THREE YEAR INTEGRATED MEDIUM TERM PLAN

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

NORTH CYNON PRIMARY CARE CLUSTER 2020 – 2023

CONTENTS

1. EXECUTIVE SUMMARY

The North Cynon cluster represents 3 GP practices with a combined population they serve of around 30’000 people. There is a mix of mainly Urban and Semi-rural households, with an average inequality gap in healthy expectancy of 6.7 years in males and 4.3 years in females, and with an estimated 77% of people in the area living in the most deprived 40% of areas in Wales. Unemployment rates are higher than the all Wales average, as are the number of households where a member of the family is caring for an elderly, sick or disabled relative. The burden of chronic disease is often higher other than for Stroke, and combined with the geography of the area can provide significant challenges to the provision of healthcare, necessitating innovation and new ways of tackling issues to try and meet the needs of individuals, while also addressing the population needs in order to meet the ideals of Prudent Healthcare. Working in the traditional isolated silos is not sustainable, or safe. Instead a fully integrated system based on the pioneering work done already in the North Cynon around Primary Care based MDT we believe is the foundation stone from which to take our next steps.

The plan has been informed by public health information on key health needs within the area; information and support provided by Cwm Taf Morgannwg University Health Board; an understanding of our localities baseline services and identification of potential service provision unmet needs, the practice development plans produced by GP practices, namely

- St John’s Medical Centre
- Parc Surgery
- Hirwaun Medical Centre
- Foundry Town Clinic

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
- Developing more effective collaboration working with community services, including nursing, local authority and third sector to improve quality of care
- Encouraging the development of new models of care, including consideration of federations, practice mergers and shared practice support
- Finding ways to cement into ‘Standard Practice’ the excellent results of the the Virtual Ward and subsequent Primary Care MDT which represents a cutting edge of Partnership working to provide better and more effective intervention
- Working to close the significant gaps in information transfer that affect patient safety, prescribing and management that exist across the UHC and local authority areas.
- Working to establish an IG framework to allow the effective and safe sharing of information in order to streamline existing processes to make them more cost effective.

- Establishing a foundation from which it might be possible to build a ‘single shared record’ to effectively manage patients across multiple sectors to improve effectiveness, reduce costs and improve patient safety
- Develop pathways of care that reflect better strategic alignment along the ideas pioneered by the Virtual Ward and involving ‘Closed and Open Loops of Care’ - where the journeys of the person through the system and the desired outcomes are the driver for innovating the method to achieve this and then building the IT around the solution that we can all agree is the best option. This is supported by the ‘Shared record’ which in turn demands shared responsibility from each provider involved on that patient journey.

PLAN ON A PAGE

Who are we?

- One of eight clusters within Cwm Taf Morgannwg University Health Board
- 30,000+ Population
- Public Health Wales data reflects high rates of social deprivation, mental health issues, long term disability/morbidity, poverty, benefits uptake and of chronic illness from legacy heavy industry particularly mining

Funding

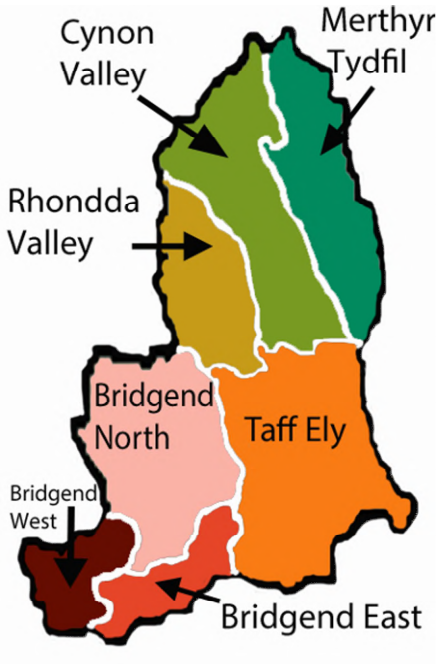
The Cluster allocation is £106,378, which is delivery agreements money received from Welsh Government.

Key Achievements

- ✓ Cluster Pharmacist
- ✓ Advanced Nurse Practitioner
- ✓ Occupational Therapy
- ✓ Care & Repair "Managing Better"
- ✓ Virtual Ward

Cluster Objectives 2020-2023

Care Navigation
Musculoskeletal Services
Greater use of technology and online consultancy
Roadmap for the Shared Record'
Agreed pathway for early pregnancy complications for our patients
Possible ENT clinic in North Cynon
Practice Merger Support
Antibiotic Resistance
Diet & Obesity



Vision for the cluster

- Explore possibilities for forming a legal entity from which to hold contracts and apply for grants to invest in and improve patient services
- Further develop the IT infrastructure and interoperability
- Improve information governance across the cluster, with joint agreements in place
- Continue close partnership working from the platform of the virtual ward and embed the EcT to provide equity across the Cluster
- Working towards prospective and preventative care, building in partners from the local authority and the Third sector
- Establishing a foundation from which it might be possible to build a 'single shared record'
- Strengthen the focus on access to services, winter preparedness and emergency planning and improved service development

2. INTRODUCTION TO THE 2020-2023 PLAN/CLUSTER

Clusters remain at the heart of the National Transformation Programme and new primary care model, and we have realised that working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities. By working as a cluster, we have created a whole system approach that integrates health, local authority and voluntary sector services, and is facilitated by collaboration and consultation. Our care for the patients within the cluster now incorporates physical, mental and emotional well-being, which is linked to healthy lifestyle choices. In line with A Healthier Wales, our key priorities include:

- Planning care locally
- Improving access and quality
- Equitable access
- A skilled local workforce
- Strong leadership

Demographics

There are approximately 30,700 patients living within the North Cynon locality, 240,131 across Rhondda Cynon Taff and 445,190 throughout Cwm Taf Morgannwg University Health Board.

