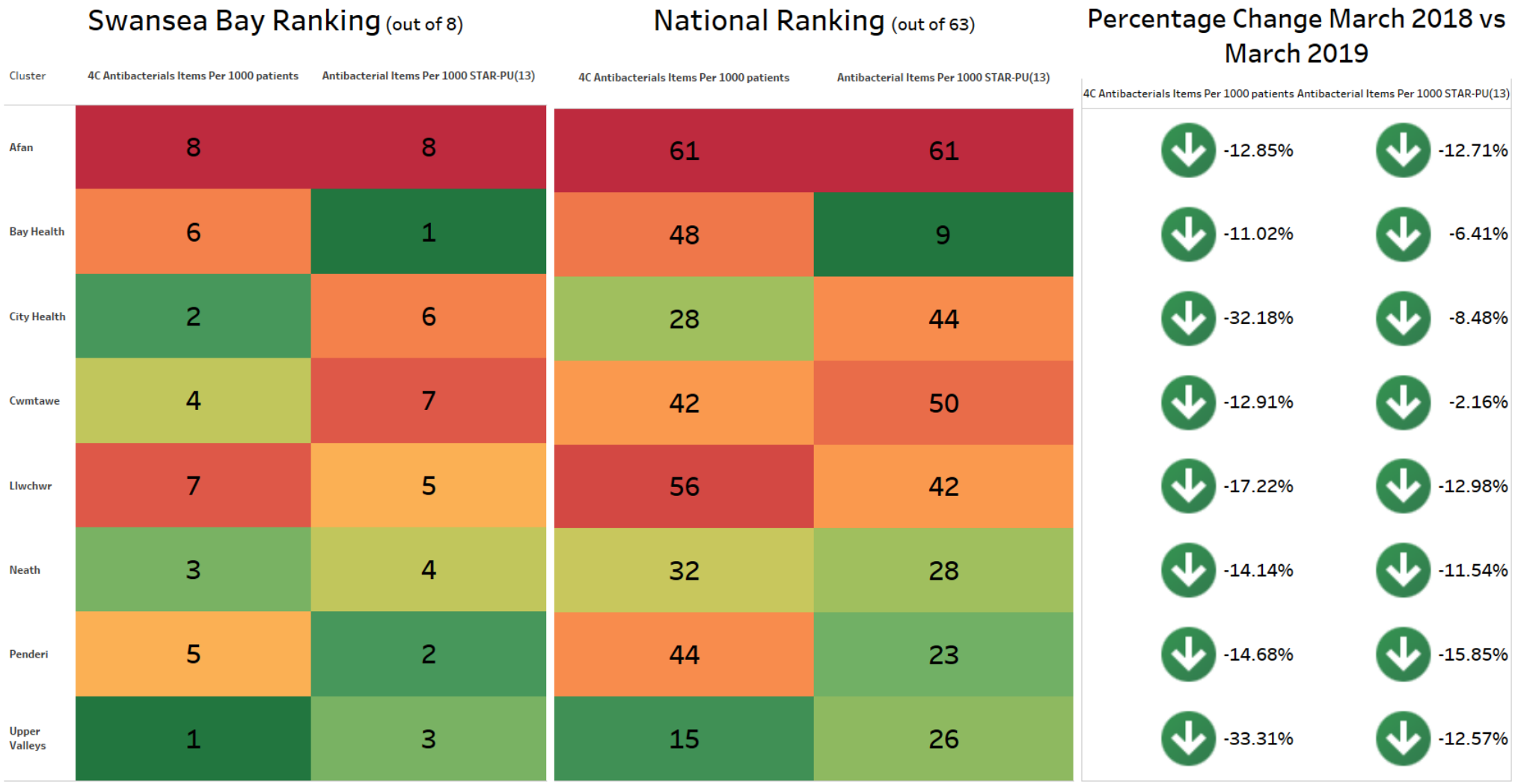
Enhanced Services Type	Enhanced Service Name	City (8)
DES	Childhood Imms	8
DES	5 Years Boasters	8
DES	Asylum Seekers	8
DES	Care Homes	4
DES	Flu	8
DES	Learning Disabilities	8
DES	Mental Health	0
DES	Minor Surgery	8
DES	Warfarin (all)	3
DES	Diabetes Type 2 DES	8
SFE	HPV	3
SFE	Meningitis	8
SFE	Pertussis	8
SFE	Pneumo	8
SFE	Rota Virus	6
SFE	Shingles	8
NES	Drug Misuse	4
NES	Homeless	1
NES	Unscheduled (all)	2
LES	Depoprovera	8
LES	Nexplanon	5
LES	IUCD	4
LES	Gonadorelins	8
LES	Hep B	6
LES	INR	8
LES	Measles Outbreak	7
LES	Sexual Health	2

LES	Shared Care (All drugs)	7
LES	Student Registrations	0
LES	Syrian Refugee	4
LES	Uni Les	0
LES	Wound Care	7
SLA	Complex Wound	3
LES	DOACS	8

