LLWCHWR CLUSTER

Integrated Medium Term Plan (IMTP)

2020 - 2023

Welcome to the Llwchwr Cluster IMTP 2020 – 2023

Section 1
Executive Summary/Plan on a page

Welcome to the Llwchwr Cluster Plan 2020-2023 which highlights the Cluster vision and priorities and how we will achieve them over the next 3 years. The Cluster has made great strides forward in tackling the 'prevention' agenda and has developed new and innovative ways of working that have reaped benefits in terms of supporting practice sustainability and addressing the Quadruple Aims outlined in Welsh Government's A Healthier Wales (2018).

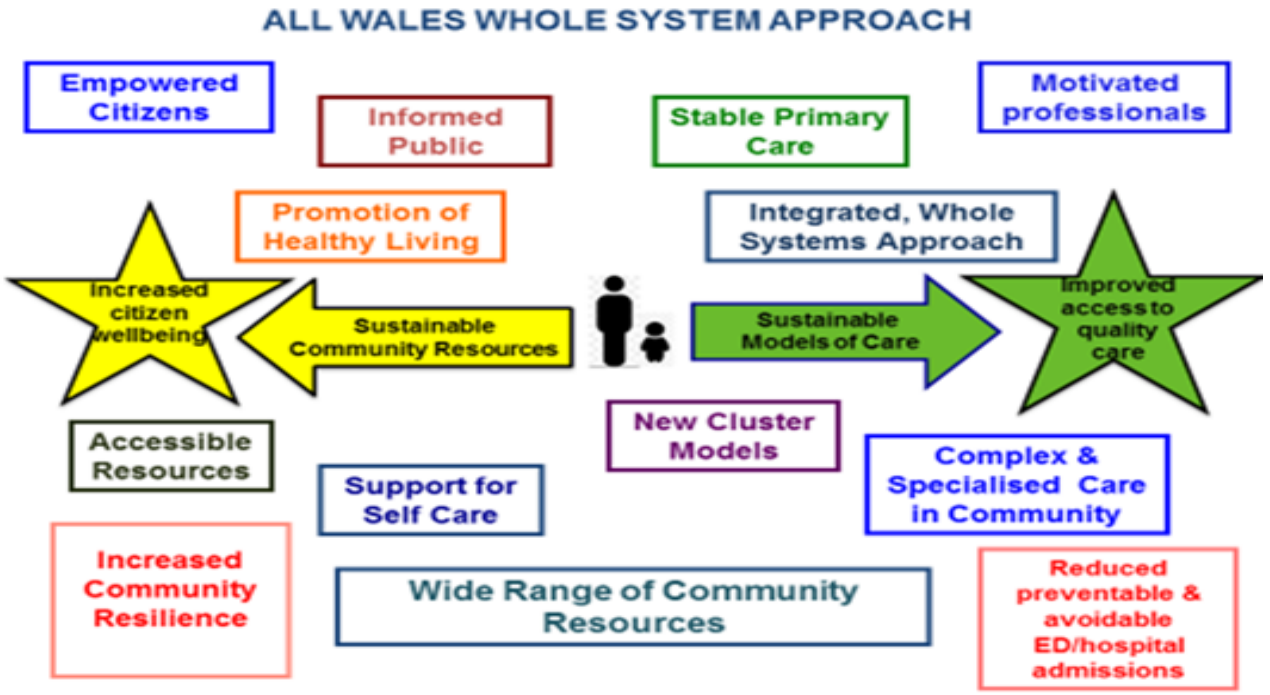
The Cluster has come a long way over the past 6 years. We have taken an innovative, preventative approach to supporting children & families by developing and testing a new model of working in partnership with the Local Authority. The 'Primary Care Child and Family Wellbeing Service' takes a holistic approach to supporting children and families experiencing mental health issues and developmental delay in the family home. The Community Voices (Patient & Carer Participation Group) Programme is now well established, having recently become a formally constituted body, with the ability to manage funds. With bi-monthly meetings, it is also attended by Practice Managers. The Group has reviewed a number of leaflets/literature available within surgeries and is in the process of producing a comprehensive "prudent" guide to accessing health and social care services. It has also requested – and secured – awareness training for staff and GPs in respect of the needs of carers. This has included increased awareness of the needs of parent carers specifically – particularly in relation to autistic children.

Over the past few years Llwchwr have worked with Third sector organisations to fund Counselling sessions for both adults and Children and Young people. This has proved very successful and will continue to help patients in their hour of need. On July 1st 2019 Llwchwr went live in their Transformation project and the benefits of this have already been evident within Primary Care, and we will continue to build on this.

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

Dr Kannan Muthuvairavan, Cluster Lead

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



Plan On A Page

Strategic Overview

Llwchwr 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 Llwchwr 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. Llwchwr Cluster will endeavour to use this exciting opportunity to support the implementation of A Healthier Wales and the new model of primary care.

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

Vision

In 2018, Llwchwr 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 Llwchwr Cluster area and its practices.

"The Llwchwr Cluster vision is to create a healthy community where Healthcare professionals and third sector organisations come together to provide holistic and equitable care or support to our cluster population of all ages."

What We Will Do

In conjunction with our Partners, Llwchwr Cluster will strive to address:

- 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
- Implementation of the Primary Care Model For Wales collaboration between primary care providers and other Cluster partners
- Developments in digital, data and technology
- Workforce Development;: including skill mix, capacity, capability, training needs, and leadership
- Estates development :ensuring safety, suitability and optimum use of premises
- Communication, Engagement and Co-production
- Improvements in Quality, Value and Patient Safety :Quality Assurance Improvement Framework, risk register, enhanced services access

