Taff Ely Primary Care Cluster IMTP 2020-2023

1. Executive Summary

Executive Summary from the Cluster leads

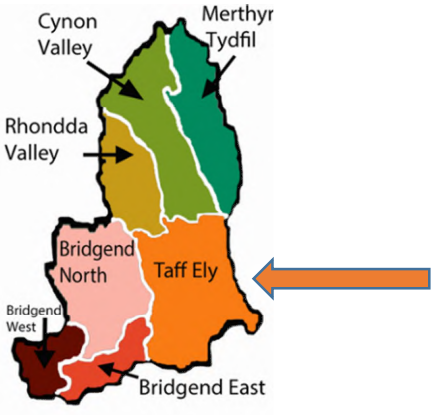
Welcome to our new Taff Ely Cluster plan. This is very much a working document that will develop year on year as the Cluster continues to mature and as the collaborative working across all members improves further.

To date the cluster has achieved a number of projects through working together to improve the health and wellbeing of its population and will continue to do this not only through targeting clinical services but also by considering projects to support social and community elements and needs of people living in its boundaries. Some of this work has been recently recognised through the Community Development work being shortlisted at the NHS Wales Awards.

This plan has been developed by Taff Ely Cluster which is made up of

- 7 GP practices
- 21 community pharmacies
- 13 Dentists
- 9 Opticians
- County Voluntary Council Interlink
- Local Authority – social care

Geographically Taff Ely is central to Cwm Taf Morgannwg Health Board area and is one of eight Clusters, with Taff Ely Cluster serving a GP practice population of 95,128



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

- Ashgrove Surgery
- Eglwysbach Surgery
- New Park Surgery
- Old School Surgery
- Parc Canol Surgery
- Taff Vale Surgery
- Taffs Well Surgery

The plan also embraces key UHB priorities for the next three years, specifically focused on:

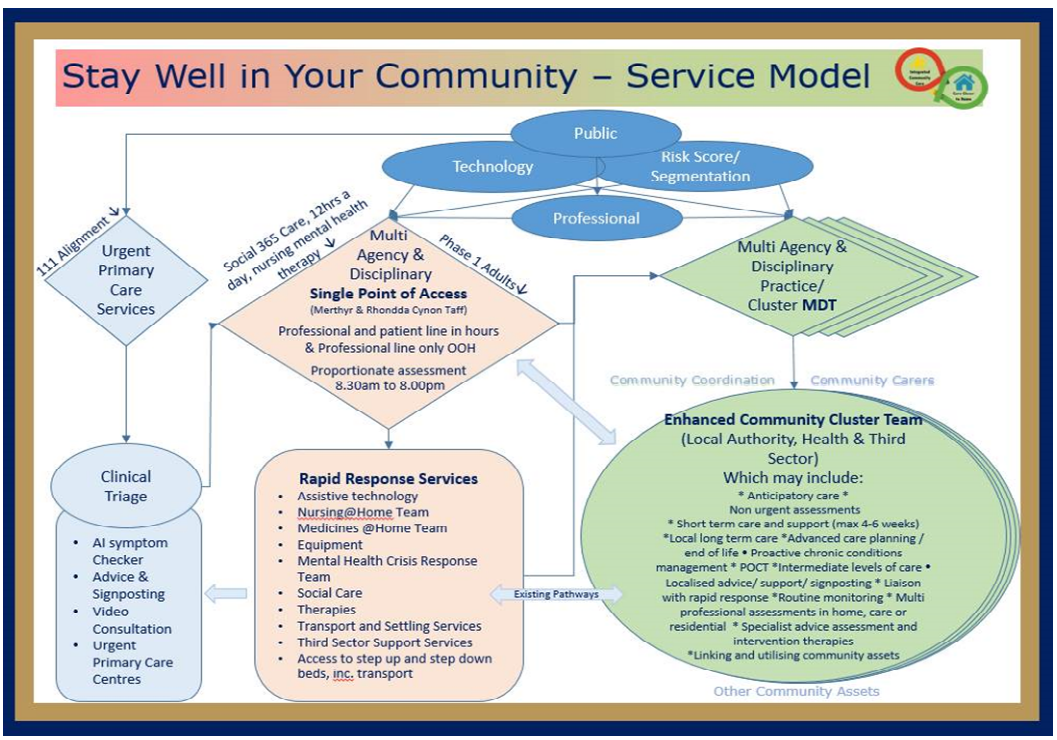
- Strengthening the sustainability of core services, referring to sustainability assessment frameworks completed by each practice
- Strengthening the focus on access to services, winter preparedness and emergency planning and improved service development
- Strengthening quality assurance in relation to clinical governance and assurance on specific QAIF indicators
- 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 for cluster

Taff Ely Cluster share the ambition of Cwm Taf Morgannwg University Health Board (CTMUHB) and Welsh Government to deliver a high quality, sustainable and integrated primary and community care service for current and future generations. The current Welsh Government investment for Taff Ely Cluster of £564,000.00 along with the funding which has been released in 2020 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 individual and community needs.