There is a high concentration of the most deprived areas in the country located within the North Cynon cluster. Over half of the registered practice population of the Cwm Taf UHB (63.3%) lives in the 40% most deprived areas in Wales; and, 61.95% in the North Cynon cluster. The percentage of children living in poverty at RCT is almost 30%.

There is a higher level of unemployment in the cluster (8.4%) compared to Wales (7%) - this is also closely related to the deprivation index.

Unemployment, child poverty and the number of people living in households with no workers as well as the number of people caring for a relative are all above the national average. It is perhaps not surprising knowing that poverty has such a strong effect on poor health outcomes then that Mental Health problems have a high prevalence in addition to the more visible chronic diseases, which in turn put a strain on other services such as the local schools and care providers to the dependents of people living with these conditions.

In addition to the figures are the observed local cultures and beliefs as well as those of society at large which can often mean people not seeking help before the point of crisis, and growing social problems tied in with age frailty, isolation and loneliness then often present as medical problems much further down the line putting a strain on secondary care and emergency care services but then also on the care and Nursing homes based in the area where arguably an earlier intervention in the community may have been cheaper, more feasible and supported the independent living of that person for much longer, even indefinitely. The population has varied needs. Adapting what we do to meet the granularity of these needs and the individuals that have them is one of the key challenges to individualising the care which then recognises the person at

the heart of what we do. Partnership working involves not only the professionals and care providers but the patient themselves and their advocates in the ideal setting, but traditional working practices do not support this.

By building a better working environment, where outcomes for patients can be better and satisfaction with the roles can be better the feeling is that more professionals including GPs will want to stay and work in the areas further adding to workforce resilience and quality service and care provision.

3. KEY ACHIEVEMENTS FROM THE 2017-2020 THREE YEAR CLUSTER PLAN

Within the last three years, the North Cynon cluster has become a hub of innovation, developing an infrastructure for Primary Care delivery which maximises efficiency across groups of practices, aligns with prudent healthcare and ultimately raises the standard of patient care.

Virtual Ward

The basis of the Virtual Ward follows the principles of the Quadruple Aims and Prudent Healthcare, in order to have a long lasting positive impact on service delivery, resilience, adaptability and sustainability.

The Virtual Ward operates as a weekly multi-disciplinary team meeting to review patients from across the North Cynon cluster, and aims to:

- Reduce the number of patients returning frequently to the practice, releasing capacity
- Provide an enhanced care package for patients, improving their quality of life
- Help to ensure appropriate hospital admissions

The deliberate and methodical working over the last 3 years has enabled the development of a fully integrated MDT based within the local practices with direct access to the members of the team via the GP practices, new trusted working practices between different provider sectors and stakeholders and much better information sharing and as a result decision making which has benefitted the patients and the providers. There remain challenges of spreading the methods of working, seeking assurances for the partnership ways of working, and developing robust frameworks for quality assurance and governance, but what has been achieved already represents a fantastic start.

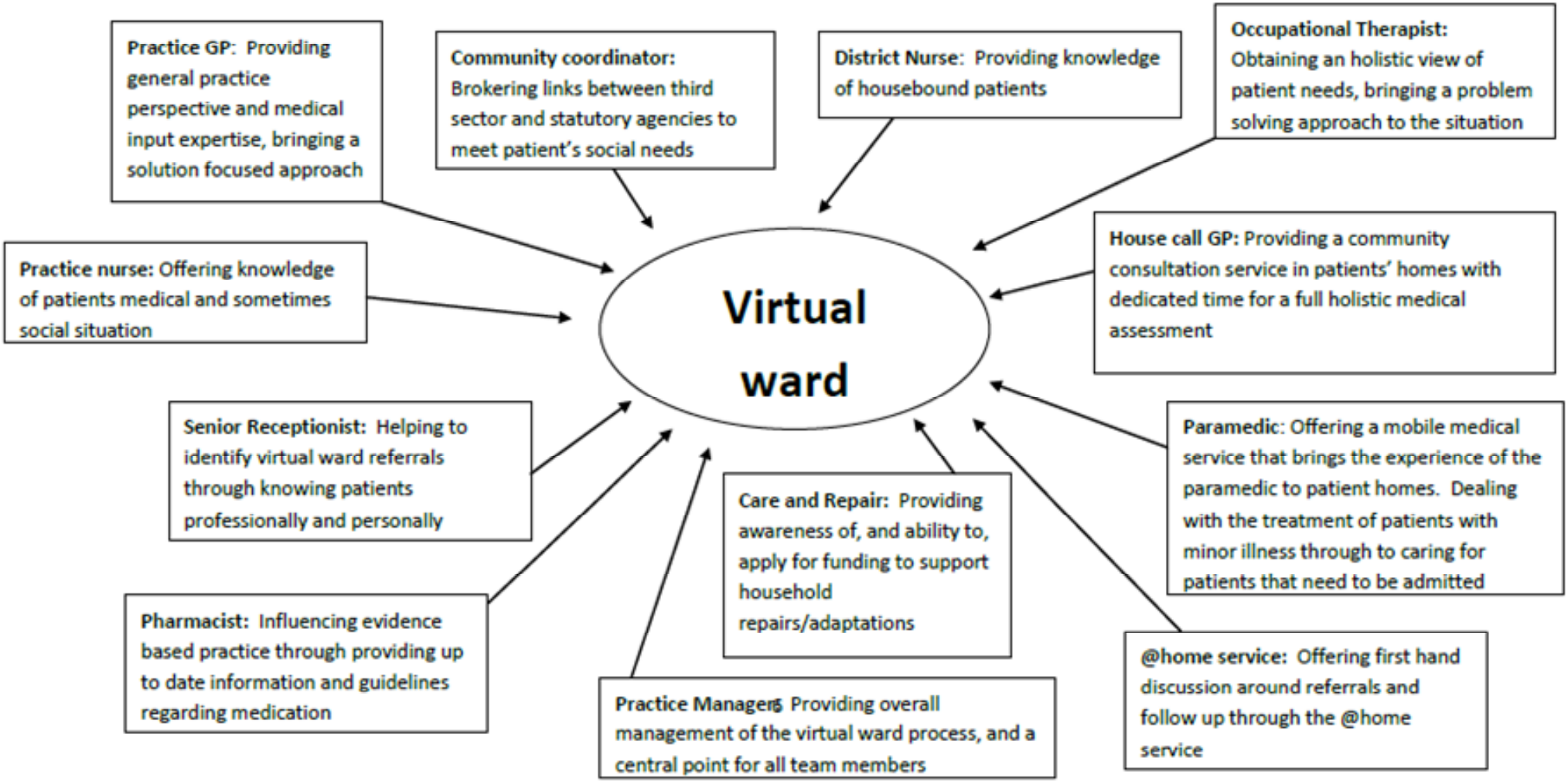
This is achieved through a multi-disciplinary approach in which identified team members' case manage patients that are virtually referred. The team members include: GP, Practice Manager, Practice Nurse, Practice house call GP, Senior Receptionist, Occupational Therapist, District Nurse, Cluster Pharmacist, Care and Repair, Cynon Community Coordinator, @home service.

