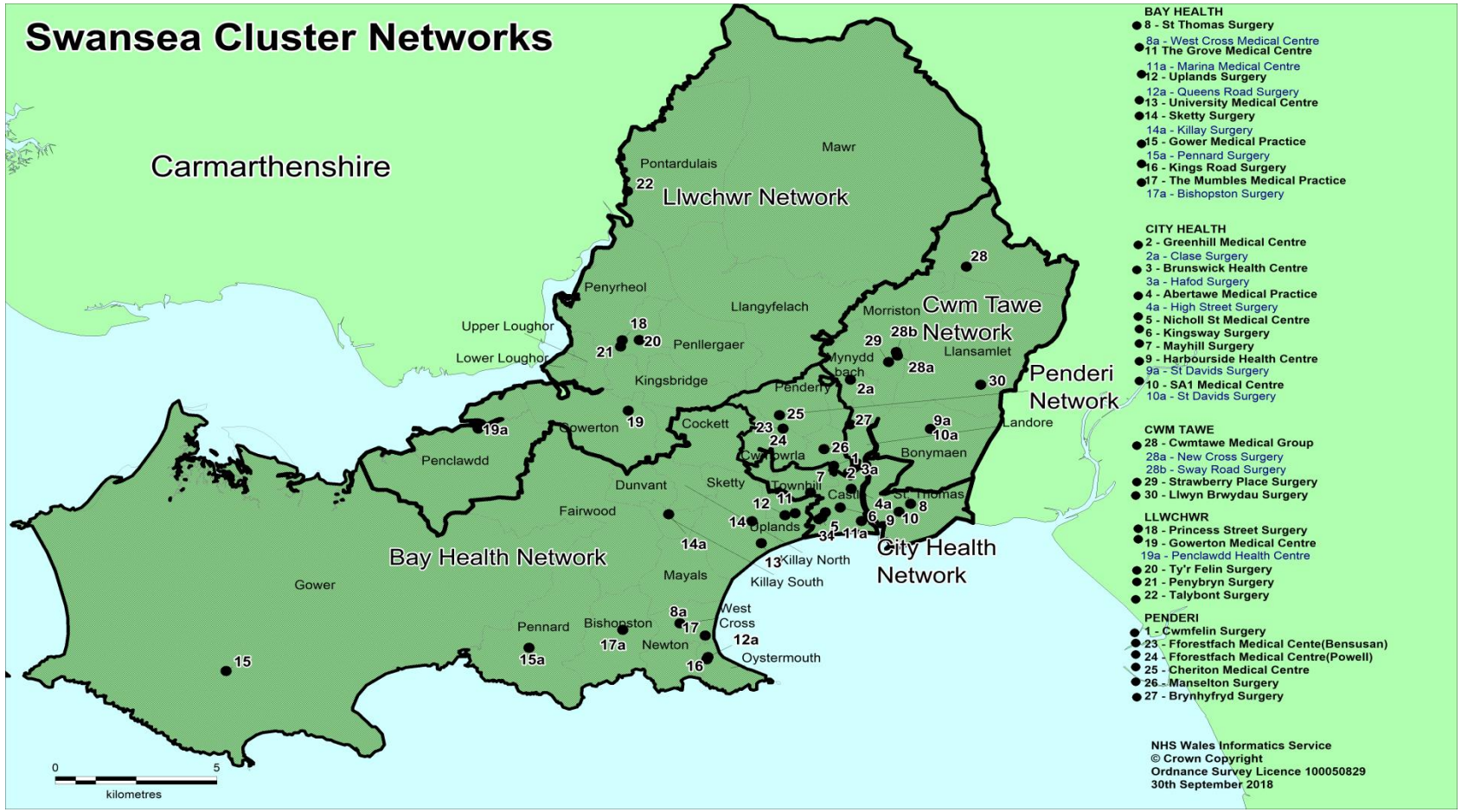
Three-Year Cluster Action Plan 2018 - 2021

Llwchwr Cluster

Welcome to the Llwchwr Three Year Cluster plan, 2018 – 2021

1. Llwchwr Cluster Overview

The Llwchwr Cluster is one of five Cluster network areas in the City and County of Swansea, covering the Llwchwr geographical area incorporating Pontardulais, Gorseinon, Gowerton and Penclawdd areas.