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 Transformation Model is outlined in the diagram shown below. This is the service delivery model for all out of hospital services that will be developing and being implemented across Primary Care and Localities. The Cluster work closely with CTMUHB project leads to develop the Enhanced Community Cluster Team and delivery of anticipatory care based on the need of the population of Taff Ely. This will continue to develop during 2020/21 with the aim to this becoming a sustainable model for the future.



Key deliverables for 2023

For the next three years the Cluster will continue to:

- Further develop the Multi-Disciplinary work to fully establish the 'Primary Care' Cluster working with Optometrist, Dental, Pharmacist colleagues and Local Authority.
- Provide appropriate education and signposting to ensure patients access the most suitable primary care and community services.
- Continue to support development of initiatives in the community to allow the population to improve their health & wellbeing, working collaboratively with community co-ordinators and 3rd sector organisations.
- Work with the Health Board to develop the Enhanced Cluster Team in line with Transformational plans

2. Introduction to the 2020-2023 Plan/Cluster

The Cluster are signed up to the values and principles set out in the Primary Care Model for Wales and will work towards actions in their cluster plan to support this. Objectives will be set to take into account the needs of the population and to work with both organisations and individuals to deliver services, projects and initiatives that matter to them in the right place at the right time and as close to their homes as possible.

This supports the model set out in the Welsh Government's plan for health and social care in Wales: 'A Healthier Wales', which focusses on:

- Service developments based on demand; planning and transformation is led through 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
- A more preventative, pro-active and coordinated care system which includes general practice and a range of services for communities
- A whole system approach that integrates health, local authority and voluntary sector services, and is facilitated by collaboration and consultation
- Care for people that incorporates physical, mental and emotional well-being, which is linked to healthy lifestyle choices
- Integrated and effective care on a 24/7 basis, with priority for the sickest people during the out-of-hours period.
- Creating stronger communities by empowering people and giving them access to a range of assets, ranging from access to debt and housing advice, to social prescriptions for gardening clubs and the leisure centre.
- Advice and support to help people remain healthy, with easy access to local services for care when it is needed
- Strong and professional leadership across sectors and agencies to drive quality improvement
- Technological solutions to improve access to information, advice and care, and to support self-care.

Governance

The Cluster have an approved Terms of Reference in place which provides governance and an accountability framework. This notes the membership and leadership of the cluster, the function, decision making and reporting and monitoring arrangements.

It also 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 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
- Co-ordinated 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 plan will also be developed, reviewed and monitored alongside the Cwm Taf Morgannwg Primary and Community IMTP and transformation plan.

There are five cluster meetings and two multi-disciplinary meetings held every year.

Risk Management
The Cluster use a risk log to identify, record and manage any risks affecting the cluster plans and working. If there are any significant risks identified, a more detailed risk assessment will be carried out, supported by the Primary Care Development Manager, using the Cwm Taf Morgannwg Datix Risk Management database. Any high risks will be reported to the Cluster meeting and also the Primary Care Quality, Safety, Risk and Governance meeting.

Outline of cluster population profile
Public Health Wales have provided the Cluster with a profile of their patient population (as shown at Appendix 1) with the following information providing a starting point. This will help the Cluster determine areas that require closer scrutiny and planning for projects based on the areas shown below:

- Demography- Population numbers, breakdown and projections
- Life expectancy and Healthy Life Expectancy
- Deprivation (WIMD – Welsh Index of Multiple Deprivation)
- Data related to households and families- poverty, unemployment, teenage pregnancy, low birth weight, carers etc.
- Chronic condition prevalence
- Mental health
- Clinical and behavioural risk factors
- Cancers and screening uptake
- Vaccination uptake

The estimated figures show that Taff Ely cluster has generally a similar or better prevalence of all chronic conditions than the welsh average with the exception of

- Diabetes and COPD in North Taff (Egwlysbach, Ashgrove and Taff Vale Practices)
- Asthma in South Taff (Parc Canol, Old School, Talbot Green and Taffs Well)

There are also some areas that Taff Ely have higher reported diagnosis, as compared to Cwm Taf, for Asthma in South Taff and Dementia in North Taff Ely. There will also be continued support for those presenting with mental health issues as RCT have higher reported mental health disorders than the welsh average

Estimated % prevalence of chronic conditions (2018)				
	North Taf Ely (practice)	South Taf Ely (practice)	Cwm Taf	Wales
CHD	3.4	3.3	3.7%	3.7%
Heart Failure	0.9	0.7	0.9%	1.0%
Stroke +TIA	2.0	1.8	2.0%	2.1%
Diabetes	6.2	5.4	6.4%	6.0%
COPD	2.4	1.6	2.8%	2.3%
Asthma	7.0	7.4	7.1%	7.1%
Dementia	0.7	0.5	0.5%	0.7%
Source: Primary Care Needs Assessment tool, 2019- using QOF data 2018				
Musculoskeletal disorder	17% in RCT (self-reported)			17%
Source: National Survey for Wales (NSW) 2017-19				

The population profile also reports lifestyle behaviours, using the National Survey for Wales and shows that although Taff Ely have more adults participating in healthy behaviours they have the highest number of adults reporting that they drink above the recommended weekly guidelines for alcohol intake.

