Rhondda Primary Care Cluster
Annual Delivery Plan 2021/2022

1. Executive Summary

Rhondda comprises of around 16 communities along the valleys of the rivers Rhondda Fawr and Rhondda Fach in the South Wales Valleys. The Rhondda Primary Care Cluster works in the context of significant socio-economic deprivation and some of the highest levels of multi-morbidity and ill health in the Cwm Taf Morgannwg Health Board footprint and nationally. This, combined with the geography of the area provides significant challenges to the provision of healthcare, necessitating innovation and exploring new ways of working.

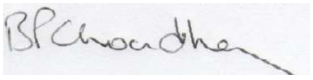
Rhondda is a large Primary Care Cluster with North and South Rhondda working together as one cluster to serve a population of approximately 89,000 patients. The 12 GP Practices, Community Pharmacies, Optometrists, Dentists, District Nurses, third sector, Public Health and Rhondda Cynon Taf County Borough Council work together to support the health and wellbeing needs of the population.

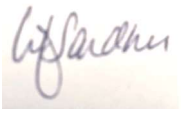
The Rhondda has seen high rates of coronavirus and at times the highest death rates in Wales. This has highlighted the urgency to tackle the health inequalities we have long known exist. Unsurprisingly the Covid-19 pandemic has meant changes to the way that we deliver services and work together as a cluster. A key focus of 2021/22 will be the recovery from the Covid-19 pandemic and the long-lasting mental and physical effects on our communities health. We want to "work with" our communities to develop health and wellbeing services which meet their needs.

Our workforce is our greatest asset and recruitment and retention of staff remains a key priority. A key focus of 2021/22 will be to support our staff through the challenges of the COVID-19 pandemic and to ensure that our workforce remains relevant and is shaped by the health and wellbeing needs of our population, including introducing new primary care roles.

The Rhondda Primary Care Cluster has worked hard over recent years to improve collaboration between primary care contractors. Testament to this is the development of the Rhondda Community Pharmacy Forum, a model which can take some credit for influencing the introduction of the Community Pharmacy Cluster Lead Role in 2021.

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





Dr Bikram Choudhary — GP Cluster Lead

Lindsey Sandhu — Practice Manager Cluster Lead

Cwm Taf Morgannwg University Health Board

Rhondda Cluster Annual Plan on a Page 21/22

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'.

Cluster Aims – to work together to:

- Provide more services closer to home and in community settings
- Improve the health and wellbeing of the local population
- Support people to stay well, lead healthier lifestyles and live independently
- Reduce health inequalities
- Support the sustainability of general practice
- Ensure a supportive working environment and career development opportunities for our staff.

Strategic alignment

- Health Board IMTP - work with Rhondda and Taff ILG to develop services closer to the community and to mainstream cluster funded services.
- Support the development of the Community Health & Wellbeing Team enabled by the Stay Well in Your Community programme.
- Primary Care Model for Wales and Strategic Programme for Primary Care.

Planned Cluster Actions

- Continue to deliver essential services whilst responding to changing Covid-19 pressures.
- Improve food and nutrition education and dietetic pathways - Recruit Band 6 Dietician.
- Improve access to mental health services locally and promote self-help – Develop blended MIND counselling and Active Monitoring service.
- Implement services to address the psychosocial aspect of chronic pain.
- Develop a cluster MSK physiotherapy service to bolster existing provision and provide a service closer to the community.
- Continuation of Care Navigation training for front-line staff.
- Improve communication and information sharing between different health, social care and voluntary sector professionals – GP/ Community Pharmacy Communication Group.
- Increasing the population coverage of preventative services to keep citizens well including covid-19 vaccinations, influenza and childhood immunisation
- Develop cluster initiatives focussed on community powered health and reducing isolation and loneliness to support resilient communities.
- Define cluster workforce plan.

Key Achievements 2020 – 2021:

- Implementation of MIND Blended Active Monitoring and Counselling Service.
- Care Navigation training
- "Simply Together" Mentoring Project
- Development of cluster level contingency plan
- Resilience and flexibility of contractors and commitment to cluster working
- Pharmacy Forum and GP/Pharmacy Communication task and finish group.
- Smooth implementation of online platforms such as eConsult, Attend Anywhere, AccurX.

Enablers

- Technology – Consultant Connect, eConsult, Attend Anywhere, AccurX, Vision Anywhre, Whatsapp
- Skilled Workforce
- Partnership working – strong collaborative working relationships with community pharmacy and third sector
- Financial Resource – additional investment in clusters.

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

As a result of the COVID-19 pandemic the context that we have been working in has significantly changed since the writing of the 2020 – 2023 Rhondda Cluster IMTP. However the overarching aims that underpin the plan remain the same.