Traditionally, practices would have seen patients presenting in surgery with ‘medical problems’ where the root causes were often social issues. Through the virtual ward, dedicated time for diagnostic reasoning involving wider team members helps to build a fuller picture of patients’ needs. This helps to ensure that the most appropriate agency is in place to help address both medical and social issues for the patient.
There is the opportunity for all team members to refer patients onto the ward. The outcome of a virtual ward meeting determines which team member is most appropriate to be tasked with identified actions to help address patients’ needs.
Patients are reviewed weekly by the multi-disciplinary team where they either remain on the virtual ward or are discharged from the ward as appropriate.

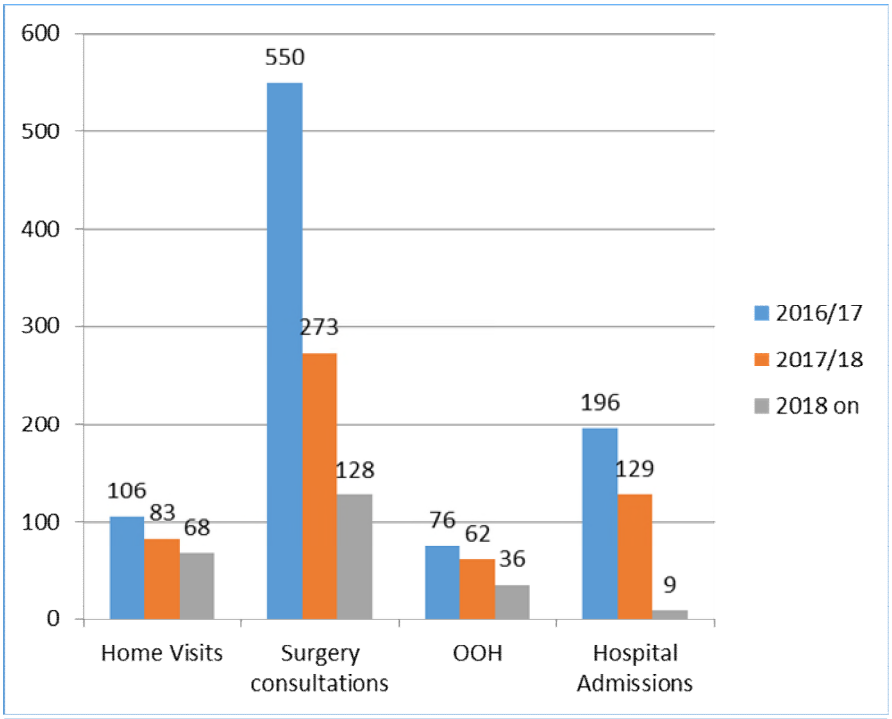
Benefits of the Virtual Ward described by the team:

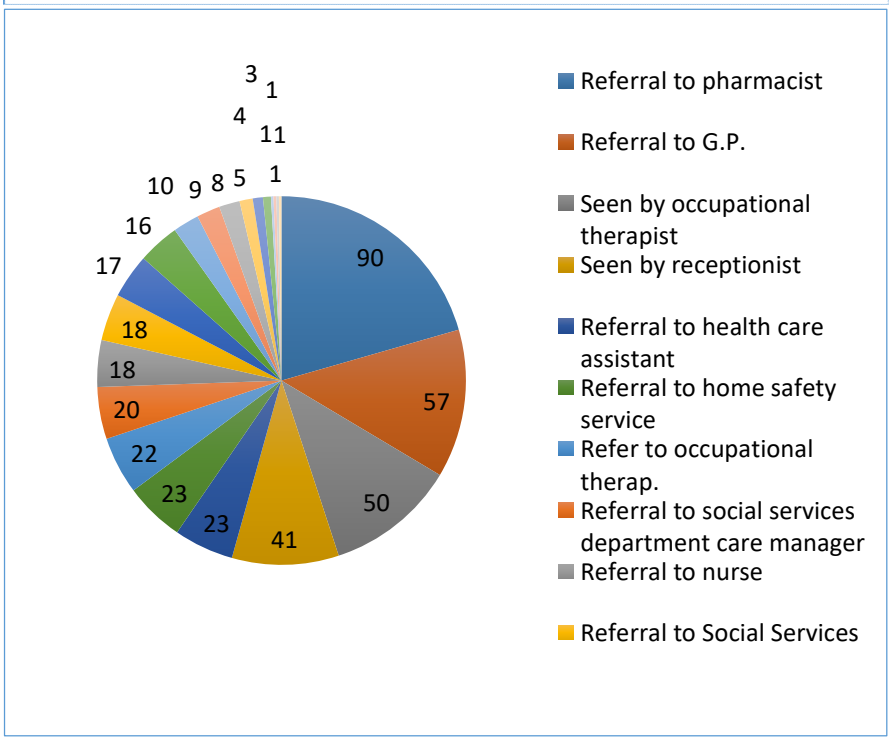
“Two way transfer and timely sharing of information helping to avoid inappropriate hospital admissions/referrals, unnecessary duplication of paperwork and repetitive questioning for patients”