Antibiotic Prescribing

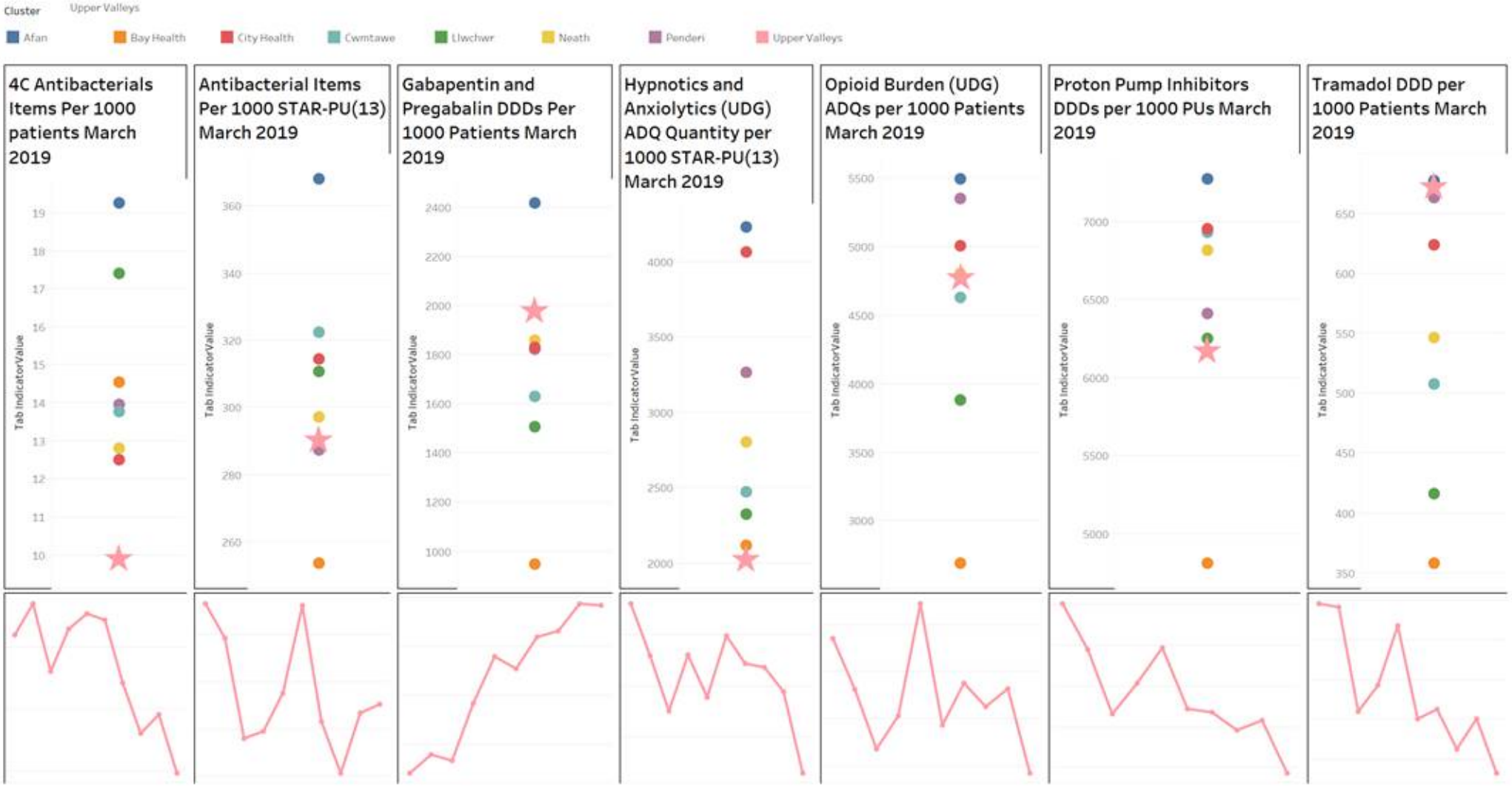
In January 2019 the UK 5 year AMR National Action Plan 2019-2024 was published, which underpins the UK AMR Strategy 20 year vision. Building on achievements seen in 2018/19 improvement goals are set for Heath Care Acquired Infection and Antimicrobial Resistance, which will be reported at a National level. 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 MDT 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 2013-17.
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%

PMS+ Scheme

The data below relates to the PMS+ 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

Across our 8 practices, the Cluster has:

DOCTORS

Head Count	Whole Time Equivalent	GP / Patient Ratio
42	30.5	1,666

NURSES – *Nurses employed directly by the Practice*

Head Count	Whole Time Equivalent	Nurse / Patient Ratio
21	12.1	4,206

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

Head Count	Whole Time Equivalent	DPC / Patient Ratio
5	2.6	19,246

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

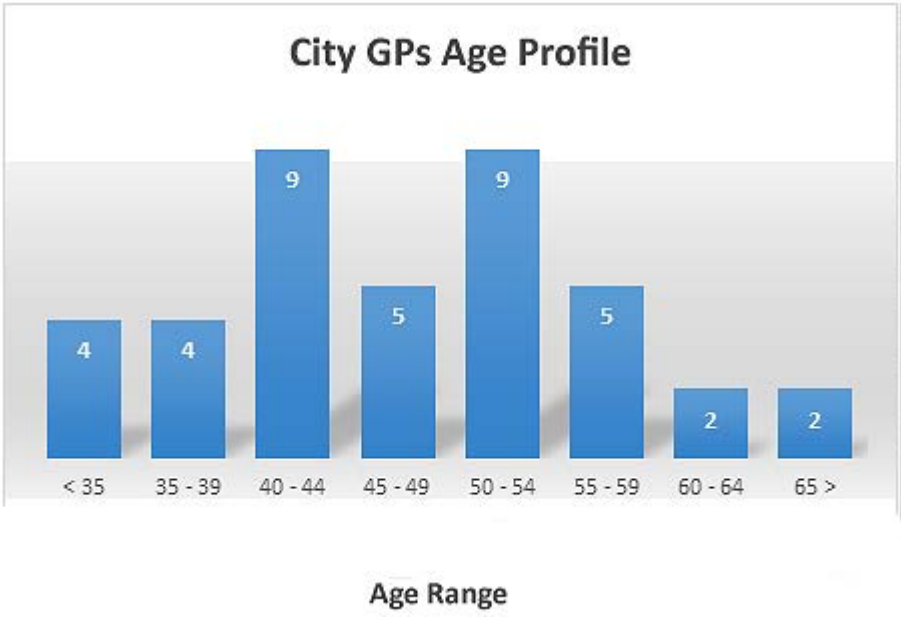
Head Count	Whole Time Equivalent	Admin / Patient Ratio
81	55.6	913

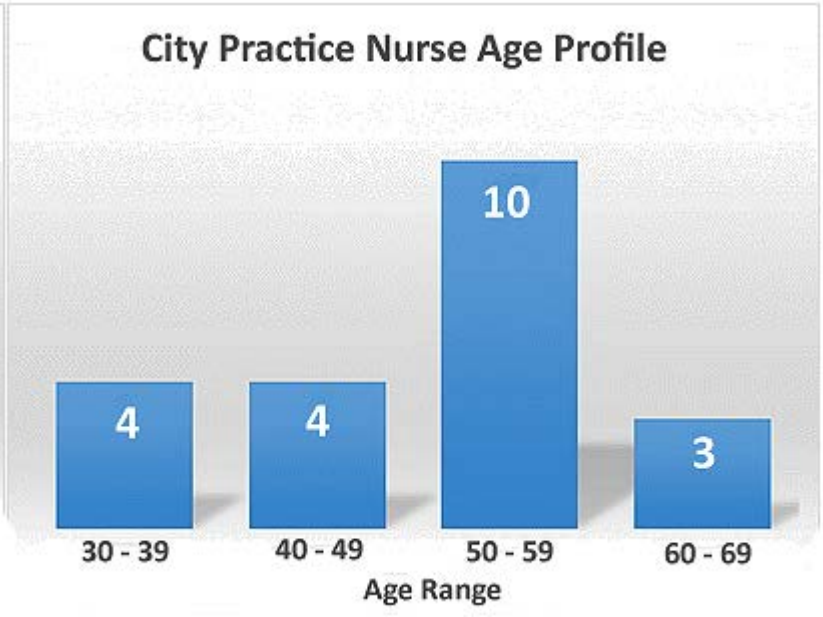
We have strengthened our multi-disciplinary team with a clinical pharmacist now in place for the fourth year, undertaking medication, polypharmacy and new patient reviews; along with any medication related queries from all staff in primary care.

In January 2018 we employed a paramedic who has become integral to the wider Cluster multi-disciplinary team. A major aim for all is supporting patients within the community setting and the paramedic provides timely access for patients, assists with the flu immunisation campaign (providing vaccinations within the community), and is at the core of the successful Health Foundation programme. Our paramedic sees around 1300 patients per year.

To ensure practice sustainability, we have agreed to develop a Cluster workforce plan, 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.

Our initial age profiling exercise shows 2 GPs retiring at the end of 2019 and indicates a future potential shortage of practice nurses.





Community Health and Social Care Teams					
Role	**Bay**	**City**	**Penderi**	**Llwchwr**	**Cwmtawe**
	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	
Primary Care Physiotherapy	7.6	13.2		9.7 (P)	
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, OTs)	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					

3 x GPs – Working on a sessional basis, one day each a week covering all Swansea Clusters, Monday, Wednesday and Friday.
School Nursing
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.
Health Visiting
City Cluster has 3 full time and 4 part time health visitors (2 currently on reduced caseloads due to sickness). A nursery nurse provides support one morning a week. Public health roles including a weekly walking group and delivery of the Healthy Child Wales Programme to fathers in Swansea prison.

Local Area Coordinators					
Role	**Bay**	**City**	**Penderi**	**Llwchwr**	**Cwmtawe**
Local Area Coordinator	4	2	1	2	2

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.

