Rhondda Primary Care Cluster
Integrated Medium Term Plan 2020 - 2023

1. Executive Summary and 'plan on a page'

The Rhondda Cluster's ambition is to improve the health and wellbeing of our community, both now and for future generations. To help us achieve this, we have developed our Integrated Medium Term Plan (IMTP) (hereafter known as 'the Plan'), for the period 2020 – 2023, to help us plan local services to meet the needs of the Rhondda.

We continue to work within the context of a community that experiences significant challenges in terms of deprivation and the burden of ill health. The Cluster has made significant progress in terms of new workforce roles and partnership working, such as establishing closer links with community pharmacies, dentists and opticians and third sector providers.

We hope that through working more closely with our partners in primary care and the third sector, we can make great strides in tackling the healthcare challenges that our population faces. Population segmentation and risk stratification has allowed us to see first-hand what we have long suspected, and has been proven by the inverse care law, that social deprivation leads to poorer health outcomes.

We have identified the following key areas to prioritise in order to improve outcomes for the future health and wellbeing of our population:

1. Obesity
2. Five Healthy Behaviours
3. Mental Health
4. Chronic Pain

We want our patients to be able to access services in the community that can help maintain a healthy lifestyle and prevent mental illness and chronic pain without having to access the GP – this will involve educating patients through targeted advertising campaigns and social media to raise awareness of services that are already available and to inform the community when new services become available. In addition, we will be training front-line-staff across the cluster in care navigation skills so that they are better equipped to navigate patients to "the right service, at the right time". In ensuring that patients see the most appropriate professional, we hope that this will improve waiting lists and lead to timely access for the patients that require these services.

We would like to thank everyone who has contributed to this plan, which is a working document that will continue to develop over the next three years.

Dr Bikram Choudhary and Lindsey Sandhu
Rhondda Primary Care Cluster Leads

Welcome

This plan has been co-produced by the following health and care providers, through facilitated discussion with the Primary Care Health Board management team:

- 12 GP Practices
- 27 Community Pharmacies
- 8 Dentists
- 11 Opticians
- County Voluntary Council (CVC) Interlink.

Overview of the Cluster

The Rhondda Cluster is one of eight clusters within Cwm Taf Morgannwg University Health Board (CTMUHB). The resident population of Rhondda Cynon Taf is 240,131. The Rhondda Cluster serves a practice population of 88,849.

The plan has been informed by public health information on key health needs within the area; information and support provided by CTMUHB; an understanding of our localities baseline services and identification of potential service provision unmet needs.

The plan also embraces key UHB priorities, 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.

Vision

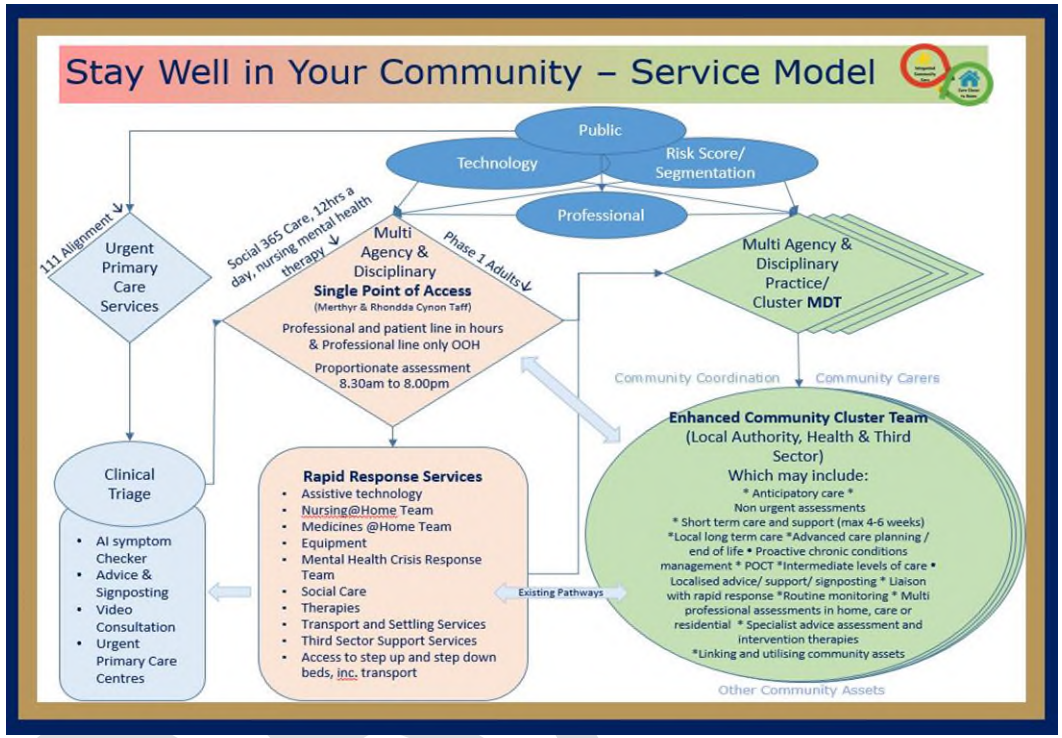
The overall vision of the Rhondda Cluster is to provide health, care and wellbeing services that are designed and delivered around the needs of individuals: 'closer to home' and with a greater emphasis on sustaining a healthy population and preventing ill health. The Cluster is committed to delivering the Primary Care Model for Wales in line with the vision set out in '*A Healthier Wales'.*

The current Welsh Government investment for the Rhondda Cluster, along with the recent funding which has been released to support transformational plans and development of multi-disciplinary teams across our primary, community and social care providers, will allow us to focus our plans on integrated care to meet the needs of individuals and community needs.

As a cluster we want to develop closer links with secondary care, social services and the third sector. The transformational model for primary and community care in Cwm Taf, which is a whole system approach to sustainable and accessible local health and wellbeing care, supports the vision set out in *'A Healthier Wales'* and is now adopted as the Primary Care Model for Wales.

The Cwm Taf Regional Partnership Board's, Stay Well in Your Community model, is outlined in Diagram 1 below. This is the service delivery model that will be developed and implemented across Primary Care and Localities. The Cluster will work closely with CTMUHB project leads to develop the Enhanced Cluster Team and delivery of anticipatory care based on the need of the population of the Rhondda. This will be developed during 2019/20 with the aim to this becoming a sustainable model for the future.

Diagram 1



Ambition

The Rhondda Cluster shares the ambition of CTMUHB and Welsh Government to deliver a high quality, sustainable and integrated primary and community care service for current and future generations. One way which we intend to do this is through educating the population to live healthier lives, through promoting the 'Five Healthy Behaviours'.

The investment in primary care clusters, pacesetters and recent allocation to support transformation plans is a welcome catalyst for transformation and to achieving the Primary Care Model for Wales.

Principles

The following will be key enabling principles for the Rhondda Cluster over the next three years:

- Prevention
  Investing in preventative interventions/ projects which are evidence based and offer value for money,
- Value-based healthcare
  Continue to implement the population management model based on segmentation and risk stratification through: segmenting the population based on their need, delivering anticipatory care consistent with evidence-based care plans, and, as far as possible, measuring systematically the cost and outcomes of the care delivered,
- Collaboration and systems working with our partners, including, all Primary Care professions, local authority and the third sector,
- Co-production with our community; patients, service-users, customers and carers.
- Addressing population need
  Using evidence to prioritise and target interventions based on the need of the Rhondda population.

