South Cynon Cluster

THREE YEAR INTEGRATED MEDIUM TERM PLAN

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

SOUTH CYNON PRIMARY CARE CLUSTER 2020 – 2023

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SOUTH CYNON
2020 – 2023

South Cynon Cluster

1. EXECUTIVE SUMMARY

The South Cynon valley is a ribbon of old communities, villages and towns in a particularly socio-economically deprived part of the South Wales Valleys. As the figures below from Public health show, we have some of the highest levels of multi-morbidity and deprivation in CTM and nationally.

We have six GP surgeries in the cluster covering a population of approximately 30,000 patients and have been working together closely as a cluster over recent years alongside our partners from the community pharmacists, optometrists, dentists, district nurses, the third sector and the local authority to support the health of our population.

Our surgeries are all relatively small averaging around 5,000 patients in each, but each providing vital services very close to their local communities. The combination of relatively small and remote GP practices in the Cynon valley makes recruitment and retention in the area a particular challenge with the shortage of GPs nationally and their current widespread lack of interest in joining GP partnerships. This workforce crisis worsens the sustainability agenda for our practices and is therefore an ongoing priority for our cluster.

With this in mind the new collaborative way of working with a local primary care cluster MDT approach to meeting the health needs of our ageing population is something we are already fully committed to and working with as a cluster. We believe this can bring huge benefits to our population with improved access to services closer to home and new and improved services and models of care for the population.

We already promote healthy living and overcoming social isolation and social problems through our new cluster health and well-being advisers, social prescribers and our MIND mental health practitioners. We want to see co-production expanded with closer collaboration of our practices with the local authority and third sector organizations which can expand the services we offer. Better integration and co-ordination of our IT services will allow us to deliver this efficiently both within the expanded cluster MDT and with these external partners.

Improving access with demand management and the use of increasing front of house signposting and triage of patients to our expanding range of community services is now being done but we want to develop the training of our staff to support this new way of networked working.

Finally our workforce is our greatest resource and recruitment and retention of staff within the cluster is a priority to improve quality of care and sustainability of services. Training of GPs, nurses, medical students, post graduate pharmacists and nurses wanting to become practice nurses or ANPs locally is going to be core to the local long term sustainability of services. With a highly skilled, committed and fully supported local workforce working in these new collaborative clinical networks, we believe we can make a huge difference to the health care people both experience and desperately need.

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:

- Cynon Vale Medical Centre
- Abercwmboi Medical Centre
- Cwmaman Surgery
- Penrhiwceiber Surgery
- Abercynon Health Centre
- Rhos House Surgery

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

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.

Key Achievements

- ✓ Health & Wellbeing Co-ordinator
- ✓ Cluster Pharmacist
- ✓ Occupational Therapy
- ✓ MIND Active Monitoring
- ✓ Diabetes Community Clinic

Gaps to address and cluster priorities for 2020-2023

Engagement and Communication Mechanisms
Local Drivers for Change
Sepsis Awareness
Holistic Care
GP Workforce

Cluster Objectives 2020-2023

Care Navigation
Enhance Bowel Screening Uptake
Social Prescribing Promotion
Flu vaccination up-take
Greater use of technology and online consultancy
IRIS - Specialist domestic violence and abuse (DVA) training
Project Diabetes
Diet & Obesity
Fibromyalgia pathways
Musculoskeletal Services

Strategic Alignment

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:

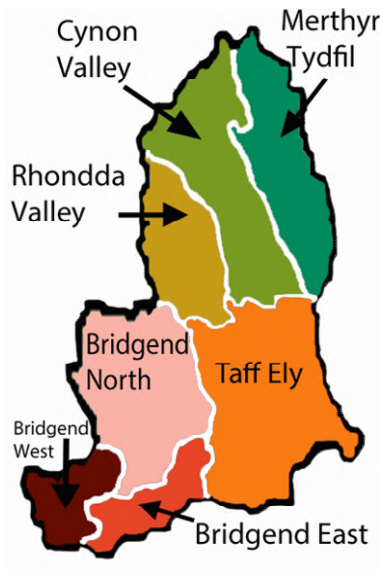
- Informed public
- Empowered citizens
- Support for self-care
- Community services
- First point of contact
- Urgent care
- Direct access
- People with complex care needs

Funding

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

Enhanced Cluster Team

Following a successful bid for funding to support A Healthier 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. If recruitment is successful, the team will consist of multiple disciplinaries (page 13), 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.



