Primary Care Integrated Medium Term Plan (IMTP)

Bridgend North Primary Care Cluster 2020-2023

Updated September 2021

Cluster IMTP 2020 - 2023

Executive Summary

The North Cluster works collaboratively together to meet local health needs and priorities. Collaborating with stakeholders across the North Cluster to improve the coordination of care, working with local communities and stakeholders to reduce health inequalities.

Key achievements from 2017-2020

- Development of a healthy homes SLA
- Development of counselling service SLA
- Employment of cluster pharmacists
- Development of a chronic disease nurse team
- Funded C-Reactive Protein (CRP) point of care pneumonia testing
- Funded testing fractionated exhaled nitric oxide (FENO) machines
- In practice HERE workflow training
- Dermoscopy training via Cardiff University

Overview / Vision of the Cluster 2020 – 2023

- Work in partnership with stakeholders across the North Cluster to to reduce health inequalities.
- Modernising diagnostics to improve the quality of practice-based care
- Form new partnerships with the 3rd sector
- To improve screening and vaccination rates

Cluster Population Area Health and Wellbeing Needs Assessment

- Areas of severe deprivation and health inequalities
- High prevalence of chronic conditions
- Low birth weight rate higher than the Bridgend average
- High levels of smoking, obesity, poor diet, inactivity and alcohol consumption
- Low levels of screening uptake
- Low levels of Childhood vaccinations / flu vaccination

Gaps to Address and Cluster Priorities

- Increase uptake of bowel and cervical screening
- Increase the uptake of childhood immunisations / flu vaccinations
- Detection and management of atrial fibrillation
- Increase cluster population participation of cluster priorities
- Standardise approach to Doctor/Patient interface via mysurgeryapp

Planned Cluster Actions

- Development of a community based ultrasound-equipped musculoskeletal service
- Development of a cluster physiotherapy service
- Increasing administration time in practice to follow-up on non-responders to screening, flu immunisations and childhood immunisations
- Social prescribing – in collaboration with the local community coordinators
- Adopt mysurgery app to improve Doctor /Patient interface
- Roll out of Consultant Connect across cluster
- Continue to update COVID -19 Business continuity plan as and when required
- Frailty Service – Recruitment of primary care chronic condition nurses and GP sesssions

Strategic Alignment and actions of others to Support Cluster Working and Maturity

The Cluster plans for the next three years will align with the principals of the Primary Care Model for Wales and Welsh Government plans for 'A Healthier Wales'. The plan will also be developed, reviewed and monitored alongside the Cwm Taf Morgannwg Primary and Community IMTP and transformation plan

Ensure Third Sector organisations and Community Pharmacy are all active members of the cluster and support the health & wellbeing agenda and community development.

1. Executive Summary

Cluster Vision

To work collaboratively together and with other partners to meet local patient needs, as well as support the ongoing work of a locality network. To understand local health needs and priorities and develop an agreed Cluster Network Action Plan linked to common themes of the individual Practice Development Plans. In addition, to work with stakeholders across the North Cluster to improve the coordination of care and integration of health and social care and work with local communities and networks to reduce health inequalities.

Overview - How we are delivering change

We are bringing care closer to home by expanding the primary care team to include an outreach chronic conditions nurse team, occupational therapist, practice based pharmacist, local community co-ordinator and primary care community mental health team. Improving the mental health well-being of our patients by providing 1:1 counselling in collaboration with ARC (Assisting recovery in the community) community mental health nurses.

Modernising diagnostics and improving quality of practice-based care by employing CRP point of care testing for the diagnosis and management of community acquired pneumonia and improving antimicrobial stewardship. Digitalising healthcare closer to home for patient convenience and to reduce out-patient pressures via dermoscopy trained GPs and tele-dermatology, for rashes and suspected cancer skin lesions helping to stream-line dermatology referrals.

Exploring new ways of working by upskilling practice staff with 'HERE WORKFLOW' helping to reduce the bureaucratic pressure on paperwork coming in to the surgery. Forming new partnerships with the 3rd sector and using social prescribing employing a more social holistic and prudent approach to healthcare. Enhanced patient communication through the introduction of QR Pods and social media.

Increasing administration time in practice to follow-up on non-responders to bowel screening, cervical screening, flu immunisations and childhood immunisations. Improving links with community pharmacists with a co-ordinated approach to improve flu vaccination rates, reduce medicines waste and improve safety around prescribing

Engaging in the QAIF contract work on the management of atrial fibrillation and continue the good work already underway on coronary heart disease screening in primary care. Engage in more social prescribing such as the referring to slimming clubs and exercise referral schemes to help fight obesity and also referring to befriending programmes, men sheds and gardening clubs and other activities to help combat loneliness.

Develop physio-led first point of contact musculoskeletal service locally for the prudent management of musculoskeletal conditions in primary care.

The cluster to become more inclusive of the wider community healthcare partners and increase communication links with secondary care via the ILG. Increase clinical links with secondary care through adoption and use of 'consultant connect'.

Continue to discuss the Health Board mainstreaming of existing cluster services to release new funds to re-innovate other programmes/services. Incorporate population needs assessment when designing and implementing new cluster programmes/ services.

Ambition / Key deliverables for 2020- 2023

Our aims and ambitions are to reduce health inequalities by:

- Increasing uptake of bowel and cervical screening
- Increasing the uptake of childhood immunisations particularly MMR by age 5 and 16.
- Increasing the uptake of flu vaccinations in the over 65 year olds and other at risk groups
- Reducing stroke risk by better detection and management of atrial fibrillation
- Being more aggressive with smoking cessation promotion
- Better detection and management of hypertension
- Reducing obesity
- Building on existing projects by improving links between the chronic condition nurses, health homes local community care co-ordinator/3rd sector and practice pharmacist
- Developing first point of contact locality-based physiotherapy service to ease pressures and improve sustainability of GP services and providing care by the right person at the right time.
- Improving access to GP appointments by improving our digital footprint and employing 'e-consult' and my health online
- Accessing mental health and wellbeing services through provision of a local cluster counselling service.
- Progressing the development of a community based ultrasound-equipped musculoskeletal service that will enhance and relieve pressures on secondary care services.
- Participating in anticipatory care across the cluster.
- Early identification and proactively managing respiratory patients via point of care CRP Testing. Working in collaboration with the antimicrobial North Network pharmacist to develop protocols and agreed outcomes.

