Integrated Medium Term Plan (IMTP)
2020 – 2023

Welcome to Upper Valleys Cluster IMTP 2020-2023

Section 1 - Executive Summary

Welcome to the Upper Valleys Integrated medium term plan which reviews and sets out our vision, progress to date and future plans

The Upper Valleys cluster has been in existence since 2011 having been established when 'Setting the Directions' mandated that service planning be organised around population groups of 25,000 – 100,000 people.

It has been an interesting journey, as GP practices learn the art of working with partners in the public and 3rd sector whilst strengthening working relationships with colleagues in other parts of the health service. It has been a steep learning curve, as we try to de-medicalise how we organise services and view our patients and service users in the round. The cluster has been growing from strength to strength in its understanding of what patients really need.

Our cluster is made up of a range of talented individuals who understand that we need to change the way we work, that we have to tackle issues in new and innovative ways and that the sustainability of primary care is under threat. We are working hard to develop and improve services taking into account our population demographics and local challenges, geographical constraints and cross border issues. We are striving to have high quality primary and community services whist increasing efficiency and minimising waste.

We have had some small successes in providing prudent health care and releasing GP time. We have established a hub of shared allied health professionals including physiotherapists skilled at managing musculoskeletal issues, and a wellbeing worker who can signpost to appropriate services with the aim of improving patient and staff mental wellbeing. We are also trialling a cluster based sexual health service with the aim of providing easily accessible long acting reversible contraception to women in a setting closer to their homes. We have prioritised prevention and year on year have increased the uptake of the flu vaccination, we have maintained uptake of childhood immunisations, reaching national targets for many, and have recently started a programme to improve our shingles immunisation uptake.

Our patients are key to the work we do and we have built in a process of asking for their views. Recently we surveyed our newly diagnosed cancer patients to help us improve the service we provide to them and have also conducted a Health and Wellbeing survey. The results of these surveys will influence how we develop services.

There are many priorities to address in the Upper Valleys and we intend to learn from our experiences and to ensure that our initiatives are grounded in evidence and data. We intend to continue with projects that have been proven to work.

The next 3 years promise to be exciting. We look forward to engaging with the Transformation programme which will provide much-needed support to develop the range of services offered in the Upper Valleys Cluster Primary and Community Setting.

Plan on a Page

Strategic Overview

The next 3 years promise to be exciting. We look forward to engaging with the Transformation programme, which will provide much-needed support to develop the range of services offered in the Upper Valleys Cluster Primary and Community Setting – *Dr Rebecca Jones*.

Vision

To work collaboratively with partners and patients to improve the health and wellbeing of our local communities.

To provide good, safe standards of care in the community, closer to our patients

What We Will Do

We will prioritise the following:

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

Section 2 - Cluster Profile

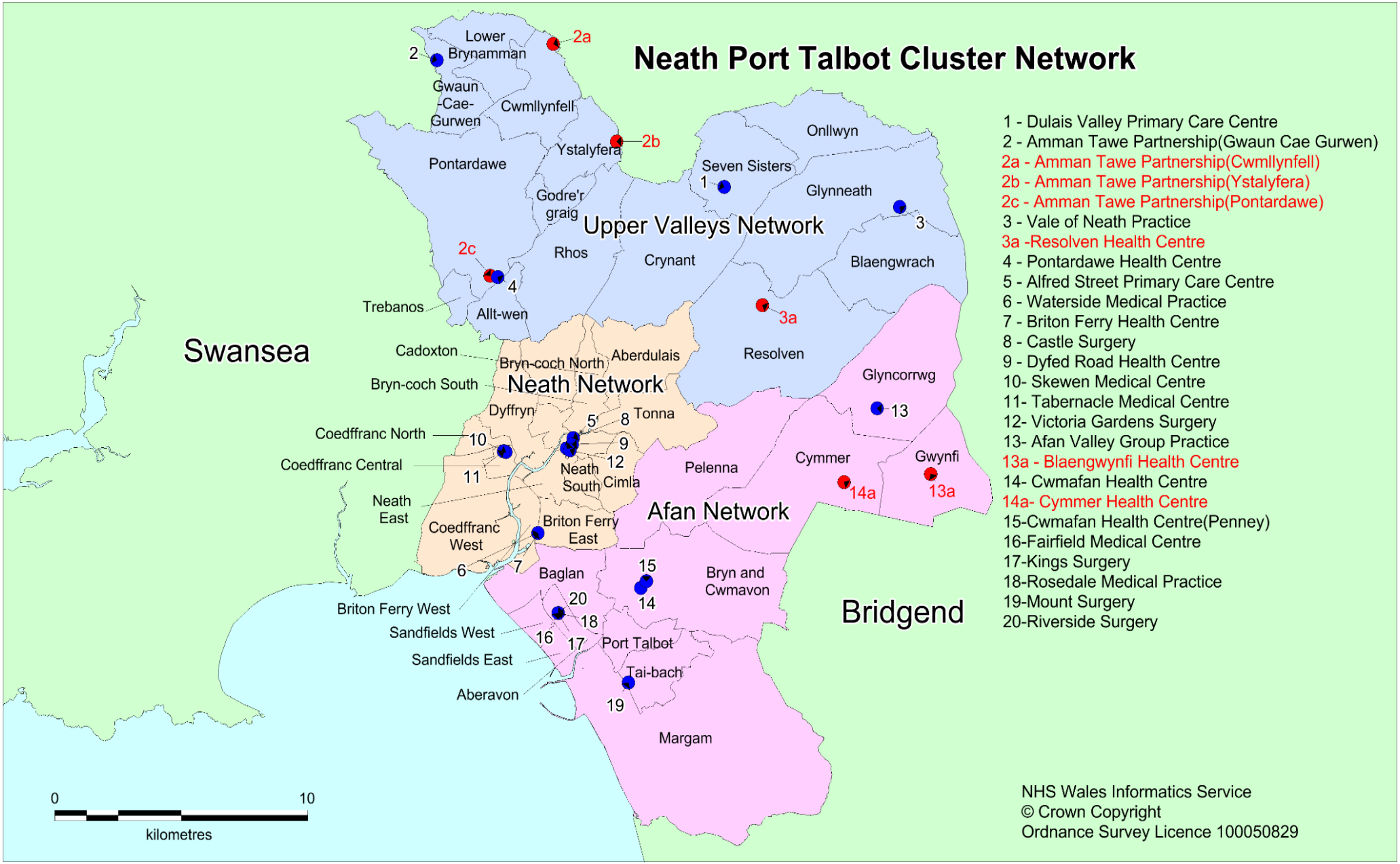
Upper Valleys Cluster is one of the 8 clusters in Swansea Bay University Health Board, geographically covering the northern wards of Neath Port Talbot County Borough Council. The Cluster shares boundaries with both Afan and Neath Clusters and with the City and County of Swansea, Bridgend, Carmarthenshire, and Powys County Borough Councils.

Upper Valleys Cluster is made up of four general practices delivering services from 8 sites and working together with partners from social services, the voluntary sector, and Swansea Bay University Health Board. The cluster serves a population of 31,088 patients registered with the GP practices.

GP Practice	Number of patients (1/7/19)
Amman Tawe Partnership	3142
Dulais Valley Primary Care Centre	6033
Pontardawe Primary Care Centre	12869
Vale of Neath Practice	9044

The cluster aims to work together 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 co-ordinated to meet 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.