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 Taf Ely (USOA)	21.1	22.4	52.7	18.7	38.3
South Taf Ely USOA)	15.5	26.3	56.7	20.5	41.4
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)					

Therefore key areas needing further analysis and planning are:

- Asthma
- Diabetes
- COPD
- Dementia
- Mental health & wellbeing
- Weight and obesity
- Alcohol

Public Health will also continue to support to work towards inclusion of data for other primary care contractors to give a Cluster wide picture for the population rather than just concentrate on GP patient data. The Cluster have also made a decision to work with children and younger people to educate and support them to avoid risky lifestyle behaviours and adoption of healthy lifestyles for the future and therefore they would also want access to data on childhood health to support planning and initiatives to ensure they are targeting appropriately.

To improve population health status and therefore more positive public health data, the Cluster will continue to work closely with Public Health Wales (PHW) colleagues to ensure that data is

captured for the population of Taff Ely. This will be done using the population needs assessment tool and also through involvement with the segmentation and risk stratification work which has been piloted in Rhondda. All practices in Taff Ely have signed the data sharing agreements with PHW.

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

Cluster Pharmacists
The Cluster have over the past 4 years funded practice based pharmacists All three were supported to undertake their 'Independent Prescribing' qualification and are all now IP trained. Included in the work is poly pharmacy / patient medication reviews, INR, asthma and hay fever reviews and chronic disease management. Polypharmacy is very topical with regard to ageing populations and increasing numbers of medications and the potential harm that can result from this.

The Cluster have decided to no longer fund the Cluster pharmacy roles, to allow them to consider other developments and initiatives. Many of the practices are now directly employing the pharmacists which demonstrates the value felt in utilising this non-GP workforce.

Valley & Vale Arts based therapy sessions 'Breathing Space' is held once a week at a local community church. Sessions include topics such as art, relaxation, photography. The Cluster are currently working with Valley & Vale to support a funding bid to continue and develop further sustainable sessions in the community.

Care Navigation

The Cluster have invested in training for frontline staff to allow additional skills to actively signpost patients on choices and services available to them. The initiative has now moved into phase 2 where further providers will be included to extend the choices being offered to patients.

The Cluster have concentrated its efforts on some key areas to ensure patients get the right messages to allow them to 'choose well' and 'take care of their own health & wellbeing', these are:

- Promotional banners, posters
- Attendance at public events e.g. Big Bite event, Public Forum, 50+forum, Carers Conference.

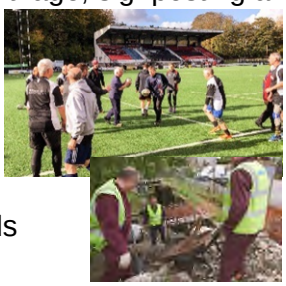
Taff Ely Cluster website - provides a dynamic and up-to-date resource for the population of Taff Ely and information on services, support, classes and initiatives available in the area.

Homeless Events
The Cluster have supported two morning events in a bid to reach out to those that are homeless in the area. The aim is to provide a 'one stop shop' in a Pontypridd town centre community church for advice from agencies such as Citizens Advice Bureau, Safe, Barod, the Job Centre, Mind, and Hapi Project during winter months. They also provided access to food, clean clothing, toiletries etc. The local police community officers also supported to engage those who had slept in the area to go along to the event.

mind for better mental health o blaid gwell iechyd meddwl | Merthyr & the Valleys

A Service Level Agreement is in place with Merthyr & the Valleys Mind to continue with an Active Monitoring service across the seven GP practices in Taff Ely. This service allows support for those suffering with mild to moderate mental health issues e.g. dealing with bereavement.

e-consult – the cluster have decided to invest in e-consult, a web based patient triage system for General Practice, which can offer multiple potential benefits including triage, signposting and reducing the need for attendance to the surgery via its 24/7 portal.



Mens Sheds/sustainable community development
The cluster have supported development of sustainable community groups. This has included walking rugby and football, garden initiatives, bowling club and canal group. This is being supported for a second year and has recently been shortlisted for the NHS Wales Awards 2019.

Community Wellbeing Co-ordinator - Taff Ely have recently employed, via Interlink, a wellbeing co-ordinator to provide health & wellbeing information, advice and support in the community. Some of this will be targeted in line with national and local campaigns. This role has also become the screening champion for the Cluster working in areas to improve uptake of bowel, cervical, AAA and breast screening.

3C's (Companionship, Conversation and Creativity)
The Cluster have supported, through Drink Wise Age Well, community based sessions with an aim to boost the confidence of older people, encourage new friendships, and allow individuals to find out about hobbies to help to improve their well-being and creativity. One of these groups have continued to meet and are now running their sessions themselves.

Healthy Lifestyles - Hapi project (Newydd Housing Association) have an established relationship with the Taff Ely Cluster. They are, in partnership with Garth Olwg Lifelong Learning Centre, continuing to deliver sessions on nutrition, cooking skills, exercise, meditation and general health and wellbeing. A GP at Parc Canol GP was instrumental to this and engaged her patients through facebook and a closed group was set up to provide regular updates and health and wellbeing advice to participants. This initiative is now being run by Hapi and Garth Olwg.