There are a total of 47,500 listed patients across 5 general practices, with individual practice list sizes ranging from between 4,914 to 14,089. The Cluster is formed of partners of GP practices, Community Health and Social Care Services, the Voluntary sector, Public Health Wales, and other primary and community services

Clusters aim to work together in order to:

- *Prevent ill health enabling people to keep themselves well and independent for as long as possible.*
- *Develop the range and quality of services that are provided in the community.*
- *Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.*
- *Improve communication and information sharing between different health, social care and voluntary sector professionals.*
- *Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.*

Through the delivery of their plans they work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales in 'a Healthier Wales' (2018):

- ✓ Improved population health and wellbeing
- ✓ better quality and more accessible health and social care services
- ✓ higher value health and social care
- ✓ a motivated and sustainable health and social care workforce

The Cluster will work collaboratively with Public Health to achieve the outcomes noted in the 'Burden of Disease' Action Plan by adopting the five ways of working as outlined in the Wellbeing of Future Generations Act. (Long term, integrated, involving, collaborative, prevention).

2.1 Swansea wide 'Headline' Information

Population:242,400. High concentrations of population in and immediately around the City Centre, the adjacent wards of Cwmbwrla and uplands (6,800 people per square km, the highest density in the county) and also in Townhill and Penderi

Population has steadily grown between 2001 and 2015. Main driver of population growth in Swansea has been migration. Recorded live births has steadily risen since 2001 and number of deaths have fallen.

Life expectancy in Swansea is increasing: Average life expectancy for males is 78 (Wales 78.5) and 82.4 for females (Wales 82.3). This will impact significantly on the provision of health, social care and other public services in Swansea

Projected population change: Welsh Government's latest trend based population projections suggest that Swansea's population will grow by 9% (21,600 people) between 2014 and 2039

2011 Census suggests that 14,326 people in Swansea were from a non white ethnic group: 6% of the total population and 20,368 (8.5%) of Swansea's Population were non white British. (above the Wales average (6.8%). Census data (2011) suggests the largest non white ethnic groups are: Chinese 2,052 (0.9%), Bangladeshi 1,944 (0.8%), Other Asian 1,739 (0.7%), Black African 1,707 (0.7%), Arab 1,694 (0.7%)

Welsh Language : Proportion of people able to speak Welsh in Swansea decreased from 13.4% (28,938) in 2001 to 11.4% (26,332) in 2011. A fall of 9% despite an increase in population.

Health and Attainment of Pupils in Primary Education Network (HAPPEN)
Established in April 2015, HAPPEN focuses on children in Swansea Schools aged 9-11 years who complete health and wellbeing assessments as part of the Swan Linx Project. Data is collected on body mass index, fitness, nutrition, physical activity, sleep, wellbeing, concentration and children's recommendations on improving health in their area. Pontardulais and Pontlliw schools, (two of the Primary Schools within the Network) have undertaken the study within the last two years, areas of interest are shown below:

	Pontardulais %	*Pontlliw %*	*Swansea %*
Sedentary Screen time for 2 hours or more a day	23%	27%	*31%*
5 Portions of Fruit and Veg a day	35%	27%	*27%*
At least 3 take aways a week	20%	7%	*18%*
Physically active for 1 hr or more a day	28%	25%	*24%*
Happy with family	86%	88%	*94%*
Happy with Life as a whole	73%	88%	*91%*

2.2 Our Local Health, Social Care and Wellbeing Needs and Priorities

Information has been collated on a wide range of health needs within the Llwchwr Cluster area in order to develop the priorities for this plan.

Key Population Features

47,462 patients registered, increasing list sizes

10266 (21.6%) patients are aged 65+ (Swansea is 19.2%)

4698 (9.9%) are aged 75+ (Swansea is 8.9%)

Population increase 2005-2010 is + 2200

Low student population

Low ethnic minority patient numbers

High numbers of Care Home patients

Low asylum seekers numbers

Cluster Features

7 Dental Practices

11 Pharmacies

6 Nursing Homes

Significant overlap of registered patients who live in adjacent areas of Carmarthenshire

It consists of 27 LSOAs

is the third highest populated of the 5 cluster areas, but has the second lowest population density

Major employers: Swansea Council (schools), Gower College Swansea, 3M plc, Toyoda Gosei, Timet UK, Crofty,