Neath Port Talbot Cluster Network
Upper Valleys Network
Neath Network
Afan Network
Swansea
Bridgend
Lower Brynamman
Gwaun -Cae- Gurwen
Cwmllynfell
Ystalyfera
Pontardawe
Godre'r graig
Onllwyn
Seven Sisters
Glynneath
Blaengwrach
Rhos
Crynant
Trebanos
Allt-wen
Resolven
Cadoxton
Bryn-coch North
Bryn-coch South
Aberdulais
Dyffryn
Tonna
Coedffranc North
Coedffranc Central
Neath South
Cimla
Neath East
Coedffranc West
Briton Ferry East
Briton Ferry West
Sandfields West
Sandfields East
Aberavon
Baglan
Pelenna
Bryn and Cwmavon
Port Talbot
Tai-bach
Margam
Glyncorrwg
Cymmer
Gwynfi
0
10
kilometres
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
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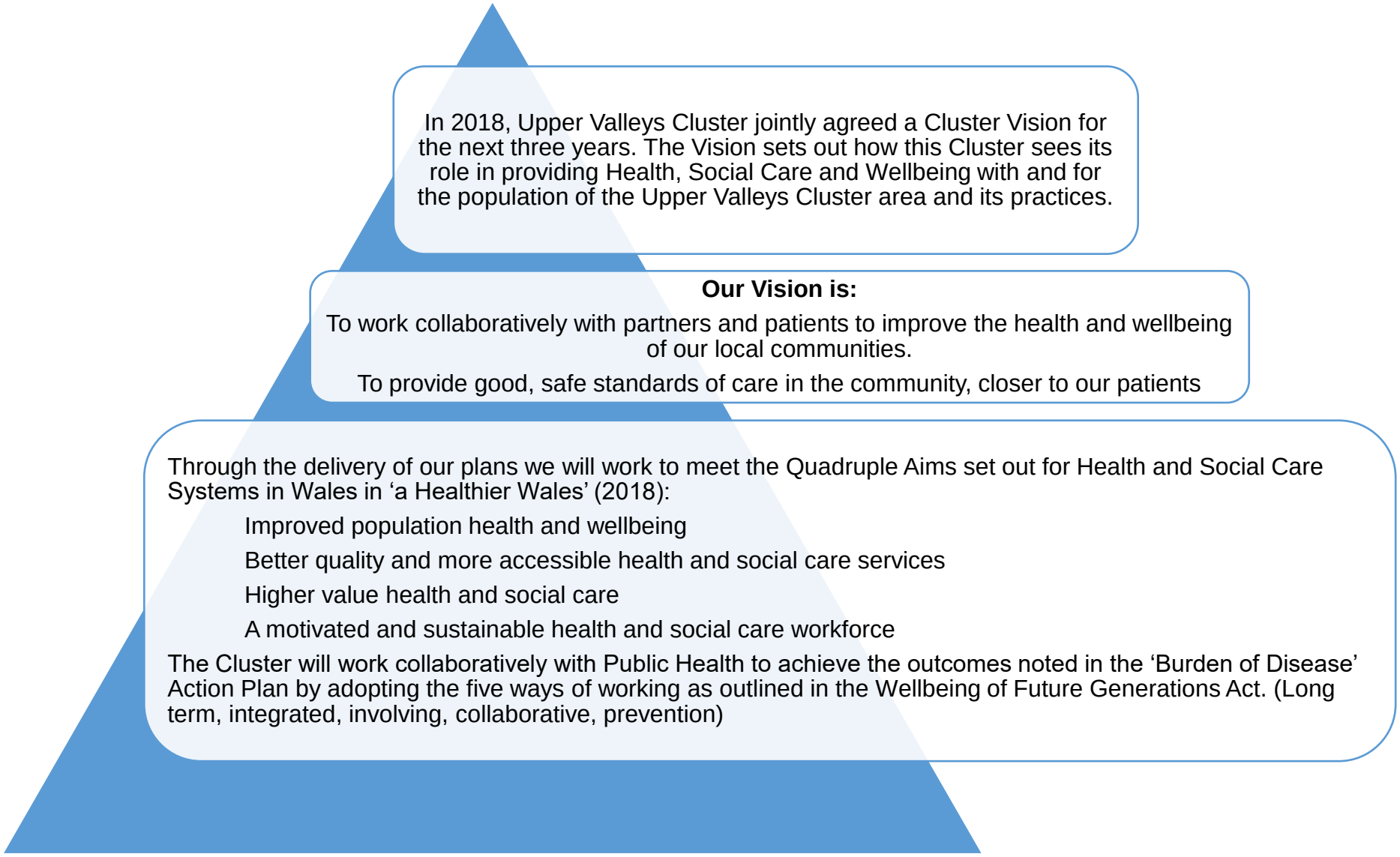
Vision



In 2018, Upper Valleys Cluster jointly agreed a Cluster Vision for the next three years. The Vision sets out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Upper Valleys Cluster area and its practices.

Our Vision is:

To work collaboratively with partners and patients to improve the health and wellbeing of our local communities.

To provide good, safe standards of care in the community, closer to our patients

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)

Purpose and Values

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

Governance Arrangements

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

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

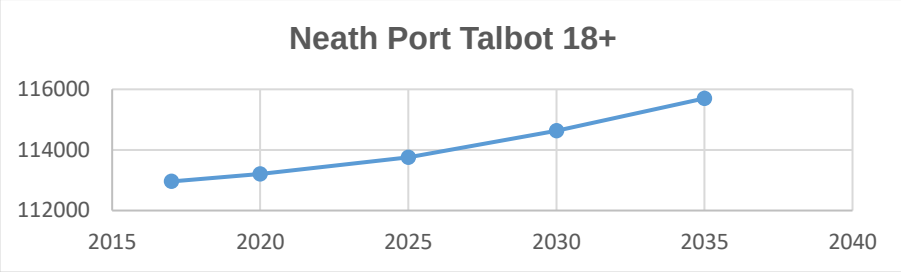
The Cluster reports progress through its own agreed communications programme to a range of stakeholders. Cluster business is also reported through the 8 Cluster Leads Forum (bi-monthly) and through the Cluster Development Team formally to the Primary Care and Community Services Delivery Unit Management 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.

Demographic Profile

Some key population features for the Upper Valleys are as follows:

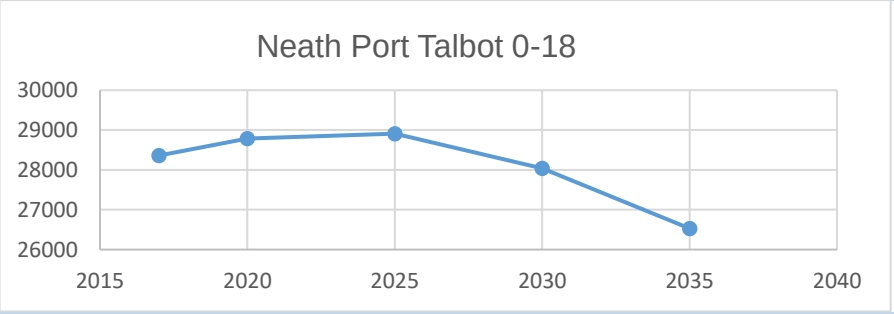
- There are 31,088 GP registered Patients (July 2019)
- 49% of them are female; and 50.6% male
- The cluster has an increasing elderly population (22.8% aged 65+ and 10.0% 75+). The population projection for NPT is for a steady increase in the number of people aged 18+ between 2017 and 2035

	Projected to	Neath Port Talbot
Population aged 18+	2017	112960
	2020	113210
	2025	113760
	2030	114630
	2035	115700



Conversely, the population of Neath Port Talbot aged 0- 18 is projected to start declining after 2025

	Projected to	Neath Port Talbot
Population aged 0-18	2017	28360
	2020	28790
	2025	28910
	2030	28040
	2035	26530



- 11.8% of the cluster population live in a Lower Super Output Area (LSOA) classified as rural.
- 49% live in the most deprived two fifths (40%) of areas in Wales
- 4.6% aged 65+ live in a nursing, non-nursing or other local authority care home
- 33.1% aged 65+ live alone
- 78.64% of People Aged 16 and over have a GP record of alcohol intake
- 28.8 % are on the Public Health Wales smoking register for Wales
- 17.2% of patients with Hypertension, Asthma, COPD, Stroke or CHD who when asked reported smoking

Additional profiling information has been mapped across the 4 Upper Valleys Cluster Valleys

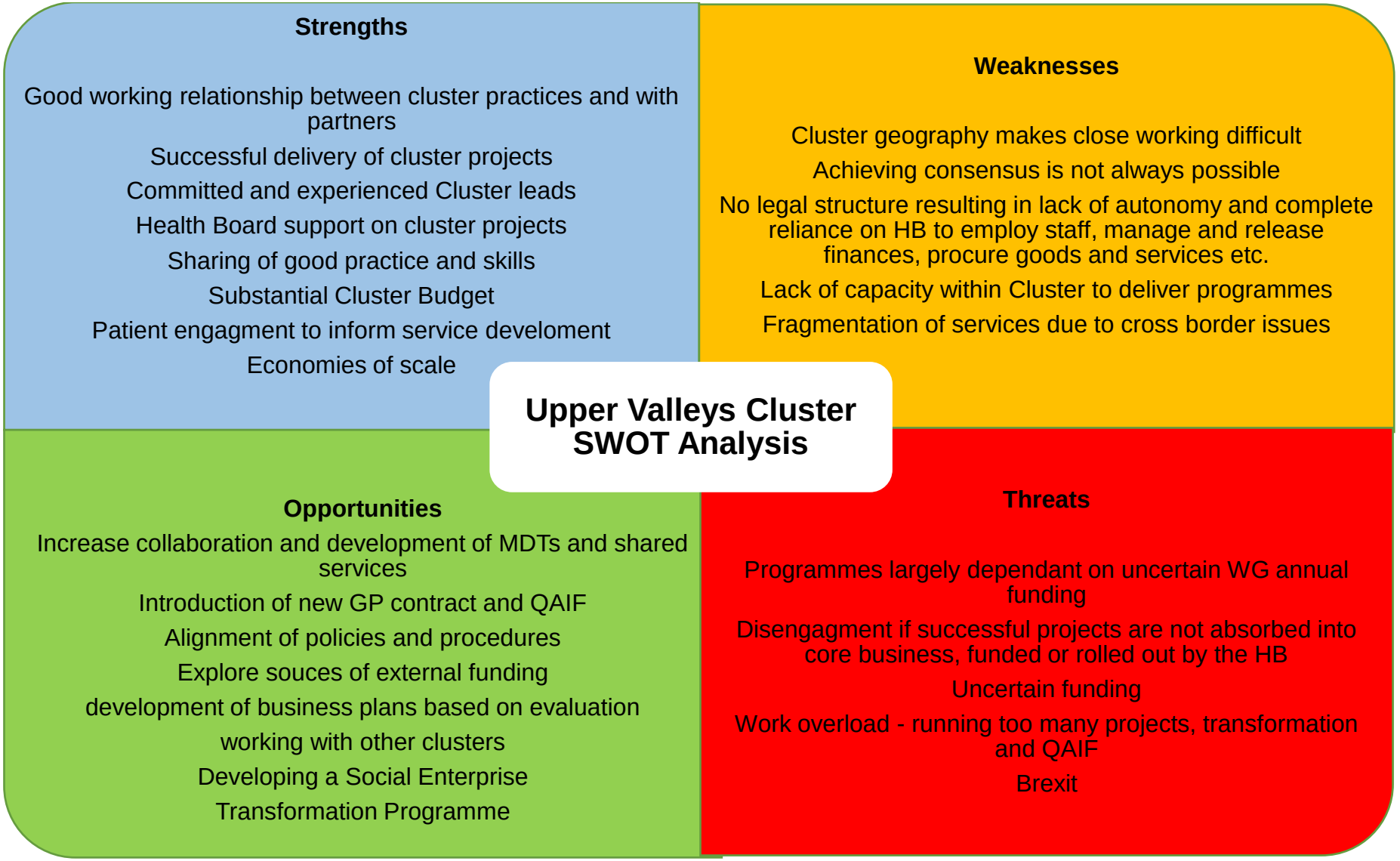
	% of people unemployed	% of people over 16 with no qualifications	%Welsh speakers	Proportion of homes identified as being deprived1
Amman Valley	4.8	30.3	57.3	68.5
Dulais Valley	3.9	34.3	24.4	68.7
Pontardawe	3.8	23.0	25.8	60.8
Swansea Valley	4.1	30.1%	44.1%	69.2