Multi-Disciplinary Meetings and collaborative working
The Cluster continue to engage with the other Primary Care Contractors and partners to widen its membership. This includes community dental, optometrist and pharmacist colleagues, Social Care, Public Health Wales and also community co-ordinators to ensure 3rd sector involvement. Multi-Disciplinary Meetings are held, outside of the main Cluster meeting, to allow a fuller discussion and support joint working and future initiatives.

Common Ailments Scheme – The scheme is available across Taff Ely. All Practices within the Clusters actively promote and sign post patients where appropriate, with the overall aim of ensuring patients access the most appropriate care provider in line with prudent healthcare.

Choose Well Campaign – work continues across the cluster to ensure that this is promoted in the best way to ensure patients are choosing the right primary care and community support services. This has included attending events such as the Local Authority run 'Big Bite event' and having a presence in the Health & Wellbeing Zone for the past three years.

Make Every Contact Count Training held by Public Health Wales was attended by all practices within the Cluster – this approach aims to empower staff working particularly in health services to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.

Further work is being undertaken with one of the GP practices as there is a plan to roll out the Making Every Contact Count (MECC) in line with recommendations of The Director of Public Health's Annual Report 'Stroke, A public health approach'. This involves scoping what this may mean in practice and how it could be achieved. As part of this work, we need to better understand the opportunities for health behaviour change conversations along the patient pathway.

MECC work around the COM- B model as it is recognised that for behaviour change conversations to take place, health care workers need to feel capable (through knowledge, skills and training) but also have the motivation and opportunity (potentially facilitated through processes and systems). PHW will continue to engage with the practice to follow up on this to ensure it can be implemented and that the systems work for them.

Valleys Steps – Mindfulness and stress control for younger people
The Cluster have worked with Valleys Steps following discussions around the younger population and how they are supported to improve their health & wellbeing, change future behaviours. The idea of giving young people a support mechanism and techniques to copy with day to day pressures was highlighted as a need. Through discussions with Valleys steps who wanted to explore ways of working with young people it was agreed to develop sessions that allowed a young person to attend with parent/guardian support. It was also agreed to support sessions for schools to raise awareness of the scheme and identifying those that may benefit from attendance.

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

In addition to the work being undertaken with Public Health Wales to analyse the population health profile for the Cluster, there are also other workstreams, although not funded directly by the cluster, will assess and have an impact on the health status of the patients.

Inverse Care Law (ICL) – Cwm Taf Health Checks
Cwm Taf Morgannwg University Health Board Cardiovascular Health Check Programme was rolled out in Taff Ely area and gave an opportunity for the team to target specific communities and individuals that were identified as high risk of Cardio-vascular disease (CVD) due to lifestyle factors.

All practices signed up, through a service level agreement, to the process. This has facilitated:

- Health Check+ software to be uploaded to allow their practice population data to be extracted
- the team to identify those in quintiles 4 & 5 (in most deprived communities and highest CVD mortality).
- The teams to be based in practices and deliver health checks, provide advice and support to those requiring it to make lifestyle changes.

From 1st April to 28th August - 1,311 were offered health checks and of these 473 took up the offer and completed a health check. The assessments established if people were smokers, overweight, had raised cholesterol or blood pressure and provided the Cluster with the following data:

Smoker – 83
Overweight (BMI 25-30) - 184
Obese (BMI OVER 30) - 156
High BP ≥140/90 - 164
Raised Cholesterol >=5mmols/L - 276
High Cholesterol >=7.5mmols/L - 7
High Cholesterol ratio≥6 - 51
Irregular pulse* - 12
Raised HbA1c - 68

On completion of the Health Check the practice is provided with a comprehensive electronic record of patients' modifiable cardiac risk factors e.g. BP and lipids, which will be read coded and reported in the Practice system. The practice then commit to follow up patients identified with raised 10yr CVD risk or individual risks i.e. high blood pressure

The team also provide information and advice to support individuals to make lifestyle changes and explain the impact this can have on their health.

Of those completed, the following actions were undertaken by the CVD team:
Referral to Stop Smoking Services - 83
Advised re activity levels - 311
Advised re weight management - 340
Referred to NERS - 4
Referred to alcohol services - 1
Diagnosis of hypertension within 3 months - 18
Diagnosis of diabetes within 3 months - 5
Diagnosis of atrial fibrillation within 3 months – 2

Community Development – based on areas identify through partner organisations and a scoping exercise the Cluster have for the last two years linked with communities across Taff Ely and supported their requests for community group and activity development , namely:

- Pontypridd walking rugby
- Pontyclun rugby & football, gardening group & film club
- Tynant & Beddau community bowling
- Grow for it
- Pontypridd canal group
- 3C's in the community with Drink Wise Age Well
- Breathing space – arts based therapy sessions

Partnership working - Some of these projects would not have been as successful without the partnership working with Shednet, Pontypridd Rugby Club, Sports for Wales, WRU, Café 50, Hapi Project, Drink Wise Age Well, Valley & Vale Ltd, Garth Olwg learning centre.
Those involved in the activities are reporting:

- Being more active
- Being fitter with weight loss
- Having healthier lifestyles and feeling better
- Having fun as well as exercise
- Improved fitness but thinks the best thing has been meeting people and the company
- Feeling better and making friends
- Keeping fit and feeling fitter
- Welcoming, good atmosphere and well run

- Physical and mental health benefits

In addition to the key areas being identified in the population health profile the Cluster will continue to encourage better and healthier behaviours. This will ensure projects link in directly with its communities to also tackle loneliness and isolation and improve general wellbeing which has featured highly in cluster plans to date.