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

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

Section 2: Cluster Profile: Members and Structure of Cluster

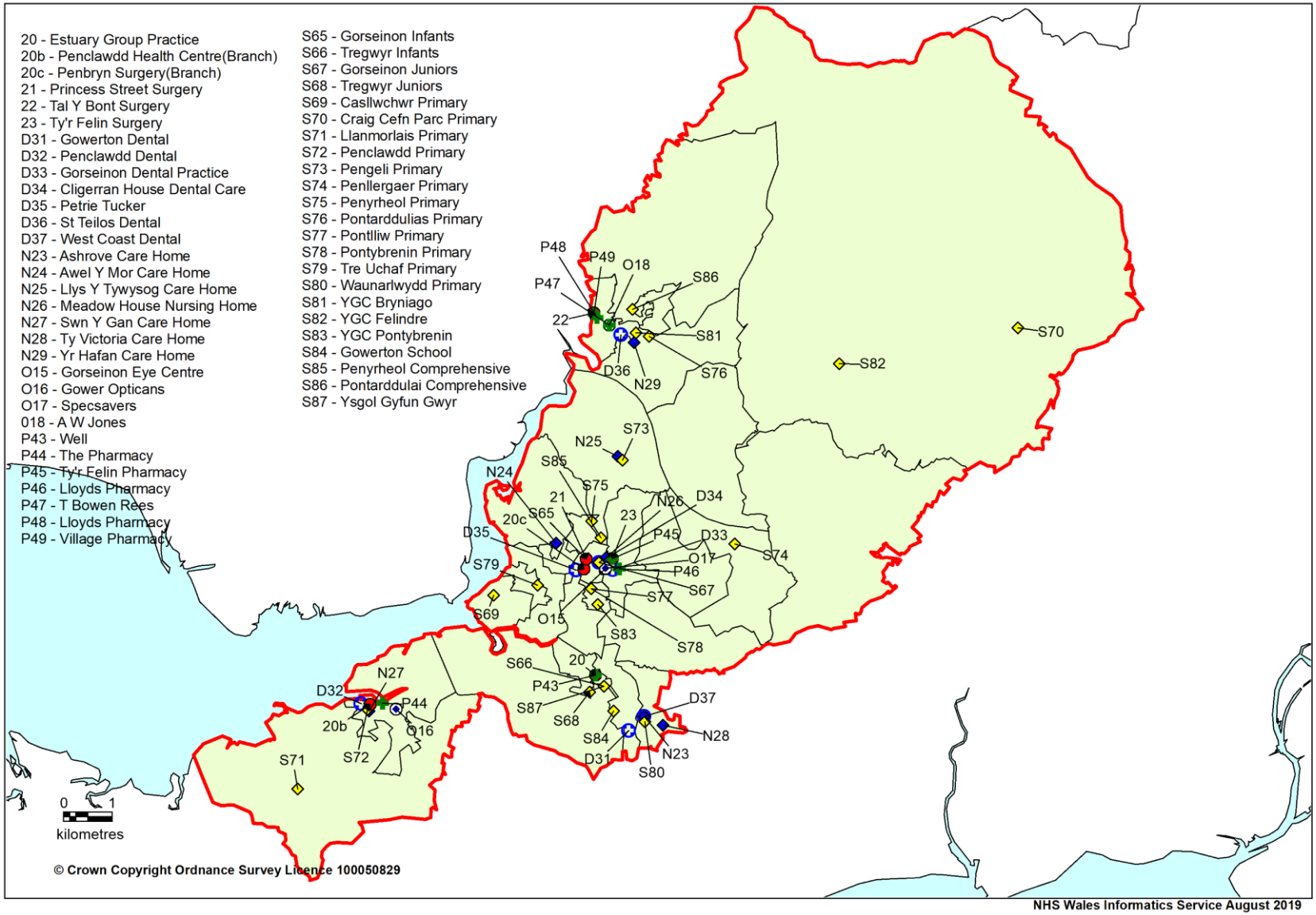
The Llwchwr Cluster is one of 8 Cluster networks in Swansea Bay University Health Board, geographically covering: Pontardulais, Gorseinon, Gowerton, Pontlliw, and Penclawdd. There are a total of 48,100 listed patients across 4 general practices, with individual practice list sizes ranging from between 8,914 to 19,089. The Cluster is formed of partners of GP practices, Community Health and Social Care Services, the Voluntary sector, Public Health Wales, and other primary and community services

Clusters 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 Llwchwr Cluster



Purpose and Values

The Swansea Bay University Health Board 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 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 by Swansea Council for Voluntary Service 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

Swansea wide 'Headline' Information

- Population: 242,000. 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.
- 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 (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.

The Llwchwr Cluster is one of 8 Cluster networks in Swansea Bay University Health Board, geographically covering: Pontardulais, Gorseinon, Gowerton, Pontlliw, and Penclawdd.

Key Population Features

- 48,100 patients registered, increasing list sizes.
- 10266 (21.6%) patients are aged 65+ (Swansea is 19.2%) and 4698 (9.9%) are aged 75+ (Swansea is 8.9%)
- Population increase 2005-2010 is + 2200
- Low student population
- Low ethnic minority patient numbers
- High numbers of Care Home patients
- Low asylum seekers numbers
- 7 Dental Practices
- 11 Pharmacies
- 6 Nursing Homes
- Significant overlap of registered patients who live in adjacent areas of Carmarthenshire
- It consists of 27 LSOAs and is the third highest populated of the 5 cluster areas, but has the second lowest population density
- Major employers: Swansea Council (schools), Gower College Swansea, 3M plc, Toyota Gosei, Timet UK, Crofty,
- Garngoch and Pontardulais Industrial Estate occupiers, agriculture businesses

Key Community Assets

Other key assets within the Llwchwr area are:

- Active Community and Voluntary Organisations.
- Leisure centres
- Entertainment venues
- Elba Sports Complex
- Loughor Castle
- Libraries

- Parc Y Werin
- Gorseinon Community Hub
- Beach access
- Lliw Resevoir
- Football and Rugby stadiums
- Access to River Loughor

Swansea Council have agreed to go 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: Llwchwr Cluster

Strengths	Weaknesses
• Strong leadership • Developing strong relationships with the University • Highly successful Patient Carer Forum • Recognising cluster population needs and working to support • Building on relationships with Secondary Care, Third Sector, Local Authority and other partners • Mature and valued Cluster PLTS programme • Strong links with the third sector and other external partners • Development of social prescribing initiatives • Active community engagement and consultation to inform cluster developments	• Risks associated with employment law for Multi-Disciplinary Team staff • Small Cluster budget • Capacity within Cluster to deliver programmes • No entity with which to draw in additional funding, no ability to expand/rollout • Wide geographical area to cover • Inability of practices to commit time to Cluster priorities due to ongoing demands with the practice
Opportunities	**Threats**
• Establish formal collaborative entity • Transformation agenda complimenting Cluster Development • Explore external funding • Development of business plans based on evaluation • Working with other clusters • To further develop MDT across the cluster, supporting sustainability • To support staff/GP resilience via PLTS • Digitalisation/Modernisation-Infrastructure improvements • Cluster IMTP development-Collaborative approach to Cluster work • Seeking areas of collaboration between GP practices and our Partners. • Identifying the learning needs of practice staff and arranging appropriate education.	• Programmes currently largely dependant on WG annual funding • Sustainability of Practices • Increase in Practice list sizes due to proposed housing developments • GP retirement and recruitment issues • Staff shortages in other areas • Staff morale and wellbeing • Contractual changes with commissioned services Capacity to deliver both the TF and Cluster agendas over the next 2 years • SBUHB organisational changes • Practice staff unable to access all Mandatory training

Section 3: Key achievements from 2018-21 plan

What we have done - our key achievements – why we are great!

The Community Voices (Patient & Carer Participation Group) Programme is now well established, having recently become a formally constituted body, with the ability to manage funds. With bi-monthly meetings, it is also attended by Practice Managers. The Group has reviewed a number of leaflets/literature available within surgeries and is in the process of producing a comprehensive "prudent" guide to accessing health and social care services. It has also requested – and secured – awareness training for staff and GPs in respect of the needs of carers. This has included increased awareness of the needs of parent carers specifically – particularly in relation to autistic children.

Queries raised in respect of repeat prescribing mechanisms were brought to the attention of all practices, and responses received were shared with the Group, resulting in practices considering how to improve communications to patients. With representation from every GP practice in the Cluster, the Group is aiming to become self-sufficient and is tasked with ensuring they have mechanisms for feeding back to other elements of the community they represent.

Our Weight Watchers/National Exercise Referral Scheme programme for newly diagnosed diabetic and pre-diabetic patients is progressing well. This programme was well received and referrals made showed evidence of significant weight loss with associated health improvements. To this end, following GP and patient requests, some of the patients were allowed a second 'free' course as the impact on their healthcare had been so significant with reduction in BMI.

The Welsh Government has provided funding for Penclawdd Health Centre to undergo extensive redevelopment, bringing it up to 21st Century standards. The intention is to finish the scheme by the end of this year.
These are important healthcare facilities for patients and carers living in Penclawdd and surrounding rural areas as they will also support increased medical training with additional doctor clinics, extension of chronic disease management clinics and extension of Early Years services in preparation of the Whole Service Transformation taking place next year.

We Have Also…

- Established an innovative relationship with the Health and Wellbeing Academy within the University to develop a joint Osteopathy Triage and Treatment proposal, with the potential to develop additional services.

- Funded the second phase expansion of The 'Primary Care Child and Family Wellbeing Service'. The service takes a holistic approach to supporting children and families experiencing mental health issues and developmental delay and is delivered in the family home.

- Produced and distributed a Falls Prevention Guide for patients across all practices within the Cluster. These have been well received by patients and additional copies ordered via Swansea Council Voluntary Service

- A programme of counselling sessions for both children and adults to support the mental health needs of our population was funded through a bespoke Cluster Third Sector Grant scheme.