Key Deliverables 2020 – 2023

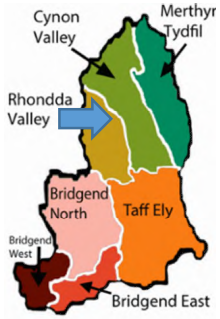
Over the next three years the Cluster will:

- Further develop the Multi-Disciplinary work to fully establish the 'Primary Care' Cluster working with Optometrist, Dental, Pharmacist, Local Authority colleagues and the third sector.
- Continue to support the development of initiatives in the community to allow the population to improve their health & wellbeing, working collaboratively with community co-ordinators and third sector organisations.
- Provide appropriate education and signposting to ensure patients access right primary care and community services.
- Work with the Health Board to develop the Extended Cluster team in line with Transformational plans.

Rhondda Primary Care Cluster IMTP 2020 - 2023

Key achievements from 2017-2020

- Rhondda Pharmacy Forum
- Rhondda Docs recruitment campaign and website
- Wellbeing Co-ordinators
- Cluster Pharmacists
- MIND Active Monitoring and Counselling
- Care home rationalisation
- Grow Rhondda, gardening on prescription project
- Slimming World to improve weight management
- Community Health & Wellbeing Team established



Vision of the Cluster 2020 – 2023

The overall vision of the Rhondda Cluster is to provide health, care and wellbeing services that are designed and delivered around the needs of individuals: 'closer to home' and with a greater emphasis on sustaining a healthy population and preventing ill health, in line with 'A Healthier Wales'.

The Cluster share the ambition of CTMUHB and Welsh Government to deliver high quality sustainability and integrated Primary and Community Care service for current and future generations.

Through developing closer links with secondary care, social services and third sector providers we will take a 'whole system approach' to health and wellbeing in the Rhondda.

Cluster Population Area Health and Wellbeing Needs Assessment

- Higher level of deprivation and poverty than the Welsh average.
- Higher estimated prevalence of all chronic conditions than the Welsh average.
  Using Population Segmentation and Risk Stratification method the most common chronic conditions (in high need/ high complex segments) were found to be hypertension, depression, hyperlipidaemia, asthma and diabetes. This method emphasises the importance of considering needs in relation to multiple morbidity and a patient centred approach. Mental Health support is also key for this cohort.
- Health related lifestyle behaviours are poor in the Rhondda.
- Bowel screening in the Rhondda is lower than the CTMUHB and Wales averages.

Gaps to Address and Cluster Priorities

- Public Health Cluster Wellbeing Needs Assessment/Population Profile
- Further explore community / stakeholder views as to gaps to services and access needs
- Improve access to health and social care services
- Continue development of multi-disciplinary working and ongoing diversification of workforce
- Obesity
- Five Healthy Behaviours
- Chronic pain management
- Mental Health

Planned Cluster Actions

- Develop mechanisms to gather patient/ service user/ community feedback
- Implement a cluster ANP service to provide enhanced care to care home residents
- Care Navigation training for front-line staff
- Develop an education programme in line with the Five Healthy Behaviours
- Commission 3rd sector organisation to provide early intervention mental health services
- Develop an MDT model enabled by the Stay Well in Your Community Transformation programme.

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

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

The Cluster are actively working to ensure that third Sector organisations, Dental, Optometry and Community Pharmacy are all active members of the cluster and have an opportunity to input into cluster plans to support the health & wellbeing of the local population.

Rhondda Cluster Leads:
Clinical Cluster Lead - Dr Bikram Choudhary (St David's Surgery)
Manager Cluster Lead - Lindsey Sandhu (St David's Surgery)

2. Introduction to the 2020-2023 Plan/Cluster

Governance arrangements

The Rhondda Cluster is maturing as can be seen by the varied membership and development of innovative initiatives, but also the fact that professional sub-groups are developing as part of the structure, for example, a Rhondda Cluster Pharmacy Group.

The Cluster have an approved Terms of Reference in place, which will be reviewed as necessary. This notes the function of the Cluster, membership, cluster leadership, decision making and reporting and monitoring arrangements.

Key Community Assets

Community and GP services in the Rhondda operate from a mixture of old and new buildings with differing levels of utilisation, in variable condition and with a proportion not strategically located (there are a number of locations where multiple GP Practices are located a short distance of each other) or meeting disability access requirements. These issues are being addressed as part of the Health Board Primary Care Estates Strategy.

Key assets for the Cluster are Community Hospitals: Ysbyty Cwm Rhondda (YCR) and Ysbyty George Thomas (YGT). The Cluster continues to support the development of YCR as an integrated health hub at the heart of the community. YGT is being developed as a Dementia Hub.

General Practitioners (GP's)

There are currently 12 practices in the Rhondda cluster:

- Cwm Gwyrdd Medical Practice
- Ferndale and Maerdy Surgery
- Forest View Surgery
- Llwynypia Surgery
- New Tynewydd Surgery
- Park Lane Surgery
- Penygraig Surgery
- Pont Newydd Surgery
- St Andrew's Surgery
- St David's Surgery
- De Winton Field Practice / Tonypandy Health Centre
- Tylorstown Surgery

Two practices in the Rhondda are managed directly by the Health Board: Ferndale Surgery and New Tynewydd Surgery.

Community Pharmacy Service (Pharmacists)

There are 27 Community Pharmacies across the Rhondda. As well as dispensing prescriptions, many of these pharmacies offer Medicines Use Reviews, Discharge Medicines Reviews, smoking cessation services, a Common Ailments Service, an emergency contraception service, palliative care drugs supplies, needle exchange and supervised administration. Community Pharmacies in the Rhondda are innovative and adaptable, continually looking at introducing new services to benefit the population and in line with cluster priorities.

In 2019 the Rhondda Pharmacist Forum was set up as a way to address the inconsistency of community pharmacy representation at cluster meetings. Three Community Pharmacy Leads have attended cluster meetings on a regular basis with a feedback mechanism between the Rhondda Pharmacist Forum and the main cluster. The Forum has greatly improved collaboration between community pharmacies in the Rhondda and between community pharmacies and the wider primary care MDT. It is pleasing to see learning from this model being adopted across Wales in 2020.

General Ophthalmic Service (Optometrists)

Across the Rhondda there are 11 optometry practices. The 11 practices across Cwm Taff are all accredited and provide the Wales Eye Health Scheme (EHEW) and 9 practices provide low vision services.

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

General Dental Services and Community Dental Services (Dentists)

There are 8 dental practices in the Rhondda, one of which is the Porth Dental Unit.
There are 4 Community Dental Services which provide treatment for people who may not otherwise seek or receive dental care, such as people with learning disabilities, elderly housebound people, people with mental or physical health problems or other disabling conditions which prevent them from visiting a dentist in the high street.

The Porth Dental Unit was the first of its kind in Wales and provides recently qualified dentists a fully equipped dental surgery while completing a two-year Dental Foundation Training Scheme.

Nursing and residential homes

There are currently 9 residential care only homes and 6 nursing homes in the Rhondda. The cluster have been actively working to develop relationships with nursing and residential homes. This project is mentioned in more detail in section 3 below.

There are 3 Community Day centres in the Rhondda.