2. INTRODUCTION INTO 2020-2023 PLAN

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 30,800 patients living within the South Cynon locality, 240,131 across Rhondda Cynon Taff and 445,190 throughout Cwm Taf Morgannwg University Health Board.

Over half of the registered practice population of the Cwm Taf UHB lives in the 40% most deprived areas in Wales; and, 81.7% in the South Cynon cluster. The percentage of children living in poverty within RCT is almost 30%.

The high deprivation levels within the cluster are the most evident difference between the cluster (81.7%) and Wales (39.9%). This is important to consider given the well-recognised link between deprivation levels and health indicators, and subsequently this influences the cluster's objectives and development plans.

There is a higher level of unemployment in the cluster (9.2%) compared to Wales (7%) - this is also closely related to the deprivation index.

Estates

In the next three years, the Cluster will support the development and commissioning of the new Mountain Ash Primary Community Facility. A new purpose built facility is planned in the Mountain Ash High Street which will replace three existing premises, which are no longer fit for purpose. This will enable the delivery of high quality integrated health and wellbeing services for the population. This development aims to provide delivery of high quality integrated health and wellbeing services for the population, increase in the number of primary care services being offered within the Cluster, and Increase in the number of health promotion activities being offered to patients in the local area. This also supports the Primary Care Transformation Model for all 5 Population Health 5 Ways of Working:

- Long term
- Involvement
- Collaboration
- Prevention
- Integration

The Cluster will aim to keep up to date on development of the building and begin to promote service changes to public and support public meetings when required.

3. KEY ACHIEVEMENTS FROM 2017-2020 PLAN

Historically, GP practices in the Cynon valley worked as one cluster consisting of ten GP practices. However in 2018, the cluster agreed to separate into two formal clusters, North and South, to support each area's differentiating objectives, priorities and vision.

Throughout 2017-2020, the cluster have gained a number of achievements. This has included the utilisation of new or improved roles throughout primary care:

Health & Wellbeing Co-ordinator

The cluster commissioned a service from Interlink for a full time Wellbeing Co-Ordinator for signposting, advocacy and Community Development purposes. This service has developed over time and can offer support such as:

- Befriending, counselling and other support groups
- Housing, benefits and financial support
- Social Activities
- Arts, gardening and creative activities
- Health and Wellbeing activities and courses
- Education and Learning
- Employment, training and volunteering

The role of the Wellbeing Co-ordinator has evidently supported patients to improve their emotional wellbeing, tackling isolation and loneliness, and helping patients to generally feel healthier through supporting lifestyle changes.

In addition to holding face-to-face appointments and telephone consultations at the six practices, one day per week is spent working with 3rd sector organisations and groups to develop further activities, courses and opportunities thereby enhancing and developing community capacity that goes hand in hand with Social Prescribing.

In April 2019, the Wellbeing Co-ordinator worked in partnership and facilitated a 'Stress Control and Mindfulness' taster course in conjunction with Valleys Steps at Abercwmboi Medical Practice. The Wellbeing Co-ordinator worked in collaboration with Cynon Valley Organic Adventures in Abercynon, not only referring patients for volunteering opportunities but also for peer support to the recently developed weekly

Men's Shed and She Shed groups. The Men's Shed at Cynon Valley Organic Adventures was formed by a referred patient who had originally been signposted to Organic Adventures to undertake a self-development course.

Liaison with third sector organisations including Women's Aid, RCT Care and Repair and Rowan Tree Cancer Care continues to ascertain current service provision in the locality.

Cluster Pharmacist

The Welsh Government's plan for a primary care service for Wales up to March 2018 clearly sets out the intention to see more pharmacists working in clinical roles in GP practices. Since the launch of the plan, there has been a significant increase in the number of pharmacists working in these patient-facing roles and almost 80% of annual cluster funding in previous years has been spent on cluster Pharmacists, which are now embedded in the practices within South Cynon, funded by the Cluster and actively engaged in face to face patient consultations and medication reviews.

