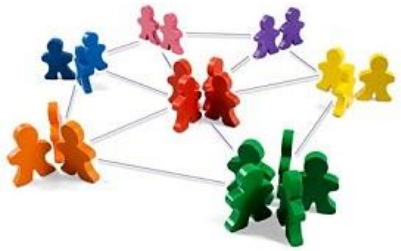
Afan Cluster



Integrated Medium Term Plan (IMTP)

2020 - 2023

Welcome to the Afan Cluster IMTP 2020 – 2023

Section 1 - Executive Summary

The Afan Cluster IMTP has been developed in consultation with the whole Afan Cluster at their meeting in September 2019 and will continue to be shaped at their meetings throughout the life of this plan.

Afan Cluster is committed to ensuring a co productive approach when delivering patient care. NPTCVS have consulted patients to understand how recent changes to the ways of working in the Health Board managed practice, which has bases in both Cymmer and Cwmavon, have affected them. The GP and Practice Manager from the Health Board managed practice regularly attend the Patient Forum facilitated by NPTCVS to listen to the views of the patients and this is invaluable.

Sustainability of general practices in the Cluster is a key issue; single handed practices, managed practice, locum availability, GP recruitment. There is a need to consider local actions to support and sustain services and consider how cluster funding could be utilised to relieve the current pressures. Patient demand and rising patient expectation is placing significant pressures on practices, which has resulted in changes to access arrangements including telephone triage and consultation, promotion of My Health Online.

Afan Cluster continues to strengthen their links with community pharmacists and there is regular representation from several Community Pharmacists at each Afan Cluster Meeting. The Cluster has received a presentation on the Common Ailments Scheme, which operates in Community Pharmacies throughout Wales, and this can assist in alleviating pressure on General Practice with patients opting to consult their Pharmacist for minor ailments such as conjunctivitis for example rather than using a patient slot to see their GP.

The Cluster will maintain a strong focus on Anticoagulation and the management of AF and also aim to increase vaccination uptake across all age groups.

Dr Mark Goodwin – Afan Cluster Lead

Plan on a Page

Strategic Overview

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

Vision

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

What We Will Do

We will prioritise the following:

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

Section 2 - Cluster Profile

Afan Cluster is one of the 8 Clusters in Swansea Bay University Health Board, geographically covering the Eastern wards of Neath Port Talbot County Borough Council. The Cluster shares boundaries with both Upper Valleys and Neath Clusters. Afan Cluster is made up of 8 GP practices, 4 practices are co-located within the Port Talbot Resource Centre (PTRC), 1 practice is split over two sites and is managed by the Health Board, 2 practices are engaged in GP training, 1 practice is a dispensing practice. The Cluster serves a registered population of 50,845 patients in an urban, semi-rural environment and includes community pharmacies, dentists and optometrists working together with partners from local authority and third sector to:

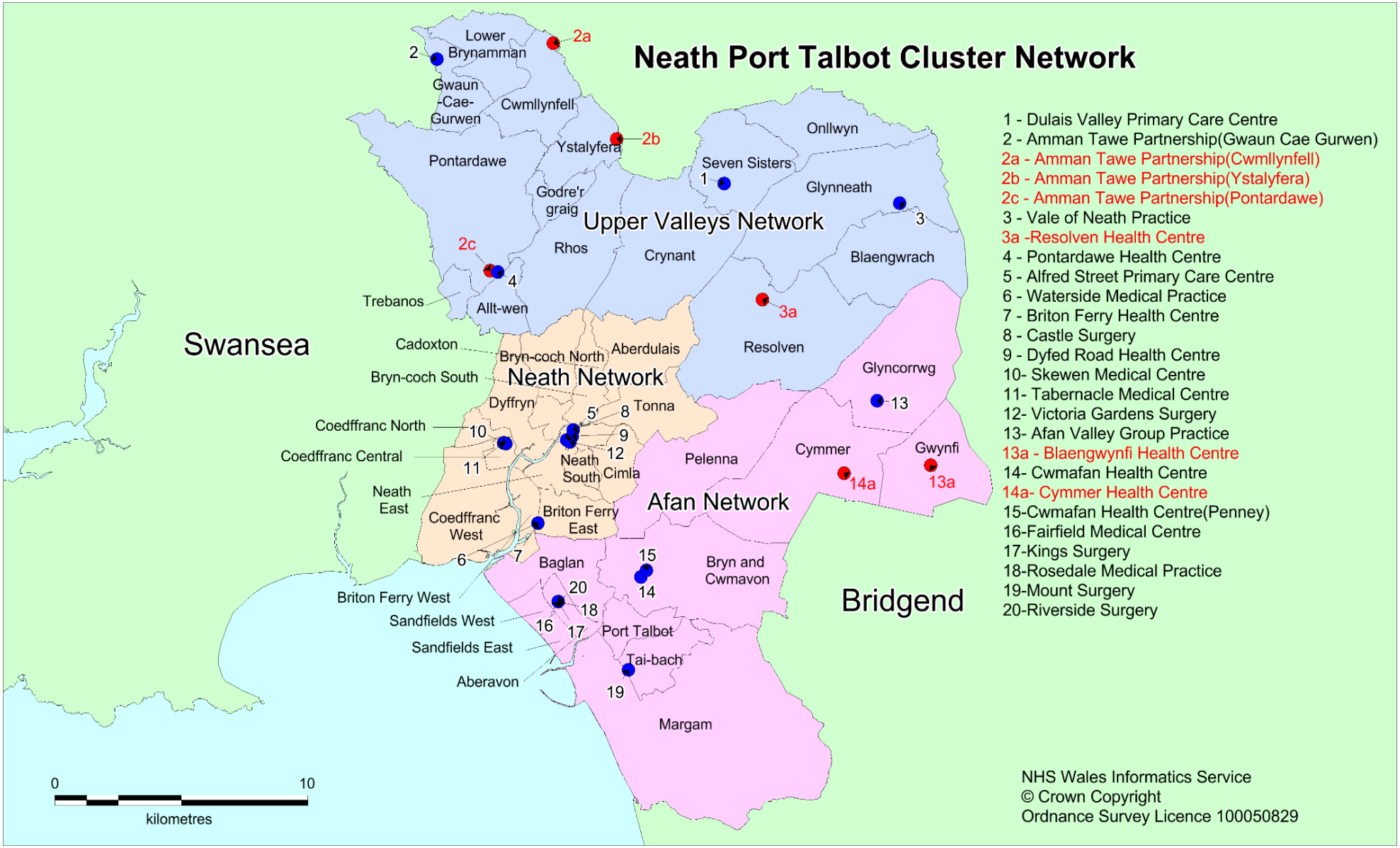
- *Prevent ill health enabling people to keep themselves well and independent for as long as possible.*
- *Develop the range and quality of services that are provided in the community.*
- *Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated 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.*

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 nominated GP practise with oversight by SBUHB 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 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.