- Physiotherapy treatment services are also delivered in the community, with rapid access for Llwchwr patients.

- Developed close working arrangements with Local Area Coordinators to support individuals to achieve personal goals and independence without medical support if appropriate.

- Reduce unnecessary use of antibiotics within primary care with the help of point of care testing.

- Purchased CRP (C-Reactive Protein) Test equipment which is now being widely used in practices. This will give early indication of heart disease, cancer and inflammation.

Section 4
Health and Wellbeing Needs Assessment

Information has been collated on a wide range of health needs within the Llwchwr 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, GP disease register, audit reports and a series of Cluster meetings.

The development of the plan has presented an opportunity for Cluster GP Practices 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.

Relevant Llwchwr Health Data.

Obesity	Bowel Screening
9.3% obesity rate, (Swansea average is 9%)	Of patients eligible for bowel screening in 2018-19, only 56.3% were screened. Target 60%
Smoking / Lung Cancer	**Mental Health**
18.1% of the Cluster population smoke. Welsh Government have set a target of 16% by 2020. 2nd lowest rate of the Clusters and significantly lower than the Health Board average	Around 32,200 people aged 16 or over in Swansea may have one Common Mental Disorder e.g. anxiety depression and OCD. 2.99% of patients aged over 65 are registered with their GP as having dementia
Asthma	**Alcohol consumption**
Highest rate in Swansea - 8.0%	Second highest rate in SBHB, highest in Swansea of reported alcohol consumption in previous 7 days 82.1%
Influenza Vaccination	**Breast screening**
Uptake of 64.4% in those 65 years and older, 41.5% in those under 65 years at clinical risk and 50.6% for 2 & 3 year olds.	73.2% of those eligible were screened (WG target 70%)
Diabetes	**Cervical Screening**
Third highest rate in Swansea – 5.8%	79.6% of those eligible were screened (Health Board average 76.1%, WG target 80%)
Childhood Immunisations	**Accident and Emergency Information**
The Cluster has strong performance 98.1% for childhood vaccinations up to the age of 4 (Welsh Government target 95%)	Emergency Admissions: 1,883. Emergency Attendances: 10,065. OOHs contact: 6,326.
Atrial Fibrillation	**Dementia**
Joint highest cluster in Swansea. Llwchwr 1082 (2.3%);Swansea 2.2%: and ABMU 2.3%	Second highest rate and numbers in Swansea clusters. Llwchwr 352 (0.7%): Swansea 0.7%: ABMU 0.7%

Diabetes	Hypertension
Llwchwr 2746 (5.8%): Swansea 5.6%: ABMU 6.2%	Second highest rate in Swansea. Llwchwr 7222 (15.3%): Swansea 13.1%: ABMU 15.3%
Heart Failure	**Stroke/TIA**
Second highest numbers in Swansea clusters Llwchwr 525 (1.1%): Swansea 1.0%: ABMU 1.1%	Joint highest rate in Swansea, second highest numbers. Llwchwr 1019 (2.2%): Swansea 2.1%: ABMU 2.1%

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**

***Health and Attainment of Pupils in Primary Education Network (*HAPPEN)**
Established in April 2015, HAPPEN focuses on children in Swansea Schools aged 9-11 years who complete health and wellbeing assessments as part of the Swan Linx Project.

Data is collected on body mass index, fitness, nutrition, physical activity, sleep, wellbeing, concentration and children's recommendations on improving health in their area. Pontardulais and Pontlliw schools, (two of the Primary Schools within the Network) have undertaken the study within the last two years, and the areas of interest are shown below*:*

	Pontardulais %	*Pontlliw %*	*Swansea %*
Sedentary Screen time for 2 hours or more a day	23%	27%	*31%*
5 Portions of Fruit and Veg a day	35%	27%	*27%*
At least 3 take aways a week	20%	7%	*18%*
Physically active for 1 hr or more a day	28%	25%	*24%*
Happy with family	86%	88%	*94%*
Happy with Life as a whole	73%	88%	*91%*

Adverse Childhood Experiences
Below indicates the national figures for ACES in Llwchwr

0 ACEs 53 %	
1 ACE 20%	
2-3 ACEs 13%	
4+ ACEs 14%	
Figures based on population adjusted prevalence in adults aged 18-69 years in Wales	

We know that exposure to ACE'S increase an individual's risk of developing health-harming behaviours. Compared with people with 0 ACE'S people who have experienced 4 or more ACES are:

- 4 times more likely to be a high risk drinker
- 6 times more likely to have had, or caused an unintended teenage pregnancy
- 6 times more likely to smoke
- 6 times more likely to have had sex under the age of 16
- 11 times more likely to have smoked cannabis
- 14 times more likely to have been a victim of violence over the last 12 months
- 15 times more likely to have committed violence against another person in the past 12 months
- 16 times more likely to have used crack cocaine or heroin
- 20 times more likely to have been incarcerated at any point in their life time.

38 % of Parents who have engaged with support from this cluster report to have experienced 4 or more ACES, 24% above the national average.

Additional learning needs

20% of families who engaged with the service have children with diagnosed additional learning needs, or are on the referral pathway.

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

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. (ABMU reference point)
(Unless stated otherwise, all data taken from Swansea Bay UHB Information Portal 2017-19)

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 • Myocardial Infarction • Heart Failure	2A		(2014-2016) **62.3** **18.3** **1.1**	(2014-2016) **65.9** **20.5** **0.0**

• CVA (all ages)			**70.6**	**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 provided by the Practices within the Cluster