“This approach offers the opportunity to see the bigger picture. The collective knowledge and intelligence of all stakeholders around the table helps to determine appropriate and timely referrals for patients. This can help prevent patients reaching crisis point”

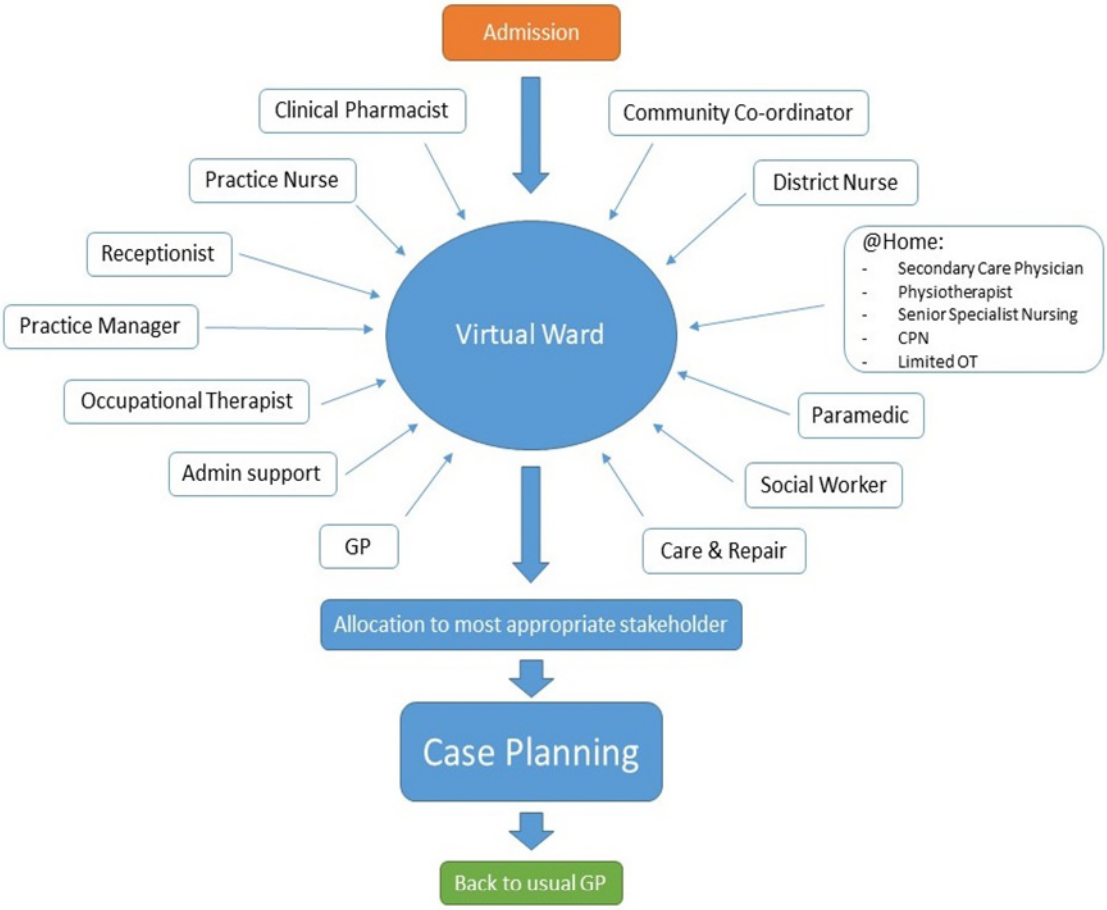

Practice GP: Providing general practice perspective and medical input expertise, bringing a solution focused approach
Community coordinator: Brokering links between third sector and statutory agencies to meet patient's social needs
District Nurse: Providing knowledge of housebound patients
Occupational Therapist: Obtaining an holistic view of patient needs, bringing a problem solving approach to the situation
Practice nurse: Offering knowledge of patients medical and sometimes social situation
Virtual ward
House call GP: Providing a community consultation service in patients' homes with dedicated time for a full holistic medical assessment
Senior Receptionist: Helping to identify virtual ward referrals through knowing patients professionally and personally
Paramedic: Offering a mobile medical service that brings the experience of the paramedic to patient homes. Dealing with the treatment of patients with minor illness through to caring for patients that need to be admitted
Care and Repair: Providing awareness of, and ability to, apply for funding to support household repairs/adaptations
Pharmacist: Influencing evidence based practice through providing up to date information and guidelines regarding medication
Practice Manager: Providing overall management of the virtual ward process, and a central point for all team members
@home service: Offering first hand discussion around referrals and follow up through the @home service

This has already achieved a proven reduction in service demand and a shift to lower cost services:





Data based on an initial cohort of 134 patients put through the Virtual Ward Design shown below.