Community Assets

Upper Valleys cluster is mainly semi-rural with beautiful countryside and natural features. It has a number of public footpaths and cycling trails, woodlands, rivers and canals, bridle paths and an abundance of wildlife, flora and fauna. There are also a number of former coal mining villages in the cluster area. The cluster has:

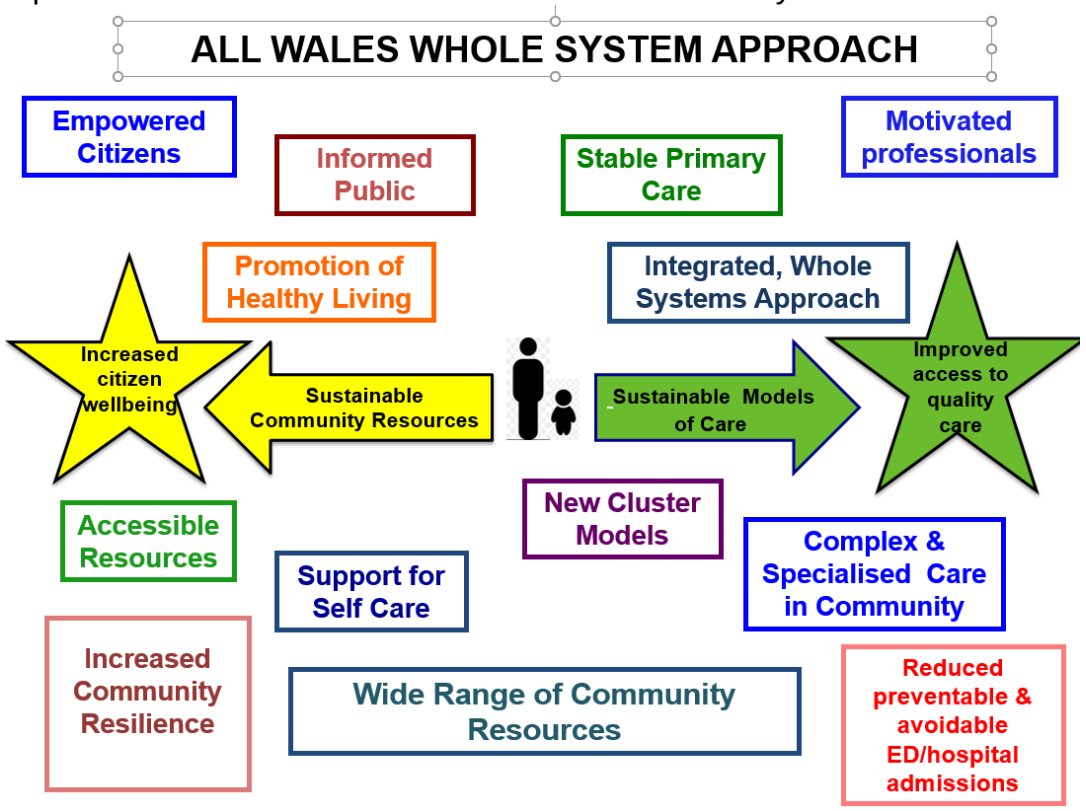
- 4 GP practices. One of which holds 2 contracts; 1 with Swansea bay Health Board and the other with Hywel Dda Health Board.
- 3 Dental Practices
- 10 community pharmacies
- 2 Leisure Centres
- 6 Libraries (4 community libraries and 2 local authority run libraries)
- Several Community centre
- 15 primary schools, 2 secondary schools
- Voluntary Sector organisations including mental health, physical activity and other charities aimed at supporting health and wellbeing

[1] (using one of the following 4 dimensions: employment, education, health/disability and household overcrowding (Census 2011)


Strengths
Good working relationship between cluster practices and with partners
Successful delivery of cluster projects
Committed and experienced Cluster leads
Health Board support on cluster projects
Sharing of good practice and skills
Substantial Cluster Budget
Patient engagment to inform service develoment
Economies of scale
Weaknesses
Cluster geography makes close working difficult
Achieving consensus is not always possible
No legal structure resulting in lack of autonomy and complete reliance on HB to employ staff, manage and release finances, procure goods and services etc.
Lack of capacity within Cluster to deliver programmes
Fragmentation of services due to cross border issues
Upper Valleys Cluster SWOT Analysis
Opportunities
Increase collaboration and development of MDTs and shared services
Introduction of new GP contract and QAIF
Alignment of policies and procedures
Explore souces of external funding
development of business plans based on evaluation
working with other clusters
Developing a Social Enterprise
Transformation Programme
Threats
Programmes largely dependant on uncertain WG annual funding
Disengagment if successful projects are not absorbed into core business, funded or rolled out by the HB
Uncertain funding
Work overload - running too many projects, transformation and QAIF
Brexit

Section 3 Key achievements from 2018-21 plan

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



Upper Valleys cluster recognises the need for close partnership working in trying to meet the needs of all our patients. In developing projects and initiatives, we have looked at available data and information. To facilitate meetings across a wide geographic area, we utilise Skype.

Skype for Business

Our cluster is an early adopter of a ***cluster based multidisciplinary team (MDT)*** as a shared resource. We have funded a physiotherapy triage and treat service to manage musculoskeletal problems as well as a wellbeing service, all enabled by the acquisition of V360, a shared appointment and clinical system. The team is built around GP practices using a **'telephone first'** call handling and triage model to direct patients to the most appropriate healthcare professional, in a majority of cases without having to

see a GP first. GP time is thus released to deal with more complex cases. The MDT offers appointments locally, reducing the distance patients have to travel to receive a service.

The cluster is setting up a ***cluster based sexual health service****,* one cluster GPwSI will provide long acting reversible contraception. Referrals are received from GPs, community pharmacies and sexual health clinics.

Improving prescribing and antimicrobial stewardship are key priorities for the cluster. In 2018-19, we adopted an MDT approach to improving respiratory prescribing. Nurses, GPs and pharmacists within the cluster attended training sessions on the management of asthma and COPD, with 100% attendance from nurses that regularly manage patients with these conditions. Feedback from these sessions was positive, 86% of attendees found the session extremely useful, 14% found it useful. There has been a *reduction in high strength inhaled corticosteroids* prescribing as a percentage of all inhaled corticosteroid prescribing from *34% to 27%,* which is now below the Swansea Bay average; as well as a drop in Inhaler costs *from above to below the national and Swansea Bay averages.*

The cluster practices have adopted **CRP Point of Care Testing,** an important diagnostic tool to support clinical decisions for patients with respiratory tract infections. This has resulted in a safe reduction of antibiotic prescribing for patients whose symptoms are caused by a virus, and where an antibiotic has no effect. This has improved shared decision making between patients and healthcare professionals.

The Cluster has also undertaken an in depth review of co-amoxiclav prescribing. Use was audited over a six-month period. Following this we have seen a 38% reduction in overall use of co-amoxiclav, whilst the national reduction was 14%.

The cluster is also keen to prevent ill health. **Improving health literacy** and ensuring that patients have the information they need when they need it is key to self-care. The cluster has therefore invested in **QR Pods** which give easy access to a range of useful information.

The cluster has introduced a multifaceted partnership approach to ***increasing uptake of the flu vaccination*****.** It has proactively delivered the flu vaccine to housebound patients, phoned patients to encourage uptake, surveyed patients who declined the vaccine to understand why, and organised Fluenz parties for children. The cluster is developing a network of community flu champions, is enlisting the support of the Local Area Coordinators to raise awareness, working with community pharmacists and setting up additional flu clinics. We have seen a steady increase in uptake in all the at risk groups greater than that seen nationally and in Swansea Bay Health Board.

