Developing the 2020-2023 Primary Care Cluster IMTPs
Primary Care IMTP Cluster Planning Template
WEST CLUSTER – Final Draft

1. Executive Summary and 'plan on a page'

Provided by Cluster GP Lead, Dr. Romilly Rees:

Bridgend West Network Cluster serves a population of approximately 35,000 people and is based around 3 GP practices. The cluster has a long and successful history of working together harmoniously and collaboratively to provide innovative services to the population it serves. It has achieved this consistently through building and maintaining excellent professional relationships built on shared goals and trust. This has enabled the effective use of resources focussed on delivery of care. The minimising of unnecessary bureaucracy, without compromising governance or strategic insight, has not only contributed to effective financial management, but has also had a significant impact on workforce morale and engagement.

Our aim has been to 'do' and not just 'talk'. In the earliest days of cluster working, in 2012 we successfully made the case for, and employed, a cluster chronic disease nurse to provide care for our housebound patients with diabetes and COPD. We have built on this foundation, gaining the trust and support of our own practice colleagues and of the wider cluster members detailed in this document.

Key to our success has been having a central degree of consistency at the heart of the cluster. We have benefitted from having a consistent small team of 3 GPs with their practice managers representing the practices and we have been very fortunate in the persons assigned by the Health Board to give administrative support. This collegiate and positive administration of the cluster initiatives has been a great asset, not only in our achievements, but also in building and sustaining relationships between the Health Board and the cluster.

The Cluster has worked enthusiastically with generosity of spirit to deliver projects of real benefit to our patients in times of challenge in primary care. Our key achievements are listed in section (3) of this report. We are particularly proud of our achievements in cluster pharmacy advice and provision, which has delivered more benefits than we could ever have imagined at the outset. We continue to expand our cluster pharmacy model and are now working increasingly closely with our community pharmacy colleagues also.

We are committed to ongoing quality assurance and improved service development including new and innovative models of care. Working together and overcoming barriers of ignorance and communication remain key.

We embrace the prospect of the delivery of the business cases for IMPT inclusion for the key service delivery schemes to support primary care. However, continuing flexibility to allow clusters the scope of submitting business cases that address their particular context rather than a 'one size fits all' approach is essential to encourage innovation and progression in the delivery of appropriate services for the particular population needs of each cluster.

The West Cluster vision is to 'understand the local health needs and priorities of their population and to work with local communities and networks to reduce health inequalities of its patients and citizens. It will also work together to improve the co-ordination of care and integration of health and social care'.

The Cluster's intention is to work together in order to:

- Prevent ill health enabling people to keep themselves well and independent for as long as possible.
- Develop the range and quality of services that are provided within the community.
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.
- Improve communication and information sharing between different health, social care and voluntary sector professionals.
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

For the next three years the Cluster will continue to*:*

- Set out the priority population level needs to the Cluster to inform programme development
- Increase wellbeing and resilience of the patient population through prevention and self-care education including social prescribing and the wider social model of care.
- Ensure a consistent approach to the implementation of the Public Health Agenda to support achievement of the NHS Tier 1 smoking cessation targets.
- Reduce obesity in the Cluster through patient education and the promotion of wellbeing and prevention messages.
- Actively promote the importance of screening programmes to improve early diagnosis and timely treatment for patients
- Promote practice websites and associated resources to all patients.
- Publicise the Community Pharmacy Common Ailments Scheme
- Increasingly enhance engagement of local Community Pharmacists to aid prudent prescribing and dispensing
- Support the Pharmacist Independent Prescribing project between the Health Board and Cardiff University.
- Promotion of digital technology such as My Health Online.
- Deliver a chronic disease management service to include:
    - patient education to increase resilience and focus on prevention to support with the proactive management of patients with chronic disease
    - Review and management of patients with chronic conditions.
- Deliver a cluster based substance misuse enhanced service
- Proactively identify and signpost people living with dementia
- Increase integration with the third sector to provide a key focus on wellbeing and prevention through engagement and active promotion of:
    - Info-engine
    - Dewis

- Social Prescribing

- Further extend the range of professionals and maximise the skill mix within the Cluster through the development of the Cluster multi-disciplinary roles.
- Increase collaboration between GP practices and other primary care providers, social services, Community Resource Team and other Cluster partners.
- Increase wellbeing, resilience and early intervention to frail elderly individuals through referral to Care & Repair.
- Increase resilience in care homes, improve liaison with appropriate services to meet the needs of residents.
- Diversification of the workforce to ensure patients are able to see the most appropriate professional in a timely manner with GPs focusing on the most vulnerable.
- Sustained use of telephone advice lines.
- Reduce wastage of medicines and achieve better health outcomes through prudent prescribing linked to the work programme of the Cluster pharmacists.
- Delivery of Diabetes Gateway and NOACS.
- Delivery of flu vaccinations to housebound patients.
- Support delivery of the three business cases for IMTP inclusion based on key service delivery schemes which support primary care:
  - Cluster physiotherapist
  - Cluster Pharmacists
  - Cluster Tier 0 Mental Health and Wellbeing Support.
- Premises improvement to enable capacity to deliver new pathways and increase capacity using a whole systems approach including transferring resources into the community focussing on health and wellbeing.
- Rollout of the Frailty Project to the remaining two GP Practices within the Cluster. The aim of this project is to tackle holistic reviews of the cluster frail elderly who might otherwise require a GP visit. The first phase of the project, which was piloted by Porthcawl Group Practice, has ended and an evaluation has been undertaken and shared with Cluster members.

The plan also embraces key UHB priorities for the next three years, specifically focused on:

- Strengthening the sustainability of core services, referring to sustainability assessment frameworks completed by each practice
- Strengthening the focus on access to services, winter preparedness and emergency planning and improved service development
- Strengthening quality assurance as set out in the new GMS Contract 2019-20 published in June of this year. The new Quality Assurance & Improvement Framework (QAIF) rewards Contractors for the provision of quality care and helps to embed quality improvement in to general practice. The QAIF consists of three domians: Quality Assurance, Quality Improvement and Access.
- Developing more effective collaboration working with community services, including nursing, local authority and third sector to improve quality of care
- Encourage the development of new models of care, including consideration of federations, practice mergers and shared practice support.

Cluster IMTP 2020 – 2023

Executive Summary

- Cluster has a long and successful history of working together harmoniously and collaboratively to provide innovate services to the population it serves.
- Effective use of resources focussed on delivery of care
- The Cluster aim is 'to do' and not just 'talk'.
- The Cluster has worked enthusiastically with generosity of spirit to deliver projects of real benefit to our patients in times of challenge in primary care
- Committed to ongoing quality assurance and improved service development including new and innovative models of care.

Key achievements from 2017-2020

- Healthy Homes Project
- Established roles and responsbilities of the Cluster Pharmacists
- Chronic Disease Nurse
- Frailty Review Project
- Patient Education

Overview / Vision of the Cluster 2020 – 2023

Bridgend West Cluster is made up of three GP Practices, covering the geographical area of Porthcawl, Pyle, Kenfig Hill and Cornelly with a Cluster population of 34,694. The Cluster also includes four nursing homes, six residential homes, nine community pharmacies and four dental practices. All working together with partners from social services, the voluntary sector and the Health Board.
The West Cluster vision is to 'understand the local health needs and priorities of their population and to work with local communities and networks to reduce health inequalities of its patients and citizens. It will also work together to improve the co-ordination of care and integration of health and social care'

Cluster Population Area Health and Wellbeing Needs Assessment

- Higher estimated prevalence of all chronic conditions
- Higher estimated prevalence of hypertension
- Adult lifestyle behaviour is comparable or poorer than the CTM average
- Cervical screening not meeting the national target level
- Lowest Flu vaccination uptake for at risk groups and 2-3 year olds

Gaps to Address and Cluster Priorities (Key Work Streams and Enablers)

- Continuing development of multi-disciplinary working and ongoing diversification of workforce
- Continued Cluster Pharmacy investment
- Development of a Chronic Conditions Team
- Public Health Cluster Wellbeing Needs Assessment/Population Profile
- Estates/premises improvements
- Roll-out of Frailty Project
- Outcome of Gastroenterology Project

Planned Cluster Actions

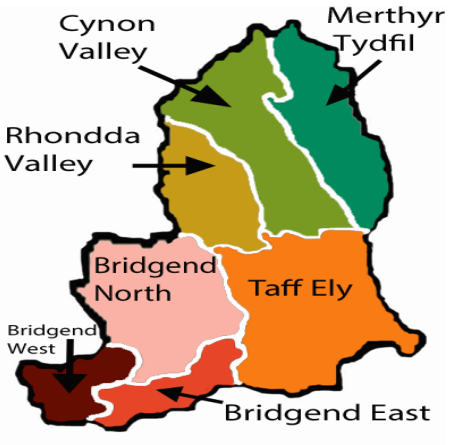
- To understand and highlight actions to meet the needs of the population served by the Cluster with an enhanced preventative approach
- To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements
- 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, co-ordination of care and the effectiveness of risk management.
- Increase collaboration between GP Practices and other primary care providers, social services, community resource team, third sector and other cluster partners.
- Support the delivery of key service schemes which support Primary care: Cluster Pharmacists, Cluster Physiotherapists, Cluster Tier 0 mental health and wellbeing support
- Premises improvement to enable capacity to deliver new pathways and increase capacity using a whole systems approach including transferring resources into the community focussing on health and wellbeing

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, Dental & Optometry Advisors, Community Pharmacy are all active members of the cluster and support the health & wellbeing agenda and community development.