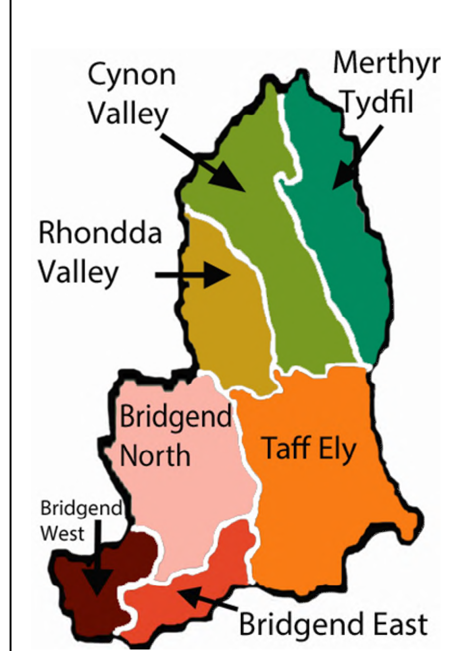
	• Collaborating with the cluster pharmacist to develop and undertake a programme approach to improve antimicrobial stewardship. • Explore D-dimer point of care in surgeries when dealing with patients presenting with possible deep vein thrombosis , enabling practices to reduce emergency care referrals and pressure on emergency departments • Accessing and developing the healthy homes project to support the patient population to remain independent and safe in their own homes for as long as possible. • Developing the chronic conditions team to support review of housebound patients living with chronic conditions and provide proactive and relevant support to help individuals to manage their conditions. • Developing a community based ultrasound-equipped musculoskeletal service that will enhance and relieve pressures on secondary care services • Developing fluenz parties within practices • Working collaboratively with 3rd sector organisation on initiatives in the community to allow the population to improve their health & wellbeing

2. Introduction to the 2020-2023 Plan/Cluster

Overview of the Cluster

Bridgend North cluster has 8 practices serving approximately 52,000 patients in a region of ex-mining south wales valleys. It's an area of high social deprivation with many health inequalities where 66% of the population live in the most deprived 40% of areas in wales.

- One of eight clusters within Cwm Taf Morgannwg University Health Board
- Bridgend North Cluster is made up of eight main general practices, three branch surgeries and two dispensing practices
- Rural and urban areas with pockets of severe deprivation, unemployment / social issues, alcohol / drug abuse
- High rates of chronic diseases in comparison to other clusters in particular COPD and CVD
- High rates of smoking and obesity



Cluster Assets Profile

The cluster is made up of the following GP practices:

- Aberkenfig
- Bronygarn
- Cwmgarw
- Llynfi
- Nantymoel
- Ogmore Vale
- Tynycoed
- Woodlands

The Cluster also includes nine nursing/residential homes, one community hospital situated at Maesteg, thirteen community pharmacies, five dental practices and seven optometrists . Working within the cluster with partners from social services, the third sector (Care Navigators) BCBC (Local Area Co-ordinators) and CTM health board.

Strategic Objectives

a. Prevention, well-being and self care
b. Timely, equitable access, and service sustainability
c. Rebalancing care closer to home
d. Implementing the Primary Care Model for Wales
e. Digital, data, and technology developments
f. Workforce development including skill mix, capacity, capability, training needs, and leadership
g. Estates developments
h. Communications, engagement and coproduction
i. Improving quality, value, and patient safety

Governance

The cluster have an approved Terms of Reference (TOR) in place, which is reviewed as necessary. The TOR outlines membership of the cluster, the function, cluster leadership, decision making and reporting and monitoring arrangements.

This provides an accountability framework and ensures that cluster plans and service developments meet a level of scrutiny, and will provide assurance to Cwm Taf Morgannwg University Health Board Executive Team and Board.

3. Key achievements from the 2020-2023 three year cluster plan

- Early identification and proactive management of pneumonia patients by introducing point of care CRP Testing
- Additional cluster employed Pharmacist to support GP Practices and improve access and medicines quality and safety for patients
- Development of Primary Care Cluster Nursing Team to support review of housebound patients living with chronic conditions and provide proactive and relevant support to help individuals to manage their conditions
- Funded dermatoscopy courses via Cardiff University and dermatoscopes for GP practices. Improving links with secondary care dermatology services and improving access to timely diagnosis of skin cancer
- Clear pathways have been implemented for a Falls Preventative Programme
- Cluster invested in HERE Workflow to establish mechanisms to effectively manage patient correspondence and reduce the workload for GP's
- Working with Carers Service to ensure carers can access relevant information, advice and support as needed
- GP's actively refer to stop smoking Wales and sign post to Community Pharmacies
- Flu vaccinations have been successfully delivered to housebound and care home patients across the Cluster and the Cluster took part in the VPDP Cluster Flu Scheme
- Developed a pathway for patients that have mental health needs to ensure they can access relevant support as needed
- Funded FENO testing (fractionated exhaled nitric oxide) machines for the diagnosis and management of asthma
- Embrace the developments in new technology to improve patient access to information and medical services. The implementation of video consulting and the 'my surgery app' provide patients with a variety of ways to manage their health care needs.
- The cluster are working collaboratively with the Medicines Management team through the prescription ordering hub. This provides patients with another form of access and alleviates pressures in primary care by directing patients to an alternative source of contact, freeing up valuable time for reception staff to deal with other calls. The prescription ordering hub will also support cost saving activities in relation to medicines waste and more cost effective prescribing.

	Key COVID actions • Developed COVID cluster wide business continuity plans, collaborative working between cluster practices to ensure patient services are maintained and practices support each other in times of disruption i.e. effects of the COVID pandemic or any other significant event that may affect the delivery of patient care. Reconfiguration of cluster practice premises to incorporate 'red zones' to isolate and treat potential COVID patients. • Successful Pfizer COVID immunisation roll out for 3 Llynfi Valley practices from 1 site, which IS an example of a successful collaboration between different practices • One cluster practice sourced visors independently for the whole of the cluster at the onset of the COVID pandemic when central supplies were scarce • Rapid adoption of new digital platforms to enable remote working during the pandemic to maintain primary care services and enable access for patients

Patient Information Hubs - QR Pods

The cluster purchased QR pods to improve communication and signposting with patients.

The QR pods allow patient to use a mobile phone or other device to scan the QR pod which will open a web page, this provide the patient with uptodate information about the practice, NHS services, self help guides and chronic diseases.

My surgery app

The cluster invested in the MySurgery app. The app enables communication between practices/ patients and links in with e-Consult and my health online. The app enables practices to triage patients and allows patients to order repeat prescriptions, submit admin requests for doctors letters, fit notes etc without having to call the surgery.

Healthy Homes Scheme

A Service Level Agreement is in place with Bridgend Care and Repair to provide a 'Healthy Homes' Scheme.The project provides a dedicated occupational therapist and caseworker linked to surgeries based in the North Cluster, to reach older frail people who have long term/complex health conditions and who live in poor or inappropriate housing.

Aims

The Project undertakes a comprehensive home visiting service that includes a:

- Financial assessment which ensures welfare benefits maximisation as well as eligibility to a range of statutory housing grants / charitable funding
- Falls Risk Assessment (FRAT)
- Environmental risk assessment in and around the vicinity of the home to identify hazards, including a Home Fire Safety Check.
- Comprehensive in-house Occupational Therapist Assessment that helps to avoid waiting times and instigate access to necessary major and mid-level adaptations
- Trusted Assessor's Assessment that will include a 'prescription' for major and minor aids and adaptations and interventions that help to prevent falls, injury, social isolation and fear of crime
- Advice/assistance regarding moving to alternative housing (i.e. sheltered housing etc.).

Outcomes

- Positive improvement to home environment measured by improved safety, comfort, security and independence for older people
- Reducing the risk of admission to hospital due to falls and accidents in the home
- Addresses the wider issues of housing disrepair, low income, fuel poverty, falls prevention, etc.
- Supports carers to continue in their caring role
- Seeks to address low income by maximising opportunities to increase income through welfare benefits maximisation
- Assists in reducing the number of presentations at GP surgeries due to housing/social care problems

Tŷ Elis

Counselling Sessions

The cluster have an SLA in place with Ty Elis to provide a counselling service to improve access to mental health and wellbeing services.To provide structured therapeutic counselling interventions to relieve persons who are emotionally distressed, to improve coping strategies and resilience's in individuals.