Training Needs

Additional training needs within the cluster have been identified as:

- IRIS (Identification and Referral to Improve Safety) - Programme based within General Practice that provides training and referral support where domestic violence and abuse has been identified
- Cluster Development Team - Leadership / Project Management and Bid Writing training
- Cultural Awareness training in relation to Asylum Seekers and Refugees
- Ensuring Mandatory Training Sessions are all up to date e.g. Safeguarding
- Training in reduction of opiates

As a Cluster, we will support the delivery of business cases to the Health Board to take on funding for successful Cluster projects to recycle money for Clusters to develop new innovations.
Our Cluster will support the further gathering of evidence where required to support those business cases for:

- Cluster Pharmacist
- Cluster Paramedic
- Early Years Worker
- Primary care (community based) audiology/earwax removal
- Any other relevant programmes

To act as an enabler, our Cluster will share good practice with other Clusters in the area to support the delivery of cases to the Health Board and wider beneficiaries for mainstreaming/funding projects.

Community Pharmacy in City Cluster

Prevention, Wellbeing and Self Care

- The Common Ailments service is currently delivered in 14 Community Pharmacies in the City Cluster area; offering advice and treatment for 26 conditions.
- Palliative care “Just In Case” packs are available in 8 City pharmacies. They contain a range of standard palliative care drugs for patients identified as requiring palliative care support and whose medical condition may deteriorate in the foreseeable future.

Timely, Equitable Access, and Service Sustainability

- Two community Pharmacies in City Cluster offer Sunday opening with 3 offering access after 6pm.

Rebalancing Care Closer To Home

- There are 13 Community Pharmacies commissioned to deliver flu vaccine for 2019/20 flu season in City Cluster. During flu season, pharmacies offer off-site vaccinations in the work place and for staff working in care homes.

Digital, data and technology developments

- QR information boards have been ordered for 7 pharmacies across City Cluster. These will provide patients with digital access via a mobile phone and will promote the breadth of services available from community pharmacy as well as all services within Primary Care. Patients who may be at risk of not being able to access sufficient information will be able to make the right choices for their health. Use of the boards and information sections will be monitored with further roll out to additional community pharmacies and secondary care sites if appropriate.
- QR business cards specific to sexual health services for those patients seeking EHC and sexual health advice from Community Pharmacy are being developed. These will offer a discreet opportunity to signpost patients appropriately.

Workforce Development; including skill mix, capacity, capability, training needs, and leadership

- Pharmacy technicians have undergone appropriate training to support Medicines Management in Care Homes, Level 3 HMQ smoking cessation services, Take Home Naloxone, Blood Borne Virus and needle exchange services. There are currently 10 Pharmacies commissioned to deliver HMQ level 3 in City Cluster.
- Blood Borne Virus [BBV] testing service is currently available in 2 City Cluster pharmacies. The delivery of this service includes pharmacy technicians who have met the requirements of the National Competence and Training Framework for the National Enhanced Service Accreditation [NESA] Generic Skills and have current certificates demonstrating compliance with this.
- Using suitably trained Pharmacy Technicians, the Take-Home Naloxone [THN] service is delivered in 2 community pharmacies delivering the highest numbers of needle exchange transactions in City Cluster. The Technicians must provide evidence of a working knowledge of Disability Discrimination Act, Mental Capacity Act, Protection of Vulnerable Adults and Information Governance.

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 Services in City Cluster

The City Cluster area benefits from:

- 4 general dental practices
- 1 specialist orthodontic practice
- 1 specialist dental practice, offering sedation and oral surgery

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.

A dental Syrian Refugee Programme was developed and implemented within City Cluster in reaction to the UK Government increasing opportunities for entry to the UK of refugees from Syria and surrounding areas. Effective planning has been undertaken by Cluster teams to enable necessary arrangements to be put in place; ensuring general dental practices are supported to enable the provision of dental care for these patients.

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
Regional (West Glamorgan) Carers Partnership
Multi-agency input via a range of partnership forums such as Safer Swansea Partenrship, the Health of Homeless and Vulnerable Groups etc.

Section 6

Cluster Financial Profile

The City Cluster has a financial allocation from the Welsh Government of £165,073. In addition, the Health Board have secured significant additional resource - from January 2020 City Health Cluster will formally undertake the Transformation Programme (Whole System – New Model of Primary Care) for an 18 month period, having been awarded £1.257m

City Cluster Funding 2019-20	
Welsh Government allocation	£165,073
Total available	**£165,073**

Additional Resource 2019-20	
PMS+ Monies	£78,725
PA Monies	£7,800
Flu Champion	£1,000
Health Foundation Award	£20,000
Total available	**£107,525**

PLANNED SPEND	
Project	**Spend allocated**
Clinical Pharmacist	£63,406
Paramedic	£51,373
MDT Expenses	£5,688
Mentorship	£2,500
Business Implementation and Development Manager	£17,791
PLTS support	£750
Workflow Optimisation	£12,143
Project Work	£9,522
Paramedic Equipment	£131
Fit For Life	£1,200
Total spend	**£164,504**
Planned Spend Balance to be allocated to further Cluster schemes	**£108,094.37**