Schools

There are 28 primary schools, 3 middle schools, 3 secondary schools, 1 special school and 1 patient referral unit in the Rhondda. Coleg y Cymoedd has a campus in Llwynypia.

Community Zone/ Neighbourhood Networks

The council's approach to building resilient communities, early intervention and prevention, includes the development of Neighbourhood Networks across the Rhondda Cynon Taf County Borough. The Neighbourhood Network is based on a set of characteristics and principles that will allow for a consistent application across the borough whilst offering flexibility to adapt to the needs of diverse communities. One of the key characteristics is that the Neighbourhood Network will comprise of a Community Hub and 'spoke/satellite' model.

The development of Community Zones is in line with the PSB approach to developing an integrated place-based approach in building resilient communities that prevents and mitigates the effects of Adverse Childhood Experiences (ACE's) and breaks the intergenerational cycle of adversity. This approach aims to transform public services to deliver greater emphasis on preventative early intervention services and engaging in a different way with communities. Through preventing the escalation of difficulties families face, ACE's for example, it will be possible to achieve better long-term outcomes and reduce the dependency on statutory services.

The Community Zone model provides opportunity for co-locating health and well-being services with other key community services. The Rhondda Cluster supports the development of Community Zones and is represented on the multi-agency Community Zone Implementation Group. The first Community Zone "pioneer area" for "Children First" opened in Upper Rhondda Fach in June 2019. The second Community Zone in the Rhondda, Porth Plaza, will provide local communities with direct access to many of the services residents need on a daily basis as well as providing opportunities to meet in community rooms, receive business support, employment support and information, advice and assistance on a range of issues that affect people's quality of life and well-being.

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

Communication Officer and Rhondda Docs Website – GP recruitment and retention is a priority for the Rhondda Cluster. As a result the cluster employed a Communication Officer to promote living and working in the Rhondda. The Rhondda Docs

website was developed in 2017 to raise the profile of the Rhondda and showcase cluster initiatives and healthcare employment opportunities.

MIND Active Monitoring – a self-directed psycho-educational programme delivered by Mind which is made up of 5 face-to-face interventions over an 8 week period. The service was offered to people presenting to GPs with a range of symptoms associated with common mental health problems such as anxiety, mild depression, stress, low confidence and self-esteem.

First Contact Physio – The cluster piloted having a physiotherapist based within two GP practices to see patients presenting with an acute MSK problem. The results showed a positive impact on access, resulting in practices having physiotherapists working in their practices on a regular basis.

Wellbeing Co-ordinator – Rhondda Cluster have employed a Wellbeing Co-ordinator, via Interlink, since 2017, to provide health & wellbeing signposting, information and advice in GP practices. The service receives around 600 referrals annually and makes 1000 referrals/ signposts to other services.

Parkrun Practices – In a partnership between RCGP and Parkrun UK, practices are encouraged to develop close links with their local parkrun. All practices in the Rhondda have signed up to become Parkrun practices.

Nursing/Residential Home project – The cluster have rationalised the number of GP practices that visit any one nursing or residential home. By allocating a home to just one or two practices, depending on the number of residents, the cluster has improved communication between the GP and the home who are now dealing with less GP practices and variances in systems, such as ordering repeat prescriptions.

Cluster Pharmacists – The Cluster have over the past 4 years funded practice based pharmacists. There are currently 5 FTE pharmacists based across the Cluster. Some of these pharmacists have been supported to undertake their 'Independent Prescribing' qualification. Included in the work is poly pharmacy / patient medication reviews, INR, asthma and hay fever reviews and chronic disease management. Having experienced the benefit of the role in increasing GP capacity, many practices now directly employ pharmacists.

Rhondda Pharmacy Forum – a Forum to improve collaboration between Pharmacists in the Rhondda and the wider Primary Care MDT.

Grow Rhondda – Grow Rhondda is a 'gardening on prescription' programme in Upper Rhondda, with the goal of improving patients' overall health and wellbeing. The gardening activities are delivered through our local Treorchy Men Sheds and the gardens within one of our community hospitals are used for the weekly gardening sessions. The scheme is aimed at patients who are over eighteen and experiencing social isolation/low self-esteem/mild anxiety & depression.

Slimming World – The Cluster have purchased Slimming World vouchers which have been distributed to practices based on their list size. The voucher entitles patients who meet the criteria to 12 weeks free Slimming World attendance.

#Your local team campaign The Your Local Team campaign has profiled a range of Rhondda primary care professionals including well-being co-ordinators, pharmacists and optometrists, who explain who they are and how they can help.

Population Management (Population Segmentation and Risk Stratification) – Rhondda have been involved in a Public Health led pilot, which seeks to segment patient populations by characteristics related to their need and use of health care resources. This method emphasises the importance of considering needs in relation to multiple morbidity, with care organised using a more patient centred approach. In doing so it is intended that the cluster will be able to identify a group of patients to wrap an MDT around and lead to the development of a new model of care. Cluster level data has been received and the Public Health Team are now working with practices to provide practice level data. The data will help the Cluster decide how best to use their limited time and resources. This model is currently being rolled out across CTMUHB.

COPD Supported Discharge Service – Although a Health Board initiative, the COPD Supported Discharge Service was piloted in the Rhondda and is heavily supported by the Cluster. The service provides a six week supported discharge service for those patients who have been discharged from hospital following an exacerbation of COPD. The aim of the service is to prevent re-admission to hospital by pro-actively monitoring/managing the patient throughout this 6 week period. The Respiratory Nursing Team works closely with both primary and secondary care colleagues to optimise the patient's clinical management plan during the 6 week period. This includes onward signposting and referrals where appropriate. Following a positive evaluation the service is being rolled out to Cynon, Merthyr and Taff clusters.

Waun Wen Lindsay Leg Club – The first Leg Club in the CTMUHB area opened in October 2018, with support from the Cluster. Leg Clubs are an evidence based initiative which provide community-based treatment, health promotion, education and ongoing care for people of all age groups who are experiencing leg-related problems. Leg Club staff work in a unique partnership with members (patients) and the local community, many of which are volunteers at the club. Patients who might otherwise be seen in wound clinic or by District Nurses are able to attend the leg club for treatment and/or advice without booking an appointment. The emphasis of the Leg Club is to empower members to participate in their care, in a social environment that eases loneliness.

Training Hub & Spoke Model – A Training Hub & Spoke Model has been established in CTMUHB to support the sustainability of General Practice. 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 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.

Pont Newydd Medical Centre in the Rhondda has been established as the first Hub and have successfully recruited seven spoke practices across CTMUHB, one of which is Cwm Gwyrdd Medical Centre. Each practice has completed the mandatory Batchelor of Nursing Education Audit - Practice Learning Environment. There are now 15 nurse mentors in place throughout the practices with 10 being new as a result of the project and there is one new sign off mentor. This has provided development opportunities to these practice nurses, which allows them to share their expertise and experience through mentorship.

The spoke practices provide 6 week placements for three undergraduate nurses per year. 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.

There has been overwhelmingly positive student evaluation with feedback from the University Of South Wales showing students rate their time with the hub and spoke model within the top 5% of placements.