The initial paradigm informing this design concept put forward by Dr Owen Thomas:

- Work from a shared single record with shared responsibility
- Improve communication
- Improve service utilising existing care infrastructure
- Efficiently assess and review the patient (most appropriate person)
- Involve the patient and/or carers in the process, construct & implement an agreed Careplan
- Step down to normal GP/community care as an end point
- Reduce Reliance on any one particular service

Further achievements include:

- Completed and submitted cluster plan to reflect priorities, supporting the Health Board's IMTP, a Healthier Wales and the National Transformation Programme

- Engagement in a six month pilot with Skills for Health and HEIW to develop and test a tool for workforce planning in Primary Care. This process has produced a workforce plan for the Cluster and feeds into the transformation plan
- Finalists in the General Practice Awards 2018 for the Virtual Ward multi-disciplinary General Practice Team.
- Recruited a shared ANP to deliver the Nursing Home DES across the Cluster
- Several of the members of the team have been invited to talking other clusters and areas of Wales to share practice
- The Virtual Ward has been taken up by the Bevan Comission for its Adopt and Spread scheme in order to try and roll this out and there has already been work in other clusters based on the work of the North Cynon to develop similar MDT style working.
- The result of the Virtual Ward, innovations, thinking behind it, benefits and challenges have been freely shared and distributed by the Team to anyone interested in order to try and spread good working practices and offer some solutions that can be adapted to local needs in order to try and challenge some of the prevailing negative perceptions of General Practice as a whole, but also to try and help with the genuine feelings of being overworked and swamped by workloads.
- Increasing visibility and advertising an ethos of being 'open for business' with a very round table and non-hierarchical approach from General Practice to work in partnership with other providers we have not previously done so with.

4. CLUSTER POPULATION AREA HEALTH AND WELLBEING NEEDS ASSESSMENT

	Life expectancy at birth for males and females (2015-2017) les		
	Wales	**RCT**	**North Cynon (USOA)**
Male	78.3years	77.5 years	77.3 years
Female	82.3years	81.0 years	80.2 years
	Source: Produced by Pubic Health Wales Observatory using ONS data (PHOF Tool, 2019)		

Estimated % prevalence of chronic conditions (2018)			
	North Cynon (practice)	**Cwm Taf**	**Wales**
CHD	4%	3.7%	3.7%
Heart Failure	1%	0.9%	1.0%
Stroke +TIA	1.9%	2.0%	2.1%
Diabetes	6.6%	6.4%	6.0%
COPD	3.0%	2.8%	2.3%

Asthma	6.5%	7.1%	7.1%
Dementia	0.5%	0.5%	0.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018			
Musculoskeletal disorder	17% in RCT (self-reported)		17%
Source: NSW 2019			

Percentage of adults that report that 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 (%)**
North Cynon (USOA)	23.1	20.6	48.7	17.4 *	35.5
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)					

	Uptake of screening % (2017/18)			
	National targets	**North Cynon (practice)**	**Cwm Taf**	**Wales**
Bowel	60%	55.2	64.8	55.7
Breast	70%	74.7	73.6	72.8
Cervical	80%	75.7	76.4	76.1
	Source: Primary Care Needs Assessment tool, 2019			

% Flu Uptake (2017/18)				
	National targets	**North Cynon (practice)**	**Cwm Taf**	**Wales**
At risk aged 6 months to 64 years	**55%**	55.2%	46.8	48.5
2 and 3 year olds	No specific Targets yet	74.7%	53.0	50.2
65+ years	75%	75.7%	67.7	68.6
Source: Primary Care Needs Assessment tool, 2019 using IVOR data				

% Child Vaccination uptake (2018/19)				
	Targets	**North Cynon (practice)**	**Cwm Taf**	**Wales**
Uptake of 6 in 1 at 1 year old	95%	96.7%	97.5%	95.4%
Up to date by age 4	95%	89%	87.9%	87.2%
MMR2 at age 5	95%	92.9%	93.1%	92.2%
MMR2 at age 16	95%	89.7%		
Source: COVER data accessed via http://nww.immunisation.wales.nhs.uk/cover				

5. CLUSTER WORKFORCE PROFILE

Within the Cynon locality, there are:
8 Dental Surgeries
4 Opticians
13 Pharmacies