2. Introduction to the 2020-2023 Plan/Cluster



The West Cluster is one of 8 Clusters within the Cwm Taff Morgannwg University Health Board footprint and is made up of the following 3 GP practices:

- Porthcawl Group Practice who are a training practice
- North Cornelly Surgery who have a branch surgery in Kenfig Hill
- Heathbridge Surgery, Kenfig Hill

Our members include representatives from District Nursing, Health Visiting, Dietetics, Bridgend Association of Voluntary Organisations (BAVO), Integrated Network Team for Adult Social Care, Medicines Management, Public Health, Secondary Care and Community Pharmacy. A representative from the LMC also regularly attends. The Cluster meets 6 times a year with meeting dates set for 2019/2020.

The development of this plan has been done in collaboration with partners including Public Health Wales, Health Board teams such community and district nursing, medicine management, third sector organisations and social care colleagues.

Information has been collated on a wide range of health needs within the West Cluster area in order to develop the priorities for the 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.

Through the delivery of the plan the West Cluster aims to align governance objectives with the new strategy for Health and Social Care in Wales and Deliver the Quadruple Aim, aligned with the principles of the Wellbeing of Future Generations (Wales) Act, Prudent Healthcare and the Social Services and Well-being Act to:

- Improve 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.

In respect of Governance arrangements, 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, reporting and monitoring arrangements.

These processes provide 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.

Overview of the Cluster*:*

- Practice population ranges from 8,661 to 15,412 with an overall cluster population of 34,694 (as at 1.7.19). 51% are female ad 49% are male.
- The Cluster covers the geographical area of Porthcawl, Pyle, Kenfig Hill and Cornelly. There are costal, rural and urban areas with pockets of severe deprivation.
- The Porthcawl area is a holiday resort and home to a large static caravan park which results in a high transient and seasonal patient population.
- 54.5% of the West Cluster population live in the most deprived two 40% of areas in Wales. The Cluster also has high levels of low income and unemployment.
- 7.6% aged 16-74 are both economically active and unemployed.
- There is a high level of substance misuse and alcohol dependency with 19% of adults drinking above guidelines for weekly alcohol consumption levels. This is higher that both the Cwm Taf Morgannwg average of 18.3% and the Welsh average of 18.9%
- 29.92% of patients are also on the Public Health Wales Smoking Register. Smoking prevelance is lower in the West than the Health Board average of 21.1% and the Welsh average of 19.2%. However, the target for Wales is currently to reduce to 16% by 2020.
- The Cluster has a high elderly population with 25.2% of patients aged 65+ and 25.2% aged 75+
- 32.6% of patients aged 65+ live alone and 4.9% aged 65+ live in a nursing, non-nursing or other local authority care home.

The Cluster was originally made up of 4 GP Practices. However, in June 2017, the single handed Practice within the Cluster closed with the patient list of approximately 1,500, being dispersed between the remaining 3 Practices.

Porthcawl Group Practice moved into their new purpose built premises at Clos Y Mametz, Porthcawl in February 2019.

Services were successfully transferred from the original Portway Surgery and South Road Clinic to the new Primary Care Centre with the building being open to patients on Monday 4th February 2019.

In addition to the General Medical Services provided by Porthcawl Group Practice there are a number of Health Board community services being delivered from these premises including district nursing, midwifery, health visiting, podiatry, wound care, MCAS and diabetic retinopathy.

Cluster Assets Profile

As outlined in Appendix 1, there are four Primary Care Contractor sites within the West area:

- One in Porthcawl
- One in North Cornelly
- Two in Kenfig Hill, Heathbridge GP Practice and branch surgery of North Cornelly.

Cwm Taf Morgannwg UHB also deliver the following services from North Cornelly Clinic: Speech & Language Therapy, podiatry, community wound clinic and sexual health.

Within the West Cluster footprint there are:

- 9 Community Pharmacies
- 4 Dental Practices
- 4 Opticians
- 10 Nursing and Residential homes
- 1 leisure centre
- 2 libraries
- One Community Hub at Pyle Life Centre
- 10 Primary Schools and 2 Secondary Schools
- Details of Third Sector providers can be accessed via DEWIS and Info Engine.
  There is also a 'Health and Well-being Wales' mobile 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 allows professionals to search the resource directory for appropriate resources or services there and then, regardless of whether there is any Internet connectivity. Currently, the directory contains information about over 800 national and over 8,000 local organisations and services.

  The App provides information about the services provided, and contact information allowing the user to access the services listed. Information from the App can be shared with members of the public using any of the usual mobile applications.

3. Key achievements from the 2017-2020 three year cluster plan (summary plan on page)

Throughout 2017-20, the Cluster have gained a number of achievements which are listed below:

Healthy Homes Project

From June 2016 to March 2019 the Cluster invested in the Healthy Homes project.

The aim of the scheme was to provide a dedicated OT and Caseworker who were linked directly to the West GP Practices in order to reach older frail people, aged 75+, who had long term and complex health conditions. It provided a vehicle for embedding a housing-related service in a primary care setting and delivered practical solutions in order to achieve change to the home environment thus carrying out preventative measures to avoid accidental injury and falls that could have led to hospital admissions and/or long term care.

During 2018/19 the West Cluster Practices referred 219 patients into the scheme, resulting in 291 caseworker home visits taking place, 79 occupational therapist assessments to assess for specialist equipment and/or larger scale adaptations to patient homes.

The project was well regarded by the Practices with improved communication and outcomes for patients being valued.

Cluster Pharmacists

As the role of the Pharmacists have become embedded into the West Cluster way of working the Cluster has increased its Pharmacist capacity in order to facilitate and improve prescribing, patient experience and concordance.

Both Pharmacists continue to increase their scope and workload both in 'face-to-face' consultations, supervision and assistance with medication-related governance and cost-saving work, as well as anticipation of emerging challenges for GP Practices with the initiation of new work streams to address some of these extra-time consuming problems for GPs and staff. The average hours of GP time saved per month by the Pharmacists is 84.

Between September 2018 and August 2019 the Cluster Pharmacists have:

- Reviewed medication of 300 new care home patients
- Conducted 500 annual DOAC reviews
- Carried out clinical consultations, medication related tasks and 900 other medication reviews.

Chronic Disease Nurse

The Cluster recruited a Chronic Disease Nurse to support the review and management of housebound patients with chronic conditions, including patient education to crease resilience. GP Practices within the West directly refer those patients who suffer from chronic respiratory disease, heart disease and/or diabetes mellitus who are either housebound or resident in a care home to the Nurse.

The aim of the Chronic Disease Nurse is to improve the quality, consistency of care for these patients and to reduce potential hospital admissions with an additional focus on prevention to support with the proactive management of patients with chronic diseases.

The Cluster have also recently recruited a part-time Health Care Support Worker in order to support the nurse with her work plan with the additional aim of developing a Chronic Conditions Team.

Frailty Review Project
Between November 2018 and February 2019 the Cluster piloted a frailty review project. The aim of the project was to use the skills of both the Cluster Pharmacist and the Cluster CCM nurse to assess patients and to manage their medication needs holistically. It utilised relationships already established within the practice to reduce GP workload. Working initially with Porthcawl Group Practice, a model was designed to direct medication reviews on a needs assessment basis evaluated using a scoring system. These patients would have generally been permanently or temporarily housebound living in their own homes. The first phase of the project has ended and an Evaluation Report, as seen in Appendix 2, has been shared with Cluster members. Subject to funding the next step will be to roll out this project out to the other two Practices within the Cluster.

This work was lead and carried out by the Cluster Chronic Disease Nurse, the Cluster Pharmacist and the GP Cluster Lead.

Patient Education
All three GP Practices within the West purchased Numed Screens which are used to display national and local Public Health messages to their patients which includes information relating to smoking, flu and screening programmes. The screens are also used for patient education, signposting to Third Sector services and Choose Well/Community Pharmacy campaigns.