Counselling for adults (from 18) who may be experiencing problems with:

- Anxiety/panic attacks
- Depression
- Stress
- Separation and loss
- Parent/Child conflict
- Family Violence
- Eating Disorders
- Disability
- Self-esteem
- Interpersonal relationships
- Anger
- Health
- Sexuality/intimacy
- Trauma

<u>Service Objectives</u>

- To provide structured therapeutic counselling interventions to relieve persons who are emotionally distressed and to improve coping strategies and resilience in individuals.
- To improve mental health and emotional wellbeing of patients.
- To work with patients to where applicable regain their autonomy and to take responsibility and control for the issues affecting their lives.
- All GP Practices will send patients for Triage at the ARC Centre in Bridgend for Triage prior to accessing the service

Outcome Monitoring

Individual patient outcomes are monitored using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS).
https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/

The following tables provides an analysis of Warwick-Edinburgh Mental Well-being Scale data for a cohort of 218 patients registered with North Cluster GP practices. The data relates to patients who have completed a course of counselling sessions and where baseline and final scores have been recorded during April 2018 - March 2020.

The data was analysed using templates provided by Warwick Medical School.
https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/.

Table 1

	Before counselling - score	**After counselling - score**	**Change**	**Positive change**	**Statistically significant change**	**Wilcoxon signed rank test P value**
Total no. of responses	218	218				
% Low wellbeing	89.91%	43.58%				
% Moderate wellbeing	10.09%	50.00%				
% High wellbeing	0.00%	6.42%				
Mean score	30.93	44.09	13.16	Yes	Yes	$p<0.05$
Standard deviation	9.29	10.52				

Table 1 highlights a statistically significant positive change in WEMWBS after counselling.

(Table 2)

		After counselling - change - (n)	After counselling - change - (%)
Number of people with a meaningful positive change (%)		185	84.86
Number of people with a meaningful negative change (%)		6	2.75

Table 2 - highlights that 84.86% of patients had a meaningful positive change to their WEMWBS after counselling.

4. Cluster population area health and wellbeing needs assessment and evidence of what the population says it wants/needs

The Bridgend North cluster has higher levels of social deprivation than the Welsh average with pockets of severe deprivation and health inequalities. The vision for Bridgend North Cluster is to focus a lot of our energy on tackling the health inequalities that exist across this locality. 65.8% of patients are living in the most deprived 40% of areas in wales (WIMD 2015).The link between deprivation and poor health is well recognised. The life expectancy at birth for males and females (2015-2017) is 76.4 years and 79.3 years respectively compared to all life expectancy of 78.3 years and 82.3 years. Bridgend North Cluster Network has 6% low birth weight babies (born weighing less than 2500g) in 2016 compared to an average bridgend figure of 5.2%. Low birth weight babies are at risk of developing problems with growth , cognitive development and onset of chronic conditions later in life .The Bridgend North Cluster has a higher estimated prevalence of all chronic conditions than the welsh average apart from dementia. The estimated prevalence of diabetes being the joint highest of all health board cluster areas.

Cluster data (2016- 2018) indicates the following five unhealthy behaviours: smoking, obesity, poor diet, inactivity and alcohol; which leads to the four chronic diseases of cancer, heart disease, stroke and diabetes, which contributes to 64% of all early deaths before the age of 75 year. The most common cancers for men in Bridgend were prostate, lung and colorectal (2014-2016). For women it was breast, lung and colorectal.

Bridgend North has a higher estimated prevalence of hypertension and atrial fibrillation (AF) than the Welsh average and one of the highest in Cwm Taf Morgannwg, this information informed the cluster decision on choosing the AF project within the Quality Assurance and Improvement Framework (QAIF). Tackling the clinical risk factors is key to achieving optimum management. Smoking prevalence is higher in Bridgend North than the health board and welsh average. The long-term health and social implications of engaging in harmful behaviours are wide-ranging.

Bridgend North had a lower uptake of bowel screening (55.5%) compared to the Cwm Taf figure of 64.8% and wales average of 55.7% (national target being 60%). We need to make it a priority to increase screening uptake to improve the detection of bowel cancer at an earlier stage and the same for cervical screening where screening uptake is lower as well.

Flu vaccination uptake in Bridgend North is below the welsh average in all risk groups and a shared concerted effort needs to be undertaken to boost immunisation rates in the forth-coming flu campaign. Childhood vaccination rates after the age of 1 year has not met any of the targets which are set to achieve 'herd immunity' and more urgency needs to be injected into this area to achieve the targets.

Data Source: Public Health Wales – Bridgend North Cluster population profile (appendix 1)

5. Cluster Workforce profile

General Practitioners (GP's)

There are 8 GP practices in the North Cluster area, urgent Primary Care 'Out of Hours' (OOH's) is provided by 111.

GP North cluster workforce (April 2020)*	
Total no GPs	39
Total weekly sessions	247
Cluster WTE	24.70
Cluster rate WTE per 1,000 population	0.47

*Includes employed locums

For QAIF 2020 / 21 the cluster is required to:

CND015W - Contributing relevant cluster information to the Primary Care Cluster IMTP which will include information on the demand and capacity tool and also the workforce development plan.*

N.B * this requirement has been suspended for 2021

Each practice in the cluster regularly updates the Wales National Workforce Reporting System (WNWRS) and analyse their current workforce numbers, skills and development needs.

The cluster regularly discusses current services available to the cluster and identifies gaps in provision. During 2021 the cluster identified the need for an additional 8a cluster pharmacist post, 2 x Band 6 Primary care Nurses and 2 x Band 3 HCSW, all posts have been successfully appointed.

Nursing Residential Homes

The cluster has nine nursing/residential homes, 7 GP practices provide services under the Care Homes Directed Enhanced Service (DES).

Community Hospital

The community hospital situated at Maesteg provides rehabilitation, providing physiotherapy and occupational therapy for inpatients/ outpatients. The outpatients department provide a range of satellite Consultant-led outpatient clinics including ENT, gastroenterology, surgery, audiology, psychiatry and cardiology.

Dental Services

Across the cluster there are 5 General dental practices (GDS). The Community Dental Service (CDS) operates across CTM HB there is a clinic based in Quarella Road in Bridgend where the team deliver services to vulnerable patients. Bridgend patients continue to access in hours and dental OOH sessions via 111.

General Ophthalmic Service (Optometrists)

Across the cluster there are 7 practices, all practices are accredited and provide the Wales Eye Health Scheme (EHEW) and 1 practice provides low vision services.

There are no primary care OOH optometry services in place across Cwm Taf Morgannwg but some practices operate over the weekend period.

Community Pharmacy Service (Pharmacists)

The Community pharmacy service is managed by the Medicines Management Directorate and will therefore be described their IMTP document. There are thirteen community pharmacies community pharmacies in the North cluster and all provide the Common Ailments Service.

3rd Sector

The cluster has SLAs in place with Bridgend Care and Repair to provide a Healthy Homes scheme and with Ty Elis to provide counselling services across the network.

Information on 3rd sector services is available via a new app which has been developed by a partnership of Welsh Government, Local Government, the NHS in Wales and Third Sector Support Wales to provide front-line staff with access to information about the wide range of well-being support services and community groups across Wales.