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

Life Expectancy/ Healthy Life Expectancy

Life expectancy at birth for males and females (2015-2017)			
	North Rhondda (USOA)	South Rhondda (USOA)	All Wales
Males	76.1	77.4	78.3
Females	81.4	79.7	82.3
Source: Public Health Wales Observatory using ONS data (PHOF Tool, 2019)			

- **Healthy life expectancy** (the number of years a person can expect to live in good health) is only available at a local authority level. For RCT it is 56.5 years for males and 60.2 years for females. For Wales, HLE is 61.4 years for men and 62 years for women.
- The differences in healthy life expectancy that exist across an area between the most and least deprived areas is referred to as the 'inequality gap'.
- The inequality gap for healthy life expectancy in RCT: 6.7 years (males) and 4.3 years (females)
  (Source: Public Health Wales Observatory PHOF Tool (2017) using ONS and WG data)

Social Deprivation

Welsh Index of Multiple Deprivation

Estimated percentage of patients living in the most deprived 40% of areas in Wales (2015)		
Cwm Taf Morgannwg	North Rhondda (practice)	South Rhondda (practice)
57.1%	82.7%	86.3%
Source: Produced by Public Health Wales Observatory using WDS (NWIS) and WIMD 2004 (WG) data		

- The highest concentration of the most **deprived** areas in the Health Board area is in the Rhondda Cluster.
- **Low birth weight babies** (born less than 2500g in 2017): North Rhondda (8.2%); South Rhondda (7.4%); RCT (7.4%). Low birth weight babies are at risk of problems with; growth, cognitive development and the onset of chronic conditions later in life. (Source: Public Health Wales Observatory PHOF Tool (2019) using WCCHD (NWIS) data).

Chronic Conditions

Estimated % prevalence of chronic conditions (2018)				
	North Rhondda (practice)	South Rhondda (practice)	Cwm Taf	Wales
CHD	4.4%	3.9%	3.7%	3.7%
Heart Failure	0.9%	0.8%	0.9%	1.0%
Stroke +TIA	2.4%	2.2%	2.0%	2.1%
Diabetes	6.9%	6.7%	6.4%	6.0%
COPD	3.5%	2.9%	2.8%	2.3%
Asthma	6.9%	7.5%	7.1%	7.1%
Dementia	0.4%	0.6%	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 2017-19				

The Rhondda cluster has generally a higher estimated prevalence of all chronic conditions than the Welsh average with the exception of dementia. Prevalence data is estimated from Audit + and as such, only captures conditions which have been diagnosed and coded.

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

Data extraction carried out during 2018 indicated that over half of people (53%) in the Rhondda cluster had 1 or more long term conditions (LTC). 31% of the population had 2 or more. For example, 94% of COPD patients had at least one other LTC.
The degree of multi-morbidity was found to be a greater driver of cost and care utilisation than age in the population.

The most common chronic conditions (in high need/high complex segments 4, 6 & 9) were found to be hypertension, depression, hyperlipidemia, asthma and diabetes.

Mental Health

11% of adults in RCT report as having a mental health disorder, higher than the Welsh average of 9% (Source NSW 2017-19).
17.5% of adults in RCT report feeling lonely. 28% of adults in RCT do not report a high level of general happiness. (Source ONS 2018)

Clinical Risk Factors

Estimated % prevalence of risk factors within population (2017/18)				
	North Rhondda (practice)	South Rhondda (practice)	Cwm Taf	Wales
Hypertension	18.5%	17.5%	16.8%	15.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018				
Atrial Fibrillation	2.2%	2.2%		2.2%

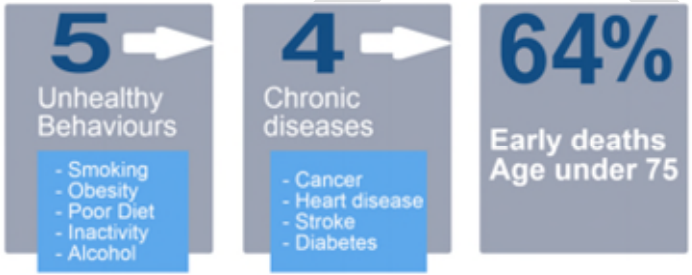
North and South Rhondda have a higher prevalence of hypertension than the Welsh average. North Rhondda has the highest estimated prevalence of hypertension in the CTMUHB area.

Adult Lifestyle Behaviour

Percentage of adults that report the following behaviours- National Survey for Wales (2016-18)					
	Smoke (%)	Eating 5 portions of fruit and veg a day (%)	Meet physical activity guidelines (%)	Drinking above guidelines for weekly alcohol consumption levels (%)	Working age adults of Healthy Weight (%)
North Rhondda (USOA)	24.3	19.9	47.3	16.8 *	34.7
South Rhondda(USOA)	24.4	20.3	48	16.9 *	35.2
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)					

Key data from the Child Measurement Programme for Wales, children aged 4 to 5 years, 2017/18 Produced by Public Health Wales Observatory, using CMP data (NWIS)												
All children	**Healthy weight or underweight**			**Overweight or obese**			**Overweight not obese**			**Obese**		
	n	**%**	(95% CI)[1]	**n**	**%**	(95% CI)[1]	**n**	**%**	(95% CI)[1]	**n**	**%**	(95% CI)[1]
Wales	23,674	73.6	*(73.1 to 74.1)*	8,486	26.4	*(25.9 to 26.9)*	4,613	14.3	*(14.0 to 14.7)*	3,873	12.0	*(11.7 to 12.4)*
Cwm Taf Morgannwg UHB	3,523	71.2	*(69.9 to 72.4)*	1,428	28.8	*(27.6 to 30.1)*	746	15.1	*(14.1 to 16.1)*	682	13.8	*(12.8 to 14.8)*
RCT	1,877	70.7	*(68.9 to 72.4)*	778	29.3	*(27.6 to 31.1)*	395	14.9	*(13.6 to 16.3)*	383	14.4	*(13.1 to 15.8)*

- Smoking prevalence is higher in Rhondda than the Health Board average.
- Around two thirds of adults in the Rhondda Cluster are above a healthy weight (overweight or obese).
- Data collected in 2017/18 showed that % of Children aged 4 to 5 years obese to be above CTMUHB and Wales.
- *Despite having a lower percentage of adults drinking above the weekly recommended levels 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.
- Chronic disease is often preventable. Previous work in Cwm Taf for the Cwm Taf Wellbeing assessment in 2017 indicated the following: -



Cancer Incidence and Prevalence

- The most common cancers for men in RCT (2014 -2016) were: prostate, lung and colorectal. For women: breast, lung and colorectal. (Source: WCISU, 2019)
- Cwm Taf has the highest lung cancer incidence rate of all health boards for both men and women (Source: WCISU, 2019). Lung cancer has the strongest link to deprivation of all the most common cancers, mainly due to the link with smoking.

Screening

Uptake of screening % (2017/18)					
	National targets	North Rhondda (practice)	South Rhondda (practice)	Cwm Taf	Wales
Bowel	60%	54.4	54.2	54.8	55.7
Breast	70%	73	71.8	73.6	72.8
Cervical	80%	77.8	77.9	76.4	76.1
Source: Primary Care Needs Assessment tool, 2019					

Bowel screening uptake in the Rhondda is below the Cwm Taf and Wales rate and the national target.
Rhondda is below the national target for Cervical Screening. In line with Wales as a whole there has been a decline in young women attending their first cervical smear.

