# South Cynon Cluster Annual Delivery Plan 2021-2022

## 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 five 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.

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:

- ✓ Meddygfa Glan Cynon
- ✓ Abercwmboi Medical Centre
- ✓ Cwmaman Surgery
- ✓ Penrhiwceiber Surgery
- ✓ Abercynon Health Centre

The plan also embraces key UHB priorities for the upcoming year, 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

Cwm Taf Morgannwg University Health Board

# South Cynon Cluster Annual Plan on a Page 2021/22

## Cluster Aims:

- To improve life expectancy and reduce health inequalities.
- To work with partners to ensure services are integrated with those of the voluntary sector, community sector and the local authority
- To commission health care that delivers quality outcomes that are focused on the need of the individual and that treats people with compassion and dignity and is delivered in the most appropriate setting.
- To work with our partners to address the prevalence of smoking and alcohol issues, obesity and diabetes, and low uptake on Public Health screening services
- To reduce the variation in the quality of care.
- To lead sustainable change to transform healthcare provision in South Cynon.

## Planned Cluster Actions:

- 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.
- Source innovative ways to offer better access to new and existing services which benefit the health and wellbeing of patients across South Cynon

## Cluster Key Work Streams:

- Cluster Pharmacy investment
- Development of a Pain Management Programme
- Embed the Advanced Nurse Practitioner role into care homes across the locality
- Continue First Contact Physiotherapy
- Explore Dermatology training for GPs within the cluster
- Public Health Cluster Wellbeing Needs Assessment/Population Profile
- Green Social Prescribing project in collaboration with Cardiff University
- Technology
- Skilled Workforce
- Partnership Working
- Financial Resource

**3. Reflections of 2020 Covid-19 service delivery and impact on Cluster working and cluster planning**

Whilst COVID19 has enhanced the huge pressure and constraints primary care face, there have been a small number of positive impacts on service delivery since the pandemic began. These include:

- Closer team working, allowing practices to trust and rely on neighbouring colleagues to create a contingency plan if one practice would not be able to open
- Encouraged closer working with North Cynon cluster to benefit the population of the Cynon Valley
- Streamlining some pathways with secondary care and community care
- Building relationships and developing services which third sector can offer, for example Care and Repair
- Forced IT development including remote working, eConsult and Attend Anywhere. Total triage is now undertaken by GPs and ways of working are more consistent across the locality.

However, an immeasurable amount of strain and pressure has impacted service delivery across South Cynon since March 2020:

- Prevention to achieve many objectives and milestones set out in the previous Integrated Medium Term Plan
- Those services which have been launched have been delayed, and their effectiveness compromised due to triaging requirements
- Less community engagement, ie. no events or groups have been able to be held
- Limited secondary and community services available to refer into
- Workforce issues worsened and exaggerated, due to isolating or shielding staff leading to a drained workforce
- Reinforced the poor services available for mental health and inverse care law, and highlighting the gaps between patients who have access to IT than those who do not.

**4. One year in reflections on the 2020/23 Cluster Plan content and ongoing relevance to direct future cluster working**

**Care Navigation**

The cluster have invested in Conexus Healthcare to commission and roll out Care Navigation training for frontline staff across all GP practices. This training would provide staff with skills to actively signpost patients on choices and services available to them when accessing care. This would also enable primary care staff to consistently work towards delivering exceptional customer service and improve patient experience, whilst working in a busy demanding environment. Prior to Covid-19, all group sessions with stakeholders had taken place and the cluster were in a position to offer the staff training sessions, however these were not able to go ahead. Currently, we have been unable to reschedule these sessions but have worked closely with Conexus Healthcare to develop and offer online training sessions for our staff to undertake.

**Bowel Screening**

Bowel Screening Wales have been working in partnership with South Cynon Cluster to deliver the Primary Care Non-responder Support Service, as part of the Bowel Cancer Moondance initiative.