As part of the GP practice team, pharmacists provide specialist advice for patients particularly the elderly, those taking multiple medicines (polypharmacy), and those with multiple conditions. Through taking responsibility for patients with long-term conditions, clinical pharmacists can free up GPs for other appointments and so help to reduce the numbers of people presenting at A&E departments.

Occupational Therapist

The role of Occupational Therapist has been rolled out throughout the cluster to develop primary care services. Occupational Therapists reduce demand on GPs by addressing and resolving underlying functional issues that are the root cause of multiple and regular contacts with the practice.
With unique & expert knowledge to enhance the cluster, Occupational Therapists work successfully within the cluster and an overall primary care setting, transforming services and working proactively in areas such as frailty, social prescribing, self-management of chronic conditions, mental health and fitness for work.

Mental Health Practitioner

MIND therapists are providing active monitoring sessions from the practice, offering brief interventions for early presentations of anxiety and depression. The cluster commissioned this service with the long-term objective of proving this intervention has prevented the patient from presenting to the GP with the same issue thus preventing the 'revolving door' pattern of attendance.

A patient from Rhos House Surgery provided the following feedback from the active monitoring service:

"I have received a lot of practical advice for dealing with my grief, it has helped me through a really tough time. The advice and exercises are something I can use every day without help from anyone else. I have reached a more positive outlook for the future, I am nowhere near where I need to be as I have a number of other situations that I need time to resolve, however I have seen a significant improvements in my anxiety and have learned how to control my stress. I couldn't suggest how to improve the service as it has helped me greatly, but I would have liked an option for a 'check in' session some weeks down the line, I think that would have been useful."

Cwm Taf Care & Repair

The Cluster have built relationships with Cwm Taf Care & Repair with representation at every cluster meeting. 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 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.

Further achievements include:

- 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
- Supported the development of intermediate clinics and support groups in the form of a Diabetes Community Clinic, delivering services closer to home, reducing wait times and improving patient experience and outcomes
- Completed and submitted cluster plan to reflect priorities, supporting the Health Board's IMTP, a Healthier Wales and the National Transformation Programme
- All members of cluster team understand and actively use *Making Every Contact Count, a* Level 2 characteristic within the Cluster maturity matrix.

4. CLUSTER POPULATION AREA HEALTH AND WELLBEING NEEDS ASSESSMENT

Life expectancy at birth for males and females (2015-2017)			
	Wales	RCT	South Cynon (USOA)
Male	78.3years	77.5 years	76.8 years
Female	82.3years	81.0 years	80.4 years

Estimated percentage of patients living in the most deprived 40% of areas in Wales (2014)	
Cwm Taf Morgannwg	South Cynon (practice)

57.1%	78.9%

Estimated % prevalence of chronic conditions (2018)			
	South Cynon (practice)	Cwm Taf	Wales
CHD	3.9%	3.7%	3.7%
Heart Failure	1.4%	0.9%	1.0%
Stroke +TIA	2.0%	2.0%	2.1%
Diabetes	7.1%	6.4%	6.0%
COPD	4.0%	2.8%	2.3%
Asthma	7.4%	7.1%	7.1%
Dementia	0.5%	0.5%	0.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018			

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 (%)
South Cynon	24.5	20.5	48.3	16.8 *	35.1
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)					

- South Cynon has the highest reported prevalence of smoking in the UHB area.
- Despite having a lower percentage of adults drinking above the weekly recommended levels than the Wales average, it should be noted that RCT has a higher level of alcohol related admissions that the Welsh average and the 2nd highest LA level for both alcohol specific and attributable mortality for 2015-17. (Source: PHWO 2019)
  This 'harm paradox', whereupon drinkers from poorer, deprived communities will experience higher risks of disease and injury despite total alcohol consumption not differing from affluent counterparts has been widely acknowledged if not fully understood.
- Health related lifestyle behaviours are generally poor in the cluster. The long term health and social implications of engaging in harmful behaviours are wide ranging.