Neath Port Talbot Cluster Network
Swansea
Bridgend
Upper Valleys Network
Neath Network
Afan Network
Lower Brynamman
Gwaun -Cae- Gurwen
Cwmllynfell
Ystalyfera
Pontardawe
Godre'r graig
Onllwyn
Seven Sisters
Glynneath
Rhos
Crynant
Blaengwrach
Trebanos
Allt-wen
Resolven
Cadoxton
Bryn-coch North
Aberdulais
Bryn-coch South
Dyffryn
Tonna
Glyncorrwg
Coedffranc North
Coedffranc Central
Neath South
Cimla
Pelenna
Cymmer
Gwynfi
Neath East
Coedffranc West
Briton Ferry East
Baglan
Bryn and Cwmavon
Briton Ferry West
Sandfields West
Sandfields East
Aberavon
Port Talbot
Tai-bach
Margam
1 - Dulais Valley Primary Care Centre
2 - Amman Tawe Partnership(Gwaun Cae Gurwen)
2a - Amman Tawe Partnership(Cwmllynfell)
2b - Amman Tawe Partnership(Ystalyfera)
2c - Amman Tawe Partnership(Pontardawe)
3 - Vale of Neath Practice
3a -Resolven Health Centre
4 - Pontardawe Health Centre
5 - Alfred Street Primary Care Centre
6 - Waterside Medical Practice
7 - Briton Ferry Health Centre
8 - Castle Surgery
9 - Dyfed Road Health Centre
10- Skewen Medical Centre
11- Tabernacle Medical Centre
12- Victoria Gardens Surgery
13- Afan Valley Group Practice
13a - Blaengwynfi Health Centre
14- Cwmafan Health Centre
14a- Cymmer Health Centre
15-Cwmafan Health Centre(Penney)
16-Fairfield Medical Centre
17-Kings Surgery
18-Rosedale Medical Practice
19-Mount Surgery
20-Riverside Surgery
0
10
kilometres
NHS Wales Informatics Service
© Crown Copyright
Ordnance Survey Licence 100050829

Cluster Vision

The Afan Cluster Vision sets out how Afan Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Afan Cluster area and its practices.

Through the delivery of our plans we will work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales in 'a Healthier Wales' (2018):

- ✓ 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

The Cluster will work collaboratively with Public Health to achieve the outcomes noted in the 'Burden of Disease' Action Plan by adopting the five ways of working as outlined in the Wellbeing of Future Generations Act. (Long term, integrated, involving, collaborative, prevention).

Our Vision is:

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

Key Population Features

- 50,845 patients registered with Afan Cluster GPs
- 50.1% female; 49.9% male
- 20.8% of patients are aged 65+ and 9.4% are aged 75+
- 5.8% live in a Lower Super Output Area (LSOA) that is classified as rural
- 49% of the Afan Cluster is in the category *most deprived area*, 32% is in *next most deprived area*
- 2.7% aged 65+ live in a nursing, non-nursing or other local authority care home
- 33.5% aged 65+ live alone
- 8.5% aged 16-74 are both economically active and unemployed

Population and Community Assets

- 2 Swimming Pools
- Several Community Centres
- An extensive range of Third Sector Organisations serves the Afan Cluster area providing services for example to Carers, those with mental health needs, citizens advice, care and repair, domestic abuse and a range of condition specific services e.g. Substance Misuse

Cluster Features

- Serves an urban, semi-rural geographical area
- Fairly static practice list sizes (0.3% increase between 2011 – 2017)
- 8 GP practices
- 13 Community Pharmacies, 7 Dental Practices and 3 Optometry Services
- 9 Nursing/Residential Homes within the cluster boundary, 7 out of 8 practices have signed up to deliver the Care Homes LES

Health Profile (comparative to all 11 clusters)

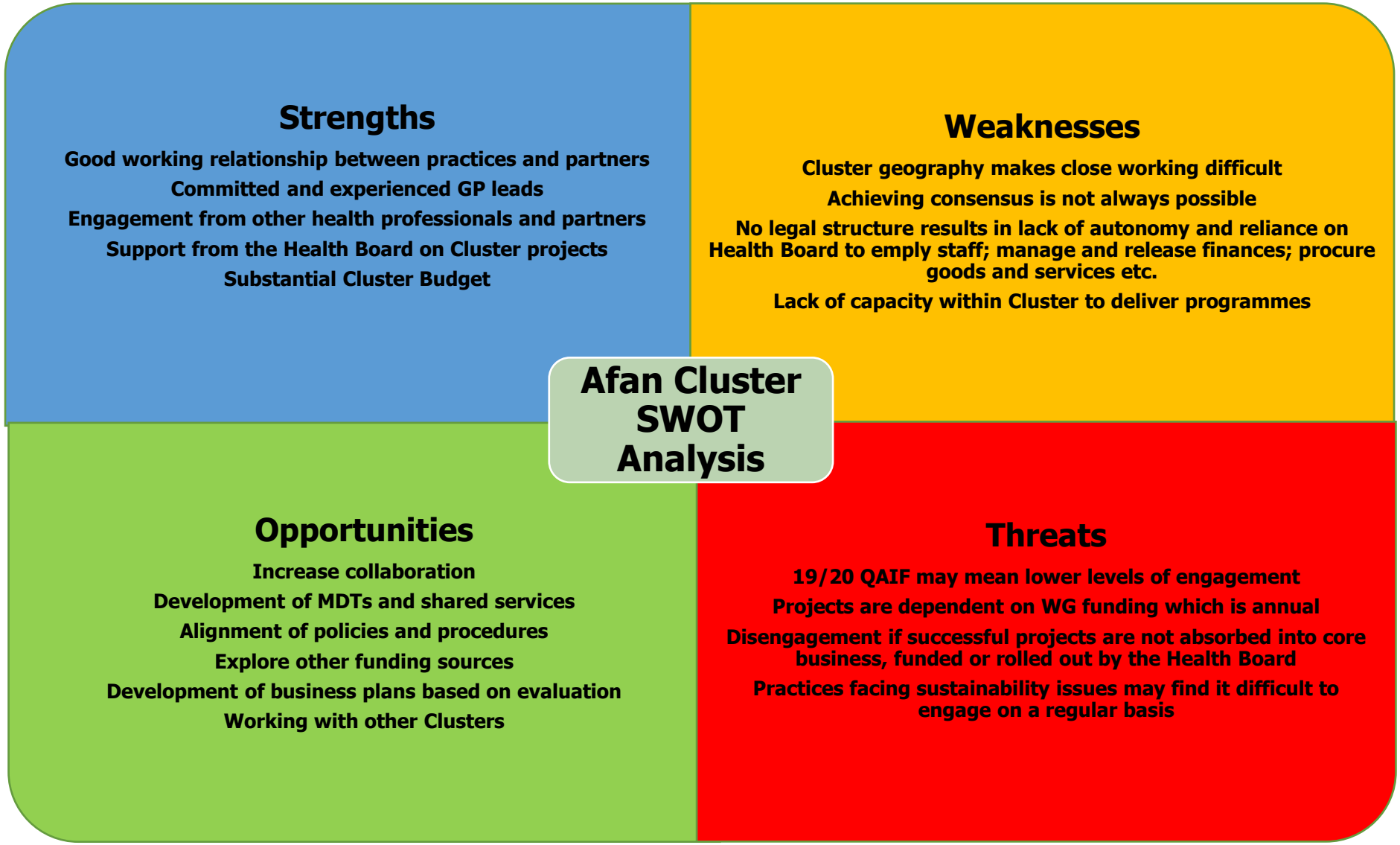
- **Chronic health conditions** - prevalence in Afan:-
  - COPD - 2.8% (2nd highest)
  - Diabetes - 7.5% (highest)
  - Cancer - 2.8% (joint 6th)
  - CVD - 3.15% (4th highest)
- **Flu Immunisation** - uptake at April 2018:-
  - 70% in patients 65+ (2nd highest)
  - 51% in patients <65 at risk (highest)
  - 57.5% in 2-3 year olds (highest)
- **A&E Attendances** - between April 2017 and March 2018 were at a rate of 390 per 1,000 (highest)
- **Smoking** - prevalence is 29.23% (3rd highest)
- **Alcohol** - aged 16+ with a record of alcohol intake is 82.85% (highest)
- **Cervical Screening** - uptake is 26.03% (4th highest)
- **Exercise** - 28.2% aged 16+ reported undertaking at least 30 minutes moderate exercise on five or more days in the previous week
- **Healthy Diet** - 30.4% aged 16+ reported consuming five or more portions of fruit or vegetables on the previous day. Obesity rates are 13.3% (2nd highest)