The App provides access to a shared Directory of Services (DoS) via their mobile device. It brings together information from Dewis Cymru (the local government well-being directory), Infoengine (the third sector services directory) and the NHS Wales directory. GP practices are encouraged to use this app to signpost patients to the appropriate support service and groups.

https://appadvice.com/app/health-well-being-wales/1449457153

Local community coordination of wellbeing activities

The North Cluster has local community coordinators employed by the Local Authority. Local community coordination helps people to develop their strengths, it reduces the need for more formal support by making connections with local networks and resources, to improve peoples wellbeing and resilience.

North Integrated Community Network Team

The North Integrated Community Network Team is a single line managed team currently comprised of the district nurse service and social workers who provide assessment, care and support for adults and those who support their care and are in the frailest health. Prior to receiving support from the Network Team, there is always opportunity for adults to receive support through rehabilitative programs developed and delivered through the Community Response Team. On considering the offer of support, the Network Team ensures that it follows the principles of Prudent Health Care and the best practice guidance laid out in the Social Services and Well-Being (Wales) Act 2014.
The team ensures that approaches to intervention would always consider maximising the person's independence and ensuring that choice and control remains with this person. Planned support will include consideration of both the physical and emotional well-being aspects of the person's life and also consider the resilience and support required to meet the needs and complement the support provided by the person's informal care network.

The team is designed to ensure that needs are met in a seamless approach through multi-agency assessment and provision. The single line approach to the team ensures that there is good opportunity for effective and timely information sharing and this provides the platform to mobilise the right support at the right time. Within the North Network, the district nurses are coordinated into four teams, operating within two community areas.

<u>District Nurse Staffing and Training</u>

The district nursing capacity for the North Network is approximately one registered nurse per 624 adults over the age of 65.The model provides the Cluster the opportunity to develop a comprehensive multi- disciplinary approach to each surgery population. It enables a "team around the person" approach to develop, which supports good quality care and preventative approaches in maintaining an adult's independence. It ensures that the "what matters" conversation happens and a strength based approach is used to provide the best outcomes for adults and their families. The multi- agency approach ensures that important work such as: safeguarding and best interest decisions are undertaken in an effective and timely manner.

The North Network has enhanced the multi-disciplinary offer through developing a carers link officer, who is able to offer tailored support around emotional well-being and a contingency planning officer, who supports choice for adults who either have unstable health or informal care arrangements, which if they were to break down, would compromise the person's independence and choice. The importance of ensuring good physical and emotional health for adults has led to cluster development in funding a chronic disease nurse to particularly engage those adults who may be prone to neglecting aspects of their life, which may lead to poorer physical or emotional health.

Transformational Bid

The successful bid under the recent Transformational Fund will allow the Cluster to expand the professional support available to provide an effective "team around the person." During 2019/2020, North Integrated Network Team will recruit additional professional staff to enhance the multi-disciplinary offer and approach within the North Cluster. These additional posts will include: occupational therapy; physiotherapy; community psychiatric nursing; speech and language therapy; pharmacy support and increased investment in district nursing. The bid also builds upon and consolidates the work competed on the Single Point of Access triage for district nursing and provides additional resources for contingency planning.

6. Cluster Financial Profile

Cluster Financial Profile

Cluster allocation (April 2021) is £372,000 which is made up from delivery agreements money received from Welsh Government.

See below examples of anticipated recurring spend on projects going forward across the cluster:

Cluster Pharmacists	£94,898
Cluster Practice Nurses and HCSW	£122,442
Care and Repair - Healthy Homes	£43,598
Ty Ellis - Counselling	£50,700
CRP testing	£18,238

The following are not allocated directly to Clusters but do have impact and benefit for the population:

- Transformational allocation to Cwm Taff (Bridgend) for the Enhanced Cluster team is year 1 £2.92m
- Year 2 £4.920m recurrent funding

Cluster development managers work in partnership with Health Board finance colleagues to ensure that any spend is aligned to this plan but also within the UHB's overall financial planning and Standing Financial Instructions. The cluster will continue to be supported by the

Finance department as the plan is progressed as their support is fundamental to ensure that the cluster continue to work within allocated resources. Delivery agreements are developed and are aligned to the primary care funding allocation and are reported to Welsh Government on an annual basis.

7. Gaps to address and cluster priorities for 2020-2023 – key work streams and enablers

Prevention

- To understand and highlight actions to meet the needs of the population served by the Cluster with a preventative approach
- To support the development and implementation of a cluster based CVD Primary Prevention Programme
- To set out the priority population level needs of the Cluster to inform programme development
- Address population behaviours/lifestyle choices such as smoking/substance misuse/obesity/lack of exercise/poor diet
- Explore resources available in 3rd sector to help co-ordinate activities to address population lifestyle choices/risky behaviours
- Involve partners such as Barnardos and Early Help team more pro-actively for the management of psychological and emotional problems in children

Sustainability

- To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements
- Practices across the cluster to continue to complete the Practice Escalation tool
- Generate new funding by mainstreaming existing cluster services, Health Board to decentralise services from secondary care to closer to home to improve access and reduce pressure of Inverse Care Law

Our three year focus:

- Ensure practices can access transformation team MDT
- Improve access to MDT for Care Home patients
- Development of a GP lead service for frailty patients
- Ensure all practices are offered access to a Cluster package of support for sustainability issues

Primary / Secondary care interface

- Planned care-to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface

Our three year focus:

- Engage effectively and make improvements between the primary and secondary care interface
- Aim to reduce wastage of medicines and achieve better health outcomes through prudent prescribing
- Ensure patients have access to newly designed enhanced services, namely care homes and oral anticoagulation with warfarin

Urgent care needs

- To provide high quality consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management. To address winter preparedness and emergency planning

Our three year focus:

- Utilising the time of multidisciplinary professionals and educating patients in how to manage selfcare and identifying the most appropriate place to receive treatment

Communication and engagement

The cluster, through the support of the cluster development manager will work with PHW colleagues to extract further cluster level quantitative data using the Primary Care Needs Assessment Tool. This will allow publicity, engagement, health & wellbeing campaigns to be targeted accordingly.

Continue to engage with 3rd sector organisations to deliver more robust and sustainable community developments e.g. funding and collaborative working for initiatives with established organisations to allow the organisations to deliver on behalf of the Cluster. BAVO to update patients on 3rd sector services via possible roll out of mysurgeryapp. Explore the use of Consultant connect for 3rd Sector referrals.

The Community Health Council will continue work with the Cluster, practices and CTM HB to engage with the population over any service changes.

Promote the use of digital technology to provide information on services, support patient choices and support sustainability and access through:

- e-consult
- ongoing use of patient information hub- QR pods
- accuRx
- mysurgeryapp
- consultant connect

8. Planned Cluster Actions and intended measurable outputs and outcomes 2020-2023

Quality Assurance and Improvement Framework (QAIF) 2019/20

With the introduction of the new Quality Assurance and Improvement Framework (QAIF) and the introduction of a "basket" of Quality Improvement Projects which are to be delivered at cluster level, the cluster will engage in the mandatory Patient Safety projects and will decide which one of the quality improvement projects (listed below) will be selected following feedback from discussions at practice level.

Introduction of a "basket" of Quality Improvement Projects to be delivered at a cluster level with a focus on Patient Safety through a mandatory project in Years 1 and 2. The basket of projects available for 2019-20 will be:

a. Reducing medicines related harm through a multi-faceted intervention in primary care clusters (patient safety).
b. Reducing stroke risk through improved management of Atrial Fibrillation in primary care clusters.
c. Ceilings of care / Advanced Care planning.
d. Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20

In practice, clusters will be required to agree and implement 2 QI projects in 2019-20

- Patient Safety – mandatory
- Quality Improvement – choice from b, c, d set out above

Contract changes for community pharmacies

Welsh Government considers the community pharmacy sector to be a fundamental part of a strong primary care service.