The means by which we might achieve the plan have adapted as we take steps to reduce the risk for our community and staff; social distancing, lockdowns and the impact that this has on the way that our community access services. We have also had to consider the negative effects of keeping our population safe from COVID-19 on their mental and physical wellbeing.

Covid-19 has increased the challenges and pressure faced by Primary Care services, yet some benefits have been realised:

- Regular communication between cluster members through regular meetings and a cluster Whatsapp group to support each other and share information.
- Closer cluster working.
  Practices and Community Pharmacies created a contingency plan to be adopted in the event that a practice or practices were unable to deliver services. This plan can be adapted to other emergency situations if needed.
  Closer working with Wellbeing Coordinators who provide link with the Local Authority Covid-19 Resilience Hub for those shielding and unable to access food or prescriptions.
- Effective use of Escalation Level reporting mechanism to trigger support response.
- Accelerated implementation of technology, including eConsult, AccuRx and Attend Anywhere.
- Rapid roll out of remote access to IT systems to enable remote working for clinicians, admin staff and cluster practitioners who were self-isolating or working from home due to social distancing e.g. use of Vision Anywhere for MIND practitioners.
- Adaptability and resilience of Primary Care in responding to new ways of working.
- Triage first model consistently implemented across the cluster.
- Effective use of websites and social media to communicate with our community.
- Optimised access to primary medical care for care home residents. All 12 GP practices in the Rhondda are delivering the revised Care Homes Directed Enhanced Service (DES).

Conversely,

- Inability to achieve some objectives set for 2020 due to covid-19 response taking priority including,
  - To explore the unmet need in relation to chronic pain management services in Cwm Taf Morgannwg and to develop an action plan to address this.
  - Full roll-out of Care Navigation (template on clinical system).
- Limitation to secondary care and primary care services to refer patients to.
- Patients fearful to access care when needed due in part to false information on social media that General Practice was “closed” to the public. This led to development of “We are here for you” communications campaign.
- Workforce pressures, due to shielding or isolating staff leading to a depleted workforce. Long-term effect on the health and wellbeing of the workforce is unknown.
- Difficulty in communicating with the community as planned i.e. no face-to-face community events or services to refer to.
- Lack of digital inclusion causing inequity in accessing services.

- Learning and mentorship affected by reduced or complete lack of face-to-face contact.

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

Delivered

Priority area – Mental Health

Rhondda RESET Project - MIND Active Monitoring and Counselling

The Cluster have had the benefit of the Counselling and Active Monitoring service for 6 months of 2020/21. This blended MIND service is unique since it is the first of its kind whereby an initial assessment by a MIND Therapeutic Practitioner can lead to Active Monitoring or Counselling, depending on the presentation. The counselling and Active Monitoring sessions are held virtually or face-to-face. The waiting list is pooled across the GP Practices to ensure effective utilisation of practitioner time. The Cluster will continue to fund this service in 2021/22.

We recognise the impact that Covid-19 has and could have upon the mental health of our population. As a result, Mental Health will remain as one of our key priorities going forward and we will continue to evaluate the effectiveness and capacity of the MIND Blended Active Monitoring and Counselling service.

Priority area - Loneliness and Isolation

"Simply Together" Project – A project in partnership with Age Connects Morgannwg. Bespoke one-to-one mentoring and coaching via telephone/video consultation. Individuals are referred through Rhondda Wellbeing Coordinators as they have been identified as vulnerable due to social isolation/ loneliness. Many of the individuals referred have been identified as Clinically Extremely Vulnerable from Coronavirus (previously known as "shielding"). The Support Worker makes weekly contact, a support plan is co-produced, including goal setting and review. Individuals are signposted or referred to other services as necessary.

The impact of Covid-19 on loneliness and social isolation is not yet known; lockdowns and shielding will cease but social isolation will continue, therefore a long-term, multi-agency approach is needed. We will continue to support services and develop partnerships with organisations that aim to reduce loneliness and isolation in our community including, Interlink and Age Connect Morgannwg. As a result of staff shortages and social distancing requirements the Waun Wen Lindsay Leg Club has been suspended in 2020. It is hoped that the Club will be able to restart in late 2021 to help reduce the social isolation of those receiving wound care in the Rhondda.

Delayed

Priority area – Weight Management

As a result of Covid-19, the pace of delivery of this priority area has been delayed.
We plan to work with the Health Board Dietetics team to deliver an education for HCSW's and other cluster staff to be trained in Agored Cymru's Level 2 Community Health & Nutrition Skills course. They will then be better equipped to deliver brief interventions and give consistent dietary advice to patients who are an unhealthy weight and / or at risk of developing diabetes or hypertension. The specialist Dietician post will be funded by the cluster.