The Moondance Bowel Cancer Project aims to transform five year bowel cancer survival rates in Wales within a decade. Thanks to funding from the Moondance Foundation, motivated partners from across the bowel cancer community will work together to deliver a series of activities to improve all areas of the patient pathway. Bowel Screening Wales were successful in bidding for funds from the project, some of which was used to fund resource to the Primary Care Non-responder Support Service. This project wanted to

address some of the feedback from previous partners regarding the workload of GPs and their practice staff in utilising the data effectively and efficiently. There is a good evidence base from previously run pilots in Wales and across the four nations that GP endorsement improves uptake of the bowel cancer screening programme. The objectives of the project were to:

- Increase uptake of the bowel cancer screening programme and reduce inequalities across South Cynon Cluster, Cwm Taf Morgannwg University Health Board.
- To inform non–responders of the benefits and risks of bowel cancer screening,
- To issue replacement test kits to participants who now want to participate.
- To act as a direct link between the cluster and Bowel Screening Wales.

Due to the impact of Covid-19 on the work of the Primary Care Support Officer, only three practices were engaged for this arm of the intervention:

- Rhos House Surgery
- Penrhiwceiber Medical Centre
- Abercynon Medical Centre

Uptake of the bowel cancer screening programme for South Cynon in 2018/19 was 53.8%. National uptake across all of Wales is 57.3%. Across the three participating practices, uptake ranges from 50.8% to 53.4%. There are a multitude of health and wellbeing factors that impact upon the local area and key population features of the South Cynon cluster footprint including higher than average cancer incidence and poorer survival outcomes.

GP Endorsement letters resulted in an increase of 22.7% participation**,** and telephone calls resulted in an increase of 3.9% participation at cluster level. This results in an overall increase of **27.2%** for the participating practices from the cluster. Of the 176 previous non-responders who have now taken up their offer of Screening, 0 received a positive result, giving a positivity rate of 0.0%.

In addition to the results of the intervention, a great deal of learning has been gathered for Bowel Screening Wales, with regards to reasons for non-participation and barriers to the service. The learning headlines are summarised below:

- Contacting participants without access to their medical history can lead to challenging conversations, for example, those who are receiving cancer treatment/palliative care
- 24 patients were uncontactable due to no number being held on their medical record
- Despite recent marketing campaigns including the new Bowel Screening Advert with Jamie Roberts very few participants were aware of the new FIT.
- More and more patients are using call screening and barring on their contact telephone numbers as well as not accepting ‘withheld numbers’ this proves problematic with ‘remote working’
- Current anxiety regarding attending hospital with Coronavirus still prevalent in the cluster area. Suspension of NHS services

**Project Diabetes**

Diabetes mellitus is one of the most common chronic diseases in Cwm Taf Morgannwg University Health Board (CTM UHB) with a prevalence of 7.9% (approx. 28,000 people) of those aged 16 years and over. It is projected to increase to affect around 45,000 people in CTM by 2025. Diabetes is associated with a number of health risks and complications and linked to increasingly high health service expenditure.

There is a growing evidence base to support interventions aimed at 'pre- diabetic' patients. A systematic review found that behavioural interventions conducted in 'real world' settings were effective in reducing weight and reducing the incidence of type 2 diabetes. Overall incidence was reduced by 26% over 12-18 months post-intervention3.

A pilot project commenced in February 2020 within South Cynon focusing on pre-diabetes. Phase 1 focuses on the identification of individuals from GP practice registers who have previously had a HbA1c blood test result which identifies them as 'pre diabetic' and thus at a higher risk of developing type 2 diabetes mellitus.
After being invited for a repeat blood test if required, all individuals age 18-74 years who are not on a diabetic register but have a HbA1c within 'pre diabetic range' will be invited into the practice for a 20-minute structured brief intervention with a band 3 Health Care Support Worker who has received additional training on prediabetes, nutrition and physical activity advice. The consultation will also include measurement of height, weight, BMI and blood pressure.

Within the next year, patients will be contacted again at 12 months' post intervention and offered a repeat HbA1c and follow up appointment with a healthcare support worker. Measurements will be repeated together with a discussion of any lifestyle changes undertaken. Evaluation of patient experience and outcomes will be supported by academic partners.