Service Demands

- **Complexity** - increasing number of patients presenting with comorbidities requiring long term care
- **Sustainability** - aging workforce, with inadequate succession plans in place
- **Recruitment** - difficulties in employing GPs and other Health Care Professionals
- **Economics** - low social economic area with pockets of deprivation resulting in high demand on health professionals

Other Influencing Factors

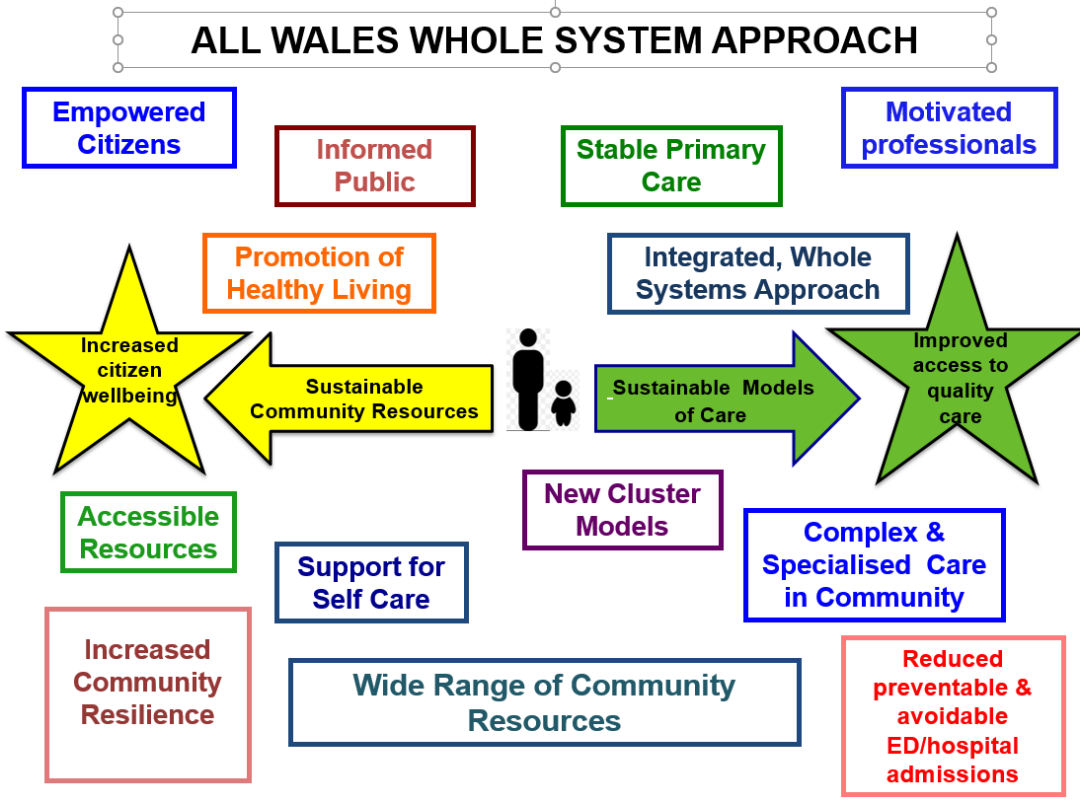
- **Transport** - Public transport is poor at the top geographical area of the cluster
- **Estates** - Primary care infrastructure is of variable quality across the cluster
- **Housing/Employment** - High levels of social housing and unemployment across the cluster
- **Environment** - Local Industry impacts on air quality in the lower geographical area of the cluster


Strengths
Good working relationship between practices and partners
Committed and experienced GP leads
Engagement from other health professionals and partners
Support from the Health Board on Cluster projects
Substantial Cluster Budget
Weaknesses
Cluster geography makes close working difficult
Achieving consensus is not always possible
No legal structure results in lack of autonomy and reliance on Health Board to emply staff; manage and release finances; procure goods and services etc.
Lack of capacity within Cluster to deliver programmes
Afan Cluster SWOT Analysis
Opportunities
Increase collaboration
Development of MDTs and shared services
Alignment of policies and procedures
Explore other funding sources
Development of business plans based on evaluation
Working with other Clusters
Threats
19/20 QAIF may mean lower levels of engagement
Projects are dependent on WG funding which is annual
Disengagement if successful projects are not absorbed into core business, funded or rolled out by the Health Board
Practices facing sustainability issues may find it difficult to engage on a regular basis

Section 3- Key Achievements from 2018-21 Plan

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

We aim to transform our cluster and plan and deliver services in the context of the Primary Care Model for Wales



Key achievements include:

✓ Working with partners to develop and promote Cluster focussed health promotion based information
✓ Willingness to explore effective means of measuring what really matters to people, understanding their experience of services and to identify their needs through cluster and partnership led patient and stakeholder engagement days.
✓ Increased partnership working with the third sector leading to the development of a Cluster Social Prescribing Development Worker.
✓ Helping the population manage their own health and long-term illnesses through the initiation of a pre-diabetic project, signposting to services that support patient self-care and independence. The practices within the cluster have offered more than 5000 HbA1C blood tests, Lifestyle advice to more than 4000 patients and in excess of 2000 CVD risk assessments to patients who have prediabetes or are at risk of developing pre diabetes.
✓ All community pharmacies deliver the Common ailments scheme and it is a key priority of the cluster to work collaboratively and refer to the service.
✓ Improved recruitment and retention through training and development of improve skills, knowledge and carer progression. ✓ A bespoke cluster HCSW Upskilling Training Programme has been completed to support sustainability ✓ The Cluster are key drivers of the ABM GP Fellowship Scheme and the training and development of Physicians Associate roles.
✓ Better management of demand through prudent healthcare with implementation of a telephone first/triage access model to direct patients to the most appropriate health care professional.
✓ A range of professionals are directly employed by a number of practices to provide direct access e.g. Pharmacist, Paramedic and Physiotherapy
✓ The result of the effective telephone first and workforce diversification means the multidisciplinary team (MDT) has more time to proactively care for people with more complex needs.
✓ Investment in new technology to help professionals work better and improve access for patients, including Vision 360 to facilitate remote access to view and edit clinical data away from the registered practice - and allows appointments to be booked by any clinicians or receptionist working in any of the cluster practices or venues.

Section 4. Our Local Health, Social Care and Wellbeing Needs and Priorities

Information has been collated on a wide range of health needs within the Afan 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 Development Plans, a review of Public Health Priorities, QoF/QaIF data, audit reports and a series of cluster meetings.

The development of the plan has presented an opportunity for GP Practices in Afan to build on the progress made in 2018/19 and has involved partners from Public Health Wales, other Health Board teams and directorates namely medicines management, physiotherapy and Nutrition and Dietetics; and the 3rd Sector and Social Services.