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
People With Dementia	£1,175,000
As part of that, Cluster based projects:	
Penderi Young People's Wellbeing Project (PYPWP)	£34,445
SCVS Swansea North Dementia and Carer Project	£38,593

Section 7

Our Cluster Three Year Action Plan

Prevention, Wellbeing and Self Care

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Identify pre-diabetics & tackle problem of increasing levels of diabetes in Cluster population. Continue to engage with pre-diabetes project to identify patients at risk of pre-diabetes. Train appropriate staff to deliver intervention. Monitor outcomes at regular intervals.	Cluster practices	March 2020	The onset of diabetes is delayed or prevented.	Continued engagement in pre diabetes project.	2 practices sharing HCAs among Cluster.	
	Reduce obesity and increase fitness in Cluster population. Develop "Fit For Life" programme.	Cluster practices	March 2020	Patients engage in exercise programmes. Reduced levels of obesity, resulting in greater wellbeing.		Classes consist of being weighed and measured by the Fit For Life team, a group discussion about nutrition and fitness, recipe swapping and discussions about weekly food diaries. This is then followed by a 30 minute exercise session which is tailored to individual needs. Feedback to date is positive and we have had some excellent weight loses so far.	

	Identify a school in Cluster area to partake in project to tackle childhood obesity. Promote walking to school / Increasing exercise levels. Promote Parkrun						
	Promote self-care through patient education.	Cluster practices	Ongoing	Generally improve health of Cluster population. Reduce burden on GP practices.	Patient engagement.		
	Increase uptake of influenza vaccine. Regular review of IVOR data. Practices share best practice and ideas.	Cluster practices PHW Health Board	Ongoing	Reduce morbidity / mortality / hospital admissions		Best in Wales for 2018-19 Under 65 At Risk category. (47.8% v 44%) Need to build on this success for other groups.	
	Smoking / COPD Increase number of patients accessing smoking cessation services and proactively identify individuals who smoke.	Cluster practices	Ongoing	Increased smoking cessation service uptake. Increased use of CO monitors recorded and fed back to practices.		Part of Primary Care Smoker recruitment Project.	
	Bowel Screening Implement comprehensive programme utilising all partner organisations to increase rates of bowel screening uptake.	Cluster practices		Improved screening uptake. Reduced morbidity / mortality / hospital admissions.		Applying for Support Worker via Moondance Project.	
	Imms and Vacs Develop a project on childhood vacs, including an audit of those not being vaccinated and develop a plan to improve figures.	Cluster Practices	March 2021	Improved rates of vaccination for children.		The Strategic Immunisation Group has agreed to support a pilot targeting the 0-5 years and 15-16 years old age groups. A member of the child health admin team will undertake the pilot and liaise directly with the practices to cross check the data held within the Child Health System and the GP Clinical System. Project delayed due to SIG staffing issues.	

	Substance Misuse Provide dedicated substance misuse worker and Cluster based service, improving health outcomes for those misusing substances.			Reduced drug and alcohol related deaths and hospital admissions.			
	Homeless Work to improve health and wellbeing outcomes for homeless population; linking with The Wallich and HHAVGHAP.						

Timely, Equitable Access, and Service Sustainability

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Ensure all practices have suitable telephony systems. Utilise My Health Online to maximum. Scope use of applications such as E-Consult and Ask My GP for Cluster to determine way forward.					All practices enabled for prescriptions. 6 of 8 enabled for appointments.	
	Access to In-Hours GMS Services Standards: Cluster practices should ensure improved access to services delivered closer to home as set out in the guidance. Inform Cluster population of wider communication/access options available. Cluster to discuss and develop action plan on findings from all Wales patient survey and share with Health Board. Cluster to consider demand and capacity analysis.	All Practices	March 2021	Achieving Access Standards and measures (Group 1 and Group 2)	Funding Telephone infrastructure Signposting materials Communication and Engagement		

Rebalancing Care Closer To Home

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Adopt a Whole System approach to healthcare and support the design, shift in infrastructure and transfer of such services to the community	All	Ongoing	Improved access to appropriate services and healthcare professionals closer to home to meet a range of needs, including the social model of care.	CDM Nurse Phlebotomist Early Years Worker Paramedic Mental Health Worker CAMHS		
	Ensure equity of access for enhanced services at Cluster level.						
	Manage patients with common ailments in the community, rather than in practice. Improve patient education.	Health Board Community Pharmacy Cluster practices	Ongoing	Fewer patients with common ailments presenting at practice	Develop links with community pharmacies		
	Deliver flu vaccination to housebound patients.	Cluster MDT		Increase in patients vaccinated; reducing risk of vulnerable patients catching flu.			
	Develop a project to monitor patients taking anti-psychotic medication – Ensuring bloods and ECG as necessary.						
	Explore set up of Memory Clinics for Cluster patients, to improve early diagnosis of dementia.						
	Establish community earwax removal service and enable community audiologist to refer directly to ENT..						
Implementing the Primary Care Model For Wales							

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Increase collaboration between GP practices and other primary care providers, Third Sector and other Cluster partners.	All	Ongoing	Practices better able to manage demand and improve patient care and experience.			
	Promote shared learning and good practices through regular incident reporting	Cluster practices	Ongoing	Improved safety and quality.			
	Develop Cluster Charity from initial Kingsway venture.						
	Progress rollout of Primary Care Child and Family Wellbeing Service (Early Years) across all Clusters.						
	Deliver oral health project in care homes.						