This will compliment work being undertaken to promote primary and community services available and will not only promote the cluster working but will also support improved access to appointments. People will have a better understanding of which services they should access and alongside an improved health and wellbeing there should be a noticeable reduced demand on GP appointments.

Practices will continue to work with the patient participation groups around individual practice services, clinical performance and pathways to ensure engagement with their practice populations.

The Cluster will continue to engage with the population at specific events such as Big Bite, Carers Conference, RCT 50+ forum meeting and events and will continue to link with the Community Health Council to ensure community engagement.

5. Cluster Workforce profile

The Cluster will work closely with CTMUHB to support recruitment, training and placement of roles to implement an enhanced cluster team to deliver a primary care multidisciplinary workforce linked strongly to the Cluster network plans. The 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 will also employ a project lead and support, data performance analyst, IT Manager and administrator to support the Clusters with their transformational plans and Welsh Government reporting.

General Practitioners (GP's)
There are 7 GP practices in Taff Ely area.

Urgent Primary Care 'Out of Hours' (OOH's) is commissioned and managed by the UHB. There are plans to roll out the 111 service across the whole of Cwm Taf, which will include Taff Ely, to bring it in line with Bridgend later in 2019.

General Dental Services (Dentists)
Across Taff Ely there are 13 dental practices. There is a community dental service delivered in Pontypridd. 'Out of hours' Emergency Dental Service (EDS) is commissioned locally by the UHB. Patients access urgent dental care services through the OOH service.

General Ophthalmic Service (Optometrists)
Taff Ely have 9 practices and 8 are accredited and provide the Wales Eye Health Scheme (EHEW) and 5 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.

Community Pharmacy Service (Pharmacists)
The Community pharmacy service is managed by the Medicines Management Directorate and will therefore be described their IMTP document. There are 21 community pharmacies in Taff Ely and all deliver the Common Ailment Scheme.

Further work will be undertaken to establish a more detailed workforce profile and training needs across the cluster for all contractor professions and health/social care community services where this exists and key third sector providers

Interlink
Interlink is the County Voluntary Council (CVC) for Rhondda Cynon Taf, supporting individuals, communities and organisations to work together to make a positive impact on the life of people who live and work in Rhondda Cynon Taf and also in Merthyr Tydfil with Voluntary Action Merthyr Tydfil (VAMT).

They act as an umbrella body to support over 550 members, some small groups and others larger charities, through helping plan and develop projects, activities and events as well as helping members plan and manage what they do.

Community Co-ordinators are employed by Interlink and work closely with the Clusters. The Cluster have funded a Community Wellbeing Co-ordinator role to be aligned to the Taff Ely Population, offering social and community support for those age 18+ on behalf of the Cluster.

Social Care

6. Cluster Financial Profile

The Cluster allocation was increased from April 2020 to £564,000 from £ 281,929.31.

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 (SFI's). The Cluster will continue to be supported by the finance department as the plan is progressed as their support is fundamental to ensure that the Cluster continue to work within allocated resources.

Delivery agreements are developed and are aligned to the Primary Care funding allocation and are reported to Welsh Government on an annual basis.

The following funding is not allocated directly to Clusters but do have impact and benefit for the population.

Transformational allocation to Cwm Taff for the Enhanced Cluster team is

- Year 1 £2.92m
- Year 2 £4.920m recurrent funding

Delivery agreement funding is also allocated to provide community clinics to establish care closer to home rather than in District General Hospitals. A COPD discharge clinic has recently started in the Cluster hub at Dewi Sant as part of roll out of the clinic following a pilot in Rhondda.

Pacesetter funding - nurse training hub and spoke
The initiative mirrors the very successful nurse training scheme that has been operating in England for a number of years; it is based on a model used in Yorkshire which has been running since 2009 and has recruited significant numbers of student nurses into primary care.

The hub is based at Pont Newydd Medical Centre and of the seven hubs successfully recruited to the scheme there are five in Taff Ely Cluster area, namely;
Eglwysbach Surgery, Old School Surgery, Ashgrove Surgery, Taffs Well Medical Centre and Taff Vale Surgery. Each practice has completed the mandatory Batchelor of Nursing Education Audit - Practice Learning Environment. Spoke practices provide placements for three undergraduate nurses per year. As of January 2018, 23 pre-registration nurses have been placed in Cwm Taf Morgannwg within the hub or spoke practices, and there have been two students who have completed their consolidation in General Practice, with a third due to return to the practice in which they spent their 6 week placement for their consolidation in November this year. All three nurses have cited their positive experience within the GP practice during their 6 week placement as the reason for returning to complete their consolidation.