Between 2019 and 2023, Afan Cluster will continue exploring areas for development and in the first year will focus on the following priorities:-

- Increasing uptake of the flu vaccination
- Tackling Pre-Diabetes to reduce the onset of Diabetes
- Supporting patients to quit smoking
- Supporting patients to manage their weight
- Supporting the development of a multi-disciplinary HUB Model of service delivery
- Supporting the GP Fellowship Scheme
- Signposting patients appropriately to address their needs as quickly as possible
- Engaging in prescribing management schemes
- Implementing robust and sustainable IMT processes
- Meaningful engagement and coproduction with patients to understand their experience of services and to identify their needs
- Exploring areas of collaboration between GP practices, Secondary Care services and with Statutory Sector and Third Sector partners
- Ensuring robust validated clinical governance processes
- Promoting shared learning and good practice

Cancer Care for Cluster IMTPs

We are committed to ensuring that delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond. We recognise the importance of involving the MDT in supporting people affected by cancer, and integrating cancer care into holistic chronic disease management in Primary Care. Our Cluster has participation in the Macmillan Cancer Quality Toolkit to explore how we deliver care and to develop actions to improve our services. Practices are using the Toolkit and the learning will be shared at our Cluster meetings to inform our ongoing plans.
As clinical pathways are shared through the Single Cancer Pathway programme we will review local experience to inform implementation. This will include ensuring that the multidisciplinary primary care team has the necessary skills and knowledge to support the SCP and detection and diagnosis of cancer.

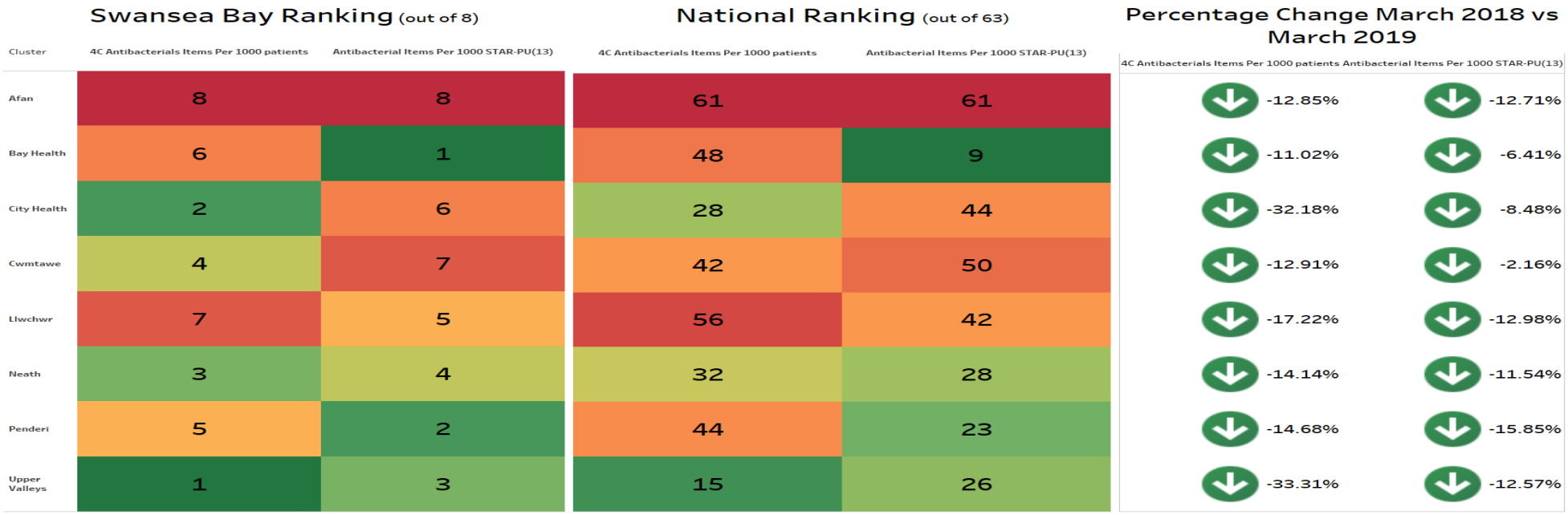
Embedding anticipatory care planning as routine practice will be a priority for our partnership.

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 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 63 Welsh clusters then it can be seen that significant improvements are still required in the fight against overall antimicrobial use and '4C' antibacterials.

- With regard to antibiotic prescribing Afan is ranked 8th out of the 8 SBU HB Clusters for 4c Antibacterial items per 1000 patients (national ranking 61 out of 63 a reduction of -12.85%) and 8th for antibacterial items per 1000 STARPU (13) (National ranking 61 out of 63 a reduction of -12.71%)



Cluster	Swansea Bay Ranking (out of 8)		National Ranking (out of 63)		Percentage Change March 2018 vs March 2019	
	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


Cluster
Upper Valleys
Afan
Bay Health
City Health
Cwmtawe
Llwchwr
Neath
Penderi
Upper Valleys
4C Antibacterials Items Per 1000 patients March 2019
Antibacterial Items Per 1000 STAR-PU(13) March 2019
Gabapentin and Pregabalin DDDs Per 1000 Patients March 2019
Hypnotics and Anxiolytics (UDG) ADQ Quantity per 1000 STAR-PU(13) March 2019
Opioid Burden (UDG) ADQs per 1000 Patients March 2019
Proton Pump Inhibitors DDDs per 1000 PUs March 2019
Tramadol DDD per 1000 Patients March 2019
Tab IndicatorValue

Section 5 - Cluster Workforce Profile

	Doctors		**Nurses**		**Pharmacist**		**Physicians Associates**		**Paramedic**		**MSK**	
Practice	*Staff*	*Hrs / sessions*	*Staff*	*Hrs*	*Staff*	*Hrs*	*Staff*	*Hrs*	*Staff*	*Hrs*	*Staff*	*Hrs*
Afan Valley												
Fairfield	2 1 Salaried	16 sessions 2 sessions	2	49	1	20	0	0	1	15	0	0
Kings												
Cwmavon – Penney	1	WTE	2	40	0	0	0	0	0	0	0	0
Cymmer / Cwmavon												
Mount												
Riverside												
Rosedale	4 Partners 2 Drs		4		4		0	0	1	WTE	1	

	HCSW		**Phlebotomy**		**Practice Management**		**Reception / Admin & Clerical**	
Practice	*Staff*	*Hrs*	*Staff*	*Hrs*	*Staff*	*Hrs*	*Staff*	*Hrs*
Afan Valley								
Fairfield	1	30	0	0	1	37	11	347
Kings								
Cwmavon – Penney	0	0	0	0	1	Variable *(as practice needs dictate)*	5	81
Cymmer / Cwmavon								
Mount								
Riverside								
Rosedale	3		0	0	1	WTE	1 x Med Sec 4 x Admin	

Cluster Projects - **Afan Mental Health Project (utilising a combination of Cluster funding, PMS savings and Pacesetter funding)**

Social Prescriber (Third Sector Hosted)		**Social Prescriber** (GP Practice Hosted)		**Mental Health Practitioner** (GP Practice Hosted)	
Total Hrs	Head Count	Total Hrs	Head Count	Total Hrs	Head Count
28	**1**	**21**	**1**	**37.5**	**1**

Some practices have strengthened their multi-disciplinary teams with clinical pharmacists, undertaking medication, polypharmacy and new patient reviews; along with any medication related queries from all staff in primary care.

There is a generally a good compliment of HCSWs and these have had significant training within the last few years.