Uptake of screening % (2017/18)				
	National targets	**South Cynon (practice)**	**Cwm Taf**	**Wales**
Bowel	60%	54.0	64.8	55.7
Breast	70%	73.5	73.6	72.8
Cervical	80%	77.3	76.4	76.1
Source: Primary Care Needs Assessment tool, 2019				

Flu Vaccination Uptake % (2017/18)				
	National targets	**South Cynon (practice)**	**Cwm Taf**	**Wales**
At risk aged 6 months to 64 years	**55%**	54.0%	46.8	48.5
2 and 3 year olds	No specific Targets yet	73.5%	53.0	50.2
65+ years	75%	77.3%	67.7	68.6
Source: Primary Care Needs Assessment tool, 2019 using IVOR data				

Childhood Vaccination Uptake % (2018/19)				
	Targets	South Cynon (practice)	Cwm Taf	Wales
Uptake of 6 in 1 at 1 year old	95%	99.5%	97.5%	95.4%
Up to date by age 4	95%	87.8%	87.9%	87.2%
MMR2 at age 5	95%	95.1%	93.1%	92.2%
MMR2 at age 16	95%	95.6%		
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. Primary care contractors 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

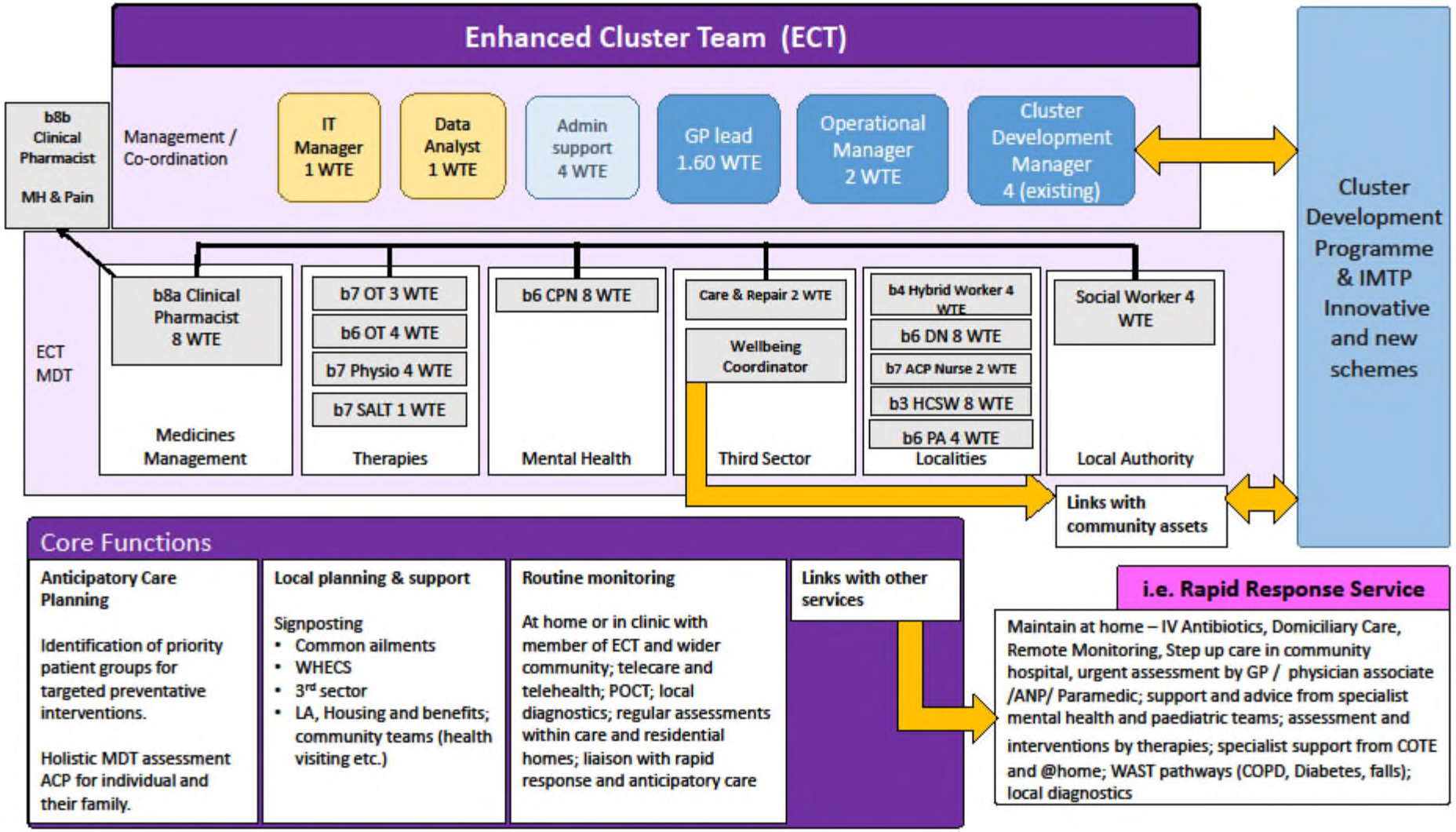
communication with community pharmacists, opticians and dentists contracted within the area.