Digital, data and technology developments

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Set out priority needs of the Cluster population to inform programme development.	Health Board	Ongoing on refresh of data.	Services are developed according to local population need		Demographics considered when preparing this plan. Current needs identified as: Preventing onset of diabetes; Increasing uptake of flu vaccine; Tackling obesity; Smoking; Increase screening uptake.	
	To improve systems of clinical governance in GP practices through Health Informatics training.	Cluster practices Health Board (Datix)	Ongoing	Improve education of clinicians, hence improve patient care.			
	Source appointment system for "common" Cluster staff.						

Workforce Development; including skill mix, capacity, capability, training needs, and leadership

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Provide standardised training for practice staff to ensure that they have the skills to perform their roles. Cluster to fund courses aimed at upskilling practice staff. Practices to identify learning needs of practice staff and put forward for relevant training.	Cluster practices Practice staff	Ongoing	Standardised Cluster staff skills, ensuring they are able to work at the top of their skills set.	Training in opiates reduction.		
	Ensure optimum use of Cluster MDT	Cluster practices Pharmacist Paramedic	Ongoing	Improved medicines management.			
	Develop workforce plan for Cluster: Pharmacist Administration Nursing & paramedical Clinical	Cluster practices Health Board NBIDM	Sept 2019	Practice sustainability. Clear plan to ensure appropriate workforce in place to deliver prudent healthcare. Better access for patients. Cross-practice working opportunities maximised.	Sleep Therapist.	Progress made to deliver a strong MDT. Opportunities for longer term planning e.g. potential to employ a Trainee Practice Nurse for practice wide resource use. Further work to be done in context of TF rollout Jan 2020.	

Estates developments

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Inform the upgrading / improvement of practice premises where needed on a Cluster basis..	Health Board Welsh Gov	Ongoing as necessary	Ensured safety and suitability of premises. Continuation of primary care services to Cluster population.			
	Develop integrated Wellness Centre.						
	Map underutilised Health Board and practice premises.						

Communications, Engagement and Co-production

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Engage with patients to understand their experience of services and to identify their needs Engage with patients in the further development of actions as part of the Cluster plan, including review and evaluation of Cluster projects. Practices to explore best method of patient engagement including questionnaires, Patient Participation Groups.	Cluster practices Health Board SCVS CHC	Ongoing	Practice objectives in line with patient needs. Ensure good lines of communication between practices and patients.	SCVS	Patient questionnaire undertaken with SCVS. Practices telephoning patients as part of flu campaign. Enquiring as to why patients do not have vaccination so that this may be addressed.	
	Establish Cluster communications strategy: Identifying key stakeholders to influence to maximise impact, including sharing best practice delivered in City Health	Cluster Lead Lead GPs BIDM PMs Health Board		Strategic stakeholders aware of key Cluster programmes. Cluster members better aware of outcome from use of time and resources.		Communications made on opportunistic basis e.g. via WG communications scheme through Health Board.	
	Establish and maximise use of Cluster website and other social media opportunities.						

Improving Quality, Value and Patient Safety

Our three year focus:

No #	What action will be taken	Who	When	What will success look like? What will the outcome be for patients?	Resource required	Current position	RAG Rating
	Quality Assurance and Improvement Framework Consider the requirements under QAIF with a focus on patient safety and identified work streams from the basket of priority areas. Patient Safety Programme: Reducing medicines related harm through a multi-faceted intervention for the Cluster population. Reducing stroke risk through improved management of Atrial Fibrilation for the Cluster population. Ceilings of Care/Advanced Care Urinary Tract infection to multi disciplinary Antimicrobial Stewardship 2019/20 To map current and discuss future enhanced service provision at individual Cluster level to ensure universal services available to patients.		**October 1st 2019- September 30th 2020**				
	Continued use of DATIX to ensure that issues concerning patient safety are flagged	GP's	Ongoing	Issues/concerns flagged via DATIX using appropriate channels resulting in reduction of risk for patients		GPs utilising DATIX- Need to ensure that practice is maintained and improved	

	To ensure that the Cluster Risk Register is updated at each Cluster Meeting	Cluster Lead	Ongoing	Risks identified and flagged on an ongoing basis resulting in better health outcomes for patients	Time	Risk Registers are routinely discussed and updated at each Cluster Meeting	

Communications and Engagement - The matrix 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			✓		✓	✓
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			✓		✓	✓

Work has taken place on engaging with the population through the Community Voices programme. The input from this has been limited and our cluster recognises the need to further engage with the local population in a co-productive approach. Work has also been undertaken in conjunction with SCVS in order to understand local health needs and potential service provision through a central Wellbeing Centre. Our Cluster plan has set out our intentions to take this forward over the next three years, with significant enhancement and acceleration via the Transformation (Whole System - New Model of Primary Care) programme.