Garngoch and Pontardulais Industrial Estate occupiers, agriculture businesses

Population & Community Assets

Gorseinon Community Hub
Active community and voluntary sector
Lliw Reservoirs
Golf Range
The Elba Sports Complex
Loughor Castle
Glanymor Park
Rugby Clubs
Parc Y Werin
Penyrheol Leisure Centre
Access to River Loughor

Cricket Clubs

Health Profiles

Second highest rate in ABMU, highest in Swansea of reported alcohol consumption in previous seven days (16+) - 82.18%

Influenza vaccination uptake is high for 2-3 year olds (3rd highest in ABMU at 50.6%) but amongst the lowest for those under 65 years in clinical risk groups (41.5%) and for those aged 65+ (64.4%)

The Cluster has strong performance (ranked first) comparatively in ABMU for uptake of childhood vaccinations until age 4 (e.g. 98.1% for 5 in 1, aged 1) however uptake rates decrease thereafter.

Bowel Screening – 56.3% of those eligible were screened in 2016/17 (ABMU average of 53.2%, WG target 60%), a slight decrease on 2015/16

Breast Screening – 73.2% of those eligible were screened in 2016/17 (ABMU average of 73.5%, WG target 70%)

Cervical Screening – 79.6% of those eligible in 2016/17 (5 yr rate/ABMU average of 76.1%, WG target 80%)

AAA Screening – 82.1 % of those eligible were screened in 2016/17 (81.9% ABMU average, WG target 80%), an increase on 2015/16 and above the national target

2.99% percent of people over 65 are registered with their GP practice as having dementia

The second lowest rate of people who smoke in Swansea networks and is significantly lower than the health board average. The estimated number of smokers is 9,940 = 18.1% of the cluster population

Service demands

Lowest (in ABMU) rates of Emergency Dept. attendances : 1,867 between Sept and November 2018 and GP Out of Hours attendances Rate per 1000 registered 25.39

Large numbers of the population requiring low level mental health services

The Cluster has the largest number of patients of with Dementia prescribed anti-psychotic medication (4.08%)

Influencing Features

Swansea Local Development Plan- Hundreds of new homes proposed in cluster area

Public Service Board - Local Wellbeing Plan focus

Early Years, Making sure children have the best start in life

Live Well, Age Well

PSB Aims to make sure all services work together by sharing resources assets and knowledge