It commits to investing in community pharmacies to take pressure off GP services, reducing unnecessary appointments and making sure people are able to see the right professional in the right setting at the right time

To encourage community pharmacy in Wales to engage with primary care cluster and develop and improve collaborative working relationships with GPs and other healthcare professionals

Within the cluster there is representation at each of the cluster meetings from community pharmacy. The cluster will continue to build on these relationships and improve collaborative working in order to improve population health and meet the clusters priorities.

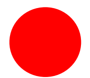
Planned Cluster Objectives and Milestones 2020- 2023

The cluster action plan is structured to under the following areas:

a. Prevention, well-being and self care
b. Timely, equitable access, and service sustainability
c. Rebalancing care closer to home
d. Implementing the Primary Care Model for Wales
e. Digital, data, and technology developments
f. Workforce development including skill mix, capacity, capability, training needs, and leadership
g. Estates developments
h. Communications, engagement and coproduction
i. Improving quality, value, and patient safety

The plan is by its very nature fluid /flexible and evolving over the next 3 years the plan itself will be reviewed and updated in response to changes in cluster planning.

The RAG rating score indicates progress against planned action:

 **Red- future work**

Amber- work in progress

Green- work completed

A) Prevention, well-being and self care						
	Cluster Objective	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1	Support the development and implementation of a cluster based CVD Primary Prevention Programme Increased primary detection of those at moderate and severe risk of developing CVD, triggering referral to appropriate local networks, contributing to the reduction of CVD inequalities in Bridgend North	Checks completed in 4 practices				
2	To ensure a consistent approach to the implementation of the public health agenda to support achievement of the NHS Tier 1 smoking cessation target	• Ensure all patients have an updated smoking status on practice records • Promote Stop Smoking Wales, Community Pharmacy Level 3 Service using available promotional material. • Promote stop smoking campaigns within practice • Consider opportunities for partnership work with Stop Smoking Wales and Community Pharmacies.				

3	Improve access to weight management interventions for overweight and obese patients within the cluster	Previously the cluster developed a cluster lifestyle coach, based with HALO leisure services, to deliver a weight management programme, based on NICE guidance (a 12 week food wise and exercise course) delivering in the community, taking referrals via, but not exclusively, from the CVD Health Checks Project. 256 patients were have been referred by the CVD project. Evaluation carried out by Swansea University.			The programme funding has now ceased, cluster will need to consider future funding.	
4	Continue to increase flu immunisation uptake within the cluster	• Ensure practice flu plans are completed and submitted to Health Board • Peer review IVOR flu vaccination uptake data on cluster basis • deliver fluenz parties in practices that feel this will increase uptake • Due to COVID restrictions some practice have hired outside venues				

5	Promote the use of Health and Wellbeing campaigns such Choose Well to increase awareness of the importance of prevention approaches	Practices continue to promote prevention and self care to patients				
6	Improved communication and integration with the third sector Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of: • Social Prescribing • Local Community Coordination • Community Navigators	Practices continue to signpost to voluntary services that support self care and independence. Practices continue to refer to Local Are Co-ordinators and Community Navigators for patients with high and level support needs. During COVID Community Navigator roles have been diversified to support the needs of the community, assisting with shopping, picking up medication and befriending for shielding and vulnerable patients.	BAVO to update patients on 3rd sector services via roll out of mysurgery app. Explore the use of Consultant connect for 3rd Sector referrals to Community Navigators.			

B) Timely, equitable access, and service sustainability						
	Cluster Objective	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1	Extend the range of professionals and maximise the skill mix within the cluster through the development of the cluster pharmacist role	Cluster has successfully recruited an additional cluster pharmacist				
2	Increase wellbeing, resilience and early intervention to frail elderly individuals through the Care and Repair - Healthy Homes scheme	Cluster continues to fund the health homes scheme. Which provide case worker and OT assessment for patients in their own home. The scheme continues to provide adaptions to patient homes and applies for grant funding for eligible patients. Advice on claiming of state benefits also provided via the case worker / OT. During COVID restrictions Care and Repair have provided help advice via telephone.				
3	Consider opportunities for network based service provision	Referral process continues within the cluster for LARC. Consideration of other Enhanced Services that could be delivered at a cluster level has been delayed due COVID.				

4	Development of a cluster Physiotherapy Service Diversion of patients with MSK related conditions to the right professional at the right time		The cluster will consider a first contact physio therapy service in conjunction with the health board physiotherapy department.			
5	Provide proactive, timely care to those who are most vulnerable and complex to manage	Cluster is able to refer to MDT(transformation project) which Physiotherapy, OT and SALT Transformation project				
6	Improve equity of service for Chronic Condition / Frailty patients	Cluster advertised for 2 x Band 7 Advance nurse practitioners, however no suitable candidates applied. The cluster is now drafting Job Descriptions for Band 6 frailty nurses to work across care homes. The cluster has agree to provide funding for GP sessions on a pilot basis to support the frailty patients across the cluster up until March 2021 initially.	The cluster successfully appointed 2 x Band 6 Primary care nurses who are now in post providing care for patients in their own homes / care homes across the cluster. The cluster has also successfully recruited 2 x Band 3 HCSWs			
7	Update and maintain a cluster risk resister	Cluster continues to update risk register as and when required	Cluster continues to update risk register as and when required			

C) Rebalancing care closer to home

	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
1	Development of a community based ultrasound-equipped musculoskeletal service that will enhance and relieve pressures on secondary care services. Plan developed to take forward MSK services for the North Cluster population	Negotiation delayed due to COVID			Reduced access to hospital based physiotherapy services during COVID restrictions	
2	Improve access to mental health and wellbeing services	Cluster continues to fund Counselling Service via Ty Elis. Patient pathway agreed, triaged via Health Board ARC service. Due to COVID restrictions Ty Elis have provided counselling via telephone / video consultation in addition to face to face counselling.	To evaluate counselling service. Develop closer links with health board mental health services; especially services for those with drug and alcohol addiction along with a Mental Health illness Explore links with CAMHS to understand current care pathways and structures to help aid the recognition and treatment of mental illness in young people.			