The cluster is also addressing our high level of obesity and diabetes by identifying people at risk of pre diabetes, testing them and delivering lifestyle advice. All practitioners have received Foodwise training.

The cluster has seen an increase in patients with Atrial Fibrillation. The GP practices have therefore reviewed their patients, offering a personalised package of care in line with recent NICE Guidelines.

Patients are at the heart of everything the cluster does. In order to understand what they feel about the services we provide and how we can continue improving, we have conducted a **patient wellbeing survey**. The responses are being analysed and will inform our future service developments.

The cluster has worked with **Macmillan** to conduct a survey of patients recently diagnosed with cancer about the care they received from their GP practices. To address the findings of the survey we have delivered training to GP practice non-clinical staff establishing a network of Cancer Champions. All GP practices are using the Macmillan Cancer Quality Toolkit to improve care of patients with cancer.

The cluster aims to be a **compassionate community.** During Dying Matters Week, we hosted *Caffi Byw Nawr* to allow patients to discuss end of life issues with a wide range of interested professionals. We also set up 'bucket list' posters across the cluster to stimulate conversations about end of life issues.

We have funded a project to improve the back office management of practice work flow. This has helped practice streamline their processes for dealing with correspondence and reduced GPs administration time.

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 Upper Valleys 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 data, audit reports and a series of cluster meetings and patient engagement events.

The development of the plan has presented an opportunity for GP Practices in Upper Valleys to build on the progress made in the last 3 years and has involved partners from Public Health Wales, other Health Board teams and directorates namely medicines management, physiotherapy, mental health; and the 3rd Sector and Social Services.

Health Profile

Indicator	Period	Former Abertawe BM	Upper Valleys
Prevalence of smoking	2013 - 2014	20.8	21.2
Healthy eating	2013 - 2014	32.5	32.6
Physical activity	2013 - 2014	29	29.7
Alcohol misuse	2013 - 2014	26.6	25.9
Prevalence of obesity in children (%)	2016-2017	12.2	
Prevalence of obesity in adults (%)	2017-2018	10.0	10.8

Diabetes

Indicator	Period	Former Abertawe BM	Upper Valleys
Prevalence of diabetes (%)	2018	6.2	6.8

All 4 cluster practices signed up for the National Diabetes audit. For patients with Type 2 diabetes, Upper Valleys Cluster achieved 36.49% for all 8 care process, lower that the ABMU average of 53.48% and the Wales average of 45.87%. With regard to all 3-treatment targets, Upper Valleys achieved 38.31% - (Wales 34.97%; ABMU 38.97%) 83% of eligible Upper Valleys patients were offered Retinopathy (Wales78%; ABMU 79%)

Cancer

Indicator	Period	Former Abertawe BM	Upper Valleys
Prevalence of Cancer ABMU	2018	2.9	3.3

Indicator	Alive at	Abertawe BM	Upper Valleys
Prevalence of bowel cancer in males, by survival (%)	Up to 1 year	12.4	20.4
	> 1 to 5 years	35.9	36.9
	> 5 to 10 years	28.0	22.3
	> 10 to 21 years	23.7	20.4
Prevalence of bowel cancer in females, by survival (%)	Up to 1 year	12.2	17.3
	> 1 to 5 years	33.8	21.2
	> 5 to 10 years	27.2	25.0
	> 10 to 21 years	26.7	36.5
Prevalence of breast cancer in females, by survival (%)	Up to 1 year	9.0	10.5
	> 1 to 5 years	28.8	24.4
	> 5 to 10 years	28.0	28.4
	> 10 to 21 years	34.2	36.7

The cluster has conducted a survey of patients who have recently been diagnosed with cancer to understand how to improve their care. The cluster is 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. The cluster is participating in the Macmillan Cancer Quality Toolkit to explore how we deliver care and to develop actions to improve our services. All 4 practices are using the Toolkit and the learning will be shared at our Cluster meetings to inform our ongoing plans.

COPD

Indicator	Period	Former Abertawe BM	Upper Valleys	Wales	UK
Prevalence of COPD (%)	2018	2.2	2.6	2.29	1.93
Prevalence of asthma (%)	2018	7.4	7.3		

The higher prevalence of patients with COPD may be reflective of the high smoking prevalence, mining history and recent activity to improve coding for COPD. In the cluster, 77.39% of patients who have been diagnosed since April 2011 have had their diagnosis confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering the register. This is below the ABMU (83.59%) and Wales (80.67%)

Cardiovascular conditions

Indicator	Period	Former Abertawe BM	Upper Valleys	Wales
Prevalence of coronary heart disease (%)	2018	3.8	4.1	3.7%
Prevalence of heart failure (%)	2018	1.0	1.2	1.03%
Prevalence of stroke and TIA (%)	2018	2.3	2.3	2%
Prevalence of hypertension (%)	2018	15.3	17.5	15.7%

The cluster has recently carried out and Atrial Fibrillation (AF) project to improve anticoagulation of patient with the aim of preventing strokes::

Indicator	Wales		ABMU HB	Swansea Bay Health Board	Upper Valleys	
	Sept 2018	Aug 2019	Sept 2018	Aug 2019	Sept 2018	Aug 2019
Number of patients with AF	69,184	75,757	12,663	9,045	756	813
Patients in AF on warfarin %	39.47	31.83	44.61	37.71	47.75	39.36
Patients in AF on NOAC %	36.89	46.43	29.72	40.94	31.22	43.54
Patients in AF on Antiplatelet Monotherapy %	7.86	6.24	9.84	7.03	7.28	5.78
No Treatment Risk CHA2DS2VASc <2	5.61	5.35	5.74	5.04	5.56	4.92
No Treatment Risk CHA2DS2VASc >2	7.89	7.56	8.09	7.29	7.01	5.41
No Treatment Risk not known	2.28	2.6	2.01	1.99	1.19	0.98

Screening

Uptake of screening for breast cancer, abdominal aortic aneurysms (AAA) are above the national target. The cluster uptake for bowel cancer and cervical screening falls below the national target.

Indicator	Period	Former Abertawe BM	Upper Valleys
Uptake of bowel screening (%) (Target 60%)	2017-2018	56.2	55.8
Uptake of breast screening (%) (minimum standard 70%)	2017-2018	73.1	72.7
Uptake of cervical screening (%) (Target 80%)	2017-2018	75.1	74.9
Uptake AAA (%) (Target 80%)	2017-2018	80.2	85.1%

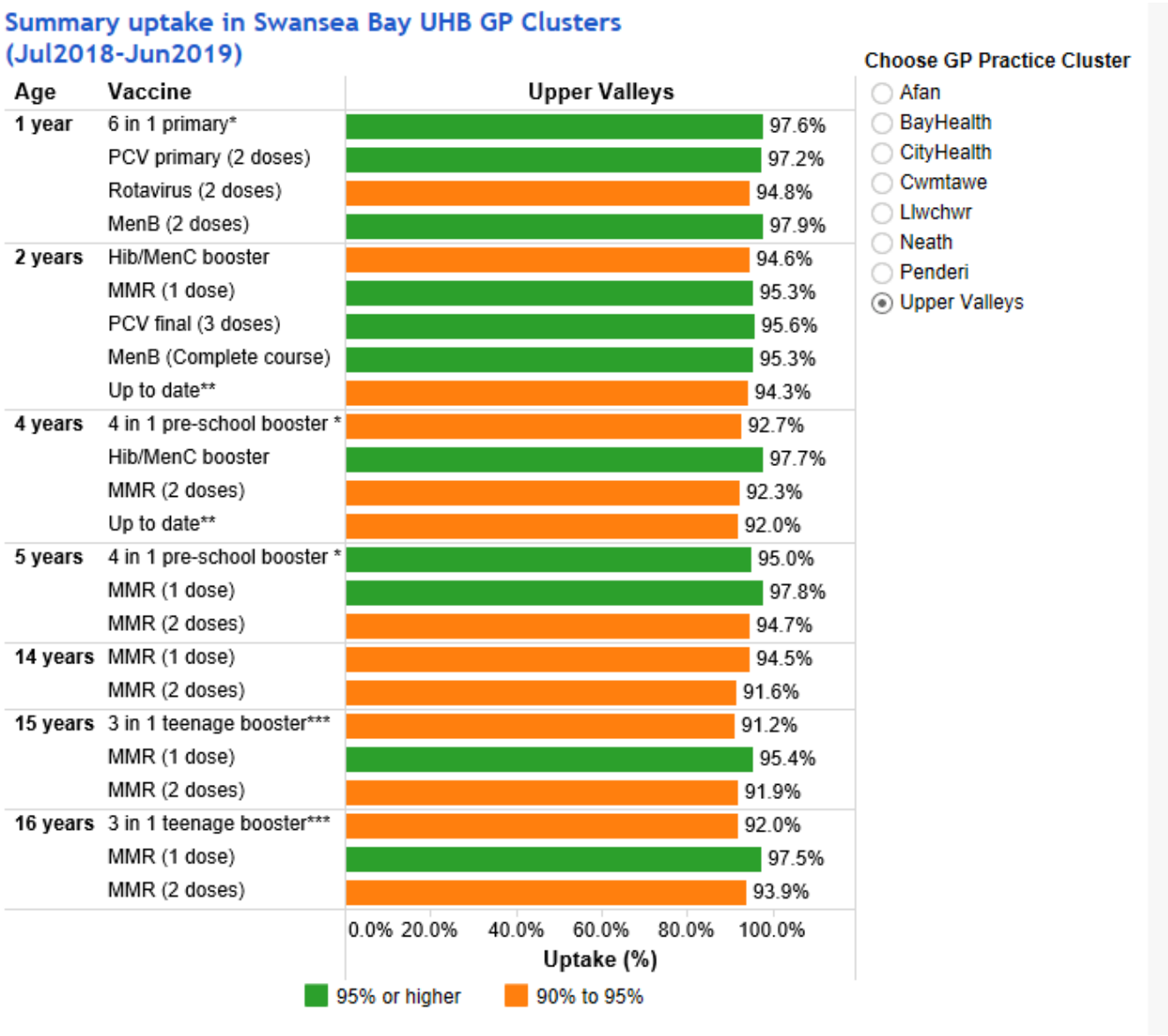
Flu

The cluster has seen a year on year improvement in the uptake of the flu vaccination. However it is yet to reach the national targets for >65 and <65s at risk.