Further achievements include:

- West GP Practices along with the CCM Nurse have carried out flu immunisations to housebound patients to improve uptake amongst elderly and 'at risk' who are unable to attend the Surgery.
- West GP Practices have become dementia friendly.

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

Bridgend West Cluster Population Profile 2019 provided by Public Health can be seen in full at Appendix 3.

Below is a summary of the headline data pertinent to the West Cluster:

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

	Bridgend West (USOA)	Bridgend (USOA)	All Wales
Males	**78.0**	77.9	78.3
Females	**82.1**	81.2	82.3

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

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).

Estimated percentage of patients living in the most deprived 40% of areas in Wales (2015)	
Cwm Taf Morgannwg	Bridgend West (practice)
57.1%	54.4%
Source: Produced by Public Health Wales Observatory using WDS (NWIS) and WIMD 2004 (WG) data (GP Practice Population Profile, 2015)	

There is a lower concentration of the most deprived areas in Wales in the West Cluster compared to Cwm Taff Morgannwg as a whole but areas of deprivation do exist within the cluster area at a small geography.

Estimated % prevalence of chronic conditions (2018)			
	Bridgend West	Cwm Taf	Wales
CHD	4.9%	3.7%	3.7%
Heart Failure	1.5%	0.9%	1.0%
Stroke +TIA	3.2%	2.0%	2.1%
Diabetes	6.5%	6.4%	6.0%
COPD	2.4%	2.8%	2.3%
Asthma	8.1%	7.1%	7.1%
Dementia	0.9%	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 West cluster has a generally higher estimated prevalence of all chronic conditions than the Welsh average with estimated prevalence of stroke and TIA, coronary heart disease, heart failure, asthma and dementia being the 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.

Estimated % prevalence of risk factors within population(2017/18)			
	Bridgend West	Cwm Taf (Previous footprint)	Wales
Hypertension	17.3%	16.8%	15.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018			

Atrial Fibrillation	3%		2.2%
Source: QOF data 2018			
High Cholesterol	Not currently available		
Raised blood glucose	Not currently available		

Bridgend West has a higher estimated prevalence of hypertension than the Welsh average and the highest prevalence of AF in the CTMUHB area.

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 (%)
West Bridgend (USOA)	19.0%	22.9%	51.0%	19.0%	37.9%
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 lower in West Bridgend than the Health Board and Welsh average with other health related lifestyle behaviours generally comparable or poorer than the Welsh average.

Uptake of screening % (2017/18)				
	National targets	**Bridgend West (practice)**	**Cwm Taf**	**Wales**
Bowel	60%	60.2	64.8	55.7
Breast	70%	74.2	73.6	72.8
Cervical	80%	75.3	76.4	76.1
Source: Primary Care Needs Assessment tool, 2019				

Screening levels in Bridgend West have achieved national target levels. There is however the need to maintain and continue to improve on these levels. Bowel screening has the lowest uptake rate of the national screening programmes across CTMUHB.

In line with Wales as a whole, there has been a decline in young women attending their first cervical smear across the Cwm Taf Morgannwg UHB area.

Influenza Uptake Rates		
As of 23rd April 2019		
65 Year olds National Target 75%	**2-3 year olds** No Specific Target	**Clinical Risk <65** National Target 55%
67.30%	**36.40%**	**37.40%**

% uptake (2018/19)				
	Targets	**Bridgend West (practice)**	Cwm Taf	Wales
Uptake of 5 in 1 at 1 year old	95%	96.7	97.6	95.4
Up to date by age 4	95%	87.8	88.3	87.2
MMR2 at age 5	95%	91.3	93.8	92.2
MMR2 at age 16	95%	83.8		
Source: COVER data accessed via http://nww.immunisation.wales.nhs.uk/cover				

Childhood vaccination levels in Bridgend West do not yet met any of the 95% targets set for the immunisation programme to achieve 'herd immunity', except for immunisation uptake of 5 in 1 in children aged 1 year.

Overall, the Public Health Cluster Population 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 estimated prevalence of atrial fibrillation is the highest for the Health Board area. Optimising management of this risk could help reduce the above average prevalence of stroke within West Bridgend.

The Bridgend West cluster has a generally higher estimated prevalence of all chronic conditions than the Welsh average with estimated prevalence of stroke and TIA, coronary heart disease, heart failure, asthma and dementia being the highest of all the Health Board cluster areas.

5. Cluster Workforce profile

Within the West Cluster there are:

General Practitioners (GPs)
Three GP Practices. Age Profile/headcount/FTE by Practice for Staff Groups, as supplied by NWSSP colleagues, is shown at Appendix 4.

General Dental Services (Dentists)
Four dental practices. The Community Dental Service (CDS) team operates across the CTM UHB footprint. There is also a clinic in Bridgend delivering services to vulnerable patients. Bridgend patients are able to access In hours and dental OOH sessions via 111.

General Ophthalmic Services (Optometrists)
Four optometrists. All are accredited to provide Wales Eye Health Scheme (EHEW) and three of the four provide low vision services.

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

Community Pharmacy Services (Pharmacists)
Nine Community Pharmacies all delivering the Common Ailments Scheme.

Integrated Community Network Teams
The West Integrated Community Network Team is a single line managed team currently comprised of a 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 West Network, the district nurses are coordinated into two teams, operating within two community areas.

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

The district nursing capacity for the West Network is one Registered Nurse (RN) per 652 adults over the age of 65. There is a national shortage of District Nurses within Wales, therefore in order to meet this demand each year nurses are released to complete the Specialist Practitioner Qualification DN (SPQ). There is also an emphasis for all registered nurses to be nurse prescribers therefore staff are nominated and released to complete this training over a year or two-year duration. Leadership within teams is also an essential requirement therefore over the next 2 years our aim is that all of our Band 7 Nurses will have or are working towards a master's qualification.

<u>Team structure</u>
Both of the teams consist of a District Nurse, staff nurses and health care support workers who are attached to a GP surgery. There is also a Cluster Lead Nurse, Clinical Lead Nurse and a Social Worker within the Network Team who are based together linked to the GP surgery/cluster. We also have a Chronic Disease Nurse with phlebotomy support within the team structure this offers specialist support to our populations within the West Network.

This team of professionals provides the Cluster with an opportunity to develop a comprehensive multi- disciplinary approach to each surgery population. It enables a "team around the person" approach to develop which can support 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 West 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.

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" approach. During 2019/2020, the West Integrated Network Team will recruit additional professional staff to enhance the multi-disciplinary offer within the West Cluster. We hope that 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 which has been proven to release DN time for patient care and provides additional resources for contingency planning.

Through the transformational bid, five community navigators have been appointed across the borough. There will be two navigators in the West one of which is already in post and is based in Pyle. Once recruited the other will be based in Porthcawl. The remit of the navigators is to provide low level support, assisting with low complexity, looking at the preventative agenda, trying to engage with people, signpost them into the right services/organisation and developing community resilience.

In addition to this, there will also be Community Resilient Development Officer who will be in post from October 2019. These posts will be concentrating on community activities, community groups to build skills to help people access services/organisations in the community.

Many of these services already work collaboratively alongside GP Practices within the Cluster. However, the view for the next three years will be to strengthen existing relationships and to proactively engage further with other primary care contracts to develop collaborative working.

6. Cluster Financial Profile

The Cluster allocation is £112,065.00 which is delivery agreement money received from Welsh Government.

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.

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 £4,92m recurrent funding.

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

1. Continuing development of multi-disciplinary working and ongoing diversification of workforce

Gaps/Cluster Priorities:

- Ongoing national recruitment issues with GP and other Health Care Professionals
- Practice sustainability
- Increasing number of patients with co-morbidities and complex presentations
- Increasing patient demand
- Timely access for patients to an appropriate profession

Key Work Streams and Enablers:

- Extend the range of professionals and maximise the skill mix within the Cluster through the development of cluster multidisciplinary roles i.e. Cluster physiotherapist, Cluster Pharmacists and Cluster Tier 0 Mental Health and Wellbeing Support.
- Succession planning proactively managed by constituent practices
- Increase wellbeing and resilience of the patient population through prevention and self-care education including social prescribing and the wider social model of care.
- Continue to publicise the Community Pharmacy Common Ailments Scheme
- Strengthen integration with third sector providers to provide a key focus on wellbeing and prevention through engagement and active promotion of Infoengine and Dewis.
- Introduction of the new Quality Assurance and Improvement Framework (QUAIF) for the GMS Contract, Wales, 2019/20 which includes new Access standard for GMS services. There is an expectation that GP Practices will meet these standards by March 2021.