Section 8

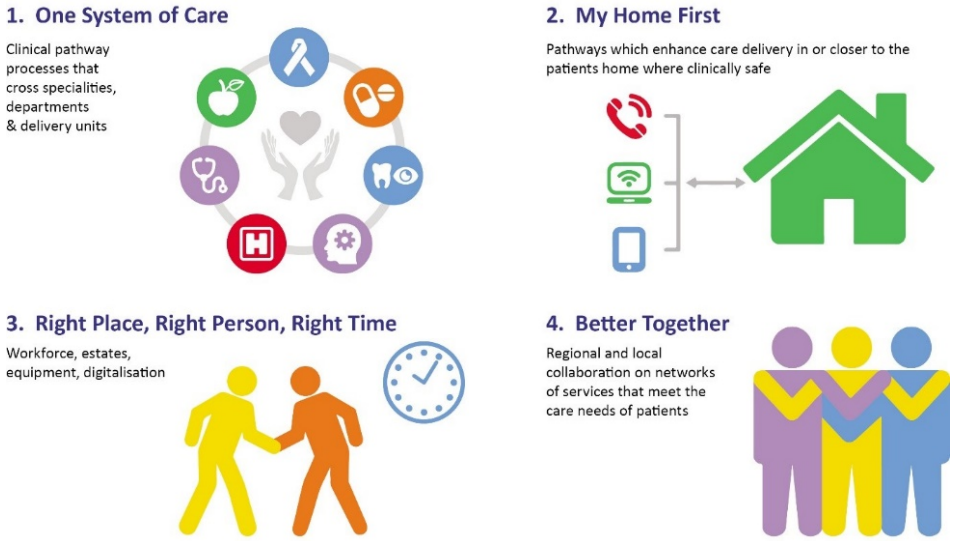
'A Healthier Wales' was published by Welsh Government in June 2018 and set out a clear long term strategy and future vision for Health and Social Care in Wales that everyone in Wales **'should have longer, healthier and happier lives, able to remain active and independent in their own homes for as long 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:

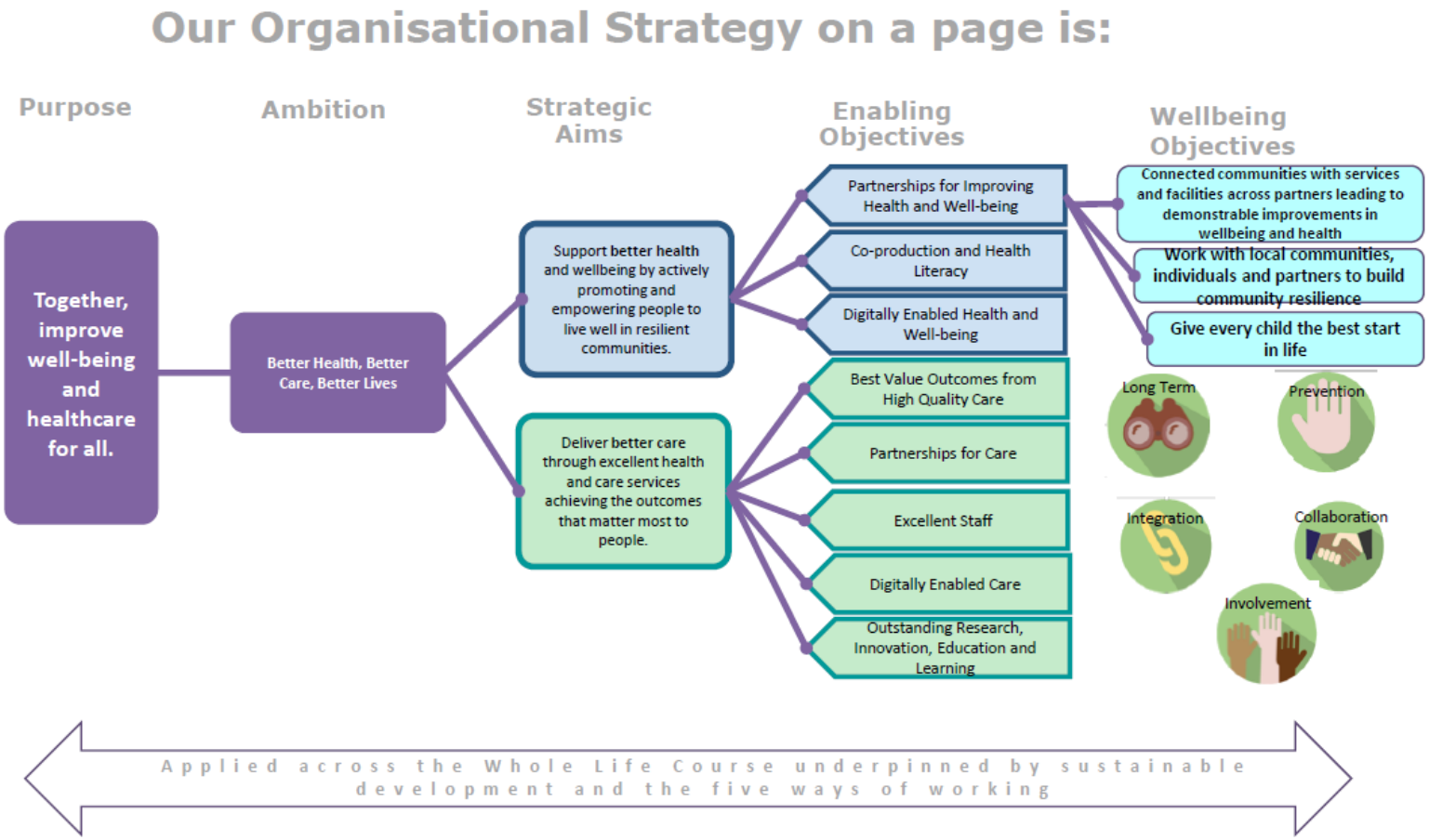
- ✓ Improved population health and wellbeing
- ✓ better quality and more accessible health and social care services
- ✓ higher value health and social care
- ✓ a motivated and sustainable health and social care workforce;