Development, implementation and evaluation of the project will be overseen by a multiagency Task and Finish Group who will report back in the diabetic delivery plan group. The formal governance and reporting route for this Prevention and Early Years fund as a whole within the Health Board is to be determined.

The overall prevention programme of which this project is part, will need to demonstrate clear alignment with the themes and priorities agreed by the Building a Healthier Wales Strategic Coordinating Group. The Strategic Coordinating Group will be responsible for maintaining system oversight and for monitoring improvement on a regional and national scale.

**eConsult**
A main priority for the cluster 2020 was the launch of eConsult, an online consultation tool that catches clinical symptoms early and offers effective, time-saving, remote triage and consultation. Due to COVID-19 restrictions to face-to-face appointments, the tool was launched in March 2020 to support remote consultations and triage, and improve the services available to modernise patient care.
The eConsult tool is embedded onto every GP practice website and utilisation has increased dramatically since the launch. The top 10 reasons for patients within South Cynon to use this type of service are:

Administrative help
General advice
Rash, spots and skin problems
Depression
Anxiety
Sore throat
My child is generally unwell
Earache
Contraception

*Benefits to the GP Practices have included:*
By knowing a patient's symptoms upfront, the GP practice can manage patients by clinical need. The practice will then be able to care for that patient based on the appropriate resources available increasing practice efficiency.
There are standardised questions that include the standard scoring systems such as PHQ9 for depression and GAD7 for anxiety so you understand you patients' needs.
Our red flag system helps to capture critical illness and signpost patients to the most appropriate care
eConsult can help save time for your NHS GP practice staff – the average eConsult takes 2-3 minutes to read thanks to a succinct clinical risk report, meaning you could help three patients in an average 10-minute GP slot
Help reduce your inappropriate GP appointments – We have found that on average 70% of eConsults don't need a face to face appointment
Improve your work-life balance and staff retention – eConsult empowers GPs, HCPs and practice staff to use their working day more efficiently

*Benefits to the patients have included:*
Patients may not need a trip to the surgery and their query may be resolved with a phone call, to keep patients safer during the COVID-19 outbreak and subsequent national lockdowns
Medical advice is available 24/7 even when the practice is closed – Patients can check their health symptoms online and receive on the spot medical advice and treatment guidance thanks to NHS Choices content
Patients will get a response from their own NHS GP practice by the end of the next working day or sooner
Access wherever and whenever patients want from any device. Unlike a telephone call patients can complete an eConsult at a pace that suits them, without taking up practice time
Patients can request sick notes and test results without the need for an appointment saving patient and practice time

**First Contact Physiotherapy**
Musculoskeletal (MSK) conditions are the most common cause of repeat GP appointments, accounting for 20-30% of GP workload in Cwm Taf Morgannwg UHB. They account for a high percentage of referrals on to secondary care.

Many of these patients can be managed effectively by a physiotherapist without any need to see the GP. Research shows where physiotherapists are present in primary care as first contact practitioners appropriate early management of MSK conditions helps to reduce onward referral to secondary care, reduce prescribing and unnecessary investigations.

- Reduce the GP MSK caseload
- Reduce referrals to orthopaedics
- Reduce referrals to secondary care physiotherapy
- Reduce prescribing
- Reduce imaging
- Provide high quality Physiotherapy service
- Improved clinical outcomes for patients
- Improved ability for patients to self-manage their own condition
- Patients offered a range of management options (excluding surgery)
- Patients report high levels of satisfaction with the service
- 70% of conditions should be managed in single appointment

**Cluster Website Launch**
The cluster commissioned Tree View Designs Ltd to launch their first cluster based website available to patients within the community to access and view cluster projects and initiatives, local services and third sector organisations, and receive regular information and updates on healthcare within their area.