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

Enhanced Services Provided by Community Pharmacies

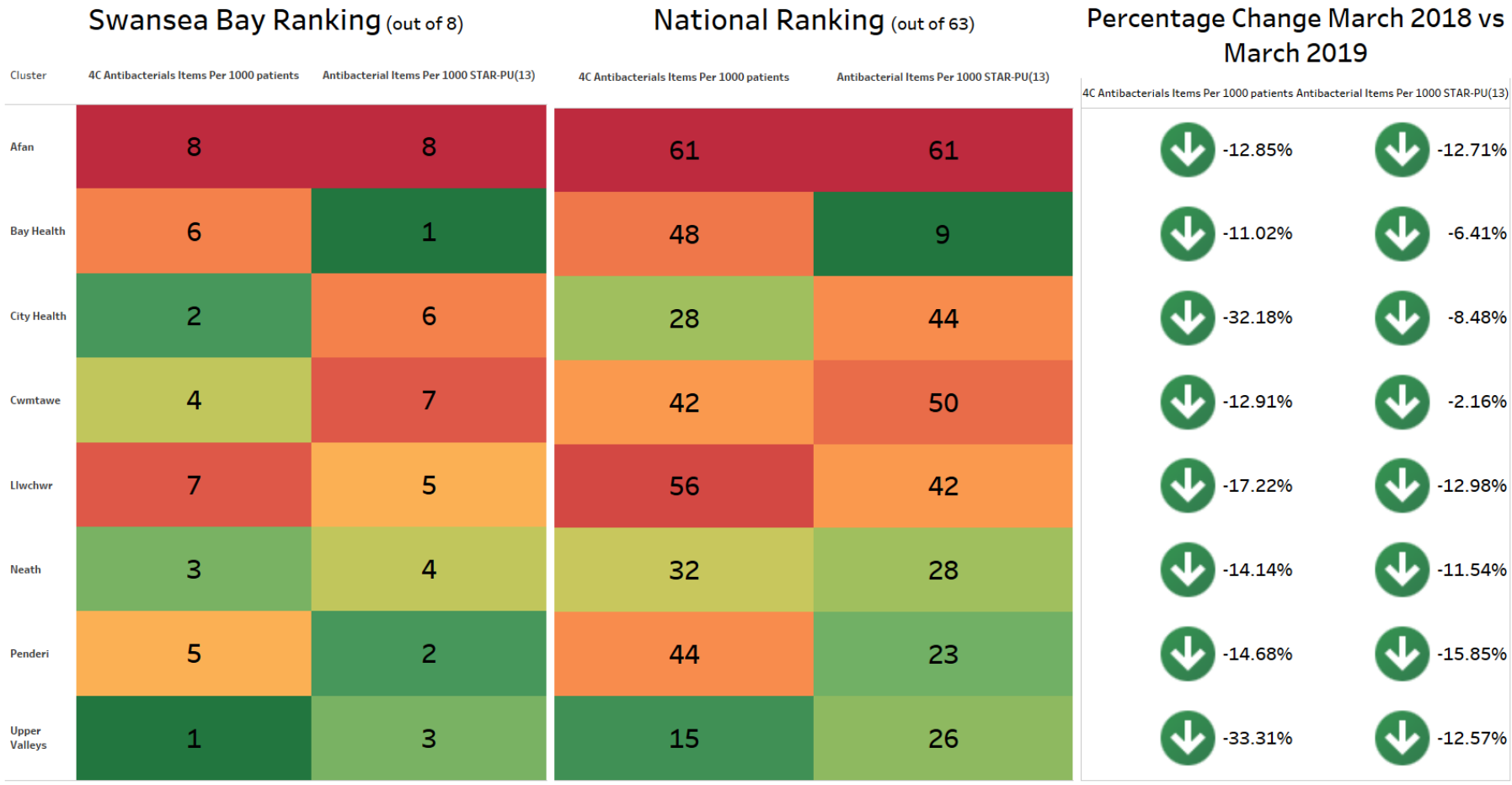
Cluster	Address	Postcode	Contract	CAS	Seasnl Flu	Smokng L2	Smokng L3	MAR	Pall Care	Just In Case	EMS	Med Mgt	Suprvsd Consumptn	Syringe Needle	THNS	BBV	TB
Llwchwr				**9**	**6**	**8**	**6**	**9**	**3**	**7**	**8**	**0**	**8**	**4**	**0**	**1**	**0**
Lloydspharmacy	5-6 Gorseinon Shopping Cent	SA4 4DJ	605832N	✓	✓	✓	✓	✓	x	✓	✓	x	✓	x	x	x	x
Lloydspharmacy	5 St Teilo Street	SA4 8TH	605800N	✓	✓	✓	✓	✓	✓	x	✓	x	✓	✓	x	x	x
T. Bowen Rees	71 St. Teilo Street	SA4 8SS	605325A	✓	x	✓	x	✓	x	✓	✓	x	✓	x	x	x	x
The Pharmacy	Sea View	SA4 3YF	605566A	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x	x	x
Ty`r Felin Pharmacy	Cecil Road	SA4 4BY	605006C	✓	x	✓	x	✓	x	✓	✓	x	x	x	x	x	x
Village Pharmacy	Station Road	SA4 8TL	605145A	✓	x	x	x	✓	✓	✓	✓	x	✓	✓	x	x	x
Well	2 Alexandra Road	SA4 4NW	605857N	✓	✓	✓	✓	✓	x	✓	✓	x	✓	x	x	x	x
Well	63 Alexandra Road	SA4 4NU	605856E	✓	✓	✓	✓	✓	x	x	x	x	✓	✓	x	✓	x
Well	Mill Street	SA4 3ED	605857O	✓	✓	✓	✓	✓	x	✓	✓	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:

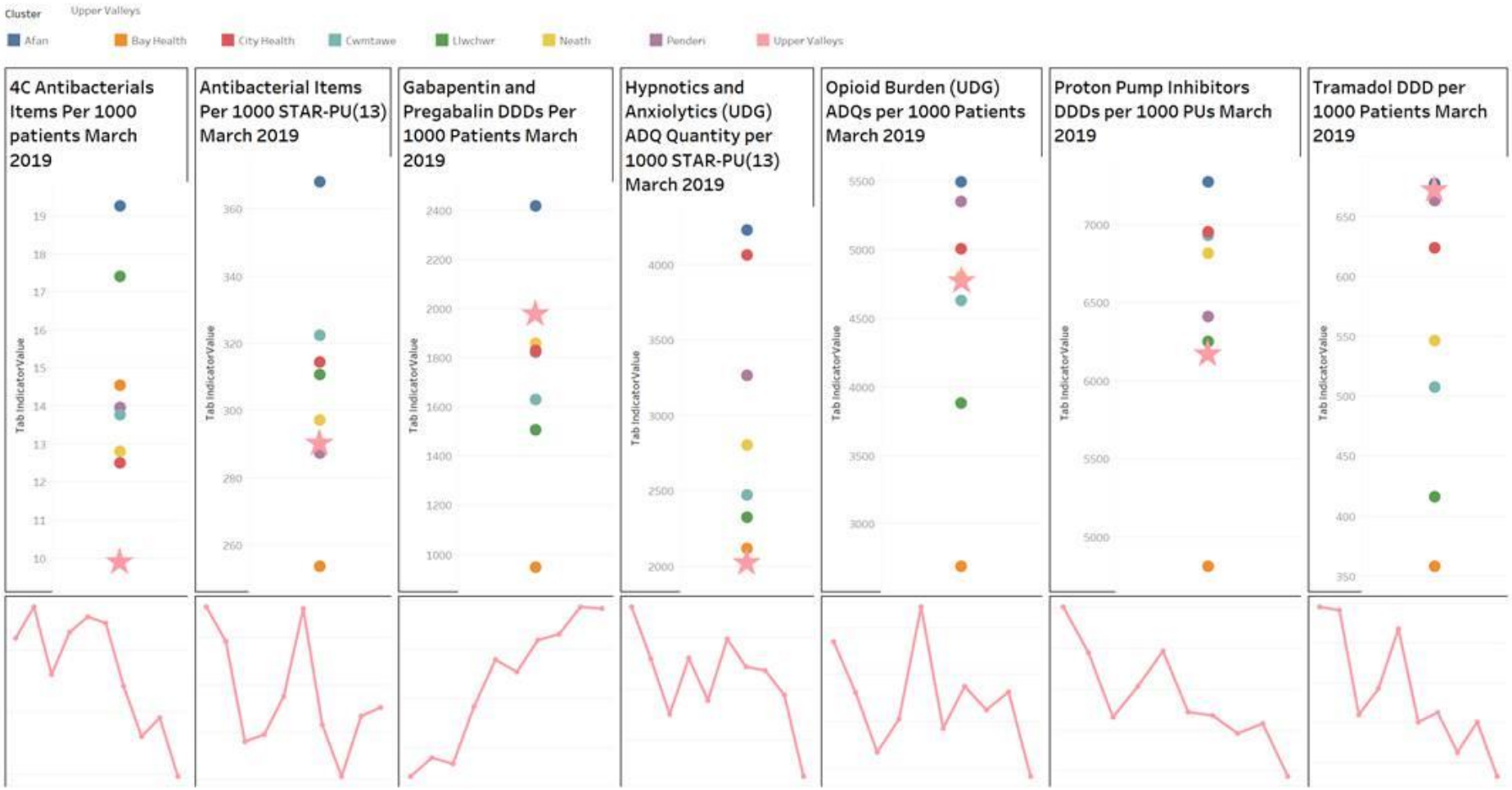
All prescribers should document indications for all antimicrobial prescriptions; it is expected that an appropriate read code will be entered whenever antimicrobials are prescribed. Primary Care clusters should ensure urgent dental cases are seen by dental services rather than by GMS. Wales Quality Improvement: Antimicrobial Stewardship – Supporting measures to improve Urinary Tract Infection (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 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 Scheme + 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: Llwchwr Cluster Workforce Profile