and ten design principles.

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.

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.

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

The Health Board 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 MDT 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.

Whole System Plan 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_1_7	Establish Wellness Centres
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_3_16	Improve choice for patient and care at end of life at front door
USC_4_12	Develop a Swansea Bay Acute Care Model through the Clinical Services Plan
USC_5_4	Implement the Neighbourhood approach
USC_5_5	Establish Wellness Centres

	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_1_7	Establish Wellness Centres
PLAN_2_1	Implement solutions inlcuding 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_2	Implement Multi Disciplinary Cluster triage model
PLAN_2_4	Ensure all clusters are operating a multi disciplinary team model
PLAN_2_5	Ensure that clusters meet the national standards for opening times
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_4	Implement solutions inlcuding 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_1_7	Establish Wellness Centres
STK_2_1	Delivery of MECC in particular to those at risk of a stroke
STK_2_3	Education in schools including first aid
STK_2_4	Local promotion e.g. through involvement of stroke prevention society
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_8	Dispatched staff trained and skilled in dealing with strokes
STK_2_9	Effective triage protocols and training in place
STK_3_7	Ensure early access to diagnostics
STK_3_8	Breakdown silos of care including through collaborative partnership working with Social Services
STK_3_10	Explore the potential to pool resources to support stroke pathways
STK_4_2	MDT in community services
STK_4_10	Access to specialist support
STK_4_11	Local areas coordinators / services
STK_5_9	Ensure signposting to stroke association
STK_5_10	Ensure links with pharmacies, ACT, GPS
STK_5_11	Ensure access to helplines and third sector
STK_6_1	All patients offered opportunities to participate at appropriate times

	CHILDREN
Ref	ACTION
CHI_1_2	MECC (School nurses, Health visitors, Midwives)
CHI_1_3	MECC - Midwives and health visitors

CHI_1_4	Alcohol substance misuse services
CHI_1_5	Smoking cessation services - Help me Quit Programme
CHI_1_6	Healthy eating/Physical activity (NERS)
CHI_1_7	Vaccination programme
CHI_1_8	Robust Sexual Health services
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_2_9	Early identification of speech, language & communication development and any other developmental delays
CHI_2_10	Access to services at a universal and targeted level
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

	MENTAL HEALTH / LEARNING DISABILITES
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

	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_10	Focus on early years healthy behaviours

CAN_2_1	Awareness Campaigns - National
CAN_2_2	Understand screening processes/management
CAN_2_8	Information and expectation of pathway
CAN_2_11	Demand and capacity modelling
CAN_2_12	Improved communication between Primary & Secondary Care
CAN_2_15	Undertake annual assessments of MDT functionality and support and challenge MDT Leads
CAN_3_1	NICE guidelines
CAN_3_10	Participate in Peer Reviews
CAN_3_11	Implement action plans
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_4_4	Education patient programme Cymru
CAN_4_13	GP Cancer Care review
CAN_4_14	Interface and communication between secondary and primary care
CAN_5_1	Plan secure and deliver well-coordinated palliative and end of life care on a 24/7 basis in line with published standards and guidance
CAN_5_3	Support all providers who care for dying patients to participate in the All-Wales Audit of the care decisions documentation
CAN_5_5	Support patient and carer self-management programmes
CAN_5_6	Encourage the initiation of serious illness conversations with patients and families, enabling informed decision-making on treatments and investigations
CAN_5_7	Encourage shared decisions-making with patients including benefits of maximising the conservative treatment approach, if patient preference is to forego intensive systemic anti-cancer treatments
CAN_5_8	Establish and prioritise people's preferences for place of death so unexpected outcomes and symptoms can be understood and accommodated.
CAN_7_3	Support the development of Wales-led cancer clinical trials and other well-designed studies and in doing so, ensure research governance.