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

Quality Assurance and Improvement Framework (QAIF) for the GMS Contract Wales
The GP practices in the cluster have now had sight of the QAIF which comes into force October 2019 and will work during the 12 month cycle to agree and implement quality improvement projects with the focus being on patient safety.

This will include the mandatory project – "Reducing medicines related harm through a multi-faceted intervention in primary care clusters (patient safety)" and a second QI project as agreed by the Cluster for implementation which will be "Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20"

The Cluster have agreed that each practice should provide reports to the April and September meetings. Reports will include information to demonstrate where changes have been made, any areas where practices have shown good practice etc. Antibiotic leads will also be identified in each practice.

There will be a review of the clinical inactive indicators to ensure data is available for collection from GP clinical systems for the purposes of assurance of standards and this is to be reported back to the Cluster at its June meeting each year.

Roll out of 111 – Cluster will support roll out in line with the project plans and will welcome updates form project leads as information becomes available.

Patient Engagement, education and participation in health & wellbeing agenda
The Cluster will continue to link with the Community Health Council, link with 3rd sector organisations and Community Co-ordinators, existing groups such as 50+ forum to ensure that they are engaging in the right way. Any communications will also need to take into account the ability for a 2 way conversation so that it is not just about the Cluster informing the patients, but gives the opportunity for patients to also feed in their thoughts and responses.

There will be a number of ways they do this, for example

- Cluster leaflet to tell people about what's on offer - to compliment Taff Ely Cluster website information but be more available and on hand in practices, community pharmacies etc. to distribute to patients.
- Surveys, questionnaires
- Patient participation groups
- Community Health Council meetings with the Cluster and attendance at community and cluster events

Communication and engagement
The Cluster, through the support of the Primary Care Development Manager will work with PHW colleagues to extract further Cluster level qualitative data using the Primary Care Needs

Assessment Tool. This will allow publicity, engagement, health & wellbeing campaigns to be targeted accordingly.

Attendance at public events such as 50+ forum, big bite event, carer's conference will allow the Cluster to promote their initiatives and engage with the population.

The cluster will continue to promote their initiatives and provide 'good news' stories by working closely with the Health Board communications team. This will also include promotion of #your local team.

Improved working, in partnership with Interlink, with 3rd sector organisations to deliver more robust and sustainable community development e.g. funding and collaborative working for initiatives with established organisations to allow the organisations to deliver on behalf of the Cluster.

Welsh Language
The Cluster Primary Care services will work towards achievement of the 6 Welsh Language standards as set out by Welsh Government to achieve the following 'good practice'.

- Referrals to Secondary care – indicating where a welsh speaking patient/family would prefer a consultation through the medium of welsh
- Practice leaflet –include information about communication needs and ability to ask for a copy in Welsh.
- Identifying welsh speaking staff Bilingual element on the Cluster Website
- Consider an initial bilingual greeting as part of telephone message
- To work with the UHB to provide training for staff
- Bilingual signage and information available

Sensory Loss
The Cluster, with the support of the UHB sensory loss manager have introduced sensory loss equipment across the Cluster. This involved roll out of sonido hearing loop systems across primary care premises plus supporting posters, information and training to ensure patients can access the system when they attend for appointment should they wish.

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

The Cluster have developed a monitoring report which is attached at Annex 1 to provide a working document to allow regular updates and reports against the planned cluster actions plus will highlight any key risks associated with initiatives.

The monitoring report is structured to align to the HB IMTP, 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

Cluster actions and projects being considered for 2020 -2023

- To develop an enhanced cluster team to support the transformational plans for Primary and community care and delivery of anticipatory care for their patient population and those most at risk to ensure their conditions are being managed and they are able to stay well at home.

- **Community Development and working more collaboratively with 3rd sector organisations**
  The Cluster have previously supported community development through financial and project support. They will not continue to do this in the same way, and will review any opportunities as they are presented to them.

- **Prescribing Quality Improvement Programme (PQIP)**
  - Antimicrobial stewardship
  - CRP Point of Care testing

- **Healthy lifestyles scheme** – particularly focussing on healthy eating, cooking skills, food choices, physical exercise, this project will focus on healthy families and chronic condition intervention e.g. pre-diabietes.

  The plan is for a nurse led service, with trained individuals, who will provide support to groups and individuals to implement lifestyles changes.

  The project is being fully supported by GPs and Public Health Wales and will be planned to ensure that there are support mechanisms in place to help individuals bring about small behavioural change. This will include
- Motivational training for 2 healthcare professionals within each practice
- Identified staff to become practice champions
- Investment in time for practice staff to work on this proposal
- Healthy lifestyle roadshows – suggested name 'My change, my health, my life'
- Link with EPP programme
- Use reports from Cardio-vascular team to help identify individuals and make contact
- Make Every Contact Count (MECC) principles and work towards encouraging small changes and improve patient choices, focussing on:
  - Exercise
  - Diet
  - Smoking
  - Alcohol
  - Obesity

- **Dermoscopy training/equipment**
  This requires investment in equipment for practices and training for GPs. The Cluster have approved purchase of Dermoscopes and also training for identified GPs in each practice. This will allow improved identifications and diagnosis of both benign and cancerous lesions. The Cluster will work with health board Macmillan GP leads to progress any joint working with secondary care.