2. Cluster Pharmacists:

Gaps/Cluster Priorities:

- Financial uncertainty as to the continued investment in pharmacist provision
- Additional support for the Pharmacy team i.e Pharmacy technician/admin to enable expansion of workstreams in line with prudent healthcare principals
- In two of the three GP Practices clinical room availability is an obstacle which can result in Pharmacists not being able to see as many patients therefore not maximising patient contact as part of their role.
- Continue to facilitate and improve prescribing, patient experience and concordance
- Ensuring continuity with new Health Board Medicines Management Team reconfiguration due to the boundary change
- Reduce wastage of medicine and achieve better health outcomes through prudent prescribing linked to the work programme of the Cluster pharmacist
- Increase scope and workload with the 3 GP Practices within the Cluster
- Supporting Medicines Management Health Board Team priorities
- Supporting GP Practices to achieve the Quality Assurance Improvement Framework (QUAIF) element of the GMS Contract 19/20
- Continued engagement with Community Pharmacist particularly around medicines stock issues, audits and the provision of community pharmacy services
- Education and mentoring of Pharmacy undergraduates, GP Registrars and medical students
- Enhanced engagement with District Nursing, Practice nurses, GP staff, care home and secondary care on medicines related issues.

Key Work Streams and Enablers:

- Pharmacists workload includes 'face-face' consultations, patent education, supervision and assistance with medication related governance
- Cost saving work as well as anticipation of emerging challenges for GP Practices
- Initiation of new work-streams to address some of these extra time consuming problems for GPs and staff.
- Continued engagement with Community Pharmacists through quarterly meetings, regular e-mail communication and attendance at Cluster meetings.
- Continued engagement with District Nursing, GP Practices, Secondary Care and Care Home staff through regular communication and attendance at Cluster meetings.

3. Development of a Chronic Conditions Team:
   Gaps/Cluster Priorities:
   - Increase capacity and upskilling of the Chronic Conditions Team. This will enable the team to strengthen the preventative element of their workplan
   - Provide support to individuals living with multiple co-morbidities and allowing them to be empowered to manage their conditions.
   - Patient education to create resilience
   - Focus on prevention to support the proactive management of patients with chronic disease

   Key Work Streams and Enablers:
   - Band 6 Nurse and HCSW in place undertaking patient reviews and development of patient support plans
   - Discussions underway on how to increase and strengthen capacity within the current team.

4. Cluster Wellbeing Needs Assessment Priority Population:
   Gaps/Cluster Priorities:
   - Higher prevalence of all chronic conditions/high disease risk
   - Adult lifestyle behaviour is comparable or poorer than the Cwm Taf Morgannwg Welsh average.
   - Cervical screening did not meet the national target level.
   - Flu vaccination uptake for at risk groups and 2-3 are the lowest across all Cluster areas.

   Key Work Streams and Enablers:
   - Understand and highlight actions to meet the needs of the population served by the West with a strengthened preventative approach.
   - Use of the priority population level needs of the Cluster to inform programme development and to ensure services are developed according to local population need.
   - Actively promote the importance of screening programmes to improve early diagnosis and timely treatment for patients.
   - Patient education and the promotion of wellbeing and prevention messages such as Choose Well.
   - Ensure patient information is high quality, standardised and evidence based.
   - The Cluster, Primary Care Development Manager and PHW colleagues will work together to extract further Cluster level qualitative data using the Primary Care Needs Assessment Tool.
5. Estates:

Gaps/Cluster Priorities:

- Premises improvement to enable capacity to deliver new pathways and increase capacity using a whole systems approach including transferring resources into the community focussing on health and wellbeing
- Improved facilities and sustainability of services.
- Increasing Cluster list size from July 2017 to July 2019 of 0.94%
- New housing developments as part of the Bridgend County Borough Council LDP

Key Work Streams and Enablers:

- Ongoing engagement between the Health Board and Welsh Government to prioritise premises planning in respect of both North Cornelly Surgery and Heathbridge GP Practice.

6. Frailty

Gaps/Cluster Priorities:

- Increase wellbeing, resilience and early intervention to frail elderly patients
- Financial constraints have meant that the roll-out of the Frailty project has been temporarily put on hold.

Key Work Streams and Enablers:

- Roll-out of the Frailty Review Project across the whole of the Cluster subject to funding.
- GP Practices to directly refer to Care & Repair those patients they feel could benefit from the service.

7. Gastroenterology Project

Gaps/Cluster Priorities:

- The West Cluster have agreed to pilot a faecal calprotection diagnosis testing project using agreed guidelines and pathways. An aide memoir and algorithm have also been developed.

Key Work Streams and Enablers:

- Project commenced on 1st April and will be reviewed with 6 months.
- Consultant Gastroenterologist regularly attends the West Cluster meeting to provide updates.

The Health Board will work with the Community Health Council, Cluster, Practices and service providers to engage with the population over any potential service changes. Communication of any changes will either be promoted through patient engagement events, via the Practice NUMED screens or the through the Practice websites.

The Cluster will promote their initiatives and 'good news' stories by working closely with the Health Board Communications Team.

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

Cluster Actions are detailed in the Action Plan below. The plan was developed prior to the recent boundary change and reflects the template agreed and used between the Cluster and the former ABMU Health Board. It is the Cluster's intention to revise this Plan in order to satisfy the new style and format required from April 2020 as stipulated in the Guidance: Developing the 2020-2023 Primary Care Cluster IMTP issued in September 2019.

Strategic Aim 1: To understand and highlight actions to meet the needs of the population served by the Cluster Network with a preventative approach

Priority areas for Cluster action for the next three years (through analysis of our cluster populations health and social status and needs):

Priority Population needs are currently identified as

- **Chronic condition burden is higher than other Cluster areas**
- **High rates of drug and alcohol misuse**
- **High Smoking Rates**

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?	Current position	RAG Rating
1	Set out the priority population level needs of the Cluster to inform programme development	All	Refreshed when new data available, 6 mthly check Dec 2018	Services are developed according to local population need	Demographics have been considered during formulation of this cluster network plan.	
2	Increase wellbeing and resilience of the patient population through prevention and self-care education including social prescribing and the wider social model of care	All	Ongoing	Patients are more able to manage their conditions and prevention is recognised as a key feature		

3	Ensure a consistent approach to the implementation of the public health agenda to support achievement of the NHS Tier 1 smoking cessation target	Stop Smoking Wales Community Pharmacy General Practice	Ongoing	Support to the smoking population to make a quit attempt and reduction in smokers	• 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.	
4	Reduce obesity in the cluster through patient education and the promotion of wellbeing and prevention messages	All	Ongoing	Reduction in the obese population		
5	Actively promote the importance of screening programmes to improve early diagnosis and timely treatment for patients	All	Ongoing	Increased uptake of relevant screening programmes leading to early diagnosis and treatment		
6	Delivery of a Chronic Disease Management service, including patient education to create resilience and a focus on prevention to support the proactive management of patients with Chronic Diseases.	Cluster & Chronic Conditions Team	Ongoing	Patients living with a chronic disease will be able to manage their condition effectively	• Band 6 Nurse and HCSW in place undertaking patient reviews and developing support plans.	
6	Delivery of a cluster based substance misuse enhanced service	Practices	Ongoing	Individuals can access a quality service in a timely manner		

7	Proactive identification and signposting of people living with dementia	All	Ongoing	People living with dementia and their carers are able to access appropriate care and support in a timely manner and proactively manage their own health and wellbeing as appropriate		

Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements

Priority areas for Cluster action for the next three years:

- Expand MDT team to meet the workforce needs of the Cluster

- Review of sustainability of core GP services across practices, sharing difficulties and addressing concerns with peers; developing access arrangements in line with current ABMU Access Standards to meet the needs of local patients; and exploring collaborative working arrangements.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Increase integration with the third sector to provide a key focus on wellbeing and prevention through engagement and active promotion of: • Infoengine • Dewis • Social Prescribing	All	Ongoing	Patients are more informed and empowered to manage their own health and prevention of ill health		

2	Extend the range of professionals and maximise the skill mix within the cluster through the development of the cluster multidisciplinary roles	All	March 2019	Increased access and signposting to voluntary services that support self-care and independence	• Consider future roles and responsibilities • Develop a physiotherapist role • Develop CCN Service • Explore the use Tier 0 Mental Health and wellbeing support	
3	Increase wellbeing, resilience and early intervention to frail elderly individuals through a primary care occupational therapy (Healthy Homes)	Bridgend Care and Repair General Practice	Ongoing	Enhanced skills and improved efficiency of services	• Using the Anticipatory Care Plans approach, identify individuals who are regular users of their service and are increasingly frail and isolated.	
4	Development of the Chronic Conditions Team to support the review and management of patients with chronic conditions	General Practice Health Board	Ongoing	Reduction of GP attendances for patients with chronic conditions and patients feel more able to manage and understand their conditions	• Band 6 Nurse currently in post • Housebound reviews underway	
5	Increase resilience in care homes, improve liaison with appropriate services to meet the need of residents	General Practice	Ongoing	Reduction of GP attendances for residents and patients feel more able to manage and understand their conditions		

Strategic Aim 3: 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.