Flu Vaccination Uptake

% Uptake (2017/18)					
	National targets	**North Rhondda** (practice)	**South Rhondda** (practice)	**Cwm Taf**	**Wales**
At risk aged 6 months to 64 years	**55%**	49.7	47.3	46.8	48.5
2 and 3 year olds	No specific Targets yet	57.1	58.6	53.0	50.2
65+ years	75%	67.2	68.1	67.7	68.6
Source: Primary Care Needs Assessment tool, 2019 using IVOR data					

Flu vaccination uptake is at a higher rate in both the Rhondda clusters than the Welsh average. However, it does not yet meet any of the targets set for the influenza vaccination programme.

Childhood Vaccination Uptake

% uptake (2018/19)					
	Targets	North Rhondda (practice)	South Rhondda (practice)	Cwm Taf	Wales
Uptake of 5 in 1 at 1 year old	95%	96.5	98.4	97.5	95.4
Up to date by age 4	95%	87.1	83.9	87.9	87.2
MMR2 at age 5	95%	92.7	95.5	93.1	92.2
MMR2 at age 16	95%	90.3	94		
Source: COVER data accessed via http://nww.immunisation.wales.nhs.uk/cover					

Childhood vaccination uptake is at a higher rate in both the Rhondda clusters than the Welsh average, apart from being up to date at 4 within South Rhondda.
However, it has not yet met any of the 95% targets set for the immunisation programme to achieve 'herd immunity', except for immunisation uptake of childhood vaccinations in children aged 1 year and MMR2 at age 5 in the South cluster.

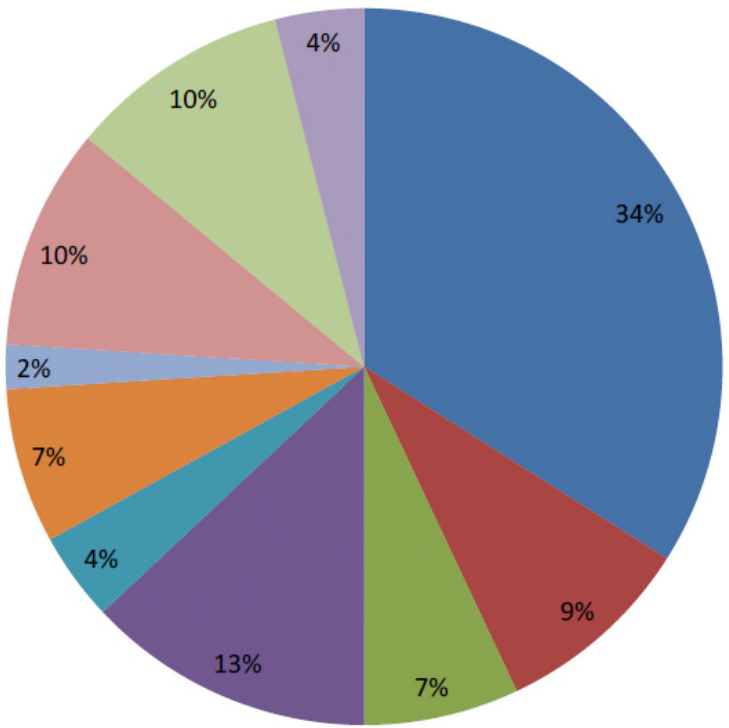
Rhondda Well-being Coordinator

The Cluster have had a Well-being Coordinator in post since 2017. This is a key service in helping to identify gaps in service provision across the cluster.

Gaps identified by the Wellbeing Coordinator are:

- On-to-one counselling services
- Bereavement support groups
- Chronic pain support groups
- One-to-one support and transport to access groups and services in the community.

The primary reasons for referral to the Rhondda Well-being Coordinator are detailed below (January – December 2018). The highest number of referrals are received for mental health issues and benefits advice.



- Mental Health
- Lonely and Isolated
- Social care support
- Benefits advice
- Debt advice
- Housing
- Employment
- wanting to engage in community
- Bereavement
- Mobility aids

3. Cluster Workforce profile

The Cluster workforce is clearly our most significant asset and it is through the commitment, professionalism and dedication of our workforce that we are able to deliver high-quality services to the population of the Rhondda.

Some of our greatest risks are as a result of workforce fragility and recruitment difficulties in a number of areas across the cluster. However, this brings opportunity for innovation and modernisation like the Training and Development Hub.

Where possible the Cluster will utilise data from the Welsh National Workforce Reporting Tool (WNWRT) to better understand workforce demographics.

The Cluster will work closely with CTMUHB to support the recruitment, training and placement of roles to implement an integrated community team to deliver a primary care multidisciplinary workforce linked strongly to Cluster plans.

The Transformation Multidisciplinary team will include:

- A GP/ Clinical Lead
- Community Occupational Therapists
- Physiotherapists
- Mental Health CPN
- Clinical Pharmacists
- District Nurses
- Advance Care Planning Nurses

This will provide an approach to wrap assessment and services around people working collaboratively across community and primary care addressing issues of frailty, chronic ill health and mental health and wellbeing.

The Health Board have. Will employ a project lead, project support, operational manager, data performance analyst, IT Manager and administrator to support the Clusters with their transformational plans, evaluation and Welsh Government reporting.

4. Cluster Financial Profile

The Rhondda Cluster allocation is £317,628, which is delivery agreements money received from Welsh Government.

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

Transformational allocation for the Enhanced Cluster team is:
Year 1 £2.92m

Year 2 £4.920m

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.

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

The priority areas for the Rhondda Cluster for 2020 – 2023 are as follows:

- Obesity
- Five Healthy Behaviours
- Mental Health
- Chronic Pain

The priorities identified above will change and develop over the duration of the plan, in line with the needs of the population and resources available to the cluster. There is a causal relationship between the priorities and they often present together.

Lifestyle behaviour change with a focus on obesity

Health related lifestyle behaviours are poor in the Rhondda and over the period of this plan, the Cluster will prioritise increasing the percentage of the population who report healthy behaviours in all areas. Smoking, poor diet, inactivity, alcohol consumption and obesity are drivers for diabetes, hypertension, heart disease, stroke, depression and cancer all of which have high prevalence in the Rhondda population. The five harmful behaviours essentially cause the four diseases that account for 64% of early deaths under 75 (cancer, heart disease, stroke, diabetes) (Cwm Taf Well-being Assessment).

For example, around two thirds of adults in the Rhondda Cluster are above a healthy weight (overweight or obese). This is higher than the Welsh average. The Cluster are awaiting data for children and young adults. The link between obesity and chronic ill health is well known. The Cluster will take actions to increase the number of working adults and children of a Healthy Weight.

As a Cluster we will promote the five behaviours that influence health – eat healthily, be more active, maintain a healthy weight, stop smoking and reduce alcohol to within safe limits.

The Cluster will also be focusing on increasing the number of children and adults reporting healthy behaviours. Most chronic diseases are preventable and adopting healthy behaviours, especially earlier in life, can prevent and delay the onset, leading to a longer and healthier life. The aim is to change the behaviour of patients so that they can be responsible for their own health and wellbeing and live healthier lives. Early intervention in these areas is key.

We have identified primary and secondary schools as key partners to help educate the next generation to make healthier choices and also to empower them to influence healthier choices in their families and peers. This is in line with the "a healthier Wales" goal in the Well-being of Future Generations Act.