Priority area - Chronic Pain Management

Prior to the start of the pandemic the Cluster were exploring the unmet need in relation to chronic pain management in Cwm Taf Morgannwg. The cluster have been working to improve

the patient and referrer awareness of EPP and plans were in the early stages to develop a Support Group for Chronic Pain sufferers alongside Versus Arthritis and Interlink. As a result of the Covid-19 pandemic and social distancing regulations this plan has not been progressed further.

This priority area remains relevant and will continue in 2021.

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 provides staff with skills to actively signpost patients the most appropriate service available to them, which may not always be their GP. Prior to Covid-19, all group sessions with stakeholders and face-to-face training with staff had taken place. Care Navigators have also completed the online training module. Currently. The Cluster plan to officially launch Care Navigation in 2021 with a clinical template to record navigations in early 2021.

Accelerated

ICT developments

The guidance from NHS Wales to move to a "total triage" model and to remote consultations early in the pandemic accelerated the implementation of E-Consult across all practices in the cluster.

The use of Attend Anywhere and AccurX across the cluster for remote consultations with patients has also been accelerated. This has increased patient choice in accessing primary care services and it is hoped that this will continue to expand with more services offering video consultation in the near future

Cluster services have been set up in a way to enable remote working, including MIND practitioners and Wellbeing Coordinators.
The Cluster has also supported practices to upgrade IT infrastructure to enable remote working and video consultations through additional laptops, cameras and headsets.

GPs now have the ability to directly connect with consultants through the Consultant Connect communication tool. This can dramatically reduce the time that it takes for a GP to gain specialist advice and the number of secondary care referrals. Rhondda Cluster have specialist advice available locally to them with consultant lines being covered by CTM based consultants for Cardiology, COTE, Gastroenterology, Paediatrics, Respiratory, Acute Medicine, Pharmacy and @home service.

Ongoing Cluster Services/ Projects

Cluster Pharmacists
The Rhondda Cluster will continue to fund five community pharmacists to work across the 12 GP Practices in the cluster, through an SLA with the Health Board.

Priority area – Weight Management
Slimming World Project
GP practices continue to have a quota of vouchers to give out patients who meet the criteria. As a result of Covid-19 Slimming World sessions are being held virtually with patients self-reporting their weight. This has reduced the rate of referral from practices and patient uptake.

To improve communication and information sharing between different health, social care and voluntary sector professionals.
Develop Rhondda GP/ Community Pharmacy Communication Group

New priorities for 2021/22

- Covid-19 Response and Recovery
- To improve access to early assessment, diagnosis, advice and management of MSK conditions

5. Key Cluster Actions for 2021/22							
Strategic Alignment / Priority Area	**Objectives**	**Planned Action** 2021/22	**Expected Outcome** Mar-22	**Possible Constraints/ Key Risks**	**Workforce Implications**	**Financial Implications**	**Monitoring process**
Covid-19 Resilience 2021/22							
Indirect harm: Essential Services[i]	Delivery of essential services as per Welsh Government guidance. *NHS Wales Operating Framework - Maintaining Essential Health Services during the COVID 19 Pandemic – summary of services deemed essential.* Ensure harm is minimised from a reduction in non- COVID activity. Access to services to continue to increase for patients and re-introduction of any suspended and enhanced service provision Decisions to be made based on clinical need.	Primary Care Contractors to continue to deliver essential services to their population. In line with Covid-19 risk level, patients to be triaged and consulted remotely using eConsult, telephone, video consultations to avoid unnecessary face-to-face contact where possible. The Cluster will work with the Primary Care Communications Officer to target communications to our local population and counter false information e.g.	Access to services in line with priority based on need. Increase in contacts for conditions that have reduced during Covid. Timely delivery and completion of Covid and flu vaccination programmes Improved and targeted communications with patient population	Lockdown measures and need to manage footfall in premises to ensure social distancing. Access for patients to secondary/ tertiary services.	Impact of Covid on available workforce / 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. Additional staff costs to allow for essential service delivery and other priorities e.g. Covid vaccination programme.	The Cluster will work with the Health Board who will use the monthly reporting mechanism to monitor activity against the essential services categories. Activity data. Flu monitored via IVOR and Practice clinical systems.