Priority areas for Cluster action for the next three years:

- 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;
- prolong independence of elderly patients through the development of anticipatory care plans.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Diversification of the workforce to ensure patients are able to see the most appropriate professional in a timely manner and GP'S can focus on the most vulnerable. E.g. Physiotherapist	All	Ongoing	Individuals can access a the most appropriate professional in a timely manner	• Business Case in development	
2	Sustained use of telephone advice lines	Practices	Ongoing	Decrease in inappropriate referrals to secondary care therefore reducing demand and waiting times for more appropriate referrals	• All practices promote the use of advice lines on a regular basis	
3	Reduce wastage of medicines and achieve better health outcomes through prudent prescribing linked to the work programme of the Cluster Pharmacists	Practices Health Board	Ongoing	Reduced demand on practices for prescribing needs Reduced medicines wastage		
4	Delivery of Diabetes gateway and NOACS	Practices	Ongoing	local rapid management of care, minimising waste and harms;		

Strategic Aim 4: 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.

Priority areas for Cluster action for the next three years:

- Using a making Every Contact Count approach, advise and educate patients in how to manage self-care and identifying the most appropriate place to receive treatment.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Promote Choose Well and health and wellbeing messages to the public using Numed screens and patient engagement	All	Ongoing	Patients understand and are aware of how to access alternative healthcare pathways	• Active promotion ongoing	
2	Promote Practice websites and associated resources to all patients	All	Ongoing	Increased awareness of the website and ability of patients to manage their long term conditions	• Active promotion ongoing	
3	Publicise the Community Pharmacy Common Ailments Scheme	All	Ongoing	Patients are aware of and access the Common Ailments Scheme as an alternative to GP's where appropriate	• Active promotion ongoing	
4	Use of QR Information Boards to provide standardised, evidence based patient information	Practices	Ongoing	Ensure patient information is high quality, standardised and evidence based		
5	Delivery of Flu vaccinations to housebound patients	Practices	Dec 2018	Protection from flu for vulnerable patients at risk and the wider population	• Nurses will be released to deliver flu vaccinations to housebound patients across the cluster during November 2018	
6	Promotion of Digital Technology such as My Health Online	Practices	Ongoing	Wider range information and access models available to patients		

Strategic Aim 5: To develop the Cluster as a structure for delivery of identified priorities.

Priority areas for Cluster action for the next three years:

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Increase collaboration between GP practices and other primary care providers, social services, Community Resource Team and other Cluster partners			GP practices are better able to manage demand & improve patient care / experience		

Strategic Aim 6: Other Cluster and area specific issues

Priority areas for Cluster action for the next three years:

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Proactive communication with both Health Boards as the Cluster will transfer to Cwm Taf on 1st April 2019.	All	1st April 2019	Clarity on transfer to new health board and its impact on services	• Communication ongoing	
2	Support the Delivery of three Business Cases for IMTP inclusion based on key service delivery schemes which support Primary Care: a) Cluster Physiotherapy b) Cluster Pharmacists, c) Cluster Tier 0 Mental Health and wellbeing support	All	Dec 2018	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	• The three cases are to be included for consideration in this years IMTP process in both ABMU & Cwm Taf.	

				where benefits have been demonstrated		
3	Engage with a robust validated clinical governance process	General Practice	31st March 2018	Improved quality and safety and efficiency of services	• To complete the Clinical Governance Practice Self-Assessment Tool and achieve at least level 2 in the areas of safeguarding (CND 005W) • Participate in peer review and governance lead meetings.	
4	Promote shared learning and good practice through increased incident reporting.	General Practice	Ongoing	Improved quality and safety of services	• Encourage use of DATIX for incident reporting • To explore a feedback mechanism to primary care	
5	Update and maintain a cluster risk resister	Cluster	Ongoing	Mitigate risks as appropriate	• Identify and agree risks	
6	Premises improvement to enable capacity to deliver new pathways and increase capacity using a whole System approach including transferring resources into the community focussing on health and wellbeing	All	Ongoing	Improved facilities and sustainable services	Porthcawl Group Practice transfer to a new integrated health and wellbeing focussed site in January 2019.	

During Spring 2019 (and following the boundary change) the Cluster have also agreed the following:

- Increase enhanced engagement with the local group of Community Pharmacists to aid prudent prescribing and dispensing.
- Support of the Pharmacist Independent Prescribing Project between the Health Board & Cardiff University. The Cluster GP Lead is currently working with a Community Pharmacist, situated with the West Cluster, as his Designated Supervising Medical Practitioner (DSMP). The initial aim is to provide an acute medicine service incorporating UTI, sore throat and simple ear conditions in the Community Pharmacy.
- North Cornelly Surgery to provide a LARC (Long Acting Reversible Contraception) Service to patients of Heathbridge GP Practice. North Cornelly currently deliver Child Health Surveillance (CHS) and Childhood Immunisations (CIs), by way of a Local Enhanced Service, to the registered population of Heathbridge House General Practice.

Contract Changes:
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 project and will decide which one of the quality improvement projects (listed below) will be selected following feedback and discussions at practice level which will be shared at the next cluster meetings scheduled for November 2019.

The Quality Improvement domain is based on the 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

Welsh Government considers the Community Pharmacy sector to be a fundamental part of a strong primary care service. Committing to the investment of Community Pharmacy 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.

Within the West Cluster there is representation at each of the Cluster meetings from our Community Pharmacy colleagues. The Cluster will continue to build on these relationships and improve collaborative working in order to improve population health and meet the clusters priorities.

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.

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' to focus on:

- Service developments based on demand; planning and transformation is led
- Co-ordinated local care teams
- Promotion of health living by making well-being less of a medicalised term
- Service planning and delivery across local communities.

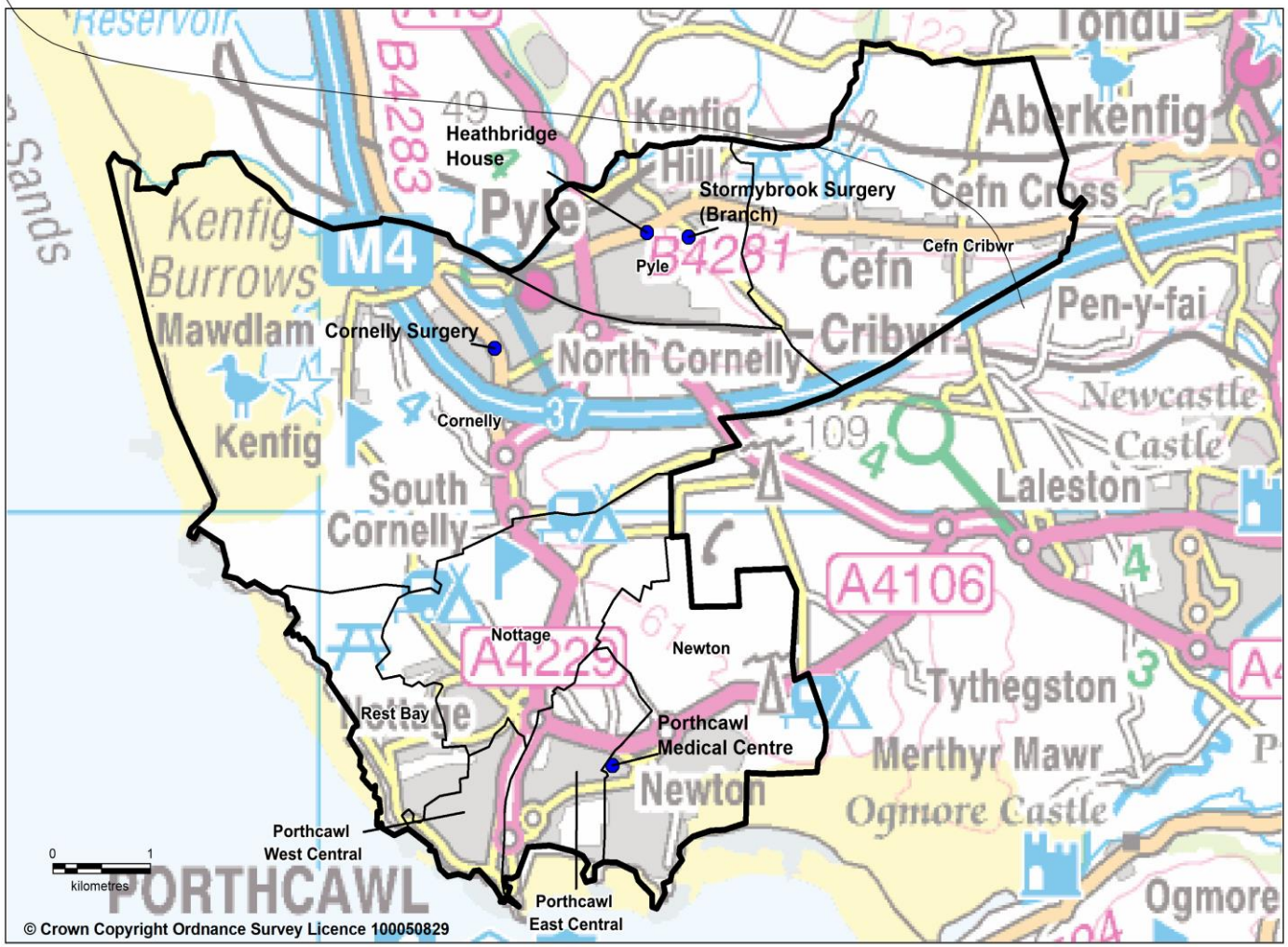
The plan will also be developed, reviewed and monitored alongside the Cwm Taf Morgannwg Primary and Community IMTP and transformation plan.