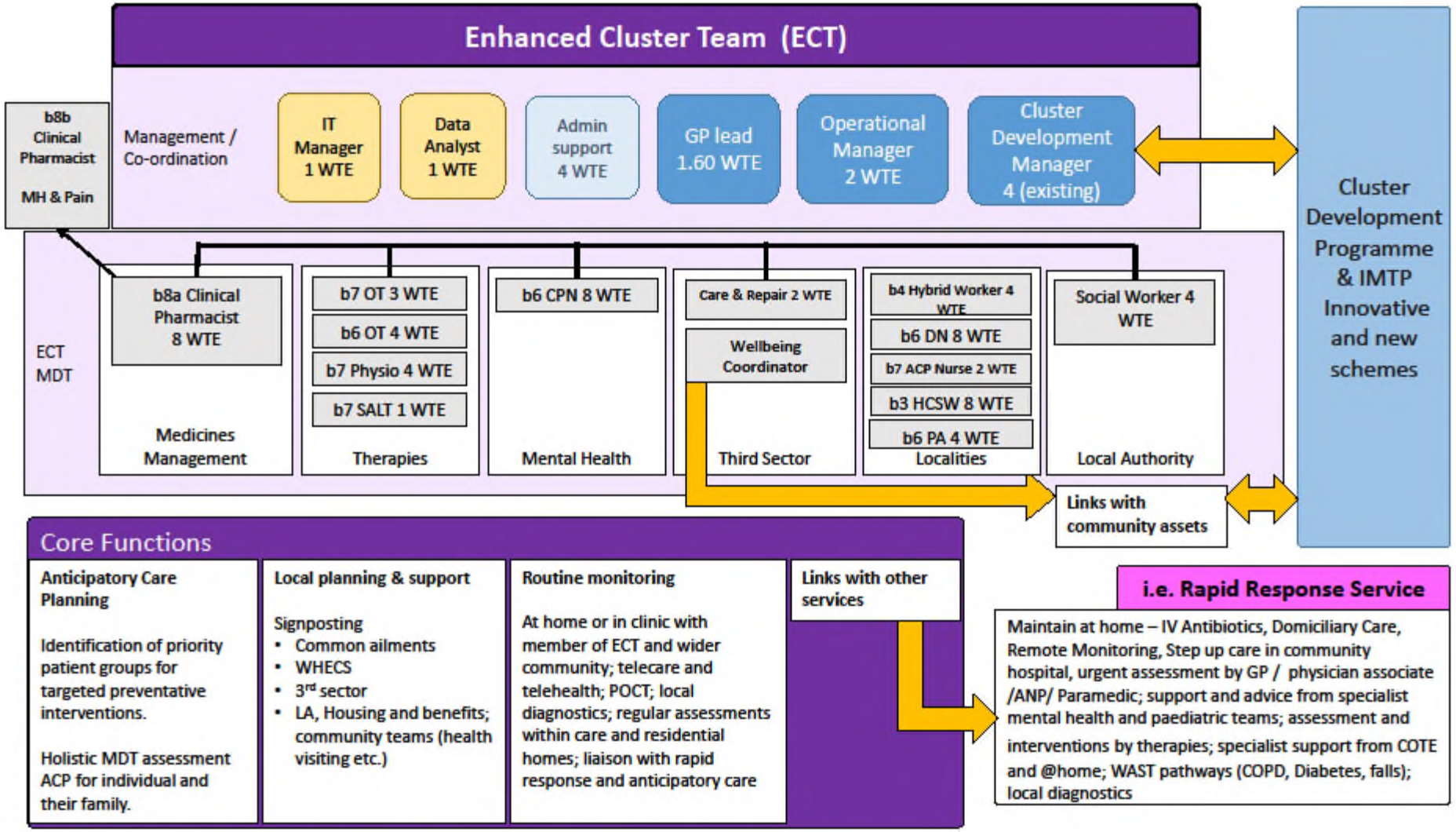
Many of these services work collaboratively alongside GP practices within the cluster, however the view for the next three years will be to proactively engage further with primary care contactors, to develop collaborative working with a view to undertaking a collaborative project involving two or more primary care contractors. Primary care contractors also have standing agenda items at each Cluster meeting, and are invited to attend, however the aim is for consistent attendance at cluster meetings and regular communication with community pharmacists, opticians and dentists contracted within the area.

Enhanced Cluster Team

As part of the Welsh Government initiative to transform the provision of Primary Care services in Wales, Cwm Taf Morgannwg is creating a multi-disciplinary health and social care Enhanced Cluster Team (ECT) which places services closer to home and provides people with the right care and support at the right time, in the right place. The creation of an ECT is built around the individual aims to maintain peoples' independence and improve the long-term health outcomes and experience of care for people who access these services.

This team will be utilised and embedded throughout each cluster within Cwm Taf Morgannwg, and in the next three years, North Cynon will adapt this team within the Virtual Ward.

South Cynon Cluster



6. CLUSTER FINANCIAL PROFILE

The cluster allocation is £106,378, which is delivery agreements 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.

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

Engagement and Communication Mechanisms

The cluster will continue to promote their initiatives and provide 'good news' stories by working closely with the Health Board communications team. This will also include promotion of #YourLocalTeam. In the next three years, the Cluster will provide information, advice and guidance to support the public to make more informed choices.

The cluster will consider operating patient events to focus on Health and Wellbeing and Virtual Ward promotion, utilising new community hubs within the local area and public areas in libraries and Cynon Valley Museum.

Local Drivers for Change

The Cluster, through the support of the Primary Care Development Manager will work with Public Health Wales colleagues to extract further Cluster level qualitative data using the Primary Care Needs Assessment Tool. As shown in Section 4, there are a number of key drivers locally which need to be recognised and actioned to support the health and wellbeing of patients living within the Cluster.

It is estimated that a staggering two-thirds of all deaths for under 75s could have been avoided through the adoption of healthier lifestyles, such as eating more healthily, tackling the wider determinants of health or healthcare interventions, such as earlier diagnosis. Therefore, the cluster will focus on number of objectives to include the 'Five Healthy Behaviours' and weight management.

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GP Workforce

There is a recruitment and retention challenge for GPs both locally and nationally. This is a result of a range of factors, including:

- An Ageing GP workforce
- An increase in the desire of GPs to work part-time with portfolio careers
- The National changes introduced by HMRC to the Pension and tax thresholds.
- Attractiveness of lucrative in-hours locum working fees and flexible working.
- The emergence of remote doctor services which enable GPs to consult remotely

Against this background the demand for GP consultations is increasing as a result of:

- An ageing population and increasing complexity
- Patients being discharged earlier from hospital
- Increasing patient expectations and the 'perceived need' for a 24/7 service
- Sustainability issues in some areas of Cwm Taf which is resulting in an 'overflow' of work to out-of-hours from 6:30pm onwards
- Increased demand due to population increase locally aligned to housing developments
- Ever increasing pressure to transfer services from secondary to primary care

Rhondda Cynon Taf and Merthyr Tydfil has the highest percentage of single handed partnerships. 21.4% of Cwm Taf practices are single handed compared to the figure reported in 2014 of 17.3% and the Welsh Average of 9.1%.
RCT and Merthyr Tydfil is one of the lowest for the number of GPs per 10,000 population. The figure has dropped since last year to 5.8 compared to the welsh average of 6.2 practitioners per 10,000 population.