		using the “We are here for you” messaging. Decisions about individual care will be made by clinicians, in discussion with patients and their families and in best interest of the individual.					
Direct harm: Rehabilitation covering the 4 population groups[ii] Rehabilitation: A Framework for Continuity and Recovery 2020-21’ Health and social care services rehabilitation framework 2020 to 2021 Allied Health Professional Framework: Looking	To consider the guidance and framework to allow access to services to support rehabilitation of patients in the 4 identified groups: 1. People recovering from Covid-19. 2. People awaiting paused planned care. 3. People awaiting paused urgent and routine planned care 4. People who avoided accessing services. As confidence gained that Covid pressure is reducing, support the acceleration of recovery planning and where appropriate the design of	To work jointly with the Health Board, R/TE ILG and Community Health & Wellbeing Team to ensure adequate resources can be provided across services and health professionals to support those recovering from Covid. Rhondda Cluster Lead representation on the Elective Care Recovery Clinical Advisory Group.	Support improved outcomes for those requiring post Covid rehabilitation. MDT support available in rehab hub for individuals with post Covid syndrome to work towards symptom resolution within 12 weeks. Improved knowledge, understanding of services available to people and how to access following signposting to self-management resources available to them.	Demand exceeds workforce capacity in Covid Rehabilitation Hub.	Primary Care and secondary care teams where needed to allow appropriate support care, intervention and access to services. Use of cluster funded roles where appropriate e.g. physiotherapy to provide early access to services. Community Health & Wellbeing Team	Unknown	R&TE ILG and Cluster lead meetings. GP reports Covid-19 Rehab Hub reports to Health Board.

Forward Together Primary Care Model for Wales.	alternative pathways in primary care.	GPs to ensure medical investigations are completed and reported on prior to referrals to Covid Rehabilitation Hub to ensure patient is 'rehab ready' To communicate service provision and support to the patient population through effective campaigns.			members for MDT assessment.		
Cluster vaccination delivery 2021 - Seasonal Flu +/- Covid-19 vaccine	To vaccinate eligible groups with Covid-19 and flu vaccinations in line with PCCIS. All 12 Rhondda practices undertaking Covid-19 vaccination programme.	Promote the vaccine programmes and engage with patients to encourage participation. Share WIS system knowledge throughout practices. Ensure appropriate PPE and Governance arrangements are in place.	All eligible patients offered vaccinations. Seasonal Flu planning – as early as possible in line with communications and ordering processes	Staffing levels due to sickness and isolation. Difficulty in planning clinics due to uncertain vaccine supply and delivery dates. Lack of clarity re groups to vaccinate has potential to cause conflict and damage relationships between	Workforce to vaccinate eligible groups. Impact of increased visits for GP/Practice Nurses, District Nursing and Community Teams for housebound patient on workload.	No impact on cluster budget anticipated.	Vaccination data – WIS, PCIP, practice systems.

		Encourage collaborative working between district nurses, community pharmacists and General Practice. Work with partners to ensure delivery in most appropriate location i.e. Care Homes, Mass Vaccination Centres etc.		vaccinators e.g. community pharmacy and GP practices and District Nursing.			
Covid-19 Cluster Hub delivery	To monitor Covid-19 levels in the community and move to network/cluster delivery model if needed.	To monitor practice escalation levels. Review service delivery as required – currently delivery is on an individual practice basis. To continue to communicate and work with Health Board and RPB should a Covid-19 Cluster Hub delivery be required.	Delivery of safe patient care Patients treated in a setting that is appropriate to their specific personal needs.	Staff availability to redeploy or backfill to delivery Hub model.	Increased workload across Primary Care	Cost of venues and set up/ infrastructure	Escalation levels. Workforce data

COVID-19 Response	Appropriately manage patients according to need during the Covid-19 Pandemic. Use technology to aid remote working and consultations, e.g. E-Consult, Attend Anywhere.	Advice and refer to HB Post Covid-19 Rehabilitation Hub. Promote NHS Wales Covid-19 Recovery app. Work with the Health Board to develop a long-term plan for post-coved 19 rehabilitation. Regularly review GP practice escalation levels. Work with Primary Care Communications Officer and use cluster social media to target communications to our local population.	Delivery of safe patient care Support those who have been affected by Covid-19.	Attend Anywhere not as user friendly as AccuRx Ongoing access to AccurX. Inequity of IT provision for older / financially challenged patients	Long Covid needs of patients still unknown in relation to health care needs in the community, already seeing increased demands. Workforce to support Covid-19 Rehabilitation Hub (GP recruitment to support Hub).	Unknown	
Ministerial Delivery Milestones 2020/21 relating to the Primary Care Model for Wales							
Strategic Alignment / Priority Area	**Objectives**	**Planned Action**	**Expected Outcome**	**Possible Constraints/ Key Risks**	**Workforce Implications**	**Financial Implications**	**Monitoring process**