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

- Primary Care Development Manager employed to support the West Cluster
- Terms of Reference in place and reviewed and updated when necessary

	• SFI's – 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 • Dental and Optometry Advisors together with Pharmacy leads to support developments of the Cluster, liaise with the Development Manager and attend Cluster meetings to update on services, contract changes and offer advice on collaborative working. • Ensure Third Sector organisations are active members of the cluster and support the health & wellbeing agenda and community development.

Bridgend West Network



NHS Wales Informatic Service August 2019

Appendix 2

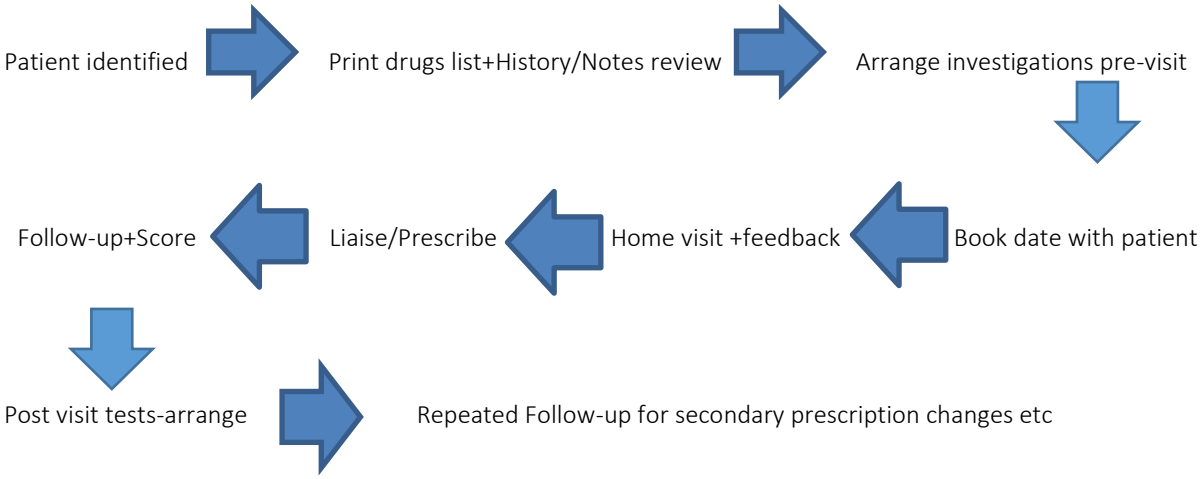
Bridgend West Cluster Frailty Medication review service report November 2018-February 2019

Reminder of the objectives:

- To reduce some of the unnecessary CALLS TO GPs by providing timely intervention.
- To provide some of the extra assessment arranging (eg. Blood monitoring requests), signposting, linking with other agencies that otherwise would take-up GP TIME.
- To indirectly reduce unnecessary visits/contacts with EMERGENCY SERVICES
- To ensure that Repeat Prescription signing, by GPs, is SUPPORTED by independent and timely Medication Review.
- To improve patients' UNDERSTANDING of their medication
- To ensure medication is still APPROPRIATE and effective
- To identify SIDE-EFFECTS and address
- To improve CONCORDANCE with medication
- To reduce WASTAGE of medication
- To achieve a service that minimises time spent in administrative activity and maximises TIME SPENT with patients (once the initial evaluation achieved).

Method:

1 day per week: spent on Visits, Follow-ups, Administration: Averaging 3-4 visits per day.



Patients were identified from referrals or from outstanding Medication review requests for housebound patients

Results:

- 20 patients identified/referred. Visited at home.
- Estimated Drug Cost-savings made per month for first cohort of 20 patients: £460 (extrapolated to recurrent savings totalling £5,520 per annum) based on 7-8 daily sessions of visits.

<u>Scoring system devised of intervention value (0-8):</u>

Score 1: Concordance checked, reassurance provided, minor changes to medication timing, re-print of lost Repeat Prescription request slip, provision of patient literature

Score 2: Appropriate Blood tests/Blood pressure/Weight instigated and assessed, Concordance checked, reassurance provided

Score 4: Plus 1 or more Drug changes made, prevented intended contact for GP appointment

Score 6: Plus liaison with Secondary Care to suggest switch/stop drugs

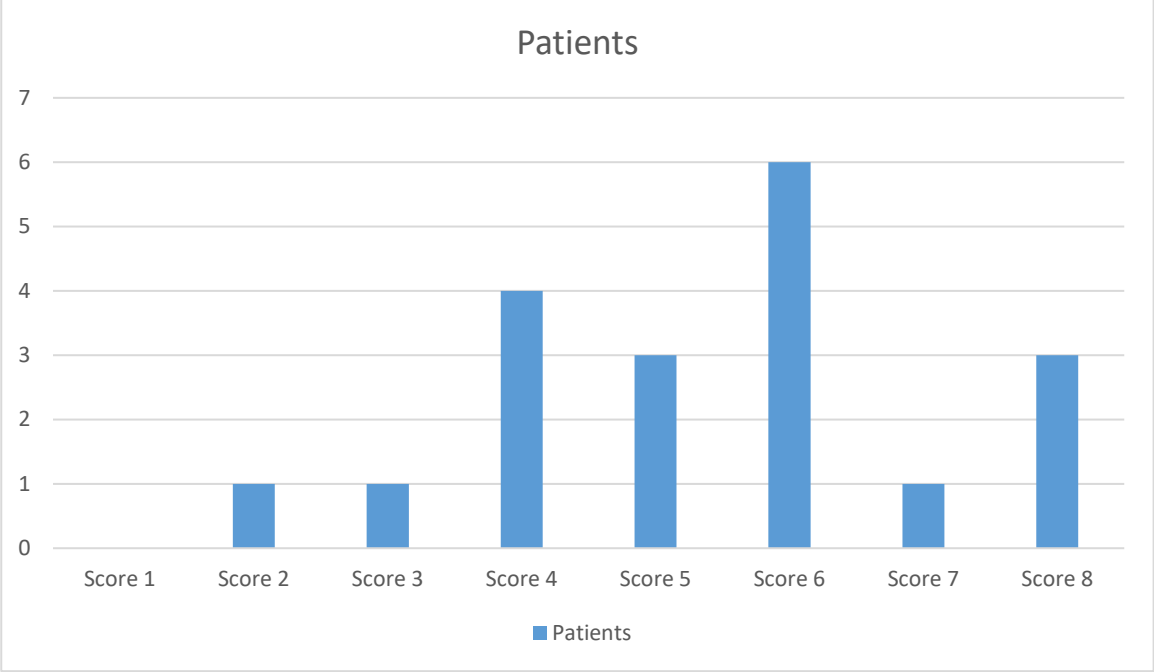
Score 8: Plus more than 2 Drug changes made /1 Harm prevented/ Large scale changes to medication regimen, Liaison with Community Pharmacy in-time to prevent perpetuation of problems/errors