In terms of Practice Nurse compliment it is anticipated that there will be a significant level of retirement within the next few years and the Afan Cluster will need to consider future recruitment of not only Practice Nurse staff but also of alternative clinical practitioner roles, i.e. Physicians Associates, Practice or Cluster Pharmacists or Pharmacy Technicians, etc.

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. University in March 2020. 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.

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.

Section 6 - Cluster Financial Profile

Cluster Funding:

The Afan Cluster has an **annual allocation of Cluster Funding of £179,299**
This has been utilised to provide and support a range of innovative projects to meet the needs of the Afan Cluster population. A main area of investment within Afan Cluster has been the continued support and development of the Pre-Diabetes Project, which has been successful in winning a National Award in 2019. Alongside this Afan Cluster has invested heavily in workforce diversification (i.e. employing Physicians Associates and allocating funds to develop a Social Prescribing model). A commitment has also been made to addressing identified training needs of any practice based staff and to the continued investment in dedicated IT Support for all practices.

Afan Cluster Funding 2019-20	
Welsh Government allocation	**£179,299**
Project	**Spend allocated**
Pre-Diabetes Project	£30,000
Home Flu Project	£5,000
Dedicated IT Support	£15,000
Training Budget	£10,000
VIPC Support Costs	£3,930
Workforce Diversification and Development Projects (i.e. Social Prescribing, Physicians Associates, etc)	£115,369
Total allocated	**£179,299**

Pacesetter Funding:
The Afan Cluster has benefitted from pacesetter funding from Welsh Government designed to support innovative projects within primary care and support the sharing of learning across Wales. In 2019 Afan has used Pacesetter funding to support the set up of the Afan Mental Health Project which works closely with the Social Prescribers who have been funded via a combination of Cluster allocation and PMS+ savings.

Transformation Funding:
The Afan Cluster is due to start the 18 month Whole System Transformation Programme on the 1st January 2020.
Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vision for the programme is to:

Achieve a transformed model of a Cluster led integrated health and social care system for the Cluster population.
The programme will concentrate on implementing a range of projects to improve well- being across the age spectrum, co-ordinate services to maximise independence and care closer to home; and to support the implementation of A Healthier Wales and the new model of primary care.

Integrated Care Funding:
Awarded on a regional basis using a multi agency approach. A wide range of projects are delivered, however although they are not cluster specific they deliver services to meet local needs.

Welsh Government Allocation per theme of ICF in West Glamorgan Region
Older People = £5,224,000
LD/MH/CN/Carers = £ 2,590,000
Edge of Care = £1,942,000
People with Dementia = £1,175,000

Section 7 Afan Cluster Three Year Action Plan

Prevention, wellbeing and self care						
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 Pre-Diabetics and tackle the problem of increasing levels of diabetes in the Cluster population	All Practices	March 2020/21	Pre-Diabetics will be identified, given lifestyle advice and monitored. In the long-term, the prevalence in the Cluster population will decrease and the onset of diabetes prevented or slowed down.	Staff time Appropriate funding stream where funding is identified as a requirement	All practices continue with Pre-Diabetes project, consistently achieving high levels of engagement. Programme of Level 2 Food and Nutrition, training and annual refresher training is being implemented and will be delivered by SBUHB Dietetics.
1.2	Ensure a consistent approach to the implementation of the public health agenda to support achievement of the NHS Tier 1 smoking cessation target	All Practices Help Me Quit Community Pharmacy PHW	March 2020/21	An increase in referrals to “Help Me Quit”. Better support to the smoking population to make an attempt to quit.	Staff time Appropriate funding stream where funding is identified as a requirement	Promoting stop smoking month. Referrals to appropriate services.
1.3	Increase uptake of influenza vaccine in target groups Flu Vaccinations at home for elderly frail and housebound patients	PHW All Practice Staff	March 2020/21	A reduction in morbidity / patient demand / hospital admissions due to influenza Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	Uptake reviewed at cluster meetings. Audit of GP databases undertaken to identify possible numbers, suitably qualified staff and capacity identified amongst current practice staff compliment Programme of flu vaccinations planned and delivered within patients homes.

1.4	Tackle obesity through interventions such as the local weight management programmes	All Practices NERS	March 2020/21	Improved population health including reduction in obesity and the likelihood of diabetes, heart disease and stroke	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	Obesity Pathway delivery review commenced in Swansea Bay March 2019
1.5	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 Development Managers	March 2020/21	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 Appropriate funding stream where funding is identified as a requirement for project delivery	Obesity Pathway Delivery Review commenced in Swansea Bay March 2019 Level 2 insight with Primary Care to commence September 2019
1.6	Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of:- • Infoengine • Dewis • Social Prescribing Local Area Coordination	Cluster	March 2020/21	Increased opportunities for patients to participate in non-model opportunities that will increase their wellbeing.	Appropriate funding stream where funding is identified as a requirement	2 part time social prescribing link worker employed and developing role within the cluster.
1.7	To increase and improve sign-posting to Third sector partner organisations	All Practices Third Sector Cluster Representative	March 2020/21	Patients receive specialist and appropriate support from Third Sector partners		Attendance of NPTCVS Health and Wellbeing Facilitator at Cluster meetings provides a link to Third Sector partner organisations in NPT The services provided by Citizens Advice via SBUHB SLA have been remodelled to provide the most appropriate and responsive services for patients within Afan Cluster

1.8	Increase uptake of the MMR vaccine in patients 16-24	NCN	March 2021	Increased protection of population from measles Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	Staff time Cluster funding	Mop up project introduced

Timely, equitable access and service sustainability						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by?**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
2.1	Work towards and implement the In-Hours Access GMS Service Standards	All Practices	March 2021/22	100% Achievement of Access Standards Improved patient access	Telephone infrastructure Communications	Practice access position will reviewed to reflect requirements to meet new standards.
2.2	Improve recruitment and retention of GPs through support of the GP Fellowship Scheme	Cluster Lead	March 2020/21	Improved patient experience, more sustainable primary care services	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	Cluster has continued to support and remains committed to GP Fellowship Scheme
2.3	Increase referrals to choose pharmacy/common ailment scheme	Cluster	March 2020/21	Greater confidence in non-clinical referral to community pharmacy services Increased referrals to community pharmacy services	Staff time	

Rebalancing Care Closer to Home						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by?**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
3.1	Improve prescribing and medicines management including engagement in Prescribing Management Schemes, medication reviews and improving performance against National Prescribing Indicators.	All Practices (supported by SBUHB Medicines Management)	March 2020/21	Improved outcomes from Medicines Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)		Engagement continuing Outcomes being achieved
3.2	Engage with Secondary Care colleagues to facilitate better clinical referral pathways and appropriately commissioned services	All Practices Secondary Care Departments SBUHB Commissioning Boards	March 2020/21	Appropriate and timely treatments for patients		
3.3	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 Venue	Primary Care target framework awaited

3.4	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 inhalers/ Referrals to Pulmonary Rehabilitation Undertaking annual reviews of patient diagnosed with COPD	Funding Venue	Primary Care target framework awaited. Whole systems approach business plan being created with HB
3.5	Diabetes care closer to home for patients with type 2 diabetes, ensuring delivery of the three National Enhanced Services	Cluster Lead GPs	March 2020	Improved outcomes for patients with diabetes Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	NES funding	The cluster has participated in the pre-diabetes imitative and key staff have received training.
3.6	Further improve antimicrobial stewardship	All Practices (supported by SBUHB Medicines Management	March 2020/21	Improved outcomes and reduced resistance and side effects	Staff time	Afan Cluster is an outlier with the highest rates of prescribing compared to all other Clusters Increases in prescribing of Co-amoxiclav, Quinolones and Cephalosporins were also noted in the Afan Cluster