Urgent Primary Care 24/7 Model - Improve access to urgent primary care services in the Rhondda	Develop the North Rhondda Urgent Primary Care Centre (UPCC) (currently Forest View Medical Centre, St Andrews Surgery, De Winton Surgery, New Tynewydd Surgery, St David's Surgery).	Continue to work with stakeholders to deliver and develop the Urgent Care Centre. Explore extending the UPCC to support a wider Rhondda population. Encourage patients to self-care. Explore developing the UPCC as an effective training environment for Independent Prescribers and ANP's. Explore increasing access to diagnostics at the UPCC.	Timely and appropriate management of patients with primary care needs. Increased capacity for same day appointments for urgent care needs in-hours. Alternative pathway to ED/ MIU presentations. Increase capacity for GMS to support patients with chronic/ long term conditions. Improved collaborative working.	Location accessibility to patients. Future funding mechanism yet to be agreed. Accommodation to expand service.	GP / ANP sessions. Predominantly locum staffed.	National Urgent Care Programme Pathfinder funding	Reporting to National Programme for Primary Care and Health Board.
Strategic Alignment / Priority Area	Objectives	Planned Action	Expected Outcome	Possible Constraints/ Key Risks	Workforce Implications	Financial Implications	Monitoring process
2020/23 3 year Cluster IMTP Priority							

Prevention and Wellbeing Improve access to early intervention mental health support and promote self-help	Continue to commission blended MIND Active Monitoring and Counselling service. Use signposting and cluster social media to promote third sector organisations and self-help.	Evaluate Cluster Blended MIND Active Monitoring and Counselling service. Work with Primary and Secondary care Mental Health services to integrate pathways.	More timely access to mental health interventions. Patients can access the “right support at the right time”.	Impact of COVID on mental health - demand exceeding capacity of MND service. Accommodation available for face-to-face consultations in practices. Access to Primary and Secondary Care mental health service data outside of the direct control of the Cluster.	MIND Active Monitoring Practitioners MIND Therapeutic Practitioners	Counselling £43,250 Active Monitoring £60,133	Evaluation and activity reports from MIND Patient feedback Work with PCMH and CH&WT team leaders to determine any impact on referrals into service and patient outcomes.
Mental Health Development of new models of care Prevention and Wellbeing - Mental Health	Review existing Mental Health pathways with stakeholders.	Cluster Development Managers and Cluster Leads to work with Mental Health team leaders from PCMHT, CH&WT and MIND to review pathways.	A clear understanding of MH service access in Primary Care Patients are able to access the ”right service at the right time”. Improved understanding for referrers Improved awareness of the	Currently lack of clarification of how all the services interact, exact level of provision and support for patients, causing some confusion for referrers into MH services and support.	GP clinical assessment for referral into most appropriate service. MH practitioners aligned to Cluster based in CH&WT. Wellbeing Co-ordinators in CH&WT to provide MH&	Unknown	Work with PCMHT and CH&WT team leaders to determine any impact on referrals into service-reductions, more appropriate & timely, better outcomes.

			different services and how they fit together and best pathway for patient Improved collaborative working with Health Board services and 3rd sector organisations to ensure any gaps in provision identified and developments based on need.		Wellbeing support in the community		
Prevention and wellbeing - Chronic Pain	Analyse unmet need in relation to pain management services and pathways. Increase self-management and peer support in patients with chronic pain. Improve management of anxiety and low mood associated with living with pain.	Define action plan to address chronic pain priority. Commission / develop support groups to tackle biopsychosocial aspects of chronic pain. Explore benefits of the use of virtual reality for chronic pain sufferers. Work with Expert Patient Programme to promote the Pain Management	Address biopsychosocial aspects of chronic pain. Support people to better understand long-term pain Reduced social isolation and improved support network for those experiencing chronic pain. Optimise analgesic medicine's use including tapering those that are unhelpful or causing harm	EPP workforce to meet demand.	Unknown	Unknown	Patient reported improvement in quality of life.