Patient	Age, Complexity	Drugs	Testing	Drug issues, main interventions	Score	Follow-up
1 CD	58, Multiple conditions	15	Yes	Stop 3 drugs, reduce 2 drugs	8	1 +recontact
2 DJ	82,Multiple	12	No	Re-arrange most of drugs	8?	To recontact>CRT
3 TC	60, Multiple	15	Yes	inhaler	4	To recontact 2019
4 JS	88,Multiple	7	Yes	Trimipramine reduction	4	To recontact 2019
5 FE	75, Multiple	10	Yes	Stop Aspirin, reduce Amitrip	6	To recontact
6 WR	96, AF, Asthma	8	Yes	Inhaler, Frusemide confusion	5	1 with son
7 RW	86,Multiple	8	Yes	Venlafax reduction	4	To recontact feb 19
8 TD	94, Multiple	9	Yes	Doac, stop simvastatin	4	6mthly July 19
9 GB	77, HT,TIA	14	Yes	Stop lactulose	2	Contact >hip op. lonely
10 AR	69, Dementia+	10	No	Reduce Asacol	6 ?	To recontact Son March 2019
11 OH	89,Multiple	11	Yes	DOAC, analgesia, stop folate, BP control	7?	Follow-up mid March 2019
12 WB	82, Multiple	5 from 10 previous review	No	Duloxetine reduction	5	Follow-up March – start Amitriptyline
13 LW	74, multiple	16	Yes	Verapamil+Bisoprolol	6	Follow-up monthly
14 DW	86, Multiple	11	Yes	Reduce/stop 3 drugs	6	Follow-up early March 2019
15 WS	80, Multiple	11	No	Simvastatin analgesia spacer	6	Follow-up March
16 MB	83, Dementia	10	Yes	Carer policy-Compliance, stop 4 drugs, CMHT	5	Re-visit March 2019
17 NE	Amputee	6	No	Omeprazole reduction, analgesia, antimicrobial discussions	3	
18 ET	77, Crohns, stroke	13	Yes	Taking OTC Aspirin+ Clopidogrel	6	
19 ME	89, Multiple	12	No	Stop Clopidogrel, Risedronate	8	Await Nephrology reply
20 CW	67,Multiple	13	Yes	Inhaler technique, analgesia, statin switch	6	Repeat tests

(“?” represents unresolved scoring or difficult to attribute score).

- Average age = 79 years old (range:58-96 years)
- Average number of drugs (excluding creams, dressings, test strips, different dosage strengths) = 11 (range: 6-16 drugs)

- Average score = 5.45 /8 (range 2-8)



Patient stories:

- 1 Patient had the police waiting for us as she thought it was a scam!
- Several patients forgotten we were due to visit/had some anxiety
- A few patients difficult to find address, difficult to contact or had difficulties on the 'phone
- 1 Patient very resistant to visit; but several useful changes made in collaboration with son who organises her medication
- 1 Blood sample driven to hospital as missed transport

Follow-ups:

- Number of patients requiring at least 1 follow-up call/visit = 16
- Number of patients requiring repeated follow-ups = approximately 9

Barriers to efficiency:

Preparation prior to visit; hard copies of medication list, research and copying of relevant Secondary care letters/Discharge information -SOLUTION: Digital

Phlebotomy; lack of access to blood testing. Temporary solution-CC taking bloods (morning visits only) but deadline for return to GP practice. One occasion missed transport ;necessitated trip to hospital lab to deliver-SOLUTION: Await new phlebotomist

Tools: Portable weighing scales. As service is new and culture of NHS budgetary responsibility-any purchases not easily sanctioned. Administration time to re-stock consumables, post Patient information.

Expired telephone contact details (also for carers), patient forgetting the appointment, other agencies arriving (eg. Carers), new service provoking anxiety (1 patient called Police) /resistance (1 patient not keen). SOLUTION: Develop a Patient Information Leaflet. Conduct ad-hoc visits to patients who are difficult to contact by telephone.

Note annotation and Follow-up actions were time consuming; time to embed each change versus risk of confusing if too many changes at once, liaison with others (community pharmacy-MDS Trays/prescriptions in advance, social services, GPs, Secondary care). SOLUTION-Partly digital. Current ability/autonomy to follow-up on other week days where urgent.

Variable physical and mental capacities, existing patient knowledge, support at home, medical conditions, numbers of medications resultant in unpredictable visit durations. Some people very flexible to allow previous visit appointment to overrun. SOLUTION: Realistic visit rate per day Maximum: 4

Refinements:

- Redesign of the proforma to achieve more legible annotation during the visit
- Patient information leaflet to explain the service
- Storage of completed patients' notes made-retain for 5 years in Porthcawl Medical Centre (Storage cabinet available)
- Process for phlebotomy once personnel in place
- Continue some dual visits to develop competencies and where predict patient requirement for both.
- Allow time for pre-planning and identification of issues prior to visit, peer review, liaison with other agencies.
- Promote service to GPs; suggesting criteria
- Devise Patient Satisfaction Survey to formalise capture of patients' suggestions

Conclusion:

The service was generally welcomed by patients and usually resulted in high scores of added value to care. Difficult to predict effects on reducing burden on GPs and other services. Multiple medication changes were made improving quality of care and indirect cost-effective improvements to prescribing. Improvements made in patients understanding and concordance with medication. Resultant follow-up contact and liaison with other agencies were frequent and often needed repeating to ensure subsequent changes were effective and embedded without creating confusion by instigating all changes at once.

Future aspirations:

1. Digital resource: During visit.
2. Budget to access Tools (Portable weighing scales, consumables, stationery)
3. Administrative assistance

Bridgend West Cluster Population Profile FINAL DRAFT

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

Bridgend West Practices: Heathbridge House, Porthcawl Primary Care Centre, Dr G Williams and Partners

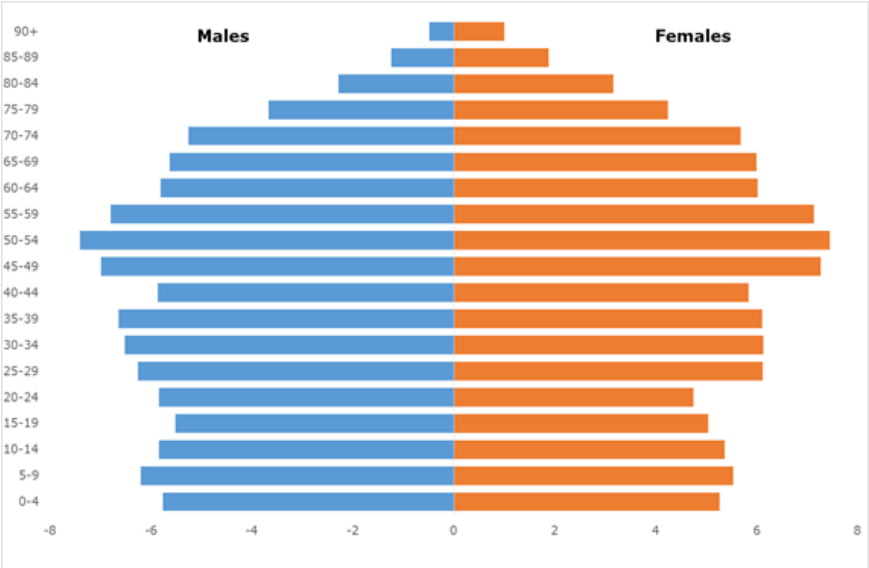
This cluster profile uses two main sources of population data: (i) data captured by registered practice; (ii) data that is captured by area of residence which is not easily attributed to Primary Care Cluster. Note: Some data is only available at local authority level and some data is not yet available 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 West: 34,663 (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

	Bridgend West (USOA)	Bridgend (USOA)	All Wales
Males	**78.0**	77.9	78.3
Females	**82.1**	81.2	82.3

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 West (practice)
57.1%	54.4%
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 lower concentration of the most deprived areas in Wales in the Bridgend West cluster compared to Cwm Taf Morgannwg as a whole but areas of deprivation do exist within the cluster area at a smaller geography.