	2016/2017	2017/2018	2018/2019	+/-
>65 (National Target 75%)	60.5%	63.6%	65.9%	5.4%
<65 at risk (National target 55%)	36.2%	43.9%	46.5 %	10.3%
2 and 3 year olds	32.5%	45.4%	54.1%	21.6%

Childhood Immunisations

The cluster needs to maintain performance in areas where it has reached the National target and work towards improving performance in the identified areas.


Summary uptake in Swansea Bay UHB GP Clusters (Jul2018-Jun2019)
Choose GP Practice Cluster
Afan
BayHealth
CityHealth
Cwmtawe
Llwchwr
Neath
Penderi
Upper Valleys
Age
Vaccine
Upper Valleys
1 year
6 in 1 primary* 97.6%
PCV primary (2 doses) 97.2%
Rotavirus (2 doses) 94.8%
MenB (2 doses) 97.9%
2 years
Hib/MenC booster 94.6%
MMR (1 dose) 95.3%
PCV final (3 doses) 95.6%
MenB (Complete course) 95.3%
Up to date** 94.3%
4 years
4 in 1 pre-school booster * 92.7%
Hib/MenC booster 97.7%
MMR (2 doses) 92.3%
Up to date** 92.0%
5 years
4 in 1 pre-school booster * 95.0%
MMR (1 dose) 97.8%
MMR (2 doses) 94.7%
14 years
MMR (1 dose) 94.5%
MMR (2 doses) 91.6%
15 years
3 in 1 teenage booster*** 91.2%
MMR (1 dose) 95.4%
MMR (2 doses) 91.9%
16 years
3 in 1 teenage booster*** 92.0%
MMR (1 dose) 97.5%
MMR (2 doses) 93.9%
0.0% 20.0% 40.0% 60.0% 80.0% 100.0%
Uptake (%)
95% or higher
90% to 95%

Dementia

Indicator	Period	Former Abertawe BM	Neath
Prevalence of dementia (%)	2018	0.7	0.9

Unscheduled Care

	Period	Cluster	Number of admissions	R (1k) all ages
Emergency Admissions:	1/08/2018 – 31/07/2019	City Health	2,727	26.68
		Neath	2,709	23.99
		Bay Health	2,319	15.56
		Afan	2,315	22.70
		Cwmtawe	2,138	25.09
		Llwchwr	1,883	19.72
		Penderi	1,870	24.49
		Upper Valleys	1,337	21.21
		SBUHB average	2,162	22.43

	Period	Cluster	Number of admissions	R (1k) all ages
Emergency Attendances:	1/08/2018 – 31/07/2019	Afan	19,657	192.77
		Neath	18,084	160.12
		City Health	14,920	145.96
		Bay Health	13,299	89.22
		Cwmtawe	12,965	152.14
		Penderi	11,360	148.78
		Llwchwr	10,065	105.42
		Upper Valleys	8,417	133.50
		SBUHB Average	13,596	141.00

	Period	Cluster	Number of admissions	R (1k) all ages
OOHs contacts	1/08/2018 – 31/07/2019	Afan	8,644	84.77
		Neath	8,242	72.98
		City Health	7,706	75.38
		BayHealth	6,782	45.5

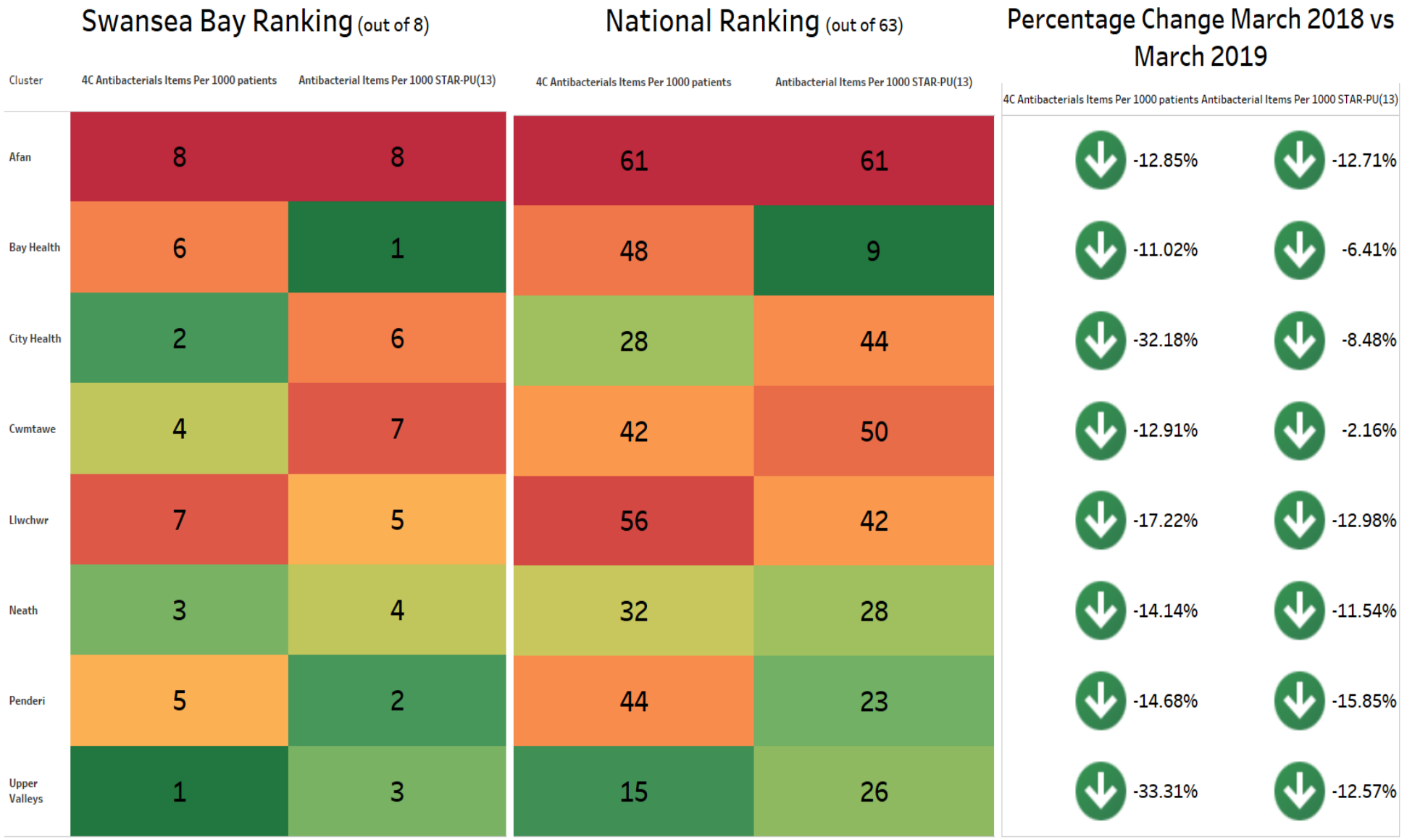
	Period	Cluster	Number of admissions	R (1k) all ages
		Cwmtawe	6,620	77.68
		Penderi	6,326	69.83
		Llwchwr	6,316	82.72
		Upper Valleys	3,781	59.97
		SBUHB Average	6,802	71.1

Antimicrobial Stewardship

In January 2019 the UK 5 year Antimicrobial Resistance (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:

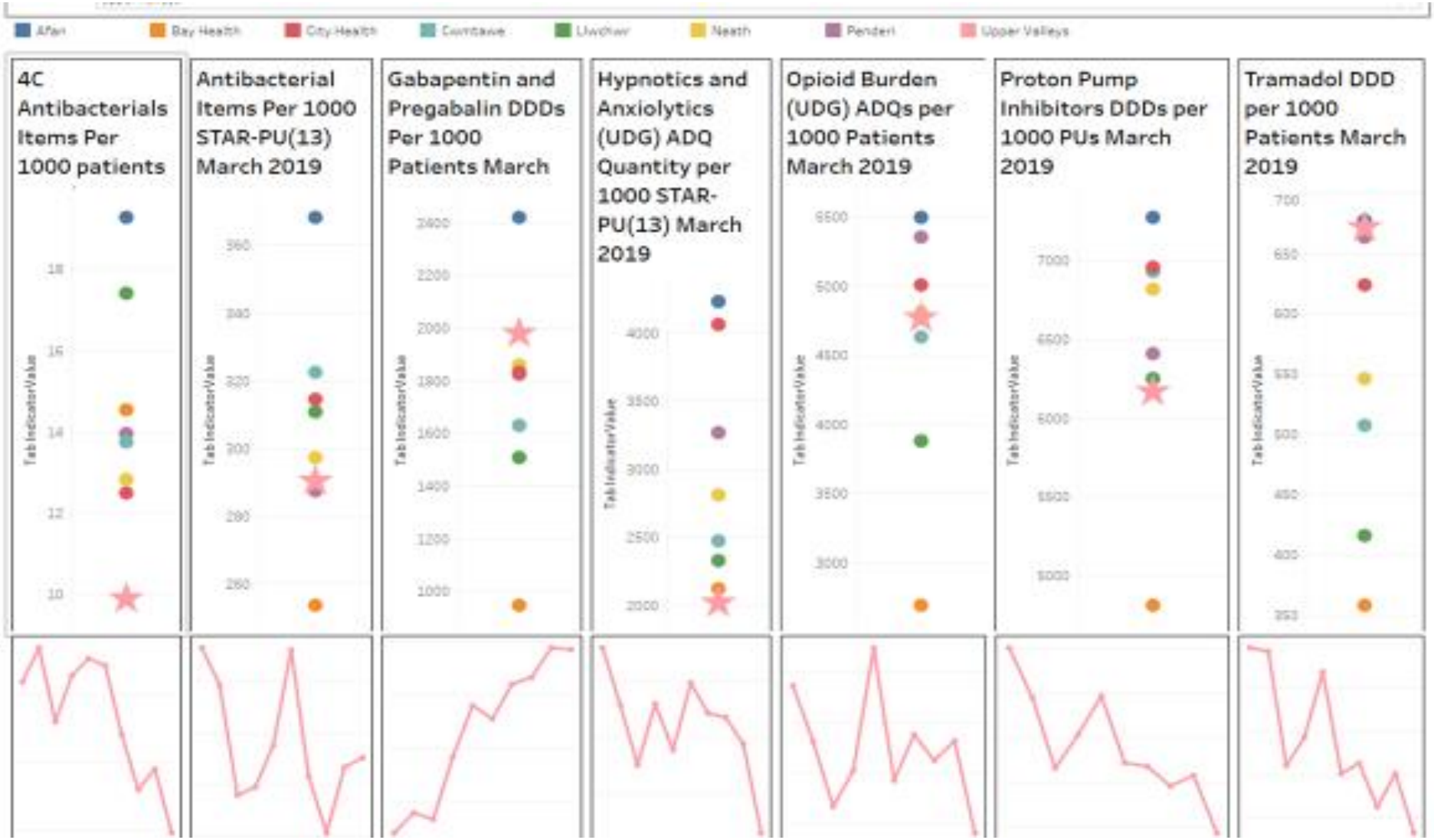
- All prescribers should document indications for all antimicrobial prescriptions; it is expected that an appropriate read code will be entered whenever antimicrobials are prescribed.
- Primary Care clusters should ensure urgent dental cases are seen by dental services rather than by GMS.
- Wales Quality 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.
- 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. Upper Valleys Cluster is ranked 1st out of the 8 SBUHB clusters for 4c Antibacterial items per 1000 patients (national ranking 15th out of 63) and 3rd for antibacterial items per 1000 STARPU (National ranking 26th out of 63)


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

PMS + Scheme

The data below demonstrates Upper Valleys prescribing of drugs highlighted by the national Prescribing Indicators. Whilst the cluster is doing well in Antimicrobial Stewardship and prescribing Hypnotics and Anxiolytics the cluster has concerns regarding its prescribing of medication for the management of pain (Tramadol, Opioids, Gabapentin and Pregabalin).



Other influencing factors

- Upper Valleys is a widely dispersed area with inadequate road and transport links. This limits the cluster's ability to set up centralised cluster services. In a recent patient survey conducted by the cluster, patients have indicated a preference not to travel more than 5 miles for services.
- Aging primary care infrastructure also poses a problem when looking for space to accommodate new services. A new primary care centre has recently been opened in Glynneath and presents opportunities to provide additional services in the area.
- The Upper Valleys area offers limited employment opportunities.
- Increasing of practice list sizes (1.2% change between 2011 – 2017)
- Increasing number of patients with co-morbidities and complex presentations
- Aging workforce
- Difficulties with GP and other HCP recruitment

Section 5 Cluster Workforce Profile

Doctors

Head count	Whole time equivalent	GP/Patient Ratio
20	14.63	2125.7

Nurses

Head count	Whole time equivalent	Nurse/Patient Ratio
17	16.95	1840

Direct Patient Care (Employed by GP Practices)

Additional Staff					
Clinical pharmacist		**HCSW**		**Pharmacy technician**	
Total Hours	**Head Count**	**Total Hours**	**Head Count**	**Total Hours**	**Head Count**
98	4	134.75	7	37	1

Direct Patient Care (Funded from Cluster allocation for the Upper Valleys Primary Care Hub MDT)

Additional Staff					
Physiotherapists		**Wellbeing worker**		**GPwSI (Sexual Health LARCs service**	
Total Hours	**Head Count**	**Total Hours**	**Head Count**	**Total Hours**	**Head Count**
48.75	2	37.5	1	8	1

Administrative/Non-Clinical Staff

Practice Manager		Reception Staff		Admin Staff	
Total Hours	**Head Count**	**Total Hours**	**Head Count**	**Total Hours**	**Head Count**
199	6	893	35	826	30

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

Community 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

Upper Valleys Cluster has a recurrent financial allocation from the Welsh Government of.£112,393 per annum. In addition, the cluster has participate over the years in the Prescribing management scheme+ and has realised a benefit of £20,854.60 in 2018/19.

In previous years, the cluster has applied it's allocation to various projects as identified in the Cluster Plan. Current spend plans are as follows:

Upper Valleys Cluster Funding 2019-20	
Welsh Government allocation	£ 112,393.00
PMS+ Monies	£20,854.60
Total	**£133,247.60**
PLANNED SPEND	
Project	**Spend allocated**
CRP testing	£14,000.00
INPS	£3,930.00
Pre-diabetes	£16,500.00
2018/19 Flu plan	£6,000.00
IM&T support	£9,000.00
LARCS Service Cluster contribution	£12,485.88
Total allocated	**£61,915.88**
To be allocated to projects in development	**£71,331.72**

Pacesetter Funding

The 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. Neath Cluster has used the initial tranche of funding to set up the Neath Primary Care hub of health care professionals including physiotherapists, a wellbeing service and audiology service. Additional Pacesetter funding is now being used to roll out a hub and spoke model across Neath Port Talbot.

Transformation Programme:

The Whole System Transformation programme which will be rolled out across Swansea Bay University Health Board was initiated in Upper Valleys in July 2019 and will run for 18 months. Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vison 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 Fund (ICF)

The ICF aims to drive and enable integrated and collaborative working between social services, health, housing, and the third and independent sectors. It is intended to help regional partnership boards develop and test new approaches and service delivery models that will support the underpinning principles of integration and prevention. Evaluation and learning lie at the core of the ICF and it is essential that any ICF programmes or projects are designed with this in mind.

Statutory Guidance identifies the following groups as priority areas of integration and all regional ICF programmes must address them proportionately, in line with their regional population assessments and area plans:

- Older people with complex needs and long term conditions, including dementia;
- People with learning disabilities;
- Children with complex needs;
- Carers, including young carers.

For these priority groups, the fund aims to find new integrated service delivery models and approaches that will:

- enable older people to maintain their independence and remain at home, avoiding unnecessary hospital admissions and delayed discharges;
- enable families to meet their children’s needs and help them to stay together;

- support carers in their caring role and enable them to maintain their own wellbeing;
- support the development of integrated care and support services for individuals with complex needs including people with learning disabilities, children with complex needs and autism;
- offer early support and prevent the escalation of needs;
- promote emotional health and wellbeing as well as prevent poor mental heath

The sums below have been distributed, by theme and on a regional basis across SBUHB using a multi-agency approach. A wide range of projects is being delivered; however even though none is Upper Valleys cluster specific, they deliver services to meet local needs.