		course to increase appropriate self-referrals and GP referrals.					
Prevention and Wellbeing – Weight management	Work with Public Health Dietetics team to recruit a dietician to deliver Level 2 Community Food and Nutrition courses to HCSW's and other cluster staff. Evaluate project. Aim: Equip HCSW's and other cluster staff with the nutrition knowledge and skills to cascade evidence based, consistent food and nutrition messages. Continue to offer existing Slimming World on Referral vouchers and evaluate project.	Recruit Band 6 Specialist Dietician. Schedule courses. Establish communication channels for staff to gain advice and guidance from Specialist Dietician. Review existing pathways.	Increase in % of population who are a healthy weight. Improve food and nutrition education and dietetic pathways. Peer support and point of advice for HCSW's.	Successful recruitment of Band 6 Specialist Dietician Slimming World groups currently meeting remotely and participants self-reporting weight.	Recruitment of Band 6 Specialist Dietician	£18,000 allocated	Evaluation score cards Patient progress data provided by Slimming World, including patient attendance and weight loss/BMI reduction.
Preventions and Wellbeing MSK Conditions - First Contact Physiotherapy	Implement a high quality, First Contact Physiotherapy service across all practices in the cluster. Aim: Improve access to early assessment,	Expand service to all practices in the cluster. Review session capacity required.	Reduce inequalities and improve outcomes for patients with musculoskeletal conditions.	Ability of provider to recruit additional physiotherapists. Difficulty in providing face-to-face	Physiotherapy workforce to cover required sessions.	£160,000 allocated	Activity reports. Evaluation report.

	diagnosis, advice and management of MSK conditions Aim: Release GP time to manage more complex presentations.	Evaluate service and work with Health Board Rhondda and Taff Ely ILG to mainstream a Health Board funded First Contact Physiotherapy service.	Reduce the GP MSK caseload Reduce referrals to orthopaedics Reduce referrals to secondary care physiotherapy Reduce prescribing.	consultations due to social distancing. Accommodation in practices.			
Bowel Screening	Promote the benefits of bowel screening to patients and enhance reporting and data analysis of non-reporting patients.	Community Pharmacists to attend virtual Bowel Screening training with Bowel Screening Wales. Ensure correct bowel screening coding used on clinical system. Utilise cluster social media, practice display screens, leaflets and posters to embed consistent messages across the Cluster. Encourage patients to undertake bowel	Increased Bowel Screening uptake Earlier bowel cancer diagnosis. Increased life expectancy.	Patient engagement. Due to COVID-19 WG temporarily paused some of the population based screening programmes. Many of the screening services are back up and running however there is a back-log of patients.	None	None	Review Bowel screening rates.

		screening through PPG's.					
Collaboration between primary care services	Continue to develop and implement actions from the Rhondda Community Pharmacy/ GP Communication Group to improve direct communication mechanisms. Encourage consistent service representation in attendance at cluster meetings.	Consider implementing Hospify application across cluster. Implement Community Pharmacy/ GP Communication template across cluster. Explore mechanism to incentivise/ remunerate all attendees to attend cluster meetings.	Improved patient experience Patients not "bounced" between Community Pharmacy and GP practices with prescription queries. Improve staff experience.	Service pressures and competing priorities. Existing differing communication processes between Community Pharmacies and GP practices.	None	Remuneration to attend Communication Group meetings.	Cluster meeting registers. Patient and staff feedback.
Domestic Violence and Abuse Improve the safety, quality of life and wellbeing of survivors of DVA.	Improve the General Practice response to domestic violence and abuse (DVA).	All Wellbeing Coordinators and new staff within GP practices to be made aware of / attend training on IRIS support and referral programme.	Increase in appropriate referrals to IRIS. Reduction of frequency of visits to GP surgeries. Reduction in visits to Emergency Units.	Operational pressures across General Practice risk to releasing staff for training.	Improved knowledge and confidence of staff in referring.	None – training is offered at no cost to General Practice.	IRIS provide quarterly reports which include training and referral data.
Strategic Alignment/ Priority Area	Objectives	Planned Action	Expected Outcome	Possible Constraints/ Key Risks	Workforce Implications	Financial Implications	Monitoring Process

Contract Reform, Health Board IMTP, RPB Area Plans, Strategic Programme, Primary Care Model for Wales Priorities not referenced above							
Work with communities and partners to reduce inequality, promote well-being and prevent ill-health.	Support ongoing developments of Ysbyty Cwm Rhondda as a Cluster hub as described in Rhondda Taff Ely Integrated Locality Group IMTP – to provide activities, services and clinics at a community site.	Continue to support the development of services - engaging community groups, and developing community clinics.	The provision of equitable, timely care closer to home.	Covid-19 pressures and restrictions. Accommodation availability in Primary Care Resource Centre.	Unknown	Unknown	Unknown at present
"Staying Well in Your Community" Transformation Programme	Further embed the Community Health and Wellbeing team within the cluster. Multi-agency, multi professional anticipatory care at a Cluster level via targeted Multiple Disciplinary Team (MDT) assessment and the implementation of individual care and support plans.	Increase number of appropriate referrals. Regular attendance at cluster meetings.	Improved health and well-being. More people will maintain independence for longer and be able to live safely at home. Fewer GP appointments. Fewer visits to A&E. Fewer ambulance calls.	Space in GP practices to further embed clinics/ roles within the cluster.	A reduction in financial allocation will likely mean a reduction in workforce.	Financial allocation not yet confirmed for 2021/22. Case and plan for sustaining services past 2022 required.	Reports provided to Welsh Government. Cluster received update reports.
Strategic Programme for Primary Care – Workforce and Organisational Development Work stream.	Development of a formal workforce planning strategy for the cluster. Plan a future model of Primary Care across health and social care, to ensure the right roles, skill mix and delivery of	To define the plan for the cluster. All practices to complete the national workforce reporting toolkit.	A model for future workforce development to ensure the right: ✓ Recruitment and retention ✓ Education and training	Data being made available for all Health & Social care staff. Engagement and involvement of all cluster members.	Managers, Workforce & OD Business Manager, Cluster Development Manager.	To be determined.	Attrition rates. National Workforce Reporting Tool data.