Mental Health

11% of adults in RCT report as having a mental health disorder. Primary care mental health provision is at full capacity and with long waiting lists to access services, patients often only get access when they reach crisis point. Earlier intervention would help reduce crisis intervention. We wish to engage with 3rd sector providers to improve early access to interventions, such as, counselling, CBT and psychological support services.

We recognise that there is a strong link between loneliness and isolation and mental health. The Cluster will work with community organisations to identify gaps in groups and services to combat loneliness and isolation as well as developing current cluster initiatives like Grow Rhondda.

Chronic Pain

There is an epidemic of chronic pain in the Rhondda. It is a common problem that presents a major challenge to health-care providers because of its complex natural history, unclear aetiology, and poor response to therapy. This condition is managed best with a multidisciplinary approach, requiring good integration and knowledge of multiple organ systems and usually has a strong psychological element which the biomedical model of pain management fails to address. Current pain clinic provision is at full capacity and does not have any psychology input.

The Cluster will take steps to de-medicalise chronic pain and develop a model whereby patients lead their own self-management programme. It is hoped that the cluster will be able to reduce the prescribing of opioids as a result. There is a recognition that to enable this the cluster needs to support the development of services to help manage pain in the community.

Communication and engagement mechanisms

- Practices will continue to use *PPG's* to engage with their practice populations
- Facebook and Twitter accounts will be used to share health and wellbeing promotion messaging with the public
- The Cluster will continue to have a presence at local events and will survey the public as to health and wellbeing gaps which need to be addressed
- The Cluster link with the CHC to gain the view of the local population
- Rhondda Cluster representatives will attend current service user Focus Groups and work towards developing a cluster focus group
- The LMC will be consulted with regards to any service changes.
- Rhondda have set up a GP/ Pharmacy Communication Task & Finish Group who meet on a monthly basis to address communication issues on a cluster wide basis. This Group will adapt to improve communication with other primary care services, i.e. optometry as time progresses.

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

The Cluster have developed an Action Plan which is attached at Annex 1. This Action Plan is a working document to detail the objectives, key milestones and risks associated with initiatives.

The Action Plan is structured to align to the Health Board IMTP, includes the themes in the Primary Care Model for Wales and will consider the following areas:

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

The Action Log details the progress towards achieving the milestones in the plan.

Quality Improvement Project
In line with the GMS Contract 2019-20 the Cluster will deliver two Quality Improvement Projects at a cluster level with a focus on Patient Safety.

1) Reducing medicines related harm through a multi-faceted intervention in primary care clusters (patient safety).
2) Reducing stroke risk through improved management of Atrial Fibrillation in primary care clusters

The actions that will be taken to improve quality in these areas will be detailed in the Action Plan below.

Enhanced Services
Cluster plans for delivering an extended range of enhanced services will develop in 2020 and be detailed here.

Challenges

There has been significant improvement in collaborative working with the third sector as well as Community Pharmacy, due in part to the inclusion of the Collaborative Working Scheme in the Pharmacy Contractual Framework, and as a result the development of a Pharmacy Sub-group. However, there continues to be challenges for Dental, Optometry and Social Services in engaging with the Cluste, including regularly attending meetings. The Cluster will continue to liaise with Health Board Advisors to disseminate information and encourage attendance at meetings. Plans for the creation of a Dental Liaison Group will go some way to providing a forum for information sharing between Dental contractors and the Cluster. The Cluster will continue to work with partners to find ways to improve collaborative working and information sharing across the cluster.

Opportunities

Population Segmentation and Risk Stratification provides a key opportunity for the Rhondda to target interventions around segments of the population. 10 segments have been identified based on patients based on their healthcare characteristics and health care usage. High need/ high complex segments have been further stratified to identify patients with high and medium risk of hospital admission in the following 12 months. Having this additional information allows us to identify patients to wrap an MDT around.

The cluster will work with the Health Board to mainstream some cluster initiatives which are evidence based and have proven to benefit the Rhondda community. It is hoping that this mainstreaming of services, and investment from the Health Board, will support the shift of resources from secondary to primary care to reflect the drive towards providing more care in the community.

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

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

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

The Cluster IMTP will dovetail into the Health Board IMTP and will be updated as there are refreshed or developed.

The plan will also be developed, reviewed and monitored alongside the Cwm Taf Morgannwg Primary and Community IMTP and transformation plan. The Cluster reports regular updates to the Primary Care Committee to provide assurances through to Executive Director and Executive Board.

The Regional Partnership Board's Stay Well in Your Community Programme, contains the Enhanced Cluster Team, and is a key part of the transformational model for primary and community care. It is a whole system approach to sustainable and accessible local health and wellbeing care and supports the vision set out in 'A Healthier Wales' and is now adopted as the Primary Care Model for Wales.

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

- A Primary Care Development Manager is employed by the Health Board to support the Rhondda Cluster
- The Health Board is leading on the recruitment, training and placement of roles for the Stay Well in Your Community Model
- Regular meetings are held with the Finance corporate team to ensure that spend is aligned to this plan but also within the UHB's overall financial planning and Standing Financial Instructions.
- The Cluster is also supported by the corporate Workforce and Planning teams from the Health Board
- Public Health Wales are members and consistent attendees at cluster meetings and support the cluster to ensure that actions are grounded in population needs assessment.
- The Cluster have close working relationship with Interlink the Council for Voluntary Action. The Rhondda Wellbeing Coordinator is engaged by the Cluster through and SLA with Interlink. The Cluster also work very closely with the ICF 50+ Community Coordinators.
- Changes to the Welsh Contractual Framework for community pharmacy in 2018 made funding available for engaging with primary care clusters under the Collaborative Working Scheme. The Rhondda Cluster Pharmacy Rhondda Community Pharmacy have set up a Cluster Pharmacy sub-group to meet alongside the main Cluster meeting. This will be an opportunity for all 27 pharmacies to engage with the cluster. There will be consistent representation at the main cluster meeting from three Pharmacists. This approach is supported by CPW. It is hoped that, in the future, this model can be adopted by Optometry and Dental.
- The Cluster reports regular updates to the Primary Care Committee to provide assurances through to Executive Director and Executive Board.

Planned Cluster Objectives and Milestones 2020-2023

The plan details cluster objectives for the years 2020-2023 that have been agreed by consensus across the cluster providing where relevant background to current position, planned objectives and outcomes and actions required to deliver improvements.

The plan is structured under the following headings:

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

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

The RAG rating score indicates progress against planned action:

Red- future work

Amber- work in progress

Green- work completed

The Action Log details the progress towards achieving the milestones in the plan.

Additional contributors to the plan/potential evolving contributors to the plan subject to evolution of plan

- Health and social care facilitators
- Primary care practice managers
- Practice nursing and allied health professions representatives
- Local voluntary sector providers and third sector
- Prescribing advisers

A) PREVENTION, WELL-BEING AND SELF-CARE						
No.	**Cluster Objective**	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1.	**To work with West Wakefield/ Conexus to deliver a Care Navigation training programme to front-line staff.** **Increase the number of signposts to appropriate services.**	Commission West Wakefield to deliver Care Navigation training to frontline staff across all GP practices. Provide staff with skills to actively signpost patients to the most appropriate choices and services available. Evaluate Care Navigation project, including views of navigators.	Consider increasing services to signpost to. Evaluate impact on GP appointments. Increase number of navigations by 10% from Year 1.		Lack of practice engagement/ capacity to attend planning workshops. Care navigator's not recording number of navigations. Difficulty in attributing Care navigation to a reduction in GP appointments. Impact of signposting on the services signposted to. Lack of capacity of services signposting to. Patients' willingness to access services signposted to.	