DOCTORS

Head Count	Whole Time Equivalent	GP / Patient Ratio
35	26.3	1,829

NURSES – *Nurses employed directly by the Practice*

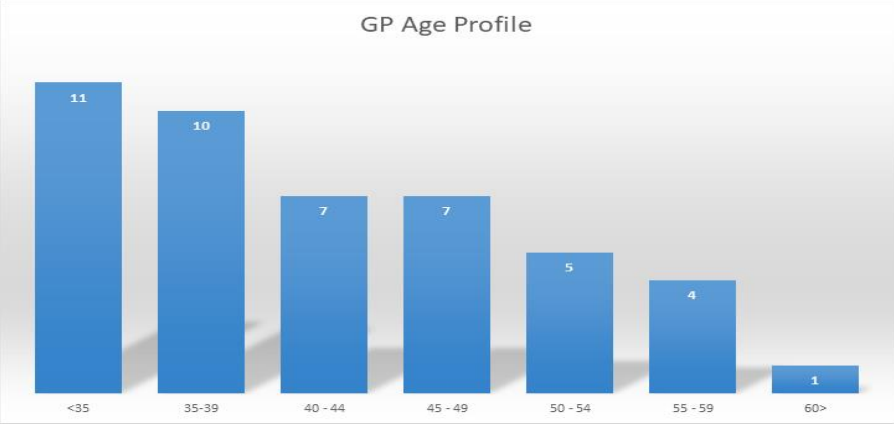
Head Count	Whole Time Equivalent	Nurse / Patient Ratio
17	9.9	4,828

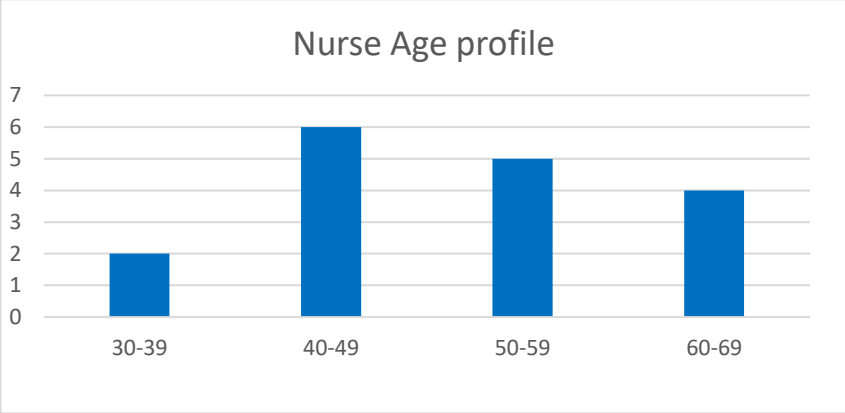
DIRECT PATIENT CARE – *Health Care Assistants, chiropodists, therapists, etc*.

Head Count	Whole Time Equivalent	DPC / Patient Ratio
6	3.9	12,462

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

Head Count	Whole Time Equivalent	Admin / Patient Ratio
76	56.2	855





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/OT	7.6	13.2		9.7 (P) / 8 (OT)	
Single Point Of Access	3.6	7.5		1	
Palliative Care (Health Care Support Worker)	8.6	N/A		N/A	
Palliative Care Nurses	1.4	N/A		N/A	
Continuing Health Care 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.

	Number of staff per cluster & wte					Total *(if not available by cluster)*
Staff Title	**Bay Health Cluster**	**City Health Cluster**	**Penderi Cluster**	**Llwchwr Cluster**	**Cwmtawe Cluster**	
	West hub	***Central Hub***		***North Hub***		
E.g District Nurse	***1***	***1***	***1***	***1***	***1***	***n/a***
District Nurses	**22.273 WTE**	**36 WTE**		**15.25 WTE**	**11.37 WTE**	
HCSW	**9.444 WTE**	**8.87 WTE**		**5.43 WTE**	**3.06 WTE**	
Out of Hours Nursing Team	**N/A**	**10.18 WTE**		**N/A**		
Physiotherapy/OT (Health)	**7.633**	**13.16 WTE**		**9.70 WTE (P) 8 WTE (OT)**		
Single Point of Access	**3.6 WTE**	**7.5 WTE**		**1.0 WTE**		
Palliative Care Team (HCSW)	**8.56 WTE**	**N/A**		**N/A**		
Palliative Care Team Nurses	**1.4 WTE**	**N/A**		**N/A**		
CHC including NB Team (HCSW)	**31.53 WTE**	**N/A**		**N/A**		
CHC Nurses including NB Team	**5.6 WTE**	**N/A**		**N/A**		
Admin	**4.4 WTE (Inc CHC Admin) 1.0 WTE (SS)**	**3.29 WTE**		**3.08 WTE (H) 1.42 WTE (SS)**		
Swansea Council (Social Workers, Homecare Team, OT's)	**31.53 WE**	**36 WTE**		**41.05 WTE**		
Description of other resources available or required,						

pertinent to Cluster discussions, e.g IT, skill mix						
High level Training Needs Identified	None reported					
Please describe any issues; insufficient capacity, recruitment, vacancies, sickness, age profile	**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

ACO: 3 x GPs (sessional basis working one day each a week covering all of Swansea clusters Monday, Wednesday and Fridays)

Speech and Language

	Number of staff per cluster								**Total *(if not available by cluster)***
Staff Title	**Bay Health Cluster**	**City Health Cluster**	**Cwmtawe Cluster**	**Llwchwr Cluster**	**Penderi Cluster**	**Afan Cluster**	**Neath Cluster**	**Upper Valleys Cluster**	
Speech and Language Therapist	***1***	***1***	***1***	***1***	***1***	***1***	***1***	***1***	***n/a***

Local Area Coordinator (all F/T)	***4***	***2***	***1***	***2***	***2***	***11***

Audiology services are available across Swansea, from Singleton Hospital. A transformation programme is underway to deliver community based services being trialled in Cwmtawe Cluster.

Current OT provision in the community is primarily provided through the Integrated Community Health and Social Care teams. Access to OT 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 OT 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

In terms of the HV ‘s 7 WTE,5 Part Time and admin support. The Nursery nurse supports on one afternoon running a post- natal group in Penyrheol leisure centre. The HV’s in the cluster also provide excellent support to the perinatal mental health groups on a Monday and Thursday and also from a public health perspective support a fathers group in HMP Swansea. All surgeries have excellent links and communication with the GP surgeries

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.

Pharmacy:

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
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.

Training Needs
Additional training needs within the Llwchwr 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
- Ensuring Mandatory Training Sessions are all up to date e.g. Safeguarding

Section 6: **Cluster Financial Profile**

The Llwchwr Cluster has a financial allocation from the Welsh Government of £146,184. In addition, Clusters have access to other funding streams such as the Health Board delivered PMS+ scheme. In addition the Health Board have secured significant additional resource for use in the Llwchwr Cluster : - Over 1 million to undertake a Transformation programme

Llwchwr Cluster Funding 2019-20	
Welsh Government allocation	**£146,184.00**
PLANNED SPEND	
Project	**Spend allocated**
Clinical Pharmacist	£53,000
Early Years Worker	£25,000
CYP Counselling	£20,000
CRP Consumables	£4,000
Physiotherapy	£10,000
Osteopathy Project	£32,000
Patient Carer Forum	£1000
Vision 360	£7,750
Any remaining Cluster funds will be spent on schemes by March 31st 2020	
Dementia Worker	21,749
Total spend	**£174,499**
Additional monies received by the cluster	
PMS+ Monies	£47,442.47

ICF Revenue Grant- dementia	£21,749

West Glamorgan Allocation per theme

Older People = £5,224,000

Learning Disabilities/Mental Health /Community Nursing/Carers £ 2,590,000

Edge of Care = £1,942,000

People with Dementia = £1,175,000

In addition, as stated earlier, from July 2019 Llwchwr Cluster is pleased to have become part of **the national Transformation Programme for an 18 month period. Llwchwr have been awarded £1,245 million and relevant actions agreed through the programme** will become part of the Cluster action plan through regular updates.