3	Extend the pathway of care for dementia support within primary care	The roll out of dementia friends awareness training across the cluster. Referrals ongoing to the British Legion Admiral Nurses.				
4	Drive changes in patient expectation / prescribing culture Minimise potential risks of increasing antibiotic resistance and C.difficile infection. Continue to improve antimicrobial stewardship	The cluster employs 2 cluster pharmacists who work with practices and provide medication reviews for patients. The cluster has chosen Atrial Fibrillation prescribing as part of QAIF 2020/21		Comprehensive, regular and consistent analysis of practices progress (including feedback to practices). The cluster to consider setting up multidisciplinary prescribing reviews. Support the North Network pharmacists to develop and undertake a programme approach to improve antimicrobial stewardship through: Consider providing education and awareness sessions with		

				GPs and other relevant practice staff. The cluster to consider developing a network of GP antimicrobial prescribing champions. The cluster to consider developing a pilot a cluster wide campaign to raise awareness of the dangers of inappropriate antibiotic use and associated antibiotic resistance.		
6	Early identification and proactive management of respiratory patients	Improved management of potential respiratory disorders Early diagnosis of COPD, access to education and pulmonary rehab. Improve reporting and interpretation of spirometry results . Training delayed due to COVID.	Ongoing			

D) Digital, data, and technology developments						
	Cluster Objective	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1	Implement e-consult via Health Board funding.	All cluster practices have implemented e-consult to triage patients.	Ongoing			
2	Improve remote working across the cluster.	Cluster have funded new laptops, ipads and additional monitors screens to enable video calling with patients and remote working outside of the surgery. One surgery in cluster trailing out using iPads to enable communication between GP practices and District Nursing Service				
3	ECG tests in the community	The cluster funded mobile ECG devices for all practices during 2020. The device allows clinicians to provide an ECG to patients in their own home or within care homes. The devices continue to be used across the cluster and enable an ECG to be carried in the community instead of the GP surgery.	Ongoing			

4	Uptake of consultant connect by practices	Increased use of Consultant Connect across cluster Enabling acccess to immediate advice from specialised consultants	Ongoing			
5	Funding of mysurgery app for practices	Cluster have funded the app and is being rolled out across practices. The app links with e-consult and my health online, practices are able to triage patients. The app allows patients to order repeat prescriptions, submit admin requests for doctors letters, fit notes etc without having to call the surgery. Future developments include online medication review and further forms. It also provides self-care advice and signposting to third sector services. Provides access to digital training resources allowing patients to become more digitally enabled.	Rolled out across the cluster			

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

No	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
1	To enrol all cluster practices though training and accreditation on to the ARTP (association for respiratory technology) register to demonstrate competency in performing and/or interpreting spirometry.	Every cluster practice will have at least one Doctor/nurse fully competent in performing and / or interpreting spirometry. Delayed due to COVID.				

F) Estates developments

No	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
1	Premises improvement to enable capacity to deliver new pathways and increase capacity.	Ongoing liaison with Primary Care Estates Manager to provide improvements as prioritised.	Ongoing			

G) Communications, engagement and coproduction

No	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
2	Continue collaboration with the third sector	The cluster has an SLA in place with Ty Elis Counselling Service and Care and Repair Healthy Homes scheme. Evaluation of both services is underway. Third sector representatives attend cluster meetings.	Ongoing			

H) Improving quality, value, and patient safety

No	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
1	Reduction in prescribing of antibiotics unnecessarily	Continue the use of C-reactive protein (CRP) tests before prescribing antibiotics for suspected respiratory infections, to help determine if treatment with antibiotics is required	Ongoing			
2	Engage with a robust validated clinical governance process	To complete the Clinical Governance Practice Self Assessment Tool and achieve at least level 2 in the areas of safeguarding (CND 016W) Participate in peer review/ clinical governance lead meetings. Meetings paused due to COVID.	Ongoing		Due to COVID clinical governance meetings have paused. However weekly GP cluster leads / ILG meetings take place.	

9. Strategic alignment and interdependencies with the health board IMTP, RPB Area Plan and Transformation Plan/Bids; and the National Strategic Programme for Primary Care.

Ensure joined up working across all programmes and strategic documents to maximise the benefits and outcomes
Assumptions, dependencies, constraints

The Cluster plans for the next three years will align with the principles of the Primary Care Model for Wales and Welsh Governments plans for 'A Healthier Wales' to focus on:

- Service developments based on demand; planning and transformation is led
- coordinated local care teams.
- The promotion of healthy living by making well-being less of a medicalised term
- Service planning and delivery across local communities

The plan will also be developed, reviewed and monitored alongside the Cwm Taf Morgannwg Primary and Community IMTP and transformation plan.

10. Health Board actions and those of other cluster partners to support cluster working and maturity.

- Primary care cluster development manager employed to support Bridgend North Cluster
- Terms of Reference in place and reviewed and updated when necessary
- Standing Financial Instructions – regular meetings with finance colleagues
- Workforce and planning support
- Cluster reports to Primary Care Committee to provide assurances through to Executive Director and Board level
- Ensure Third Sector organisations are active members of the cluster and support the health & wellbeing agenda and community development.

Bridgend North Cluster Population Profile FINAL DRAFT

This summary provides an overview of headline data for the population served by the Bridgend North Cluster. This consists of patients registered with:

Bridgend North Practices: New Street Surgery, Tyn Y Coed Surgery, Ogmore Vale Surgery, Nantymoel Surgery, Woodlands Surgery, Llynfi Surgery, Bron Y Garn Surgery, Cwm Garw Surgery

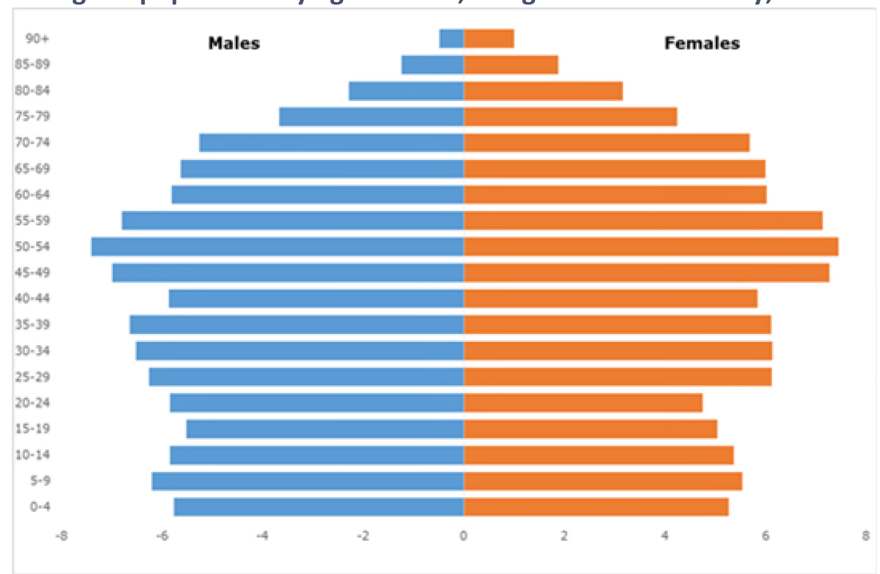
This cluster profile uses two main sources of population data: (i) data captured by registered practice; (ii) data that is captured by area of residence which is not easily attributed to Primary Care Cluster. Note: Some data is only available at local authority level and some data is not yet available as new Cwm Taf Morgannwg footprint.

Demography

Population

- **Resident population (2018 estimates):** Cwm Taf Morgannwg University Health Board: 445,190, Bridgend: 144,876 (Source: ONS)
- **Practice population (2019)**: Bridgend North: 51,964 (Source: shared services)

Percentage of population by age and sex, Bridgend local authority, 2018



Population projections up to 2039 will be reviewed by the Public Health Wales Observatory later this year and forwarded when available.

Life expectancy / Healthy life expectancy

Life expectancy at birth for males and females (2015-2017)

	Bridgend North (USOA)	Bridgend (USOA)	All Wales
Males	**76.4 years**	77.9 years	78.3 years
Females	**79.3 years**	81.2 years	82.3years

Source: Public Health Wales Observatory using ONS data (PHOF Tool, 2019)

- **Healthy life expectancy** (the number of years a person can expect to live in good health) is only available at a local authority level. For Bridgend it is 60.9 years for males and 61.3 years for females. For Wales, HLE is 61.4 years for men and 62 years for women.