  Physiotherapy – the cluster have approved funding to progress a first contact physiotherapy service. A service level agreement has been signed with the Health Board to deliver sessions in GP practices.

  This will allow patients to have access to the physiotherapist and effectively manage their condition without the need to see a GP . By presenting and having earlier intervention it

will provide better outcomes for patients, reduce the need for repeat visits and also reduced referrals to secondary care, prescribing and unnecessary intervention.

Quarterly performance reports will be provided back to the Cluster to allow monitoring against targets.

Pharmacist / Pharmacy technician roles

Following on from the original Cluster project and most practices employing clinical pharmacist, it was felt that an additional resource will be beneficial to support the development of the MDT team and skill mix within practice. It will also release time for the GPs and Pharmacist as the pharmacy technician could be carrying out specific activity e.g. medication reviews, releasing the clinical pharmacist to support more complex cases and support GP activity more directly. The technician can also act as a named link for the practice to improve communication with community health professionals

The project aims to:

- Reduce medicine waste and avoidance, supporting reduced costs for the practice and Health Board.
- Support reduced demand for GP appointments and releasing GP practice time for more complex conditions
- Reduce some areas of work and demand for the clinical pharmacist to allow them to deal with higher complex cases and provide expert advice and support to other health professionals.
- Improve patient care and experience – better management of conditions
- Improve discharge information
- Assist with reduction of hospital admissions /A&E attendances
- Improve communication and quality of information between Primary and Secondary care
- Support better communication with community pharmacies, dental practices and Optometrists.

Mental Health Service Provision

Adults

Merthyr & the Valleys Mind are continuing to provide an Active Monitoring service to support individuals 16 and over, who present with mild to moderate issues affecting their mental wellbeing. Sessions aim to provide support early for those dealing with anxieties, depression, dealing with bereavement.

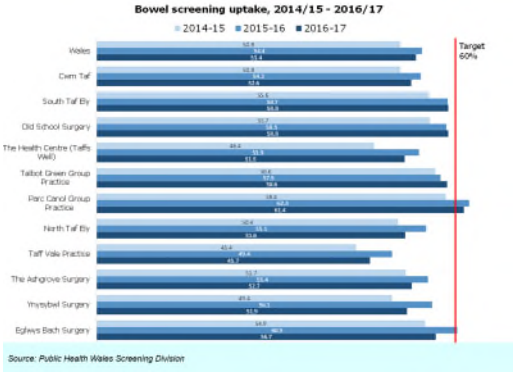
Young People

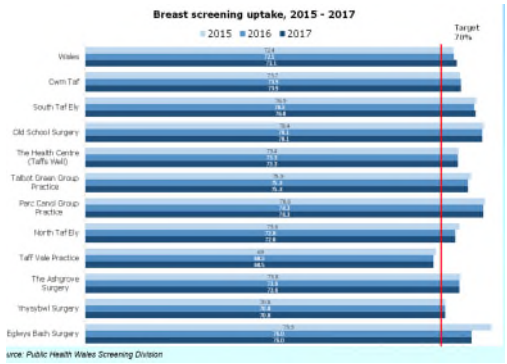
Further to discussions at Cluster meetings, where GPs indicated that they were having many appointments with young people who were struggling with daily life and pressures, it was recognised that there was a need for support with their mental health and wellbeing. This linked with dialogue taking place with Valleys Steps who were receiving reports from a local college that there was a dramatic rise in students presenting with a variety of mental/emotional health issues.

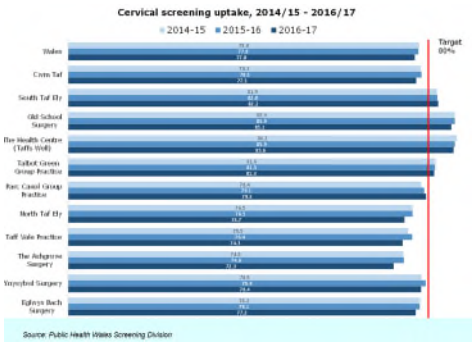
From this point and a number of meetings later, it was agreed that there was merit in testing a model that builds upon Valleys Steps open programme through provision of a pilot project delivered over two years targeted at parents and their children. This would allow the young person to attend with a parent/guardian over a 6-8 week period, providing technics and support for the young person but also for the parent to allow them to support and promote the wellbeing of their children. With the hope to build more resilience into the family unit to aid better management of stressors in day to day life. The project would also include taster sessions to be delivered in school settings for staff, parents or adults working with children to raise awareness on recognising issues in

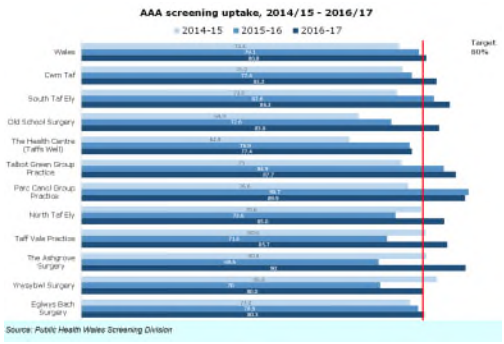
young people but to also promote the availability of the 6-8 week sessions so that they can signpost to Valleys Steps.