In addition, £3.6m has been awarded through Transformation Funds to Swansea's Our Neighbourhood Approach, delivered across Llwchwr and Cwmtawe Clusters:

Early Help Hubs & Transition- providing family support services from a range of different partnerships integrating local authority services with multi-disciplinary working with colleagues from Health, Police, Education and the third sector. Alongside the Early Help Hub initiative will be transition workers focused upon linking with education, Child and Family Services and health provision to establish the level and type of future needs of children aged from 15 years - 17 yrs. In addition, mental health staff with specific focus on substance misuse will work with partners to support two mental health staff would be placed in each of the CMHT's with a focus on better linking with substance misuse services for those identified with such issues

Building Community Assets: The Hubs will also include space for meetings, direct work and communal areas that can be accessed by families. Third sector organisations and wider partners would also be able to run group work and offer access to information and advice from these Hubs. Local Area co-ordination (LAC) resource will be increased in the area.

With a strong emphasis on a co-productive approach and community 'owned' assets the third sector specific element includes Community Development Workers and sector specific funding which is easily accessible for identified costs including the training and expenses of volunteers.

Community Based Care & Review: enabling individuals to remain within their own community, homes and as independent as possible for as long as possible through Adult Services community based Care and Review. The team will build upon the integrated model in place with health and community services of a reablement focused resource linked with timely, regular engagement with individuals and their support network.

Section 7

The development of the plan has presented an opportunity for Llwchwr Cluster 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.

Our Cluster Three Year Action Plan

Prevention, Wellbeing and Self Care

Our three year focus:

Cluster members will work co productively with partners and the local community to promote health literacy and self care among its population; assessing improvements on an annual basis

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	Identify additional funding to allow the cluster to commission a lifestyle coach/physical trainer to develop a series of exercise programmes to be delivered to cluster patients, though group sessions within the community, targeting weight management, pain management, diabetes, hypertension	Manager	Ongoing to March 2021	A 5% reduction in those patients classed as obese within the target area.	Significant funding Approximately £320k	Questionnaire has been developed to identify patient needs, completed and formed part of the HAF bid Funding bid submitted and awaiting outcome. Unfortunately the bid was unsuccessful, but the cluster are looking

						for further funding sources
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	Maintain and encourage further Improvement in the uptake of childhood immunisations, particularly for those in areas of high deprivation through the Childhood Immunisation Group Improve Flu Vaccination uptake rates for children, people with chronic conditions, people over 65 and staff through Flu immunisation campaign and Flu Action Plan through Flu steering group	Cluster practices PHW Health Board	Ongoing	Reduce morbidity / mortality / hospital admissions Improve COPD outcomes	Explore the possibility of holding evening and/or weekend clinics Access COPD funds (TF)	Regular review of IVOR data. Practices share best practice and ideas. Identify and target those at greater Risk
1.4	Increase referrals to National Exercise Referral Scheme	Cluster practices	Ongoing	Increased numbers of patients referred to NERS.	NERS Capacity	Working with NERS to increase referrals and

				Better management of obesity in patients		link in with HAF project bid; 15/16 152 16/17 78 17/18 125 18/19 112
1.5	Explore opportunities to link with the Carers Centre to provide support to newly identified carers looking after people with Dementia	SCVS, Carers Centre, Cluster, BSM	Oct 2020	More patients identified as Carers and supported	Carers Partnership Scheme	Making links with the Carers Centre, and make use of the Dementia worker following the bid
1.6	To further promote existing No smoking pathways and target Young People	PHW Community Pharmacist Practices	Oct 19 and ongoing	Less Children and young people smoking leading to healthier lifestyles	Time/PHW/Community Pharmacists	Link with PHW made
1.7	Promote self-care through patient education.	Cluster practices	Ongoing	Generally improve health of Cluster population. Reduce burden on GP practices.	Patient engagement Increase level of funding from Cluster	Working with Carer Forum to produce leaflet
1.8	To continue to work with Local Area Coordinators	Practices LACs	Ongoing	Improve access to non medical support	LAC funding	Practices and LACs working well together

Timely, equitable access, and service sustainability

Our three year focus:

To work collaboratively with partners to develop easily accessible shared resources to meet the needs of patients and to ensure patients know how and when to access the services

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	Work with partners to deliver programme of Transformation for Our Neighbourhood Approach including the implementation of the ONA Community Development Role	SCVS HB CDR	Oct 2019 and ongoing	A full list of all available services for the patients of Llwchwr Peer support	Funding for the Community worker via TF Funds	Development worker appointed and working with practices
2.2	Work with partners to deliver programme of Transformation of Clusters, robustly evaluated, underpinned with training, support, clinical time and workforce development and resulting development	HB Practices	Start July 19 for 18 months	Successful Transformation of services for patients	Transformation funds (whole system)	Llwchwr went live July 2019. Leadership group in place and meeting monthly
2.3	Access to In-Hours GMS Services Standards:	All practices	March 2021	Achieving Access Standards and measures (Group 1 and Group 2)	Funding (QUAIF)	All practices in the Cluster have QR Boards

	Cluster practices should ensure improved access to services delivered closer to home as set out in the guidance and, Inform cluster population of wider communication/access options available. Cluster to discuss and develop action plan on finding from all Wales patient survey and share with Health Board Cluster to consider demand and capacity analysis				Telephone infrastructure Signposting materials Communication and Engagement	Patient Carer Forum leaflet currently being developed
2.4	Set up and build a relationship with the Health and Wellbeing Academy within the University. To include an Osteopathy service potentially including counselling services, and sleep deprivation	Health and Wellbeing Academy with support from the Network	Ongoing and April 2019	Patients being triaged and treated and not requiring further treatment within secondary care. Improved patient experience Better access to services Reduced visits to GPs	Cluster funding	Discussions underway, and business plans written in draft. For further discussion at the next Cluster meeting, with the aim to commence the service in October 2019. Further discussions ongoing with the Health Board Legal Dept
2.5	To ensure information on appropriate access to health services is produced and shared in different formats and varying media for patients. Information to be co produced and patient feedback sought	Practice Managers Cluster Dev Team	March 2020	Patients accessing appropriate services according to health and wellbeing need. Reduced pressure on GP practices	Time Production of leaflets-costs	Access leaflets being developed by the Patient Carer Group- to be reviewed and updated, when required Cluster Website to be established ensure that access information is clearly displayed

Rebalancing Care Closer to Home

Our three year focus:

To progress the 'whole system approach' and empower the Llwchwr community to co produce new and innovative 'doorstep' services that meet the needs of the local population

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	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	Transformation underway in July 19. New practice MDTs identified and some appointed
3.2	Manage patients with common ailments in the community, rather than in practice. Continue to build on the Choose Well campaign, and work with Community Pharmacist to improve patient education	Health Board Community Pharmacy Cluster practice	Ongoing	Fewer patients with common ailments presenting at practice	Develop links with community pharmacies Work with media and other communication outlets	
3.3	Improve community care of patients with COPD by ensuring patients with COPD have a flu / Pneumoccocal vaccination and creating self-management educational programmes with patients	Cluster Pulmonary Rehab Team	March 2023	Improve identification of patients with COPD using Spirometry Optimise treatments in the community with appropriate	Funding Venue	Primary care target framework awaited. Whole systems approach business plan being created with HB

				inhalers/ Referrals to Pulmonary Rehabilitation Aiming to Undertake annual reviews of patient diagnosed with COPD		
3.4	Improve community care of patients with heart failure by ensuring patients with heart failure have a flu vaccination and creating self-management educational programmes with patients	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 (TF) Venue	Primary care target framework awaited. Whole systems approach business plan being created with HB