The website launch supports a number of the delivery milestones within the Primary Care Model for Wales, including an *informed public*; this website provides an outlet for regular information to patients, educating and empowering people to take ownership of their own health.

www.southcynoncluster.co.uk

| 5. Key Cluster Actions for 2021/22 | | | | | | |
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| **Objectives** | **Planned Action** | **Expected Outcome** | **Possible Constraints/ Key Risks** | **Workforce Implications** | **Financial Implications** | **Monitoring process** |
| **NHS Wales Operating Framework - Maintaining Essential Health Services during the COVID 19 Pandemic – summary of services deemed essential** | Primary Care Contractors to continue to deliver essential services to their population whilst taking into account COVID19 restrictions<br><br>Access to services to continue to improve for patients and re-introduction of any suspended and enhanced service provision<br><br>Practices to ensure access to health advice support and interventions using multiple routes e.g. telephone, e-consult, video consultation.<br><br>To continue to work with Health Board Primary Care Team and ILG to ensure plans work jointly across teams | Access to services to continue in most appropriate way.<br><br>Increase in contacts around conditions that have reduced during COVID19<br><br>Timely delivery and completion of COVID19 and flu vaccination programmes<br><br>Improved and targeted communications with patient population | Lockdown measures and need to manage access, need for social distancing, control measures which does impact on number of patients that can be seen at premises at any one time<br><br>Ability to access referrals on to other specialist services. | Impact of COVID19 on available workforce cohort/specific skills which could impact on ability to deliver a particular service area. | Adjustments to premises, additional costs of social distancing measures, cleaning regimes etc.<br><br>Additional staff costs to allow normal service delivery against any other requirements e.g. COVID19 vaccination priorities, | |
| **Advanced Nurse Practitioner to support Care Home DES** | Training and induction for ANP, embedding role into care homes across locality in 2021/22 | Release GP appointments and availability | Lack of willingness of care homes to utilise role | Benefits to GP workload in each practice who are currently managing care home patients | Current budget allocation for 2021/22 to fund this service is £57,684.00 | Monthly review with member of staff |

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| | | Educate & empower care home staff to manage patients<br><br>Additional clinical management and support 'at the coalface' to manage complex patients | Changes to the Care Home Directed Enhanced Service in 2021/22 | and weekly 'ward rounds' | | Qualitative feedback from care home managers and staff<br><br>Documentation checks of CGAs |
| **Pain Management Programme** | Commission CTM UHB Physiotherapy and Pain Management Pharmacist to deliver service, via virtual and face to face consultations for patients referred by a GP<br><br>Engage with EPP Programme for further educational sessions in community settings | Support people to better understand long-term pain<br><br>Increase activity and mobility<br><br>Improve management of anxiety and low mood associated with living with pain<br><br>Address social isolation and build support networks<br><br>Optimise analgesic medicine's use including tapering those that are unhelpful or causing harm | Limits on patients who can access service. No complex or unstable mental health conditions, or diagnosed substance use disorder. Patients no suitable with high levels of psychological distress e.g. resulting from physical or psychological trauma | Additional resource for clinicians to refer patients who have previously had limited access to pain management | Current budget allocation for 2021/22 to fund this service is £15,000.00 | Patient-reported global improvement and improvement in daily physical and emotional functioning, including sleep.<br><br>Major adverse effects (defined as leading to withdrawal from treatment)<br><br>Patient-reported pain relief/intensity reduction |
| **First Contact Physiotherapy** | Continue the FCP Service into 2021/22 | Reduce inequalities and improve outcomes for patients with musculoskeletal conditions either through a cluster funded service | Limited resource available within the CTM UHB Physiotherapy team to provide, including difficulties in | Embedding a culture of prevention, self-management and resilience in line with the national agenda to shift resource | Current budget allocation for 2021/22 to fund this service is £33,500.00 | A minimum data set collected as standard, with the FCP provider submitting quarterly reports to the cluster. |