Wellbeing Future generations (Wales) Act

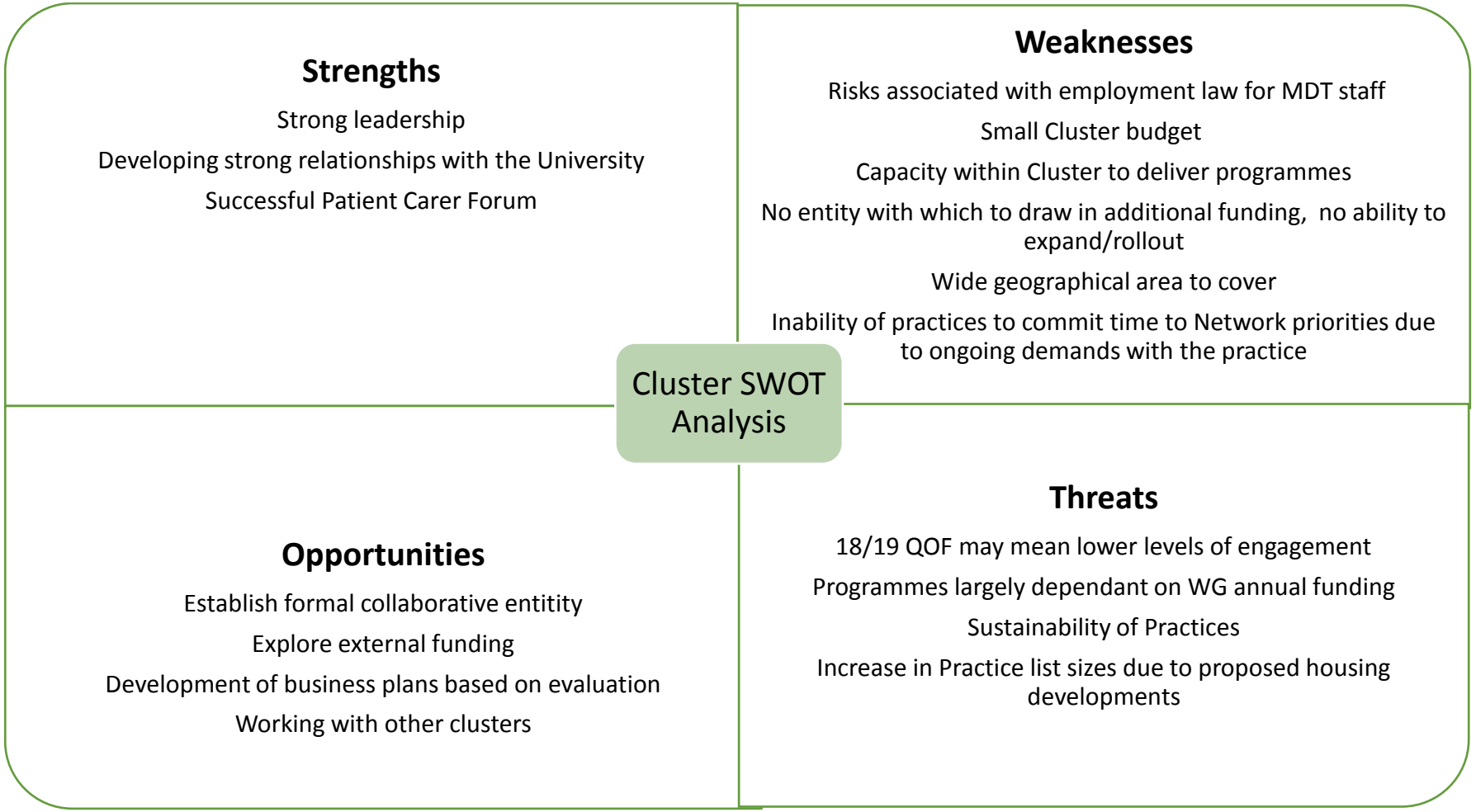
2.3 Antibiotic Prescribing: Detailed below is the most current figures for antibiotic prescribing within the Swansea Cluster areas. Nationally there was a 2.2% reduction in antibiotic prescribing levels for the same period Llwchwr increased its antibiotic prescribing level by 2.6%.

Entity	Items Apr 17 - Mar 18	Items Apr 16 - Mar 17	Items % Variation	Items Difference
Llwchwr (Swansea)	35,397	34,500	2.6%	897

2.4 Llwchwr Cluster Disease Register

Disease Register	Llwchwr Register Total 2018 (%)	Swansea %	ABMU %	Trends/Highlights
Atrial Fibrillation	1082 (2.3%)	2.2%	2.3%	Joint highest cluster in Swansea – rate and #s
Asthma	3762 (8.0%)	7.0%	7.4%	Highest rate in Swansea clusters, 2 highest numbers in Swansea
Cancer	1404 (3.0%)	2.7%	2.9%	Second highest numbers in Swansea, joint highest rate in Swansea clusters
Dementia	352 (0.7%)	0.7%	0.7%	Second highest rate and numbers in Swansea clusters
Obesity	4384 (9.3%)	9.0%	10%	
Diabetes	2746 (5.8%)	5.6%	6.2%	
Hypertension	7222 (15.3%)	13.1%	15.3%	Second highest rate in Swansea
Heart Failure	525 (1.1%)	1.0%	1.1%	Second highest numbers in Swansea clusters
Stroke/TIA	1019 (2.2%)	2.1%	2.3%	Joint highest rate in Swansea, second highest numbers

3. ***Strengths, Weaknesses, Opportunities Threats analysis (SWOT) Llwchwr Cluster***



4. ***Cluster Vision***

In June 2018, Llwchwr Network jointly agreed a Cluster Vision for the next three years. The Vision sets out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Llwchwr area and its practices.

LLWCHWR CLUSTER

"The Llwchwr Cluster vision is to create a healthy community where Healthcare professionals and third sector organisations come together to provide holistic and equitable care or support to our cluster population of all ages."