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.

If recruitment to these roles is successful over the upcoming months, then this team will be utilised and embedded throughout each cluster within Cwm Taf Morgannwg. In the next three years, South Cynon will adapt this team in the best possible way to enhance patient care.

South Cynon Cluster



Cluster Administrative Workforce Profile

Workforce profiles within the GP practices for South Cynon show a number of risks which will be managed and reviewed over the next three years:

- 37% of Practice Managers are likely to retire within the next 2-5 years and 22% of current Practice Nurses are likely to retire in the next 2 years.
- 17% of the current GP workforce is vacant (2.25 WTE), with one post having been advertised for over a year. GP positions are considered the most difficult to recruit for, and the cluster have found issues with using locums in that locums are not keen to fulfil the requirements of a single-handed practice such as being on-call, signing prescriptions and attending house calls.
- Practices provided annual spend on temporary staff, which ranged from £15,000 to £93,000 with a total average across the cluster of £50,000. This cost is considered unsustainable for the continuity of services and quality of care.
- Skills gaps centre around low IT skills. People newly appointed to post having partially completed training and with a lack of hours released for training.

The cluster will look to roll out cluster specific training via Health Board sources or external support to all staff to include:

- Sensory Awareness
- Protection of Vulnerable Adults (POVA)
- Disability Awareness
- Fire Safety
- Medical Records Summarising

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 have recently developed a logo for the Cluster to develop unique branding to be used on formal Cluster documents, information leaflets and event promotion.

Attendance at public events such as 50+ forum and Big Bite event, and holding Health & Wellbeing events within the locality will allow the Cluster to promote their initiatives and engage with the population.

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 obesity, cancer screening and diabetes prevention.

The cluster would also look to develop a local Community Health Champions programme, creating a network which is an integral part of a wider workforce working towards prevention of ill health. This would allow the cluster to tailor information and support to the demographics and issues of the local area, promoting a culture change by using engaged, trained and supported public to volunteer and use their life experience, understanding and position of influence to help their friends, families, neighbours, communities, and work colleagues lead healthier lives.

Sepsis Awareness

Sepsis is estimated by the UK Sepsis Trust to cause the deaths of around 44,000 people in the UK annually. This equates to approximately 2,200 people in Wales each year, which represents approximately 13% of all hospital deaths. Not all death is avoidable but there is still likely to be a sizeable proportion that is. Sepsis also carries a terrible cost, not only in terms of mortality but also in the after effects that survivors may have to carry with them for the rest of their lives.

The main vehicle for the continued improvement of recognition and treatment of sepsis in Wales is through participation of all Health Boards and Trusts in the 1000 Lives Improvement service Acute Deterioration Programme led Rapid Response to Acute Illness Learning Set (RRAILS).

To support this, 1000 Lives have developed a suite of e-learning modules that can be accessed through the ESR and Learning@Wales. In the next three years, the cluster will look to actively engage with 1000 Lives and promote e-Learning sessions on Sepsis awareness, and educating patients on this illness, including promotion of symptoms:

Holistic Care

People who present with both health and social care needs can be supported by seamless care from community resource teams, frailty or other integrated local health and care teams. Complex issues and mental health problems arising from welfare, housing and employment problems can be better managed through a whole system, multi-professional approach.

Effective cluster working enables the multi-professional team to connect with and utilise third-sector organisations to have more time to proactively care for people with complex needs in the community.

The will be a focus in the next three years, for the cluster to liaise with third-sector organisations to explore approaches to lifestyle changes in line with the 'Five Ways to Wellbeing', such as yoga classes, healthy cooking classes, mindfulness and reflexology.

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.