Implementing the Primary Care Model for Wales						
No #	**What action will be taken**	**Who is responsible for delivering?**	**When will it be completed ?**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
4.1	Active Promotion of Choose Well and Winter health initiatives such as My Winter Health Plan to reduce demand on unscheduled care services	All	March 2020/21	Individuals access appropriate services at the right time	Staff time	
4.2	Progress rollout of Primary Care Child and Family Wellbeing Service (Early Years) across all Clusters	PCSDU	March 2021	Stratified service delivery based on levels of demand/prevalence to best meet the population needs Significant reduction in demands on GP services, medicines Reduction in impact on Mental Health Services, Social Care Improved patient reported outcome measures	Approx £25-£30k per Cluster, configured to demand across the Health Board	No service in place in Afan Cluster, scheme tested and evaluated in 3 Clusters
4.3	Recruit additional clinical roles within Primary Care to support and strengthen the skill mix, eg Physicians Associates, Pharmacy	All Practices SBUHB	March 2020/21	Improved patient experience, more sustainable primary care services	Staff time Appropriate funding stream where funding is identified	Three newly qualified Physicians Associates appointed in the Cluster with ongoing training and liaison with University and intention to develop further opportunities in subsequent years

	and Physiotherapist roles and support the development of a multidisciplinary HUB Model of service delivery including the redesign of how services are delivered in the Port Talbot Resource Centre to meet individuals needs				as a requirement for project delivery	Further Cluster discussions needed in relation to Pharmacy and other roles that would assist in widening skill mix and assist in sustainability HUB Steering Group established to scope the elements required by Afan Cluster for a HUB Model
4.4	Work with partners to deliver programme of cluster transformation	Cluster Lead Cluster members Cluster Development Manager Transformation project manager	March 2021	To achieve a transformed sustainable model of cluster led integrated health and social care	Staff time Transformation funding and project support	Afan cluster will commence the programme from 1st January 2020.
4.5	Increase collaboration between GP practices and other primary care providers, social services, Community Resource Team and other Cluster partners	GP practices Other primary care providers	March 2020/21	GP practices are better able to manage demand & improve patient care / experience	Staff time	Partners are involved in development of projects Additional work needs to be undertaken to ensure alignment with other service aims e.g. HV, DN, CRT, social services etc.
4.6	Support the development of Business Cases for sustainability of key service delivery schemes	All	March 2021	Areas of work have been piloted by Clusters over recent years and have been seen to provide	Staff time Project support	Areas of work are to be included for consideration in this year's IMTP process in both Swansea Bay University Health Board & Cwm Taf.

	which support Primary Care: • Physiotherapy • Mental • Pharmacists • Other identified services			benefits to access and patient experience alike. The principle that Cluster monies were provided to facilitate innovation now means there is a need to identify alternative funding for such projects where benefits have been demonstrated		

Digital Data and technology developments						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
5.1	Development of common patient information tools (ie QR Pods, Cluster Website)	All Practices	March 2020/21	Better information governance, consistent patient information, ease of access to information	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	Concept explored and agreed in the Afan Cluster Development Session QR Pods commissioned Cluster and individual Practice logos designed and agreed
5.2	Ensure effective use of IT software, development of appropriate data collation frameworks / templates and provide identified support to all practices.	Palexra	March 2020/21	All Practices able to fully utilise their IT systems in a consistent and timely manner	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	All practices engaged Palexra have undertaken training with Vision for the development of logic based Vision+ templates which will enable Afan Cluster to develop and future-proof data collection requirements for upcoming projects

Workforce development including skill mix capacity training needs and leadership						
No #	**What action will be taken**	**Who is responsible for delivering?**	**When will it be completed ?**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
6.1	Cluster Lead to engage in Clinical Governance Meetings and Cluster Lead Meetings facilitated by Health Board in order to share good practice and ensure high quality and evidence-based services are provided in Primary Care	Cluster Lead (supported by Unit Medical Director and Head of Primary Care)	March 2020/21	Robust Clinical Governance is improved and monitored	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	Cluster Lead is engaged in relevant fora and attends meetings
6.2	Ensure GDPR compliance	All Practices	March 2020/21	Appropriate Clinical information flows	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	Training needs being identified for new and existing practice staff Appropriate Training to meet identified needs to be commissioned and delivered
6.3	Upskill multi-disciplinary team	Cluster	March 2020/21	Trained and skilled workforce within the cluster	Funding	Training development audit to be completed to inform cluster transformation
6.4	Develop cluster workforce strategy	Cluster	March 2021	Robust workforce and succession plan	Workforce planning tools	All practices have completed the National Workforce Reporting tool.

Estates						
No #	**What action will be taken**	**Who is responsible for delivering?**	**When will it be completed ?**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
7.1	Work with SBUHB to consider development of sustainable first class premises in the cluster and provide access to a Health and Wellbeing approach through potential new development in the Upper Afan Valley and improvement grant applications where needed for improvement of practice premises to enable capacity to deliver new pathways and increase capacity	All Practices (supported by SBUHB Primary Care Estates Manager)	March 2021	Improved facilities and sustainable services	Staff time Appropriate funding stream where funding is identified as a requirement for project delivery	SBUHB Primary Care Estates Manager has undertaken an audit of current premises Maximum and appropriate utilisation of HB owned premises

Communication, engagement and coproduction						
No #	**What action will be taken**	**Who is responsible for delivering?**	**When will it be completed ?**	**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 identify their needs	All Practices	March 2020/21		Staff time Appropriate funding stream where funding is identified as a requirement	Participate in the national all Wales Survey Develop cluster patient participation group
8.1	Develop cluster communication strategy aligned to cluster transformation	Cluster	March 2021	To develop and implement a robust communication strategy	Staff time	

Improving Quality Value and Patient Safety						
No #	**What action will be taken**	**Who is responsible for delivery**	**When will it be completed ?**	**What will success look like? What will the outcome be for patients?**	**Resource required**	**Current position**
9.1	Work together with partners to ensuring that delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond. We recognise the importance of involving the MDT in supporting people affected by cancer, and integrating cancer care into holistic chronic disease management in Primary Care. As clinical pathways are shared through the Single Cancer Pathway Programme we will review local experience to inform implementation. Practices will work to embedding anticipatory care planning as routine practice.	Practices	March 2020/21	Integrating cancer care into holistic chronic disease management in Primary Care		

9.2	Map current and discuss future enhanced service provision at cluster level	Cluster	March 2021	Equity of services delivered closure to home	Enhanced services funding Infrastructure	
9.3	Engage in agreed cluster QAIF projects • Patient safety Programme (mandatory) • Reducing stroke risk through improved management of Atrial Fibrillation	NCN Partners	October 2020	Adults with suspected UTI are reviewed and managed Reduced reduce the stroke risk associated with suboptimal prescribing of anticoagulant and antiplatelet therapy	Staff time Project support	

Communications and Engagement

The matrix below demonstrates how Cluster related issues and developments should be shared and communicated with the Cluster, its partner organisations and the wider community

Communications Matrix	Cluster Meetings	Cluster Spend Plan	Cluster IMTP	Newsletter	Media Releases
Cluster Lead	✓	✓	✓	✓	✓
Cluster GPs	✓	✓	✓	✓	✓
Cluster Practice Staff / Employees	✓	✓	✓	✓	✓
Patients/Citizens			✓	✓	✓
Local Schools & Colleges			✓	✓	✓
Neath Port Talbot Council for Voluntary Service	✓	✓	✓	✓	✓
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 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**, namely:

- **Prevention and early intervention** – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing
- **Safety** – not only healthcare that does no harm, but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other forms of harm
- **Independence** – supporting people to manage their own health and wellbeing, be resilient and independent for longer, in their own homes and localities, including speeding up recovery after treatment and care, and supporting self-management of long-term conditions
- **Voice** – empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care; simple and timely communication and coordinated engagement appropriate to age and level of understanding
- **Personalised** – health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes
- **Seamless** – services and information which are less complex and better coordinated for the individual; close professional integration; joint working, and information sharing between services and providers to avoid transitions between services which create uncertainty for the individual
- **Higher value** – achieving better outcomes and a better experience for people at a reduced cost; care and treatment which is designed to achieve 'what matters' and which is delivered by the right person at the right time; less variation and no harm
- **Evidence driven** – using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working

- **Scalable** – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations
- **Transformative** – ensuring new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add a permanent extra layer to what we do now.