Theme	**£**
Older People	5,224,000
LD/MH/CN/Carers =	2,590,000
Edge of Care	1,942,000
People with Dementia = £1	1,175,000

Section 7 Upper Valleys 3 year cluster plan

Prevention, wellbeing and self care						
No#	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
1.1.	Continue to maintain performance in the uptake of childhood immunisations • Review uptake data on cluster basis	UVCN	March 2020/21	Improved health and wellbeing of children. Reduced morbidity & mortality Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	Staff time	
1.2.	Increase uptake of influenza vaccine in target groups • Regularly review IVOR data for flu vaccination • Develop and implement a seasonal flu plan • Practices to share "best practice	UVCN practices LACs Community pharmacies	March 2020/21	Reduce morbidity / mortality / hospital admissions due to influenza Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	Staff time Cluster funding	Community flu champions recruited and trained Flu plan developed and being rolled out
1.3.	Support patients to manage their weight • Work with primary schools to identify schools with higher prevalence of childhood obesity • Review practice data and work towards recording weight and height of patients • Improve collaboration with exercise providers in the community	NCN Dietetics Team Swansea Bay public health team Cluster leads	March 2020/21	Improved health and wellbeing Reduced obesity Obesity pathway delivery review completed Greater understanding of level 2 provision in primary care, in order to improve and deliver a consistent and	Staff time Cluster funding PHW support	Obesity Pathway delivery review commenced in Swansea Bay March 2019. Level 2 insight with primary care to commence September 2019

Prevention, wellbeing and self care						
No#	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**

	• Contribute to the obesity pathway delivery review:
	  ○ Completion of baseline survey by practices
	  ○ Participation in qualitative interviews
	• Increase referrals to NERS
	• Map local organisations which support physical activity
		cluster development managers		coherent patient centred obesity pathway		

1.4.	Identify and manage patients who have pre diabetes • Continue to engage with Pre-diabetes scheme to identify patients at risk of pre-diabetes • Train appropriate staff to deliver intervention • Monitor outcomes at regular intervals	UVCN practices	March 2020/21	The onset of diabetes is delayed or prevented.	Staff time Cluster funding	The UVCN continues to engage in the pre diabetes project
1.5.	Explore and develop strategies to support patents of children with behavioural problems	UVCN Paediatric OT	March 2020/21	Parental stress reduced Positive impact on child/ parent interactions	Staff time Cluster funding	
1.6	Increase awareness of the community pharmacy Common ailment scheme, and Emergency Medical Supplies	UVCN	March 2020/21	Patients are aware of services offered in community pharmacies	Staff time Communications support	Community pharmacies are engaged in cluster meetings and are offering local services
1.7	Develop a consistent approach within Cluster to reduce smoking	UVCN	March 2020/21	GP time saved Increased referrals to “Help Me Quit”	Staff time Communication ssupport	Practices are now referring to the pharmacies under the common ailments scheme

Prevention, wellbeing and self care						
No#	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
	Work with Local Public Health team to develop and implement sustainable processes/initiatives that lead to increased referrals to the Help Me Quit local smoking cessation services" Increase engagement with the local Pharmacies Level 3 service.	Community Pharmacies Help Me Quit		Reduced local prevalence of smoking – reduced morbidity / mortality Patients are seen at the right time by the right person at the right place		

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 is the patient outcome?**	**Resource required**	**Current position**
2.1	Support further development of the Upper Valleys Primary Care Multidisciplinary Hub	ABMU HB	March 2021/22	A MDT of AHP is employed and serving the cluster practices	Staff time Transformation funding	A hub Steering group has been established Services to be included in the MDT have been agreed
2.2	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.
2.3	Explore areas of collaboration with community pharmacies	UVCN Community Pharmacies	March 2021/22	GP time saved Patients are seen at the right time by the right person at the right place	Staff time Meeting facilitation	Practices are now referring to the pharmacies under the common ailments scheme

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 is the patient outcome?**	**Resource required**	**Current position**
3.1	Manage patients who require a Trail without Catheter (TWOC) in their own homes • Work with the DN service and Swansea Bay Urology Service to develop a project to support patients in the community	UVCN	March 2020/21	Suitable patients with urinary retention who have recently been catheterised will have TWOC in the community thus saving travel to hospital and saving urology service time	Staff time Bladder scanner	
3.2	Improve EOL for patients and patient's family • Engage in the Advance Care Planning element of the Macmillan Primary Care Cancer toolkit • Organise Caffi Byw Nawr and other activities' during dying matters week annually • Explore the feasibility of engaging a cluster advance care planning nurse	UVCN	March 2020/21	Patients and their families experience better EOLC services	Staff time	Caffi Byw Nawr events delivered in the cluster. Bucket list poster displayed in practices during Dying matters week
3.3	Improve the care of frail patients Through the Transformation programme explore • Development of an Upper Valleys suite (virtual ward) • Working with the Acute Clinical Team to reduce hospital admissions by managing patients in their own homes	UVCN Transformation board	October 2021	Unnecessary hospital admissions reduced Patients cared for in their own homes	Staff time Transformation funding	The cluster has discussed compassionate communities and have agreed to identify their frail patients Meetings have been held to establish need

3.4	Manage appropriate patients with diabetes closer to home • Engage in the Diabetes NES • Support the upskilling of practice diabetes leads and work collaboratively • Engagement with SBUHB on the diabetes pathway development	UVCN	March 2020/21	Improved management of patients with diabetes closer to home Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	Staff time	All practices have signed up to the Diabetes NES and have had the relevant training
3.5	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. Whole systems approach business plan being created with HB
3.6	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	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

Implementing the Primary Care Model for Wales						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
4.1	Continue to signpost patients to the most appropriate professional	UVCN	March 2020/21	GP time saved Patients are seen a the right time by the right person at the right place	Transformation funding Engagement of relevant departments e.g. MSK, Physio etc.	Practices continue to triage appropriate MSK patients to the Cluster physio service Links have been made with the LACs and referrals made to them
4.2	Engaging with the transformation programme, explore the feasibility of establishing a social enterprise to facilitate and progress relevant cluster projects	UVCN Transformation board	March 2020/21	Legal vehicle for implementing cluster programmes is established	Staff time Project support	Leadership group established to progress programme
4.3	Support the development of Business Cases for sustainability of key service delivery schemes which support Primary Care: • Physiotherapy • Wellbeing • Cluster LARCs service	All	March 2021	These three area have been piloted by Clusters over recent years and have been seen to provide 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	Staff time Project support	The three cases are to be included for consideration in this year's IMTP process in Swansea Bay University Health Board
4.4	Improve links with Dementia support services	UVCN	March 2020/21	Better patient care	Staff time	

		Dementia support workers				
4.5	Support and engage in the rollout of Primary Care Child and Family Wellbeing Service (Early Years) across all Clusters	UVCN Primary & Community Services Unit	October 2023	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 Upper Valleys cluster, scheme tested and evaluated in 3 Clusters.		

Digital data and technology developments						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
5.1	Promote the use of My Health on line in • Increase patient registration • Roll out use of MHOL for repeat prescriptions	UVCN	March 2020/21	Patients have quick and improved access to services	Staff time Communication support	Not all the practices currently use the full range of MHOL options
5.2	Continue to work towards standard utilisation of guidelines for practice data entry and collection	UVCN	March 2020/21	Standard data available for development of projects	Staff time	The cluster has been using the services of IT companies to develop standardised guidelines

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 by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
6.1	Improve back office practice workflow through HERE workflow project	UVCN	March 2020/21	Practice efficiency improved and GP time saved	Staff time	UVCN practices have received training and are implementing the programme
6.2	Identify learning needs of practice staff • Review staff profile and competencies	UVCN	March 2020/21	Practices have a skilled work force	Staff time	Some training has been delivered to HCSW
6.3	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 by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
7.1	Work with SBUHB to support improvement grant applications where needed for improvement of practice premises to enable capacity to deliver new pathways and increase capacity	UVCN SBUHB Estates department	March 2020/21	Improved facilities and sustainable services	Staff time Estates department support	One practice has previously applied for give improvement grant
7.2	Work with SBUHB to map and identify available space to accommodate new services	UVCN SBUHB estates department	March 2020/21	Free space identified to host new services	Staff time Estates department support	Space has been identified in the practices to host services such as the wellbeing worker, the physio therapists and the LARCs service
7.3	Work with 3rd sector to increase presence in primary care and community settings	NPTCVS	March 2020/21	Patients are aware of local services		Work is ongoing

Communication, Engagement and Co-production						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
8.1	Engage with patients to understand their experience of services and to identify their needs and facilitate their participation in the development and evaluation of services Review findings of patient	UVCN	March 2020/21	Patients have the opportunity to influence service development Projects are developed based on patient need	Staff time NPTCVS support	Patient engagement to date includes Feedback from patients on • MSK project • CRP project • Wellbeing survey • Cancer survey – worked with Macmillan to ask patients recently diagnosed with cancer about their experience of

	survey and utilise for future planning					primary care during their cancer journey Phoning of patients as part of the flu project – asking patients who did not have their flu vaccination last year why not, to try to establish their reasons so this can be addressed in future years. • Flu champions training
8.2	**Continue to work towards improving health literacy and** • Develop Cluster website, QR Pods and resources	UVCN	October 2020	Patients have the information they need	Cluster funding Staff time Communications support	QR Boards developed