Expanding and Strengthening Primary and Community Care – A Healthier Wales Regional Partnership Board – wellbeing plan.	MDT working across the Cluster.	Cluster Development Manager to attend Workforce Planning Training to support cluster.	✓ Skill mix.				

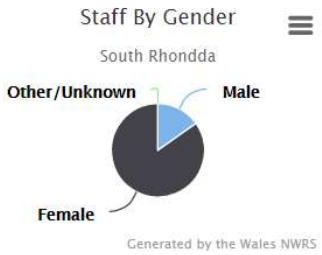
6. Cluster workforce Implications for 2021/22

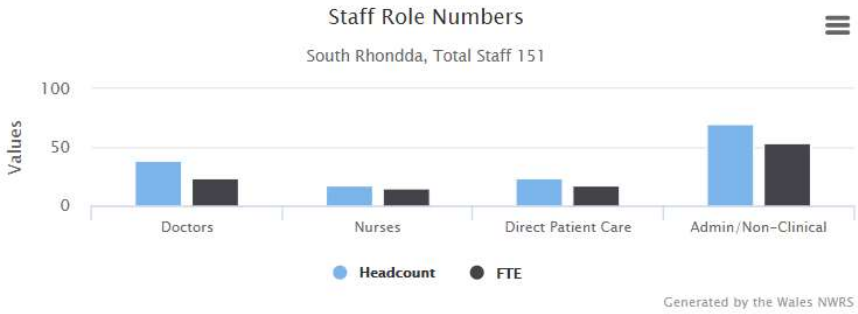
CC507 - South Rhondda

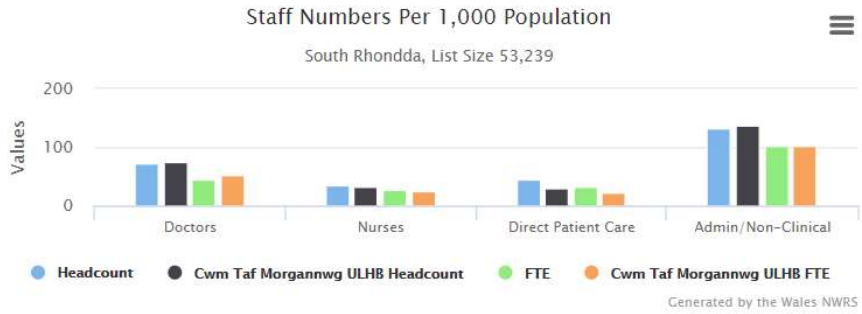
Parent: 7A5
Parent Name: Cwm Taf Morgannwg ULHB

Data Timepoint: October 2020 (Provisional)

Data Status: Live/Provisional







The Cluster will work with Health Board Workforce colleagues develop a clear workforce strategy with a focus on future sustainability and a community approach. The Covid-19 pandemic has caused unprecedented changes to our normal way of working making it essential that we refocus our workforce planning. It is imperative that we support our existing workforce during these challenging times. This includes supporting staffs general wellbeing and supporting new training requirements, for example, new systems such as the Welsh Immunisation System (WIS).

GP Workforce

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

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

Enhancing skill mix, multi-disciplinary working and ensuring that GPs are 'only doing what only they can do' is a key priority of the cluster. An effective use of workforce skills will mean that GPs and advanced practitioners, have more time to care for people with co-morbidities, who are often elderly.

The cluster funds the following roles:

- 5 FTE Cluster Pharmacists (Health Board employed)
- 0.4 WTE Dietician (Health Board employed)
- 3 MIND Counsellors (CTM MIND employed)
- 4 Active Monitoring Practitioners (CTM MIND employed).