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South Cynon Cluster

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	Primary Care Model for Wales Theme
1.	***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 - Adaptation of new skills and change by practice staff	✓ *Timely, equitable access, and service sustainability* ✓ *Implementing the Primary Care Model for Wales* ✓ *Workforce development including skill mix, capacity, capability, training needs, and leadership*
2.	***Enhance Bowel Screening Uptake*** Promote the benefits of bowel screening to patients, and enhance reporting and data analysis of non-reporting patients	Correct bowel screening coding used on clinical system Check contact details of patients over 60 are accurate, and search for 60-74 year old patients with a non-response	Utilise display screens, leaflets and posters to embed consistent messages across the Cluster	Increase the uptake of bowel screening by 6% to meet the national target rate	RAG Rating: Amber - Willingness to participate in screening by public - Accurate data recording by Bowel Screening Wales	✓ *Prevention, well-being and self-care* ✓ *Improving quality, value, and patient safety*

		result in the last two years.				
3.	***Social Prescribing Promotion***	Evaluate Health and Wellbeing Event in October 2019 and plan next event	Utilise cluster funding to develop and enhance third sector offerings for obesity/diet	Reduction of burden on GP appointments for patients presenting with non-medical and obesity related issues	RAG Rating: Amber	✓ *Communications, engagement and coproduction*
4.	***Flu vaccination up-take***	Regular flu updates provided to the Cluster by email	Work collaboratively with Public Health Wales to improve and enhance annual campaigns	Improve flu vaccination uptake by 2%	RAG Rating: Red	✓ *Prevention, well-being and self-care* ✓ *Improving quality, value, and patient safety*
5.	***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 effective, time-saving, remote triage and consultation.	Deliver modern patient access, embedded onto each GP practice website	Continuous improvement and evaluation of services available to modernise patient care	RAG Rating: Green	✓ *Digital, data, and technology developments* ✓ *Improving quality, value, and patient safety*
6.	***IRIS - Specialist domestic violence and***	All Wellbeing Coordinators and new staff within GP practices to attend	To continue to implement and extend the domestic abuse training and	Reduction of frequency of visits to GP surgeries	RAG Rating: Green	✓ *Workforce development including skill mix, capacity, capability,*

	abuse (DVA) training, support and referral programme for general practices	training on IRIS service	advocacy service across the cluster	Reduction in the number of prescriptions issued Reduction in visits to Sexual Health Clinics		*training needs, and leadership* ✓ *Improving quality, value, and patient safety*
7.	***Project Diabetes***	Engage practices Educate GPs, nurses and Healthcare Support Assistants Develop pre-diabetes pack Launch 'Project Diabetes' in collaboration with Public Health Wales	Develop programme to collect and analyse data on weight and HBA1c Launch patient education courses on pre-diabetes support ie. cooking classes, dietary information, lifestyle changes	Evaluate reduction in pre-diabetes levels and observe culture change in the community	RAG Rating: Red	✓ *Prevention, well-being and self-care* ✓ *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 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	RAG Rating: Green	✓ *Prevention, well-being and self-care* ✓ *Improving quality, value, and patient safety*

		Budget meal plans for healthier eating		support community projects		
9.	***Fibromyalgia pathways***	Promote EPP courses ran for fibromyalgia patients and explore alternative therapy	Raise awareness of fibromyalgia and improve pathways with secondary care	To be agreed in 2021	RAG Rating: Green	✓ *Prevention, well-being and self-care* ✓ *Improving quality, value, and patient safety* ✓ *Communications, engagement and coproduction*
10.	***Musculoskeletal Services***	Explore new provisions for primary care physiotherapy	Reduce inequalities and improve outcomes for patients with musculoskeletal conditions either through secondary care, or cluster funded services	Develop ways to measure and evidence successful musculoskeletal services Embed a culture of prevention, self-management and resilience in line with the national agenda	RAG Rating: Red	✓ *Prevention, well-being and self-care* ✓ *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 recognises the importance of collaborative working to ensure effective practice.

- Primary Care Development Manager employed to support the South 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
- Cwm Taf Care & Repair
- 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 which has been trialled and tested at Abercwmboi Medical Practice, with great success.
- Newydd Housing Association has developed a non clinical community based project for RCT aimed at improving general health and well being. 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.