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 West (5.6%); 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 West	Cwm Taf	Wales
CHD	4.9%	3.7%	3.7%
Heart Failure	1.5%	0.9%	1.0%
Stroke +TIA	3.2%	2.0%	2.1%
Diabetes	6.5%	6.4%	6.0%
COPD	2.4%	2.8%	2.3%
Asthma	8.1%	7.1%	7.1%
Dementia	0.9%	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 West cluster has a generally higher estimated prevalence of all chronic conditions than the Welsh average with estimated prevalence of stroke and TIA, coronary heart disease, heart failure, asthma and dementia being the 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

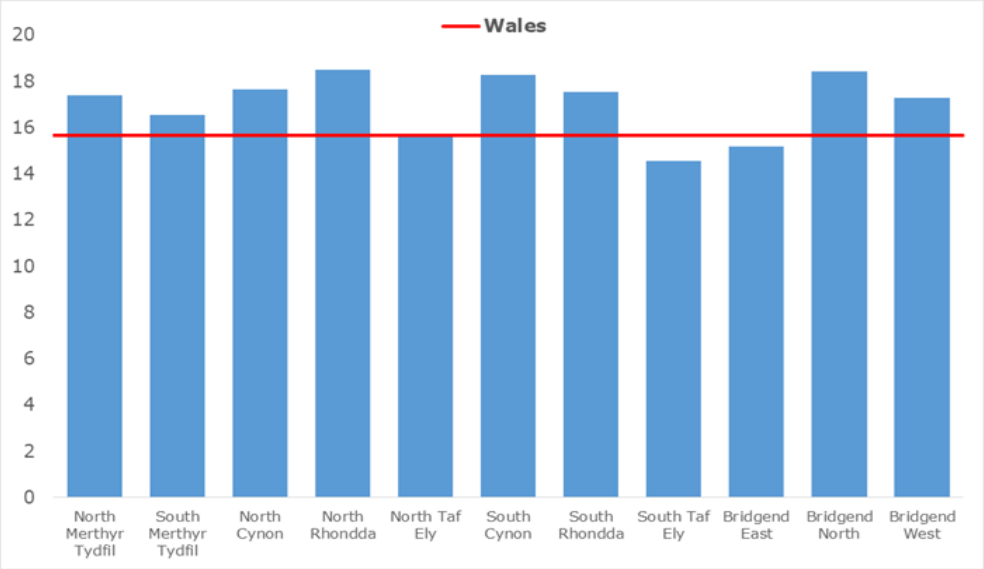
10% of adults in Bridgend report as having a mental health disorder. Wales average 9%
(Source NSW 2017-19)
Mental wellbeing is an important factor in individual's overall health.
11.8% of adults in Bridgend report feeling lonely, the lowest of all Local Authority areas. Wales average: 16.7% (PHOF 2019) 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 West	Cwm Taf (Previous footprint)	Wales
Hypertension	17.3%	16.8%	15.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018			
Atrial Fibrillation	3%		2.2%
Source: QOF data 2018			
High Cholesterol	Not currently available		
Raised blood glucose	Not currently available		

Bridgend West has a higher estimated prevalence of hypertension than the Welsh average and the highest prevalence of AF in the CTMUHB area.



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 (%)
West Bridgend (USOA)	19.0%	22.9%	51.0%	19.0%	37.9%
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 lower in West Bridgend than the Health Board and Welsh average. The target for Wales is currently to reduce to 16% by 2020.

- Other health related lifestyle behaviours are generally comparable or 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: -

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 West (practice)	Cwm Taf	Wales
Bowel	60%	60.2	64.8	55.7
Breast	70%	74.2	73.6	72.8
Cervical	80%	75.3	76.4	76.1
Source: Primary Care Needs Assessment tool, 2019				

Screening levels in Bridgend West have achieved national target levels. There is however the need to maintain and continue to improve on these levels.
Bowel screening has the lowest uptake rate of the national screening programmes across CTMUHB.
In line with Wales as a whole, there has been a decline in young women attending their first cervical smear across the Cwm Taf Morgannwg UHB area.

Prevention of infectious diseases

Flu vaccination uptake

% Uptake (2017/18)				
	National targets	Bridgend West (practice)	Cwm Taf	Wales
At risk aged 6 months to 64 years	**55%**	39.9	46.8	48.5
2 and 3 year olds	No specific Targets yet	34.2	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 for at risk groups and 2-3 years were the lowest for all cluster areas across the Health Board for 2017/18. Last year's figures at cluster level are awaited.

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 West (practice)**	Cwm Taf	Wales
Uptake of 5 in 1 at 1 year old	95%	96.7	97.6	95.4
Up to date by age 4	95%	87.8	88.3	87.2
MMR2 at age 5	95%	91.3	93.8	92.2
MMR2 at age 16	95%	83.8		
Source: COVER data accessed via http://nww.immunisation.wales.nhs.uk/cover				

Childhood vaccination levels in Bridgend West not yet met any of the 95% targets set for the immunisation programme to achieve 'herd immunity', except for immunisation uptake of childhood vaccinations in children aged 1 year.

Cluster Summary

The Bridgend West cluster has on average a lower level of deprivation and poverty than the Welsh average but areas of deprivation do exist at a lower geography within the cluster.
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 estimated prevalence of atrial fibrillation is the highest for the Health Board area. Optimising management of this risk could help reduce the above average prevalence of stroke within West Bridgend.

The Bridgend West cluster has a generally higher estimated prevalence of all chronic conditions than the Welsh average with estimated prevalence of stroke and TIA, coronary heart disease, heart failure, asthma and dementia being the 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.

The benefits of flu vaccination are widely acknowledged. Primary care working with partners has a key role on promoting uptake particularly for the at 'risk group' which has the lowest uptake in Bridgend West.

	W95034			W95041			W95063		
Staff Group	Head Count	FTE	Contracted Hours	Head Count	FTE	Contracted Hours	Head Count	FTE	Contracted Hours
Admin_Non_Clinical	**19**	**10.58**	**396.75**	**21**	**18.75**	**703**	**6**	**2.00**	**75**
65 and Over	0	0.00	0	1	1.01	38	1	1.00	37.5
60 - 64	5	1.89	71	2	1.95	73	0	0.00	0
55 - 59	2	1.37	51.5	4	3.96	148.5	2	1.00	37.5
50 - 54	2	1.11	41.5	6	5.17	194	1	0.00	0
45 - 49	4	3.07	115	0	0.00	0	0	0.00	0
40 - 44	3	1.71	64	2	1.44	54	2	0.00	0
35 - 39	1	0.48	18	3	2.17	81.5	0	0.00	0
30 - 34	1	0.71	26.75	1	1.01	38	0	0.00	0
18 - 29	1	0.24	9	2	2.03	76	0	0.00	0
No Date of Birth	0	0.00	0	0	0.00	0	0	0.00	0
Direct_Patient_Care	**5**	**1.44**	**54**	**4**	**3.53**	**132.5**	**1**	**0.00**	**0**
65 and over	1	0.13	5	0	0.00	0	0	0.00	0
60 - 64	1	0.32	12	0	0.00	0	0	0.00	0
55 - 59	2	0.91	34	1	0.92	34.5	0	0.00	0
50 - 54	0	0.00	0	2	2.01	75.5	1	0.00	0
45 - 49	1	0.08	3	0	0.00	0	0	0.00	0
40 - 44	0	0.00	0	1	0.60	22.5	0	0.00	0
35 - 39	0	0.00	0	0	0.00	0	0	0.00	0
30 - 34	0	0.00	0	0	0.00	0	0	0.00	0
18 - 29	0	0.00	0	0	0.00	0	0	0.00	0
No Date of birth	0	0.00	0	0	0.00	0	0	0.00	0

GP	**9**	**0.85**	**32**	**14**	**11.36**	**425.89**	**6**	**3.00**	**112.5**
65 and Over	1	0.00	0	0	0.00	0	0	0.00	0
60 - 64	0	0.00	0	0	0.00	0	0	0.00	0
55 -59	1	0.00	0	1	0.89	33.34	0	0.00	0
50 - 54	0	0.00	0	3	2.67	100.02	1	0.00	0
45 - 49	2	0.00	0	1	0.56	20.84	0	0.00	0
40 - 44	0	0.00	0	1	0.56	20.84	1	1.00	37.5
35 - 39	2	0.00	0	4	3.24	121.67	4	2.00	75
30 - 34	1	0.85	32	4	3.44	129.18	0	0.00	0
18 - 29	0	0.00	0	0	0.00	0	0	0.00	0
No Date of Birth	2	0.00	0	0	0.00	0	0	0.00	0
Nurses	**8**	**2.61**	**98**	**5**	**4.08**	**153**	**0**	**0.00**	**0**
65 and Over	1	0.00	0	0	0.00	0	0	0.00	0
60 - 64	0	0.00	0	0	0.00	0	0	0.00	0
55 - 59	1	0.43	16	3	2.51	94	0	0.00	0
50 - 54	1	0.21	8	1	0.64	24	0	0.00	0
45 - 49	2	1.33	50	1	0.93	35	0	0.00	0
40 - 44	0	0.00	0	0	0.00	0	0	0.00	0
35 - 39	0	0.00	0	0	0.00	0	0	0.00	0
30 - 34	1	0.64	24	0	0.00	0	0	0.00	0
18 - 29	0	0.00	0	0	0.00	0	0	0.00	0
No Date of Birth	2	0.00	0	0	0.00	0	0	0.00	0