Implementing the Primary Care Model for Wales

Our three year focus:

To progress the 'whole system approach' through a collaborative approach ensuring that services are delivered seamlessly and patients see the most appropriate health/social care professional to meet their needs

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	Increase collaboration between GP practices and other primary	All	Ongoing	Practices better able to manage demand and	Time	Working well

	care providers, Third Sector and other Cluster partners.			improve patient care and experience.		Opportunities to design and deliver services at Cluster level
4.2	Patients will be empowered to take ownership of their own health and wellbeing needs by adopting a co productive approach to Health and Wellbeing	Cluster Lead GP's Cluster Dev Team Practice Managers	Ongoing	Services will be developed collaboratively across the Cluster with patient involvement. Patients will know which service to access and how to access it resulting in an informed and resilient community.	Time Funds	Development of patient information related to access and Cluster Website development
4.3	A comprehensive staff training programme will be undertaken for all practice staff focussing on : -Co production - MECC - Health Literacy - IRIS - Completion of Mandatory Training - Complex Needs - ACE's See also Workforce section	Cluster Lead GPs Cluster Dev Team Practice Managers	Ongoing Phased approach over 3 Years	All staff trained and fully briefed resulting in an informed workforce	Time	Health Literacy training to be undertaken at a future PLTS session
4.4	The Cluster to look to become a legal entity (CIC)	Cluster SCVS	November 2019	Ability to make decision and obtain additional funding	TF Funding	Decisions ongoing, and awaiting the appointment of Directors
4.5	Progress rollout of Primary Care Child and Family Wellbeing Service (Early Years) across all Clusters.	Health Board	March 2023	Early years: Making sure children have the best start in life. The patients continue to receive early years support and see the most	Early Years Worker £25k per year per Cluster	Early Years worker embedded Clusters

				appropriate person for their concerns Addressing ACE's		

Digital, data and technology developments

Our three year focus:

To improve the cluster digital infrastructure developing opportunities to maximise collaborative cluster work and make evidence based cluster decisions with robust data sets

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	To improve systems of clinical governance in GP practices To continue to discuss SEAs at Cluster meetings	Cluster practices Health Board (Datix)	Ongoing	Improve education of clinicians, hence improve patient care.	Funding	SEAs being discussed and lessons learnt
5.2	Increase use of My Health Online	Practice administration staff Health Board Digital Communities Wales Library	March 2021	Reduce impact on practices Better access for patients More patients in Llwchwr Cluster using My Health Online	Venue Demonstration Staff capacity	An event will take place in Oct 19 to raise awareness of My Health Online

5.3	Infrastructure to be put in place to facilitate collaborative working between practices eg: Vision 360, Vision Anywhere	Cluster Lead GP's Cluster Dev Team Practice Managers	March 2021	Improved appointment system for patients. Patients able to access appointments delivered by MDT across the Cluster as appropriate	Appropriate Software (Approx £8,000)	Meeting taken place with Vision 360. Cost agreed, awaiting implementation

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

Our three year focus:

To embrace the Transformation Agenda and review and strengthen the cluster workforce through evolving service models creating a motivated, engaged and sustainable workforce

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	Continue to develop 3 year plan to identify and implement the most appropriate and effective MDT for the Cluster	Practice Managers Health Board GP Leads	April Annually	That the Cluster continues to developed in accordance with the changing role of primary care	TF Cluster practices	Practices discussing MDT requirements
6.2	Develop Leadership/Bid Writing and Project Management Skills of Cluster Development/Leadership Team	Cluster Lead Cluster Dev Team	March 2020 and ongoing	Informed and Trained Cluster Leadership. Effective bids submitted resulting in increased revenue for the Cluster to develop Cluster projects and initiatives	Cluster Funds to support Bid Writing Training	Bid Writing Session attended in May 2019 run by SCVS Business Case Development Training to be held in October 2019 for Cluster Development Team

6.3	Practices are looking to implement the Diabetes NES. Training to take place on 'injection therapy'	GP's	March 2021	Better outcomes for patients. GPs able to support diabetic patients more effectively	Time	Cluster Lead to canvass opinion on Diabetes NES
6.4	To develop a formal training programme for practice nurses	GPs PMs Cluster Dev Team	March 2021	Practice Nurses able to access relevant and timely training programme that meets patient needs	Time. Funding TBC	Training for practice nurses is currently 'ad hoc'. There is a need to strengthen and formalise training across the Cluster resulting in sharing of good practice among practice nurses and better patient outcomes
6.5	To continue to develop the role of the Integrated Cluster Pharmacist to work On reducing antibiotic prescribing across all practices Anticoagulation/INR Reducing Opiates	GPs Cluster Pharmacist	Ongoing	Improvement of Cluster priorities such as Anticoagulation	Cluster Funding	Pharmacist continues to work well with the practices and patients

Estates Development

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 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 Estates Manager	May 2020	Clear understanding of available estates. Clear understanding of relevant organisational estates strategies impacting the Cluster The Cluster able to influence estates' strategies More prudent use of estates for better patient access to services at lower cost to providers.	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
7.2	Improve IT connections available within the practices where necessary.	Estates Manager Health Board Practice Managers Cluster Lead Stakeholder partners	2020-2023	Improved options for digital connectivity	Funding	
7.3	To offer Store and Scan for practices	GP Practices	Oct 2019	More storage space for practices	TF Funding	One practice has taken up the offer
7.4	Work together with partners 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 MDT	Practices –	Ongoing	Integrating cancer care into holistic chronic disease management in Primary Care.	Time/workforce	Issues around cancer diagnosis rates

	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		Ongoing	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		
7.5	To ensure that Cluster Development Team are aware of Capital Funding opportunities and improvement grants that can be accessed and the Cluster have prioritised capital expenditure moving forward	Cluster Lead Cluster Dev Team	Opportunistically	Cluster Development Team are aware of Funding Opportunities and actively bidding for funds to support cluster developments	Time	

Communications, Engagement and co-production

Our three year focus:

To actively engage the community in the design of cluster health and wellbeing services that meet their needs and support self care initiatives

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	Engage with patients to understand their experience of services and to identify their needs	Cluster practices Health Board Patient Carer Forum	Ongoing	Practice objectives in line with patient needs.	Fund Patient Carer Group	Work closely with the Patient Carer Forum in producing a patients leaflet
8.2	Funding: Work to obtaining money from the Windfarm and other funds to establish and support community projects within the Llwchwr Cluster Network Identify and secure additional funding streams	Members of the Network Cluster Lead Lead GPs PMs, HB	Ongoing	New and existing community projects receiving funding within the Llwchwr Network External funding available for the cluster to deliver services meeting its identified priorities	Business Support Capacity	Meeting has taken place to stimulate ideas and identify potential groups and projects. Little leverage of additional funding and resources currently done.
8.3	Map the existing services available within Llwchwr with a view to maximising resources available.	CDM Health Board Cluster	Jan 2020	Improved value and access to services. Effective use of resources		
8.4	**Establish Cluster communications strategy:** Identifying key stakeholders to influence to maximise impact, including sharing best practice delivered in Llwchwr Health	Cluster Lead Lead GPs 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.