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| | | | recruiting to Physiotherapist posts | | | |
| **Ty Elis Counselling** | Support the continuous roll out of mental health counselling service across the cluster, provided by Ty Elis Counselling | To provide structured therapeutic counselling interventions to relieve patients who are emotionally distressed and to improve coping strategies and resilience in individuals<br><br>To improve mental health and emotional wellbeing of patients<br><br>To work with patients to where applicable regain their autonomy and to take responsibility and control for the issues affecting their lives. | The service is not appropriate for:<br><br>Families<br>Couples<br>Young People under 18<br>People with unstable serious psychotic illness.<br><br>There are currently limited resources and services available in the locality for these groups. | Less primary care appointments booked for mental health problems | Current budget allocation for 2021/22 to fund this service is £34,065.00 | Individual patient outcomes monitored using the Warwick Edinburgh Mental Wellbeing Scale<br><br>Quarterly reports submitted to cluster reflecting:<br>-the number of counselling appointments held<br>-the number of people per week attending counselling<br>-the number of Did Not Attends [DNAs]<br>-Collation of information on user satisfaction.<br>-The number of any complaints – as per complaints procedure<br>-Collation of information on the level of support provided to each individual i.e. number of sessions provided. |
| **Green Social Prescribing** | Work collaboratively with Cardiff University and Cynon Valley Organic Adventures Ltd to launch a nature trail in Abercynon which will provide opportunities for GP referrals and | A co-produced nature trail in Abercynon designed in partnership with the local community which promotes wellbeing | Need to increase the awareness of healthcare professionals of the potential benefits of prescribing nature based activities | Additional avenue for HCPs and Wellbeing Co-ordinators to refer patients who would benefit from social prescribing | Costs covered through sponsor, Welsh (Gov) European Funding Office. Cardiff University will work with local schools to develop educational resources and nature | Increased awareness of the potential benefits of green prescribing for the local population amongst healthcare professional in South Cynon |

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| | community members to engage in nature-based activities to enhance their personal wellbeing. | An app based wellbeing tool which can be used to measure the subjective wellbeing of individuals engaging with the trail<br><br>A model green prescribing approach which could be replicated at other sites across Wales | Activities need to be planned and designed in partnership with the local community and the intended green space users | | monitoring activities linked to biodiversity and climate change . | Evidence to show that engagement with nature through the medium of a nature trial has a positive impact on community wellbeing |

## 6. Cluster Workforce 2021/22

The Covid-19 pandemic has caused unprecedented changes to our normal way of working, making it imperative for us to adjust expectations and renew our focus in the wake of what may potentially become the new normal with regards to workforce planning, requirements and contingency.

**Community Health and Wellbeing Team**

As part of the Welsh Government initiative to transform the provision of Primary Care services in Wales, a multi-disciplinary health and social care team was created 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 this team 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.

In the last year, recruitment to the posts within this team have been successful and have been utilised and embedded throughout each cluster in Cwm Taf Morgannwg. Despite the challenges the cluster have faced in recent months, the Community Health and Wellbeing Team have regularly met on a weekly basis to review patients within the community at risk.

**Health & Wellbeing Co-ordinator**

This service has continued to develop over the last year, supporting our clinicians and administrative staff to signpost patients to receive help for the following:

- 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 five 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.

**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.

**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 year, 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.

**GP Workforce**

There remains to be 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%.

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.

Successful workforce planning is regularly reviewed at cluster level through collaborating with all practices in the cluster and with other identified stakeholder groups, working together to identify shared sustainable workforce solutions for local primary care services. We use our effective cluster leadership to drive workforce planning within the cluster and review as part of our risk management.

**7. Cluster financial implications for 2021/22**

The Cluster allocation is £212,378.00, which is delivery agreements funding 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.

Cluster Leads meet with the Health Board and peers on a quarterly basis at a CTM UHB Cluster Leads Meeting, where is it continuously raised that many services and projects have been trialled but are still not centrally funded, for example Mental Health services and Cluster Pharmacists. These services provided to the cluster and funded by the cluster budget are expensive, but too valuable to not commission each year. However, this equates to a large amount of the cluster budget designated each year, and the cluster unable to trial new innovation and ways of working.

**8. Strategic influence / links / alignment with Health Board Annual Plan 2021/22**

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.

A new Health Board structure was created in April 2020 which allocated each area of the Health Board into 'Integrated Locality Groups'. Going forward, the Cynon cluster have been involved in many meetings and discussions with their new leadership team with some success. In the next year, the difficulties and conflicts of interest between the Integrated Locality Group and the central Primary Care team will be aligned to ensure that the GMS contract, core services and cluster enthusiasm can work collaboratively together.