- The differences in healthy life expectancy that exist across an area between the most and least deprived areas is referred to as the 'inequality gap'.
- The inequality gap for healthy life expectancy in Bridgend: 6.1 years (males) and 5.6 years (females) (Source: Public Health Wales Observatory PHOF Tool (2017) using ONS and WG data)

Social deprivation

Welsh Index of Multiple Deprivation

Estimated percentage of patients living in the most deprived 40% of areas in Wales (2015)	
Cwm Taf Morgannwg	Bridgend North (practice)
57.1%	65.8%
Source: Produced by Public Health Wales Observatory using WDS (NWIS) and WIMD 2004 (WG) data (GP Practice Population Profile, 2015)	

The link between deprivation and poor health is well recognised. There is a higher concentration of the most deprived areas in Wales in the Bridgend North cluster compared to Cwm Taf Morgannwg as a whole.

NB: The Welsh Index of Multiple Deprivation(WIMD) is the Welsh Governments official measure of deprivation for small areas designed to identify those small areas with the highest concentrations of several types of deprivation based on a range of domains including income and employment

Children, families and households

- **Children living in poverty -** In Bridgend: 25% children (aged 0-18) live in poverty compared to the Welsh average of 24% (Source: Public Health Wales Observatory PHOF Tool (2019) using WG and ONS data)
- **Low birth weight babies** (born less than 2500g in 2016): Bridgend North (6%); Bridgend (5.2%). Birth weight is an important determinant of future health. Low birth weight babies are at risk of problems with; growth, cognitive development and the onset of chronic conditions later in life. (Source: Public Health Wales Observatory PHOF Tool (2019) using WCCHD (NWIS) data)
- **Teenage pregnancy-** Bridgend has the 5th highest rate of teenage pregnancy in Wales amongst all local authority areas
- **Unemployment rates** for Bridgend (March 2019) indicated that 4.5% of economically active people were unemployed; Wales: 4.6%
  In Bridgend, 20.4% of households, (where at least one person aged 16-64 years were living) were classified as a workless household; Wales: (17.5%) (Source: ONS)
- **Carers –** 12.6% of the population in Bridgend self-reported that they are a carer for a family member or friend, slightly higher than the Wales average of 12%. The 2011 census reported that there are 17,552 carers in Bridgend with 31.3% of carers providing over 50 hours of care a week.

Chronic disease

Chronic conditions

Estimated % prevalence of chronic conditions (2018)			
	Bridgend North	Cwm Taf	Wales
CHD	4.3%	3.7%	3.7%
Heart Failure	1.3%	0.9%	1.0%
Stroke +TIA	2.5%	2.0%	2.1%
Diabetes	7.1%	6.4%	6.0%
COPD	3.1%	2.8%	2.3%
Asthma	8.0%	7.1%	7.1%
Dementia	0.6%	0.5%	0.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018			
Musculoskeletal disorder	16% in Bridgend (self-reported)		17%
Source: NSW 2017-19			

The Bridgend North cluster has a higher estimated prevalence of all chronic conditions than the Welsh average apart from dementia. The estimated prevalence of diabetes being the joint highest of all the Health Board cluster areas.

Prevalence data is estimated from Audit + and as such, only captures conditions which have been diagnosed and coded. This may therefore be an underestimate of 'true' prevalence.

In addition, to the traditional aggregate data focussed on specific diseases**, population segmentation and risk stratification** looks at the same population through a different lens, using patient-level data built up into needs-based segments (data-driven, utilisation-based needs assessment). This method currently being piloted in the Rhondda cluster, emphasises the importance of considering needs in relation to multiple morbidity, with care organised using a more patient centred approach.

The degree of multi-morbidity was found to be a greater driver of cost and care utilisation than age in the population

It is anticipated that data for the Bridgend clusters will have undergone initial analysis and be available by early 2020.

Mental Health

10% of adults in Bridgend report as having a mental health disorder. Wales average 9%
(Source NSW 2017-19)

Mental wellbeing is an important factor in individual's overall health.

11.8% of adults in Bridgend report feeling lonely, the lowest of all Local Authority areas. Wales average: 16.7% (PHOF 2019) 27.1 % of adults in Bridgend do not report a high level of general happiness compared to the Welsh average of 25.3%. (Source ONS 2018)

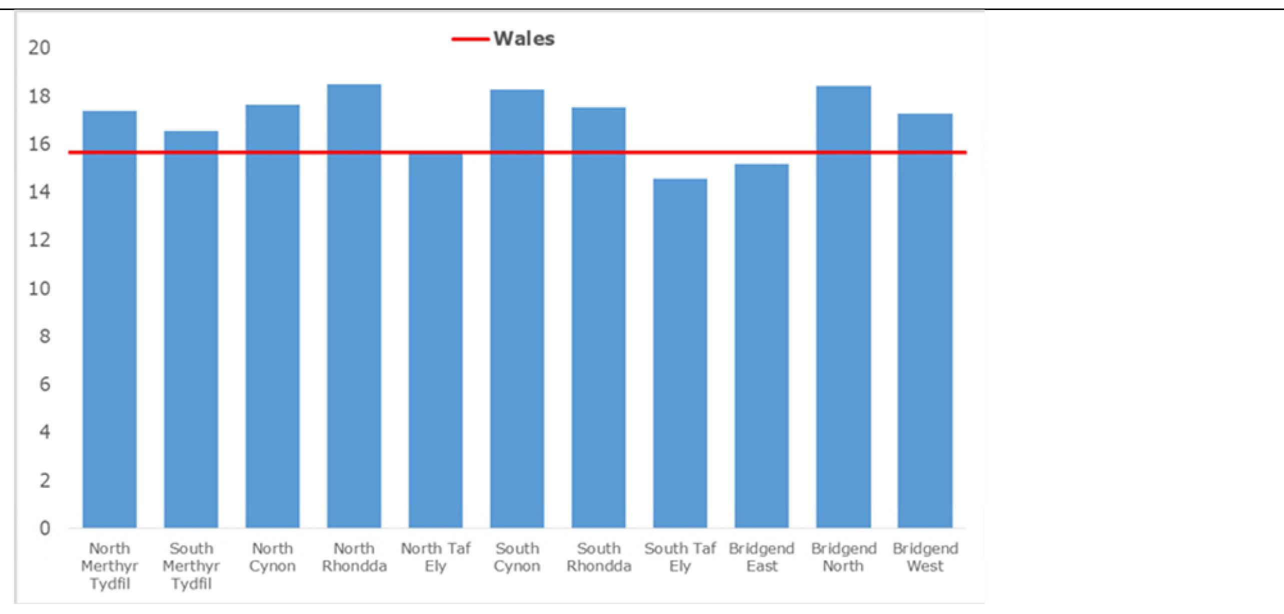
Risk Factors

Clinical Risk Factors

Estimated % prevalence of risk factors within population(2017/18)

	Bridgend North	Cwm Taf (Previous footprint)	Wales
Hypertension	18.4%	16.8%	15.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018			
Atrial Fibrillation	2.4%		2.2%
Source: QOF data 2018			
High Cholesterol	Not currently available		
Raised blood glucose	Not currently available		

Bridgend North has a higher estimated prevalence of hypertension and atrial fibrillation than the Welsh average.