Improving Quality, Value and Patient Safety

Our three year focus:

To deliver high quality cluster services sharing data and lessons learned with a focus on review and continual improvement

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	Continue to improve prescribing and medicines management including engagement in Prescribing Management Schemes and improving performance against National Prescribing indicators	Cluster practices Medicines Management Team	2019 and Ongoing	Improved Medicines Management. Prudent use of finite resources. Improved patient care.	Time	
9.2	Quality Assurance and Improvement Framework: Consider the requirements under QAIF 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.	Cluster practices	2019 and ongoing			

	d. Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20					
9.3	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, and will inform a cluster communications strategy.

Communications Matrix	Cluster Meetings	Cluster Spend Plan	Cluster IMTP	Grant Scheme Updates	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			□		□
Community Health Council			□		□
Citizens Advice Bureau					□
Community Health Council			□		□

Welsh Government		□	□	□	□
Local AMs / MPs					□
Media			□		□
Chairman / Executive Team		□	□	□	□
Heads Of Clinical Services					□
Out Of Hours					□
SBUHB Patient Feedback Team					□
Shared Services Partnership					□
NWIS					□

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 aims

- ✓ 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

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:

1. One System of Care

Clinical pathway processes that cross specialities, departments & delivery units

2. My Home First

Pathways which enhance care delivery in or closer to the patients home where clinically safe

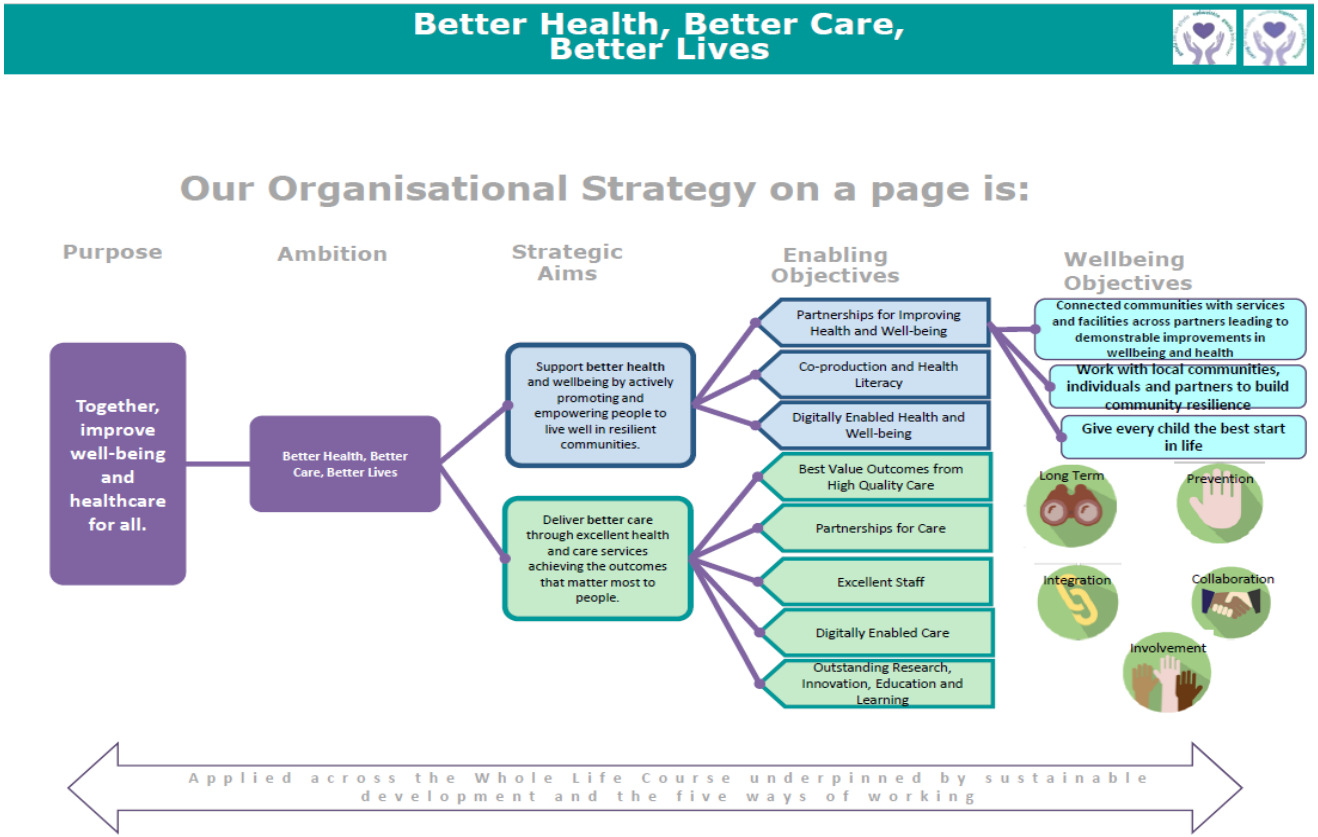
3. Right Place, Right Person, Right Time

Workforce, estates, equipment, digitalisation

4. Better Together

Regional and local collaboration on networks of services that meet the care needs of patients

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.

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 the Cluster Development Team and 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
3. To it by the Local Health Board.
4. 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.
5. 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.
6. 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:
    (a) An awareness of the Welsh language (including awareness of its history and its role in Welsh culture); and
    (b) An understanding of how the Welsh language can be used when delivering services, or any part of a service, under the contract.
7. When delivering services, or any part of a service, under the contract, the contractor is encouraged to:
    (a) establish the language preference of a patient; and
    (b) 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 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_5	Evaluate and agree recommendations regarding Care and Repair Scheme
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_7	Work closely with WAST to ensure appropriate triage preventing hospital admission
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_3_1	Continue remodelling of multi disciplinary primary care out of hour services
USC_3_3	Continue to maximise use of 111

	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_2_5	Ensure that clusters meet the national standards for opening times
PLAN_2_6	Ensure that good quality robust information is available to understand how demand is being distributed across the planned care system
PLAN_2_7	Ensure that clinicians are provided with the time to deliver the right balance of face to face and non face to face communication of outcome and that job plans and inter HB contract are amended accordingly
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 dagnostic services across clinical pathways to ensure services are sustainably "right-sized"
PLAN_3_4	Implement a digital solution 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

	MENTAL HEALTH / LEARNING DISABILITIES
REF	ACTION

MHLD_1_1	Implement actions for delivery of Neighbourhood approach as per the Neighbourhood approach implementation plan
MHLD_1_2	Support the Cluster transformation actions around social prescribing as per the CSP
MHLD_3_1	Review of Community Mental Health Team role and function
MHLD_3_2	Further development of EIP services for young people
MHLD_3_3	Development of cluster based Primary Mental Health care
MHLD_3_4	Redesign of stepped model of care
MHLD_3_5	Monitoring of 26 week access target for high intensity psychological therapies
MHLD_3_6	Development of physical health monitoring strategy for serious mental illness
MHLD_3_7	Consolidation of community teams and day hospital service in Swansea

	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_5	Defined, clear and up to date pathways are in place

	CHILDREN
Ref	ACTION
CHI_1_1	Public Health campaigns
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_2_7	Identifying and addressing needs at an early stage can help to prevent the difficulties that they can experience from arising.
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_10	Access to services at a universal and targeted level

CHI_4_1	We will ensure that arrangements are in place to consider the impact on children and young people living in an environment where they are exposed to mental illness
CHI_4_2	We will ensure that arrangements are in place to consider the impact on children and young people living in an environment where they are exposed to substance misuse.

	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_5	Brief intervention embedded across all tumour sites
CAN_1_6	Vaccination programme for HPV
CAN_1_7	PKB - Directed information and support
CAN_1_8	Digital Forums /groups/support/coaching
CAN_1_9	Needs assessments and targeted intervention
CAN_1_10	Focus on early years healthy behaviours
CAN_2_1	Awareness Campaigns - National
CAN_2_2	Understand screening processes/management
CAN_2_3	Consider role within MECC