"Hub and Spoke" Training

General practice is currently facing an unprecedented workforce crisis comprising of severe GP shortages and a looming shortage of practice nurses, with many due to retire in the next few years. The timing of this coincides with increasing demands on primary care with an ageing population with multiple comorbidities and increasing chronic diseases in the wider population.

The vast majority of patient encounters within the NHS occur in primary care; the direction of travel within the NHS is to move more health-related services from secondary care to primary care.The significant workforce issues currently result in increased pressure on services that are already provided and will prevent new services from being developed.

Historically student nurses have had little or no exposure to general practice. Compared to the well-established placements that medical students have in general practice and the clear training path that there is for GP training, no clear comparable pathways exist for practice nurses. In most cases pre-registration nurses have a 6-8

week placement out of their whole training programme in primary care and community but out of this placement may spend just a week in a GP Practice.

A “Hub and Spoke” initiative is being trialled within Cwm Taf Morgannwg which mirrors the very successful nurse training scheme that has been operating in England for a number of years; it is based on a model used in Yorkshire which has been running since 2009 and has recruited significant numbers of student nurses into primary care.

As of January 2018, 23 pre-registration nurses have been placed in Cwm Taf Morgannwg within the hub or spoke practices , and there have been two students who have completed their consolidation in General Practice, with a third due to return to the practice in which they spent their 6 week placement for their consolidation in November this year. All three nurses have cited their positive experience within the GP practice during their 6 week placement as the reason for returning to complete their consolidation.

Third Sector Working

The Third Sector makes a huge contribution to the health and wellbeing of people living in Wales, mainly:

- Community associations, self-help groups, voluntary organisations, charities, faith-based organisations, social enterprises, community businesses, housing associations, cooperatives and mutual organisations.

- Displaying a range of institutional forms, including registered and unregistered charities, companies limited by guarantee (which may also be registered charities), Community Interest Companies, Industrial and Provident Societies and unincorporated associations.

- Each organisation has its own aims, culture, values and way of doing things.

- Third Sector organisations share some important common characteristics including: being independent, non-governmental bodies established voluntarily by citizens who choose to organise and are motivated by the desire to further social, cultural or environmental objectives, rather than making a profit.

In the next three years, the mission of the cluster will be to work towards prospective and preventative care, building in partners from the local authority and the third sector into everyday General Practice in order to improve the resilience of our population and restore and maintain independence rather than an over reliance on any one individual provider;

- Cwm Taf Care & Repair

The Cluster have built relationships with Cwm Taf Care & Repair with representation at every cluster meeting and weekly attendance at the Virtual Ward. A charity which helps older people in Wales live independently in their own homes, they offer practical help to create safe, warm and accessible homes. This help can range from delivering major modifications for people most in need, to offering advice and recommendations to people who need reliable professionals to carry out work.

Care & Repair complete a full Healthy Homes Check, which involves visiting the patient at home and looking around their property for any signs of wear and tear, repairs, aids and adaptations needed to ensure they are warm, comfortable, safe and secure. Furthermore, Care & Repair offer a number of additional services;

- Discuss benefits to ensure all patients are getting the income they should be and refer to DWP when required.
- Discuss energy efficiency, and whether or not the patient is having difficulty with bills. This is to ensure the client is heating their home appropriately in the winter months, and Care & Repair have partnerships with Citizens Advice Bureau and the Energy Advisor in Rhondda Cynon Taf CBC who visit all patients which are referred by them to look at tariffs.
- Care & Repair also refer patients to Welsh Water, to lower the rates of pay, and ensure they are getting the Warm Home Discount that the Government give for everyone on a particular benefit.
- Fire Safety, ensuring there are sufficient working smoke alarms in the property. If not, patients are referred to the Fire Service as they install alarms free of charge.
- Discuss loneliness and isolation, and refer to the Community Coordinators or other third sector organisations that could alleviate this.
- Safety & security and ensure all locks to windows and doors are in good working order. If not, Care & Repair have an internal scheme to get locks repaired and renewed.
- Partnership working with Priority Service Registers with Wales & West Utilities and Western Power. These services are free of charge and ensure priority is given to patients should there be a gas leak or power cut. Wales & West Utilities also supply free Carbon Monoxide detectors that Care & Repair can give to patients.

Patient feedback has been fantastic across Cwm Taf UHB, and comments have been received such as;
“C&R have been excellent. The workmen who came to our home were marvellous and you cannot fault them. Our home is warmer and I find that now the cold does not affect my breathing as much as it used to. It could get quite chilly but now it’s nice and warm at a constant temperature. It’s so much easier to control the heat in each room. We even have a wireless thermostat. C&R have helped us no end. Thank you so much.’

In the next three years, the cluster will continue to work closely with Care & Repair, promoting the services available to ensure GP referrals are being made from all practices, and explore additional resource and projects which could be funded by the cluster to ensure patients are living in warm, safe and accessible homes which are suitable for their needs, and live independently for as long as they wish.

- Newydd Housing Association

This organisation has developed a non clinical community based project for RCT aimed at improving general health and well being

The HAPI (healthy, aspiring, prosperous and inclusive) project makes a positive difference to the health and wellbeing of the communities living in and around the Cynon and Taf Ely area. HAPI is delivered as part of Newydd Housing Association's commitment to creating sustainable communities.
HAPI hopes to work with 5,500 people over the next five years, with project being supported by four key outcomes:
To increase the skills of participants to progress into employment through gaining new skills, including qualifications; Train volunteers with the knowledge and skills to support self-help intervention groups, to improve community wellbeing and sustain the project. This will be done through recruiting HAPI Champions, who will support project staff in the delivery of sessions, as well as become peer mentors
Reduce health inequalities through targeted support to promote physical activity and healthy eating. Project staff are trained by Cwm Taf public health dietitians, allowing them to deliver sessions focusing on how to maintain a healthy weight, sustaining a healthy balanced diet, as well as how to cook healthily and on a budget.
The HAPI project currently delivers weekly walking group from Alltwen Independent Living Scheme and deliver ad hoc physical activity sessions and healthy eating which tends to be delivered at school locations with either pupils only or both pupil and parent sessions. However, over the next three years the cluster will explore further opportunities for collaborative working with the organisation and explore funding through the cluster.