In 2021/22 we will continue to develop the role of Care Navigators to improve patient education and to encourage patients to access the right service at the right time.

The Cluster will support the development of strong leadership within the Cluster through encouraging Practice Managers to attend the NHS Wales Confident Practice Managers course.

The vehicle for developing and testing larger multi-disciplinary teams around the cluster, has been the Transformation funded "Staying Well in Your Community". One element of the "Staying Well in Your Community" Programme is the Community Health & Wellbeing Team.

The team is a multi-disciplinary, anticipatory Primary Care Model, combining Health, Social Care and Third Sector professionals to offer support to service users in a GP practice who have the highest resource utilisation and most complex needs. The MDT aims to reduce demand on general practice both in and out of hours, and on acute and secondary care services. An MDT meeting is held on one day a week to design, implement and monitor care plans, with delivery of clinical activity taking place over the remaining four days of the week from the team and primary care. This is further enhanced by dedicated clinics within the community.

The Community Health and Wellbeing Team comprises the following roles:

- A GP/ Clinical Lead
- Community Occupational Therapists
- Physiotherapists
- Mental Health Practitioners
- Clinical Pharmacists (Advanced Pharmacist – Pain, Advanced Pharmacist – Mental Health)
- Wellbeing Coordinators
- District Nurses
- Social Worker
- Care & Repair Support Worker.

Training Needs

- Care Navigation training for receptionists and administrators
- Level 2 Community Health & Nutrition Skills for HCSW's
- Confident Practice Managers Programme
- IRIS Domestic Violence and Abuse Training
- Improving Bowel Screening uptake training for pharmacy teams with Bowel Screening Unit.

7. Cluster financial implications for 2021/22

The Rhondda Cluster allocation is £630,000.

Spending	
	£
Initial Allocation	315,000
New 20-21 allocation	315,000
Total Available Funding	**630,000**
Planned Spend	
5WTE Practice Based Pharmacists	315,000
Mental Health MIND Active Monitoring	60,133
Mental Health MIND Counselling	43,250
0.4 WTE Dietician	18,000
Task and Finish Groups	4,000
First Contact Physiotherapy service	160,000
TOTAL	**600,383**
Under / (over) Utilised	
% of Available Funding	95%

The Rhondda Cluster continues to fund 5 WTE practice based Pharmacists in each of the 12 practices. The amount allocated this year includes actual staff costs, management fee and travel expenses.

The Cluster will continue to fund MIND Active Monitoring and Counselling for 2021/22.

We will be working with a Physiotherapy service, who has already established First Contact Physiotherapy clinics in some Rhondda practices, to expand the service offer to the whole of the Rhondda population.

During 2021/2022, we plan to evaluate the long standing Cluster Pharmacists posts and MIND service, and consider whether they are best funded from Cluster budget or whether a case for practice employing pharmacists or mainstreaming is required.

We are awaiting confirmation of the Transformation fund allocation for the Community Health & Wellbeing team for 2021/22. Options for mainstreaming funding will be explored in 2021/22 with the Health Board in the event that funding comes to an end in 2022.

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

The Cluster plan aligns with the principles of the Primary Care Model for Wales and Welsh Governments plans for 'A Healthier Wales' to focus on:

- Informed public
- Empowered citizens
- Support for self-care
- Community services
- First point of contact
- Urgent care
- Direct access.

The following strategic plans will influence and dovetail with the Cluster Annual Plan.

- Primary Care Model for Wales
- Ministerial Delivery milestones 2020/21
- Strategic Programme for Primary Care
- Transformational Plans for Primary Care
- Primary Care IMTP
- Rhondda & Taff Ely IMTP.

Some cluster plans are determined by the contracts of the members e.g. the GMS contract necessitates the discussion of elements of Access Standards and QAIF delivery and the Cluster Annual Plan will be updated to reflect plans as requirements are suspended or reintroduces.

The management arrangements of Cwm Taf Morgannwg University Health Board were reorganised in 2020. As part of this change the Rhondda Primary Cluster has moved to be part of the Rhondda & Taf Primary Care & Community Service Group as opposed to being part of the Primary Care Team. This

has the benefit of improved focus on the needs of the local population as well as strengthening our working relationships with colleagues in that area, for the benefit of our patients. It remains to be seen whether this has a negative effect on alignment with the GMS arm of the Primary Care Team.

Governance

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 use a risk log to identify, record and manage any identified risks. If there are any significant risks identified, a more detailed risk assessment is carried out. Any high risks will be reported to the Cluster meeting, the Primary Care Quality, Safety, Risk and Governance meeting and also to the Rhondda and Taff ILG as appropriate.