2.	**To increase the % of the cluster population who are a healthy weight.** **(Priority 1)**	Evaluate Slimming World project. Promote Park Run. Review healthy eating and physical activity services across the Rhondda to identify gaps in service. - NERS - Joint Care Programme. Develop relationships with identified education providers. Scope work already being undertaken by schools e.g. Healthy Schools programme.				

3.	**To improve % of cluster population reporting the 5 healthy behaviours.** **(Priority 2)**	Develop relationships with identified education providers.	Develop education programme for delivery. Research current/ design promotional materials.			
4.	**To improve access to early Mental Health interventions.** **(Priority 3)**	Improve early access to interventions, such as, counselling CBT and psychological support services. Explore service which best meets the needs of the population. Work with the Primary Care Mental Service (PCMHS), including PCMHS Focus Group to improve clarity of pathways into mental health services for service users. Approve Referral Decision Guide in partnership with PCMHS.			Capacity of PCMHS and CMHT	 Draft Referral Decision guide developed. PCMHS to meet with cluster for feedback and to gain understandin g of issues.
5.	**To decrease GP appointments for chronic pain and**	Identify practice level chronic pain data.	Reduction in opioid prescribing by ??		Unable to gather baseline data required.	

	increase the % of patients with chronic pain leading their own self-management programme. **(Priority 4)**	Explore new pathways for chronic pain. Promote Education Patient Programme courses through practice screens/ posters/ leaflets. Support the development of a chronic pain support group in partnership with Versus Arthritis and Interlink.	Decrease GP appointments for chronic pain.		Development of chronic pain support group on hold due to pandemic.	
6.	**Cluster ANP service To support Care Home DES, home visits, chronic condition reviews.**	Recruit x2 ANP's Rota developed Relationships developed with care homes. Evaluation measures			Unable to recruit x2 ANP's	
7.	**To develop Grow Rhondda as a community gardening on prescription project with the aim of increasing the numbers benefitting from the project.**	Open up the project to third sector referral partners. Develop new promotional materials. Plan "relaunch". Increase referrals by 50%. Increase numbers attending the project by 50%.				

		Evaluate project in conjunction with referral partners.				
8.	**To develop the Digital Health Hub/ Health on the High Street model in the Rhondda**	Work with Digital Communities Wales and third sector partners to trial a Digital Health Hub in the Rhondda. - Increase use of digital self-help resources which are quality assured. -To use My Health Online and EConsult	Identify community venue/s. Work with the local EPP (Education Programmes for Patients) Cymru team and Digital Communities Wales to develop training programme. Establish booking/ referral process for training.			
9.	**To apply a preventative approach to service planning using population segmentation and risk stratification and value based health care to inform service redesign.**	Completion of Phase 2 of the Rhondda segmentation and risk stratification project. Ascertain whether patients identified are appropriate for review by MDT. Identify if patients within the segment require similar health needs.			The data set currently does not include social services data.	

10.	**Increase Bowel Screening uptake through promoting the benefits of bowel screening to patients, and enhance reporting and data analysis of non-reporting patients** **TBC**	Ensure correct bowel screening coding used on clinical system Check non responder contact details are accurate.	Utilise cluster social media, practice display screens, leaflets and posters to embed consistent messages across the Cluster. Encourage patients to undertake bowel screening through PPG's.	Increase bowel screening uptake to national target of 60%.		
11.	**Further develop the Well-being Coordinator role to encourage healthy behaviours and self-care**	Identify training opportunities for Wellbeing Coordinator.			Wellbeing coordinator role funded by Transformation programme – ability to influence work plan.	
12.	**To reduce the rate of flu through improving flu vaccination up-take.**	Regularly share cluster level flu uptake data. Identify Flu Champions within practices. Develop consistent Flu Champion role Work collaboratively with Public Health Wales to improve and enhance local and national campaigns (with support from Primary Care Communications Officer). Explore flu advert on Rhondda radio.	Explore training to educate flu champions. Regular flu updates provided to the Cluster by email.	Improve flu vaccination uptake by 2%		

		Use of practice screens to remind patients to have a flu vaccination where appropriate.				
13.	**Partnership working with third sector to support new community initiatives**	Work with third sector partners to identify gaps in current services. Work with third sector organisations to develop proposals based on the health and wellbeing needs of the population	Work with third sector providers to develop services based on gaps.		Wellbeing coordinator role funded by Transformation programme – ability to influence work plan.	 Rhondda Wellbeing Coordinator provides report with gaps in services identified.
14.	**To reduce loneliness and isolation in the Rhondda**	The Rhondda Primary Care Cluster is one of the key partners in the Age Connect Morgannwg's Foundational Economy Project, Simply Together. Cluster staff including, GP Wellbeing Coordinators to identify individuals who would benefit from support worker support and refer to the project.			COVID-19 delayed start of project. No face-to-face support to access community groups/ services able to be delivered at present.	

		Due to COVID-19 service delivery changed from face-to-face support to virtual support in the form of coaching to achieve goals.				

B) TIMELY, EQUITABLE ACCESS AND SERVICE SUSTAINABILITY						
No.	**Cluster Objective**	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1.	**To work with West Wakefield/ Conexus to deliver a Care Navigation training programme to front-line staff.**	Commission West Wakefield/ Conexus to deliver Care Navigation training to frontline staff across all GP practices. Provide staff with skills to actively signpost patients to the "right place, at the right time". Promote Care Navigation materials.			Due to COVID-19 6 services presently unable to deliver services in the same way as described during the training with care navigators.	
2.	**To work in partnership with Primary Care Mental Health Services to ensure that patients are directed to the most appropriate services**	Cluster representation on PCMHSS focus group to understand patient perspective and barriers when accessing services. Develop and trial PCMHSS Referral Decision Guide.	Promote decision guide. Audit inappropriate referrals.			
3.	**Further promote the access to the services provided by other primary care professionals such as the provision of eye care services, community pharmacy**	Have a presence at local events. Care Navigation. Cluster newsletter.				

	and also community audiology.					
4.	**To improve upon access for patients through Pharmacists undertaking tasks within the practice e.g. medication reviews, which would usually be done by the GP.**	Work with the medicines management team to feedback on cluster pharmacy service and gaps in skills and training.			The future of funding for cluster pharmacists is currently unknown. Cluster pharmacists are currently (19/20) funded through an SLA with the Health Board. Some practices have been left without this support due to staff vacancies.	

C) REBALANCING CARE CLOSER TO HOME						
No.	**Cluster Objective**	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1.	**To explore using Community Zone buildings for Health & Wellbeing.**	Develop partnership with RCTCBC Explore opportunities in relation to Porth Plaza development.				
2.	**To further develop the role of the Rhondda Wellbeing Coordinator to enable the community to maintain independence in their homes for longer.**	Relationships developed with key organisations and services to ensure patients are signposted to the most appropriate service.	Explore opportunities for Wellbeing Coordinator resource out in the community to develop community services and groups.		Wellbeing coordinator role funded by Transformation programme – ability to influence work plan.	
3	**Develop and refine the enhanced cluster MDT model**	Enable more people to remain in their home and receive timely intervention to prevent deterioration in their condition	Develop and refine the CHWT team – recruit additional member e.g. ANP's, visiting paramedics, palliative care nurses.	Upskill the team – consider IP / ANP training	Capacity of the MDT Recruitment and retention challenges Ongoing funding	
4	**Continue to use Attend Anywhere.** **Consultant Connect to gain secondary care advice.**	All practices utilising Attend Anywhere and Consultant Connect to increase patient choice and accessibility.				