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

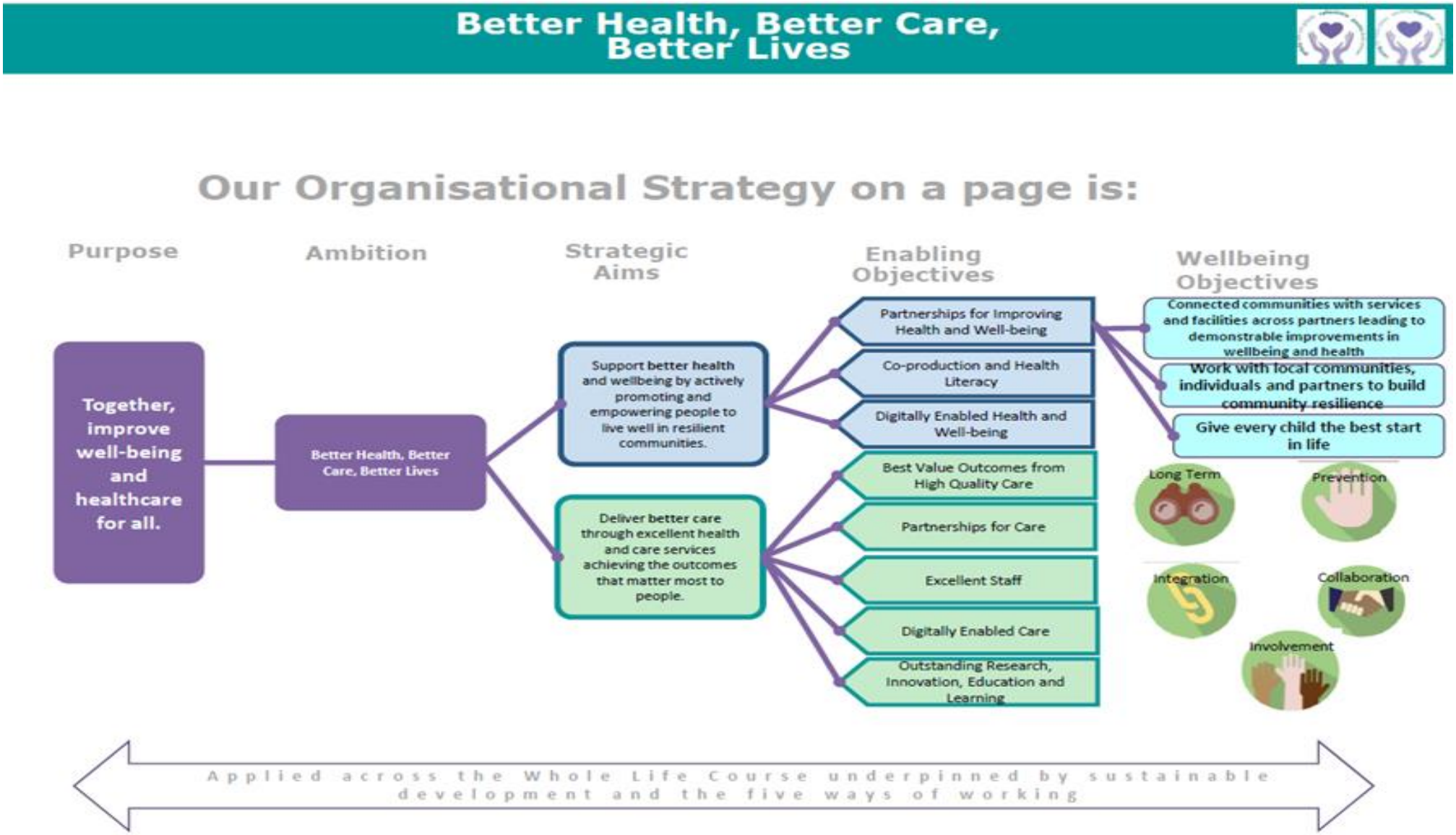
3. Right Place, Right Person, Right Time

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:

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) is 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 Regional Partnership area**,** with the main aims of:

- Improving health and wellbeing across the age spectrum, including a key focus on **facilitating self-care and building community resilience,** and with targeted population groups dependent on cluster demographics.
- Coordinating services **to maximise wellbeing, independence and care closer to home** including flexibility to coproduce, design and implement services in partnership with the community.
- **Testing out the vision and aims described with 'A Healthier Wales'** and implement components of the overall model, demonstrating proof of concept and an ability to evaluate and redesign.

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

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

The Health Board Cluster Development Team, supported by other services, 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

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.

- Population Health
- Planned Care
- Older People
- Unscheduled Care
- Maternity, Children & Young People
- Mental Health & Learning Disabilities
- Cancer

The cluster will continue to work towards achieving the Level 3 of the Maturity Matrix of the Primary Care Model for Wales. An initial assessment of maturity is shown in the table below. A more in-depth analysis will be conducted in year 1 of this IMTP.

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
Informed Public	Case for change agreed by whole cluster team	Cluster Communication and Engagement Strategy agreed and publicised, including vision, purpose and functions of cluster	Clear understanding by public of: • Case for change • New systems of care • How to access local information, advice, support and care
	Key messages for local communication agreed, aligned to national priorities	Systems and channels for public engagement/communication established, reflecting preferences of stakeholders	Cluster Communication and Engagement Strategy in active use, with wide range of communication methods and resources
	Cluster stakeholder groups identified	Communication and engagement with public & service users underway	Clear understanding of how to access health information & advice, including self care information and use of on line symptom checkers through 111
Empowered Citizens	Options for engaging and involving service users in information / service design have been researched and agreed by cluster team	Systems for promoting and receiving feedback from service users are established within the cluster	All new & redesigned local services and assets developed through co-production with service user reps
	Widespread support for use of behaviour change techniques by professionals	Active engagement and involvement of service user representatives in design of cluster services & assets	Service user feedback actively used in redesign of cluster services
	Resources are available to support culture and behaviour change amongst local stakeholders	All members of cluster team trained in behaviour change techniques	Evidence of widespread culture / behaviour change in stakeholders, with ownership of well-being and appropriate use of services