- Valleys Steps

The cluster has engaged with Valleys Steps through GP referrals since 2016, offering Mindfulness and Stress Control courses . In the next three years, the cluster will explore opportunities of different models which would be offered by Valleys Steps at a cost. For example, smaller courses ran in practice by referral only.

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8. PLANNED CLUSTER ACTIONS AND INTENDED MEASURABLE OUTPUTS AND OUTCOMES 2020-2023

No.	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	Theme
1.	***Promotion of the Virtual Ward across the cluster***	One GP from any practice covering virtual ward and managing patient systems	Developing the data collection around MDT working with a view to changing the data collection from reactive data to 'proactive data'	Linking with the Population segmentation work stream in order to try and maximise the potential of this data	RAG Rating: Green	✓ *Timely, equitable access, and service sustainability* ✓ *Improving quality, value, and patient safety*
2.	***'Roadmap for the Shared Record'***	Developing the concepts of 'Closed and Open Loops of Care' in order to start to address fragmented service provision and start to join up information recording and sharing	To be agreed in 2020	To be agreed in 2020	RAG Rating: Amber	✓ *Digital, data, and technology developments* ✓ *Improving quality, value, and patient safety*
3.	***Agreed pathway for early pregnancy complications for our patients***	Allowing midwives to directly refer into the Early Pregnancy Assessment Unit, without GP consent or referral	Streamline and faster service for expecting mothers Better communication channels	Strengthening relationships between primary and secondary care for further pathways	RAG Rating: Amber	✓ *Improving quality, value, and patient safety*

4.	***Possible ENT clinic in North Cynon***	Explore ENT provisions which could be serviced by the cluster	To be agreed in 2020	To be agreed in 2020	RAG Rating: Red	✓ *Timely, equitable access, and service sustainability* ✓ *Rebalancing care closer to home*
5.	***Care Navigation***	Invest in Conexus Healthcare to commission and roll out Care Navigation training for frontline staff across all six GP practices. Provide staff with skills to actively signpost patients on choices and services available to them when accessing care.	Enable primary care staff to consistently work towards delivering exceptional customer service and improve patient experience, whilst working in a busy demanding environment.	Continuously evaluate the service to utilise effectively and overcome barriers	RAG Rating: Green	✓ *Timely, equitable access, and service sustainability* ✓ *Implementing the Primary Care Model for Wales* ✓ *Workforce development including skill mix, capacity, capability, training needs, and leadership*
6.	***Practice Merger***	Support the merging of St Johns Medical Centre and Parc Surgery, and aid the transition for	Evaluate patient feedback to improve requirements	To be agreed in 2021	RAG Rating: Amber	✓ *Communications, engagement and coproduction* ✓ *Estates developments*

		patients in the area in line with Health Board support				
7.	***Antibiotic Resistance***	Promote antibiotic resistance educational video within the cluster ie. reception screens	Continuously promote patient self-care and prevention of antibiotic requirements	To be agreed in 2021	RAG Rating: Green	✓ *Improving quality, value, and patient safety*
8.	***Diet & Obesity***	Staff training on holding healthy lifestyle conversations Support and signpost to community led classes on healthy cooking	Explore funding and interest for Public Health Dietitian or Psychologist recruited within the cluster	Explore projects and initiatives to tackle childhood obesity. Ie. promotion of 10 Steps to a Healthy Weight programme Liaise with Public Health Healthy Schools teams to support community projects	RAG Rating: Red	✓ *Prevention, well-being and self-care* ✓ *Improving quality, value, and patient safety*
9.	***Greater use of technology and online consultancy***	Embrace mainstreamed services available from the Health Board such as eConsult, an online consultation tool that catches clinical symptoms early and offers	Deliver modern patient access, embedded onto each GP practice website	Continuous improvement and evaluation of services available to modernise patient care	RAG Rating: Amber	✓ *Digital, data, and technology developments* ✓ *Improving quality, value, and patient safety*

		effective, time-saving, remote triage and consultation.				
10.	***IRIS - Specialist domestic violence and abuse (DVA) training, support and referral programme for general practices***	All Wellbeing Coordinators and new staff within GP practices to attend training on IRIS service	To continue to implement and extend the domestic abuse training and advocacy service across the cluster	Reduction of frequency of visits to GP surgeries Reduction in the number of prescriptions issued Reduction in visits to Emergency Units Reduction in visits to Sexual Health Clinics	RAG Rating: Green	✓ *Workforce development including skill mix, capacity, capability, training needs, and leadership* ✓ *Improving quality, value, and patient safety*

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 have an approved Terms of Reference in place, which is reviewed as necessary. This notes the 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.

The Cluster plan 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:

Key components of this model are:

- Informed public
- Empowered citizens
- Support for self-care
- Community services
- First point of contact
- Urgent care
- Direct access
- People with complex care needs
- MDT working

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

The cluster recognise the importance of collaborative working to ensure

- Primary Care Development Manager employed to support the North Cynon Cluster
- Terms of Reference in place and reviewed and updated when necessary
- Workforce and Planning support
- Cluster reports to Primary Care Committee to provide assurances through to Executive Director and Board level
- Dental and Optometry Advisors and Pharmacy leads support developments of the Cluster and liaise with the Development Manager and attend Cluster meetings to update on services, contract changes and offer advice on collaborative working.

- Interlink in their role as umbrella organisation for third sector organisations are active members of the cluster and support the health & wellbeing agenda and community development