- **Health Screening**
  Increase health screening uptake based on the data received from Public Health Wales with particular support to the following screening for life campaigns
  - Bowel
  - Breast
  - Cervical
  - Abdominal Aortic Aneurysm









This graph is specific to cancers and therefore covers only bowel, breast and cervical screening

Uptake of screening % (2017/18)						
	National targets	**North Taf Ely (practice)**	**South Taf Ely(practice)**	**Cwm Taf**	**Wales**	
Bowel	60%	56.1	60.5	64.8	55.7	
Breast	70%	72.1	77.2	73.6	72.8	
Cervical	80%	73.3	81.7	76.4	76.1	
Source: Produced by Public Care Hub using QOF (Primary Care Needs Assessment tool, 2019)						

- **Homeless Project and future service provision**
  Support for those that are homeless to have access to health, community and social services. This will need participation of GP practices to provide a network enhanced service and the cluster to support development of a specialist nurse role to support those requiring health needs assessments, access to services and support. The Cluster will also work collaboratively to ensure access to services being identified such as dental, optometry, podiatry, social care and mental health support.

- **Digital, data and technology developments**
  Continued use of digital technology to provide information on services, support patient choices and support sustainability and access through

- o e-consult
- o website development
- o use of social media to promote projects, services and community groups
- o video consultations

Cluster have approved funding to support IT equipment within the practices to support effective and efficient use of e-consult and video consultations which were introduced during the covid pandemic but to also ensure that this way of working can continue when services return to normal – as it has been recognised that patient consultations will continue through these mediums into the future.

The cluster have also employed, via the Health Board, a Communications officer to support the development of the website, social media and to also ensure that messages are being produced and promoted as and when necessary, which will allow continuity across the cluster and further developments.

There are a number of factors that the Cluster need to consider when planning services, projects and initiatives, this includes the following:

Estates developments
There are significant housing developments planned over the next 10 years which impact mainly on Llanharan and Llanharry, Talbot Green and Church Village. Many of the current main surgery premises are used to maximum and therefore some are exploring opportunities for improvements and new builds. The Health board will continue with the Local Authority planning officers to identify timelines for housing developments and link with GP surgeries and other primary care services in line with any potential impact.

Dewi Sant Health Park Development
Dewi Sant is being developed as a Health Park, through a capital funding programme of the Health Board to support a wide range of community and primary care services. This includes an area which is specifically allocated as a Cluster hub to allow services to be delivered from the site on Cluster network basis. It is also available for use by 3rd sector organisations and links directly with one of the GP practices as they have re-located one of their branches to the site.

Covid-19
COVID-19 has had a significant impact on the delivery of Primary Care Services, on the Cluster's current services and intended actions for 2020. In order to enable primary care services to concentrate on delivering core services during the pandemic, and to ensure the safety of staff and the community, many cluster services have been suspended, delayed or delivered in different ways.

Impact of the cluster on dental, pharmacy, optometry and GMS contract reform and plans for delivering extended range of enhanced services.

Contract changes for community pharmacies
Welsh Government considers the community pharmacy sector to be a fundamental part of a strong primary care service and has therefore made commitment to:

- investing in community pharmacies to take pressure off GP services, reducing unnecessary appointments and making sure people are able to see the right professional in the right setting at the right time
- encourage community pharmacies in Wales to engage with primary care cluster and develop and improve collaborative working relationships with GPs and other healthcare professionals

New contract demonstrates the need to work, not only with their follow GP practices, but also in collaboration with the wider cluster partners. The Taff Ely Cluster invite the cluster partners to

Cluster meeting and encourage submission of initiatives based on the population needs and Cluster plans.

Engagement of other health professionals is varied and attendance at Cluster meetings continues to be a challenge particularly for Optometrists and Dentists. The Cluster will continue to invite them and engage with the Health Board advisors to disseminate information and encourage attendance at meetings and opportunities for collaborative working.

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

- Primary Care Development Manager employed to support Taff Ely Cluster
- Terms of Reference in place and reviewed and updated when necessary
- Standing Financial Instructions – regular meetings with Finance colleagues and budget reports and spend to Cluster
- Workforce and planning support
- Cluster reports to Primary Care Committee to provide assurances through to Executive Director and Board level
- Dental and Optometry Advisors and Pharmacy leads support developments of the Cluster and liaise with the Development Manager and attend Cluster meetings to update on services, contract changes and offer advice on collaborative working.
- Interlink in their role as umbrella organisation for 3rd sector organisations are active members of the cluster and support the health & wellbeing agenda and community development

The Cluster will continue work in partnership achieve the aims within the plan and will ensure that any partnership working and support continues to be included throughout, as applicable.