D) IMPLEMENTING THE PRIMARY CARE MODEL FOR WALES						
No.	**Cluster Objective**	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1.	**Implement the "Stay Well in Your Community" Transformation Model**	Work in partnership with Cwm Taf Morgannwg UHB, RCTCBC and third sector in supporting the implementation and development of the transformational model. Involve OOH / 111 / @Home etc. Develop roles of CHWT MDT Team. Re-launch the CHWT team post COVID-19 "first wave" and with new referral process.	Support the development and evaluation of the model.		Ability of Health Board to recruit to roles. Limited impact on primary care workload. Capacity of Cluster to support MDT. Difficulty in evidencing outcomes. Service delivery of CHWT halted due to COVID-19 and staff redeployed to other roles.	

E) DIGITAL, DATA, AND TECHNOLOGY DEVELOPMENTS						
No.	**Cluster Objective**	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**

1.	**To support access & sustainability through the use of Technology**	Implement an online consultation tool (e.g. E-consult) that catches clinical symptoms early and offers effective, time-saving, remote triage and consultation. Advertise/promote MHOL and MHTexts. Patient access to signposting and self-help information 24/7. Improved practice efficiency with shorter appointment waiting times and saved appointments. Increase the use of Numed screens in waiting rooms with information e.g. EPP.	Evaluation of E-consult. consultation tool and whether there has been a reduction in patient contacts with GP, A&E and OOH. Workflow training for admin staff to decrease paperwork and GP admin time. Explore tele dermatology with the dermatology department.		Not all practices in cluster wishing to implement online tool (11/12). Lack of engagement from patients in accessing self-help information. Difficulty in obtaining data to evaluate outcomes. IT infrastructure issues.	
2.	**To develop the Rhondda docs website.**	Widen the remit of the Rhondda docs website to include the other Primary Care professions.	Rebrand Rhondda docs website to Rhondda Primary Care Cluster.		Rhondda docs no longer supported by Wordpress limiting changes that can be made.	

F) WORKFORCE DEVELOPMENT INCLUDING SKILL MIX, CAPACITY, CAPABILITY, TRAINING NEEDS, AND LEADERSHIP						
No.	**Cluster Objective**	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1.	**To improve the skills and knowledge of front line staff to enable them to navigate patients/ service users to the most appropriate service.**	Services identified to navigate to. 150 front line staff across the Cluster trained in Care navigating to these services. 26 managers trained.				
2.	**To improve recruitment and retention of GP workforce.**	Increase the number of GP training practices in the Rhondda from 1 to 2. Year 10 taster days with Treorchy Comprehensive School to promote Primary Care roles as attractive career choices. Scope primary care career promotion work undertaken with other schools (contact Schools and college liaison). Cluster GP's to actively engage in			Capacity of Cluster members to organise and attend Year 10 taster day. Capacity of Cluster members to be involved in #yourlocalteam.	

		#yourlocalteam campaign.				
3.	**To improve the awareness of community services and organisations across the Rhondda Cluster.**	Work with HEIW and Interlink Wellbeing Community Coordinators to deliver awareness sessions to ST2's and ST3's on the Community services and organisations that can be signposted to. Use cluster Facebook and Twitter accounts to promote community services to "followers".				
4.	**To improve read coding and summarising skills across the Cluster.**	Identify additional administrative staff requiring Read coding and summarising across the cluster. Arrange training course.				
5	**Workflow training**	Train key practice staff in workflow management to read code and action letters from secondary care – so reducing GP time readings letters without any GP actions.	80% reduction in the number of letters GP's have to read and action themselves.			

G) ESTATES DEVELOPMENTS

No.	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
1.	**Work with CTMUHB to explore opportunities to co-locate GP services within the YGT site or repurpose vacant RCT council buildings**			Have greater number of GP premises that are fit for modern general practice with multi-disciplinary working.	Feasibility of proposed projects	

H) COMMUNICATIONS, ENGAGEMENT AND COPRODUCTION

No.	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
1.	**To develop improved mechanisms for engagement and coproduction with patients/ service users/ community.**	Identify number of practices with PPGs across the Rhondda Cluster. Support the creation of PPGs. Use Facebook and Twitter to promote cluster and community initiatives. Actively engage with phase2 of the #yourlocalteam campaign.	Creation of PPGs across all Rhondda GP Practices. Development of Cluster focus group. Identify established service user, patient and carer focus groups which would benefit from Cluster representation. Provide Cluster representation at established focus groups.		Lack of patient interest in setting up a PPG. Lack of practice time to arrange and engage with PPG.	

2.	**To improve the communication of Cluster news and progress of Cluster projects across cluster membership.**	Design a Cluster newsletter template. Publish newsletter on a quarterly basis. Each Cluster profession to provide content for newsletter stories.	Gather feedback on newsletter. Improved Cluster communication and engagement.			
3.	**To improve Cluster engagement through the setting up of professional Cluster Sub Groups.**	Pharmacy Forum set up and quarterly meetings arranged. Nominated pharmacy representatives to have a standing agenda item at each main cluster meeting.				
4.	**To strengthen partnership working and relationships with Pharmacy, Dental and Optometry, local authority, third sector services working across the Cluster.**	Standing agenda item at Cluster Meetings. Regular communication between lead primary care contractors and Cluster Lead Team. Improved understanding of challenges and barriers of each contractor in engaging with Cluster working. See H3 above.	Consistent attendance at cluster meetings from all contractors. Rhondda GP/ Pharmacy Task & Finish Group established.	Undertake collaborative project involving two or more primary care contractors.		

I) IMPROVING QUALITY, VALUE, AND PATIENT SAFETY						
No.	**Cluster Objective**	**Year 1 Milestones**	**Year 2 Milestones**	**Year 3 Milestones**	**Risks**	**RAG Rating**
1.	**To support the increase in Dementia Friendly towns across the Rhondda** **TBC**	Scope work already being undertaken with help from RCT CBC.				
2.	**To improve the accuracy and quality of read coding and summarising across GP practices**	Identify administrative staff requiring read coding and summarising across the cluster. Arrange training course.				
3.	**To ensure each nursing home has a quality service provided by a dedicated GP resource which should in turn free up some much needed capacity due to a reduction in travel time.**	Continue to monitor the implementation of this project to ensure patient satisfaction and quality of service provision.			Impact on patient choice – feedback/ concerns/ complaints re project to be monitored. Patients can request alternative GP.	

QUALITY IMPROVEMENT PROJECTS

No.	Cluster Objective	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones	Risks	RAG Rating
1.	**Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the cluster population**	Agree individual general practice action plans before 31st March 2020. Review improvement in individual practice outcome measures.	Continued improvement New Patient Safety project (unknown)		Practice capacity to undertake quality improvement projects.	
2	**Reducing stroke risk through improved management of Atrial Fibrillation in primary care clusters**	Agree individual general practice action plans before 31st December. Review improvements by 31st March 2020.	Continued improvement.		Practice capacity to undertake quality improvement projects.