Improving Quality, Value and Patient Safety						
No #	**What action will be taken**	**Who is responsible for delivering**	**When will it be completed by**	**What will success look like? What is the patient outcome?**	**Resource required**	**Current position**
9.1	Engage in prescribing management schemes	UVCN Med management team	March 2020/21	Reduction in wastage of medicines and Improved prescribing practice Reduced variation across cluster, Health Board and all Wales Position (Primary Care Measures)	Staff time Med management support	Practices have signed up to the cluster prescribing benefits share scheme and to the PMS
9.2	Improve the care of frail patients by developing and 'Upper Valleys Suite' through the Transformation programme	UVCN Social services Adult MH CRT	March 2021	Reduction in emergency admissions Early identification and management of frail patients	Staff time Transformation funding	The cluster has discussed compassionate communities and have agreed to identify their frail patients

Improving Quality, Value and Patient Safety						
9.3	Continue to implement CRP POC testing to improve anti-biotic prescribing.	UVCN	March 2020/21	Reduction in antibiotic prescribing rates for Upper Respiratory conditions Patients receive appropriate care	Staff time Cluster funding	Utilise CRP testing in order to reduce the use of antibiotics for adult patients with upper respiratory tract infections 3 out of 4 practices are participating in the project
9.4	Further improve antimicrobial stewardship	GP practices Medicines Management team Practice Antibiotic Lead	March 2020/21	Improved outcomes and reduced resistance and side effects	Staff time	Practices have reviewed their antibiotic prescription rates and conducted a Co-amoxical audit
9.5	**Engage in agreed cluster QAIF projects** • Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20 • Patient safety Programme (mandatory)	UVCN Partners	October 2020	Adults with suspected UTI are reviewed and managed Reduced medicines related harm through a multi-faceted intervention for the cluster population.	Staff time Project support	
9.6	**Support patients to manage chronic pain** • Review patients on Tramadol, Opioid, and gabapentenoids • Engage with Expert Patients Programme (EPP) to facilitate the provision of	UVCN EPP	Sept 2020/21	Improved quality and safety	Staff time EPP support	

Improving Quality, Value and Patient Safety						
	local chronic pain management courses					
9.7	Promote shared learning and good practices through regular incident reporting	UVCN	March 2020/21	Improved safety and quality	Staff time	
9.8	Continue to engage with a robust clinical governance and information governance process ensuring that practices and cluster services are GDPR compliant using data and quality impact assessments as required.	UVCN	March 2020/21	Improved safety and quality	Staff time	DSA in place for MSK project Consent to share audit data in place GDPR leaflets and material distributed
9.9	Improve **Cancer** diagnosis • MacMillan Primary Care Cancer toolkit • Work Collaboratively to support cancer awareness week • Cancer Champions • Continue to support RDC • Work with Macmillan to improve citizen knowledge about cancer • Review uptake of bowel cancer screening to evaluate effect of new FIT screening test	UVCN	March 2020	Patients with suspected cancer receive a rapid diagnosis	Staff time Project support	Support the NPTH rapid cancer diagnosis centre pilot UVCN practices have actively been referring patients with suspected cancer to the RDC Cancer Red Wales training A survey has be conducted with patients recently diagnosed with Cancer and actions developed to address issues raised.
9.10	Work together with partners to ensure that delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond.	Practices	March 2020/21	Integrating cancer care into holistic chronic disease management in Primary Care.	MDT support	Cancer diagnosis rates issues – Anjula do you have a link on something data wise for Cluster level

Improving Quality, Value and Patient Safety						
	• Involve 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, review local experience to inform implementation. • Work to embed anticipatory care planning as routine practice			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		
9.11	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	

Communication and Engagement; The matrix below demonstrates how Cluster related issues and developments are shared and communicated with the Cluster, its partner organisations and the wider community

Communications Matrix	Cluster Meetings	Cluster Spend Plan	Cluster IMTP	Newsletter	Media Releases
Cluster Lead	✓	✓	✓	✓	✓
Cluster GPs	✓	✓	✓	✓	✓
Cluster Practice Staff / Employees	✓	✓	✓	✓	✓
Patients/Citizens			✓	✓	✓
Local Schools			✓	✓	✓
Neath Port Talbot Council for Voluntary Services	✓	✓	✓	✓	✓
Service Providers			✓	✓	✓
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			✓	✓	✓
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

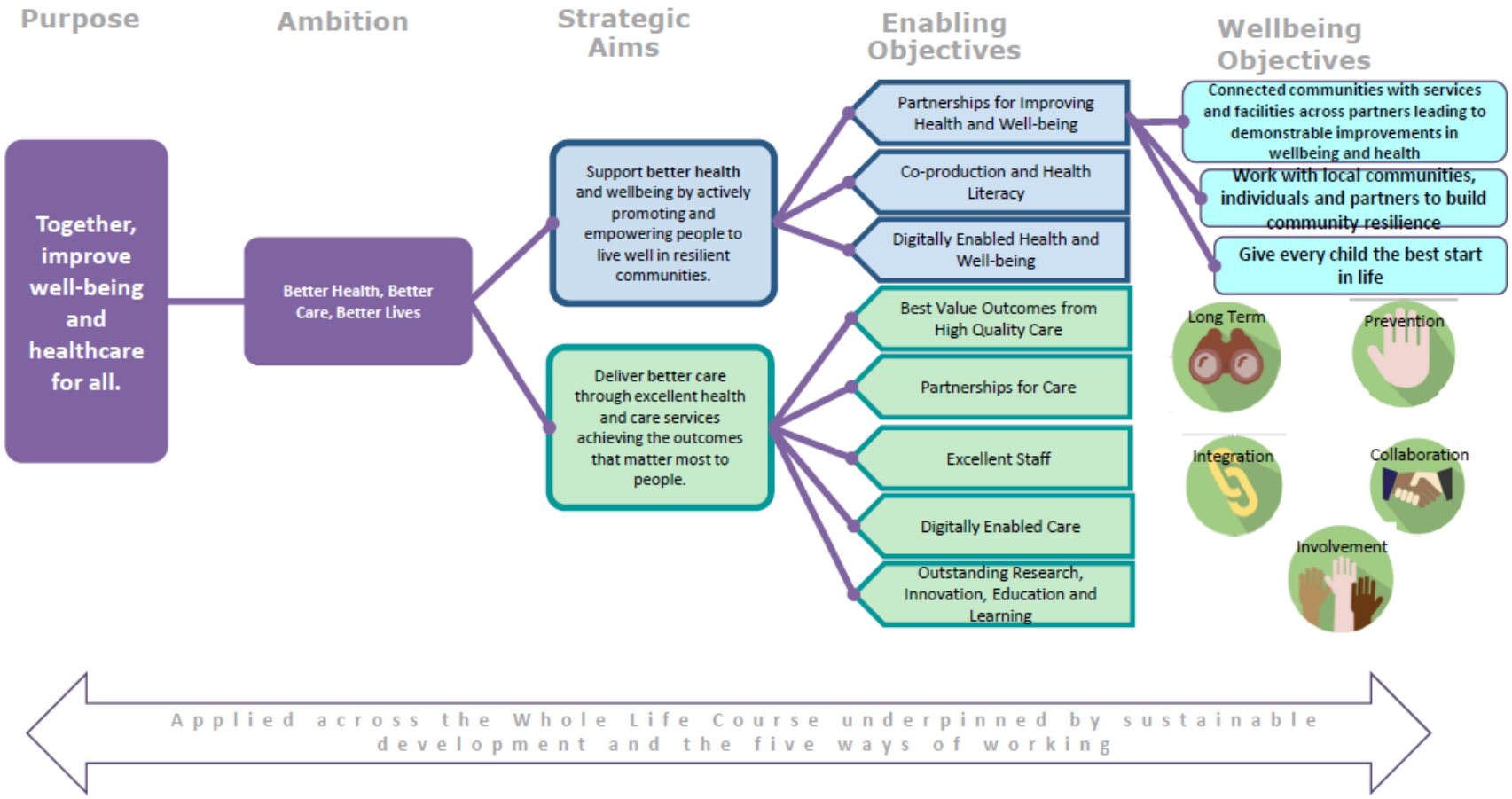
Workforce, estates, equipment, digitalisation

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:

Our Organisational Strategy on a page is:



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

Swansea Wellbeing Plan:

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

Neath Port Talbot Wellbeing Plan:

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

(Green Infrastructure and Digital Inclusion runs through all areas)

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

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

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

- Improving health and wellbeing across the age spectrum, including a key focus on **facilitating self-care and building community resilience,** and with targeted population groups dependent on cluster demographics.
- Coordinating services **to maximise wellbeing, independence and care closer to home** including flexibility to coproduce, design and implement services in partnership with the community.

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

In addition, the Cluster's 'Whole System Approach Programme' must be viewed in the context of, and as part of a wider health and social care regional transformation process. It will dovetail with 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 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, Cluster Governance Assurance guidance, 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
- Developing the Cluster IMTPs
- Developing internal cluster training
- Acting as key links for national Transformation programmes
- Providing capacity to support key stages of the Transformation programme where required
- Developing 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	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**
		• Service user reps involved in planning / design of all new services • 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

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	Cluster Lead in post	Cluster governance framework in place, with robust processes for cluster decision-making, risk management and accountability for all partner organisations.	Cluster partnership working is promoted through co-location of staff, joint 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

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
		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
		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)

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	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
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	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

Components and Characteristics of Primary Care Model for Wales			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
	• Data analysis, IT systems, new technologies		
			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