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	All members of cluster team understand and actively promote *Making Choices Together* and *Every Contact Counts*	All members of cluster team understand and actively use *Making Every Contact Counts*	Local cluster champions in place to promote and support new initiatives
		All members of team trained in shared decision-making and use *Making Choices Together* techniques for a few prioritised conditions	Service users actively encouraged and supported to make informed choices on all care and treatments
			IT systems in place with designs to support decision-making
			Activation measures used to monitor service user motivation& empowerment
Support for Wellbeing, Disease Prevention and Self Care	Options for signposting and care navigation systems have been researched and understood	Cluster plans and business cases address gaps in local services that promote well-being and self-care	Widespread information, advice and support are available to promote ownership of health and wellbeing, esp. amongst young people
	Smart technologies that support self-care and self-monitoring have been scoped and costed	Signposting and navigation systems direct service users to information and support for self-care	Wide range of local health & wellbeing resources are available to support self-care, promoted through cluster signposting / navigation
		Technologies that support self-care are included in cluster business plans	Smart technologies in widespread use to support self-monitoring and self-care, especially for long term conditions
			Pro active use of 111 /NHS Direct symptom checkers
Community Services	Cluster teams and Regional Partnership Boards use Population Needs & Wellbeing Assessments to fully understand community health and wellbeing requirements	Cluster plans and business cases address gaps in local community services & assets through • Prioritisation of cluster projects to address service needs • Service user reps involved in planning / design of all new services	Comprehensive up-to-date Directory of Cluster Services published, including sources of information, advice & support in choice of formats; accessible through national Directory of Service hosted on 111 platform with links to

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
		• Robust evaluation of initiatives to ensure value for money • Active consideration of factors relating to special needs, equality and health literacy is integral to prioritisation and design of services	other national directories eg. DEWIS Cymru
	Cluster plans are integral to IMTPs of Health Boards and Local Authority planning mechanisms	Methods and technologies enabling service users to access support & advice from healthcare teams researched	Range of methods is available to access support, advice and treatment quickly and easily: e.g. phone, email, video-call
	Existing cluster services and assets are scoped and analysed	Cluster services with direct access / selfreferral routes are promoted e.g. community pharmacy, optometry, audiology and physiotherapy services	Systems for signposting are in place to direct people to community resources easily and quickly
	Gaps in cluster services and assets that support well-being, disease prevention, care and treatments within local community are actively addressed in next planning round		Wide range of community services established for care and treatment, tailored to needs of the community and redressing health inequalities
			Systems are in place to empower people with differing levels of health literacy and sensory impairments to access advice, care and treatment
Cluster Working	Joint agreement by integrated cluster team on vision, purpose and functions of their cluster		
	Cluster strategy has been drawn up, shaped by cluster data and intelligence	Cluster operational model agreed through use of options appraisal, with legal advice sought as necessary	Cluster model in operation to promote multidisciplinary approach & integrated care
	Cluster Lead in post	Cluster governance framework in place, with robust processes for cluster decision-making, risk management and	Cluster partnership working is promoted through co-location of staff, joint

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
		accountability for all partner organisations.	contracts, shared learning, staff rotations, etc.
	Code of conduct and Terms of Reference is agreed by Cluster Stakeholder Team	Integration and partnership working actively promoted within cluster	Range of professionals in post to increase capacity and expertise of cluster team, delivering holistic care closer to home
	Cluster workforce plans drawn up, based on assessment of population needs and cluster skills/capacity requirements	Cluster recruitment / sustainability plans agreed to ensure stability of Primary Care services	Contractual arrangements for cluster staff in place to ensure effective lines of accountability, robust indemnity and pension arrangements
		Primary Care training placements are established for cluster staff	All cluster professionals are supported by appropriate training, clinical supervision, mentorship arrangements
Call-handling, Signposting, Clinical Triage / Telephone First Systems	Clear understanding of cluster call handling, signposting, clinical triage / Telephone First systems & processes by cluster team:		GP practices and Primary Care services are stable and sustainable, employing a workforce trained in cluster environment
	Service users involved in designing feedback systems to evaluate call handling, signposting and triage systems	Use of service user feedback to design signposting, call-handling, triage systems	Safe and effective cluster call-handling & triage systems in place to assist service users in accessing right information, advice & care from clinical and non-clinical services
		Agreement by cluster team on operational models for call-handling, signposting, clinical triage systems	Non-clinical referrals are assisted by link workers, social prescribers, care navigation, etc and citizens are signposted using the national Directory of Service
		IT systems installed to support safe and effective call-handling / triage processes	Robust protocols, guidance and support are in place for all cluster call-handling, signposting and triage systems

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
		Guidance and protocols in place for all cluster call-handling and triage systems	Service user feedback, monitoring, significant event analysis & audits inform redesign of systems
		Training and refresher courses attended by all staff involved in cluster callhandling & triage systems / processes	Regular refresher courses attended by staff delivering call-handling/triage services
111 and Out-of Hours Care	Systematic patient feedback systems embedded in 111/GPOOH services	Regular risk assessment & audits for all cluster call-handling and triage systems	Excellent communication systems across in- and out- of-hours interface with handover of care through effective sharing of 'Special Patient Notes' and Anticipatory Care Plans
	Flexible boundaries to allow patients to be assessed in service closest to home (not where they are registered)	OOH advice & care delivered by multiprofessional team including core disciplines available to all services – eg. pharmacists, nurses, doctors, paramedics	OOH and 111 Staff have access to relevant, up-to-date records through Welsh GP Record
	Equitable access to emergency/urgent dental conditions in line with national specification		People effectively signposted to appropriate advice & care by use of MDT in OOH period, with potential for scheduling into alternative pathways (eg. community services) by 111/GPOOH service without hand-off back to own GP
	Flexible workforce solutions that allow professionals to work remotely		Specialist skills available during OOH period through regional working (eg. Mental Health Specialists)
	Consistent policies on management of home visits		Use of digital technology to improve patient experience and efficient service delivery
			Integrated pathways between 111/GPOOH and 999 service

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
People with Complex Care Needs	People with more complex needs are identified by use of benchmarking, disease registers, risk stratification tools, admissions data, etc	Multi-professional teams increase cluster capacity and tailor consultation times to the needs of more complex patients	CRTs, Frailty and Integrated Health & Care teams support complex care through MDT approach within primary care / community settings
	Analysis of cluster professional capacity and skills to deliver complex care undertaken, e.g. GPwSIs, ACPs, Community Resource Team, Frailty Team, Integrated Health & Care team, specialist teams	Cluster Outreach Services deliver specialist care through an MDT approach, closer to home	Virtual Wards and Community Hubs are used to care for acutely ill people, with hospital specialists working alongside cluster teams
	Increased emphasis on disease prevention for long term conditions in cluster community, using LPHT support / expertise, PNAs and PWBAs	Community diagnostic services support complex care closer to home	Increased range of planned care delivered within the community, with local access to specialist expertise and diagnostics
Infrastructure to support Transformation	Good understanding by cluster team of infrastructure requirements for effective cluster working: estates & facilities, IT systems, community diagnostic services, etc.	Cluster infrastructure scoped to identify development needs, with prioritisation Appropriate channels, mechanisms and support are used to escalate significant deficiencies in cluster infrastructure, with clarity on risks to safe, effective cluster working	Local estates and facilities are fit for purpose, sustainable and support multiprofessional team working and training
	Support and expertise is readily available to promote and support cluster working, e.g. • PNAs and cluster planning • Business case development • Data analysis, IT systems, new technologies	Where appropriate, business cases address deficiencies in infrastructure and facilities, e.g. community diagnostic services, smart technologies	Informatics and telephony systems in place with designs that support and promote multi-professional working
			Digital options that enable service users to access care quickly and easily are commonplace
			Direct access to range of diagnostic services is available to cluster teams