Prevalence data is estimated from Audit + and as such, only captures conditions which have been diagnosed and coded. This may therefore be an underestimate of 'true' prevalence.

Achieving optimum management is key in tackling clinical risk factors. A previous review of QOF data for 2016/17 found that almost 1 in 5 patients on registers in the old Cwm Taf UHB area did not achieve the level of 150/90mmHg or less as a desired blood pressure reading.
Data regarding the management of Atrial fibrillation at a cluster and with consent, practice basis is available via the Primary Care Portal -Stop a Stroke tool.

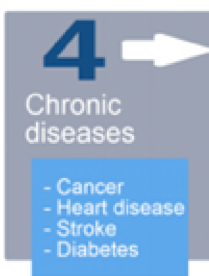
Adult Lifestyle behaviours

Percentage of adults that report the following behaviours- National Survey for Wales (2016-18)

	Smoke (%)	Eating 5 portions of fruit and veg a day (%)	Meet physical activity guidelines (%)	Drinking above guidelines for weekly alcohol consumption levels (%)	Working age adults of Healthy Weight (%)
Bridgend North (USOA)	22.9%	21.0%	49.3%	17.6%	35.7%
Cwm Taf Morgannwg	21.1%	22.3%	51.2%	18.3%	37.4%
Wales	19.2%	23.4%	52.8%	18.9%	39.1%

Source: Produced by Public Health Observatory (2019)

- Smoking prevalence is higher in North Bridgend than the Health Board and Welsh average.
- Other health related lifestyle behaviours are generally poorer than the Welsh average. The long term health and social implications of engaging in harmful behaviours are wide ranging.
- Chronic disease is often preventable. Previous work in Cwm Taf for the Cwm Taf Wellbeing assessment in 2017 indicated the following: -



64%

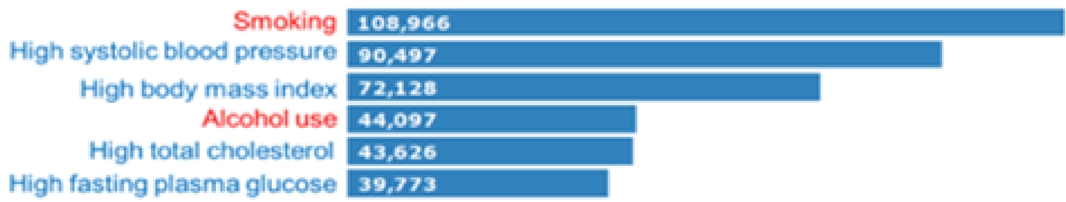
Early deaths Age under 75

The Global Burden of Disease Study is a comprehensive research study of disease burden that assesses mortality and disability from major diseases, injuries, and risk factors. Welsh data from the 2016 study was used to estimate the burden associated with disability-adjusted life years (**DALYs**) These are a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

Almost half of all years lost are attributable to 3 conditions: cancers, cardiovascular disease and musculoskeletal disorders with mental and substance misuse disorders in 4th place.

A large proportion of these health conditions are caused by adjustable risk factors

Highest number of DALYs lost by risk factor, Wales 2016 Source PHWO using Global Health Data Exchange (IHME)



Cancers and Screening

Cancer incidence and prevalence

- The most common cancers for men in Bridgend (2014 -2016) were; prostate, lung and colorectal. For women: breast, lung and colorectal. (Source: WCISU, 2019)

Screening

Uptake of screening % (2017/18)				
	National targets	**Bridgend North (practice)**	**Cwm Taf**	**Wales**
Bowel	60%	55.5%	64.8	55.7
Breast	70%	74.4%	73.6	72.8
Cervical	80%	75.8%	76.4	76.1

Source: Primary Care Needs Assessment tool, 2019

Screening uptake does not meet national targets for the bowel and cervical programmes.
Bowel screening has the lowest uptake rate of the national screening programmes across CTMUHB. Also the largest inequalities are found in bowel screening uptake.
In line with Wales as a whole, there has been a decline in young women attending their first cervical smear across Cwm Taf Morgannwg.

Prevention of infectious diseases

Flu vaccination uptake

% Uptake (2017/18)				
	National targets	**Bridgend North(practice)**	**Cwm Taf (old footprint)**	**Wales**
At risk aged 6 months to 64 years	**55%**	43.1%	46.8%	48.5%
2 and 3 year olds	No specific Targets yet	49.3%	53.0%	50.2%
65+ years	75%	67.3%	67.7%	68.6%
Source: Primary Care Needs Assessment tool, 2019 using IVOR data				

Flu vaccination uptake is below the Wales average for all groups.
Data for 2018/19 at a Health Board and LA level is available at http://nww.immunisation.wales.nhs.uk/ct-ivor
Also given is the breakdown for different at risk groups.

Childhood Vaccination Uptake

% uptake (2018/19)				
	Targets	**Bridgend North(practice)**	**Cwm Taf (old footprint)**	**Wales**
Uptake of 6 in 1 at 1 year old	95%	96.1%	97.6	95.4
Up to date by age 4	95%	86.8%	88.3	87.2
MMR2 at age 5	95%	92.9%	93.8	92.2
MMR2 at age 16	95%	90%		
Source: COVER data accessed via http://nww.immunisation.wales.nhs.uk/cover				

Childhood vaccination uptake in Bridgend North has not yet met any of the 95% targets set for the profiled immunisation programmes to achieve ‘herd immunity’, except for immunisation uptake of 6 in 1 vaccination in children aged 1 year.

Cluster Summary

The Bridgend North cluster has a higher level of deprivation and poverty than the Welsh average.

Data indicates a poor profile of behavioural and clinical risk. Using the evidence related to the disease burden associated with that risk would indicate a focus on smoking, obesity, alcohol misuse and detection and optimum management of hypertension. In addition, the prevalence of atrial fibrillation is higher than the Welsh average optimising management of this risk could help reduce the above average prevalence of stroke within the North Bridgend cluster.

The North Bridgend cluster has generally a higher estimated prevalence of all chronic conditions than the Welsh average. The estimated prevalence of diabetes being the joint highest of all the Health Board cluster areas. A key issue is the level of multi-morbidity which generates the need to review how services are delivered and develop more patient centred approaches. Support for mental health also needs to be a key component of care for this cohort.

Screening is vital in the earlier detection of cancer. Improving the levels of bowel screening uptake is of particular concern within the CTMUHB area.

Next Steps

The overview provides headline data as a starting point to determine areas that require closer scrutiny and consideration within the planning process

Once key areas for potential action have been agreed the Local Public Health Team can offer further guidance to: -

A) Build up the picture using other sources of data where available

B) Explore stakeholder/community views in regard to the priority areas

C) Look at clinical guidance, evidence base and best practice examples

D) Look at current practice/local assets

E) Determine outcomes and baseline data and formulate action plan

Links

The primary care needs assessment tool which has links to the clinical guidance and evidence base related to many of the topics within this summary can be accessed via http://www.primarycareone.wales.nhs.uk/pcna

The Global Burden of Disease Study is a comprehensive research study of disease burden that assesses mortality and disability from major diseases, injuries, and risk factors. http://www.healthdata.org/gbd

Public Health Outcomes Framework (PHOF) for Wales.
http://www.publichealthwalesobservatory.wales.nhs.uk/phof

For further information, please contact Cwm Taf Morgannwg Local Public Health Team

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