5. ***Llwchwr Cluster Practice Priority Issues***

Practices have expressed a range of areas which are a priority for them in delivering a sustainable and effective primary care service. These issues have also been taken into account in developing the Llwchwr Cluster Plan

Our Cluster Plan

Strategic Aim 1: To understand and highlight actions to meet the needs of the population served by the Cluster Network with a preventative approach

Our three year focus:

- Developing and delivering a preventative work programme focusing action on reducing rates of Obesity
- Improve the pace of reduction of smoking rates and respiratory disease for the Llwchwr Health population

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
1.1	**Obesity:** Increase referrals to National Exercise Referral Scheme	Cluster practices	Ongoing	Increased numbers of patients referred to NERS. Better management of obesity in patients	Service underutilised as part of approach to approach to weight management	
1.2	Work in partnership with HWB Abertawe to deliver Health and Well-being programmes to cluster patients	Cluster practices	Aug 2019	To have delivered 3 HWB Health and Well-being programmes and to have identified patients in need of more intensive support.	Identified a resource to help patients learn healthy cooking in Llwchwr	
1.3	Make use of intelligence/data gathered by HAPPEN Programme to inform development of cluster initiatives	HB, PHW, Cluster	Ongoing	More targeted interventions provided. Those a greatest need of preventative	Lack of local information around children and young people obesity and contributory lifestyles	

				interventions able to access		
1.4	Gather correct information	Cluster practices	Dec 2019	Registers are as accurate as possible through correct coding and increased measuring of patient BMIs		
1.5	Explore accessing Dietician expertise for advice or service provision in Cluster	Cluster practices	March 2019	Improve support for patients to manage obesity		
1.6	Provide general lifestyle advice and enhance communication around health promotion eg through Facebook page.	Cluster practices	Aug 2019	Healthier patients requiring less visits to the GP	Looking to develop a Facebook page	
1.7	**Dementia:** Increase the proactive identification of patients with Dementia	Cluster practices	March 2020	Earlier Identification of patients with Dementia resulting in better treatment and improved support		
1.8	Increase the identification of unidentified Carers linked to Dementia patients	Cluster practices/Carers Centre	Sept 2019	Improve the lives of carers with responsibility of caring with those suffering with dementia		
1.9	Explore opportunities to link with the Carers Centre to provide support to newly identified carers looking after people with Dementia	SCVS, Carers Centre, Cluster, BSM	Sept 2019			
1.10	Undertake MECC (Making Every Contact Count Training) for professionals to provide additional support for patients	All	Ongoing/ March 2019	All teams to Complete mandatory training for Making Every Contact Count (MECC)	Working to get as many personnel trained as possible	

Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements.

Our three year focus:

To undertake a proactive approach to deliver sustainability by:

- Expanding MDT team to meet the workforce needs of the Cluster, including establishing working relationship with the Health and Wellbeing Academy within the University, with an initial focus on delivery of Osteopathy services and potential to progress to counselling services, and sleep deprivation

- Delivering a comprehensive Cluster training programme which supports staff and clinicians to work in the most effective way possible

- Establishing the best components of the new model of primary care for the Cluster including the merging of practices

- Enabling discussions before crisis point between practices

- Pooling expert roles/functions within practices

- Realising opportunities to best use new clinical space for establishing MDT hub, prescribing authorisation, admin functions

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
2.1	Provide training for all practice staff in Vision	PMs	Sept 2019	Better trained practice staff and better outcomes for patients		
2.2	Establish a prescribing hub for the Cluster	BM/CD		Implementation of a prescribing hub Reduced levels of prescribing Safer prescribing Better efficiency for staff		.

2.3	Set up and build a relationship with the Health and Wellbeing Academy within the University. To include an Osteopathy service potentially including counselling services, and sleep deprivation	Health and Wellbeing Academy with support from the Network	Ongoing and April 2019	Patients being triaged and treated and not requiring further treatment within secondary care. Improved patient experience Better access to services Reduced visits to GPs	Discussions underway, and business plans written in draft. For further discussion at the next Cluster meeting, with the aim to commence the service in April 2019	
2.4	Schedule a calendar of time-outs to enable cluster to forward plan for practice sustainability issues	BSM/HB	March 2019	Pro active approach to sustainability of Cluster practices		
2.5	Ensure sustainability is a standing agenda item on Cluster agenda	HB	Dec 2018	Discussions on Sustainability held at each Cluster meeting		
2.6	Increase of My Health Online – Work in partnership with Digital Communities Wales to improve update.	All	March 2019	Reduce impact on practices Better access for patients More patients in Llwchwr using MHOL	A digital/health event is being arranged in collaboration with digital communities and SVCS for March 2019 to raise awareness of My Health Online and try to increase the uptake	
2.7	Develop a menu of training options available for staff and support delivery with cluster resource	All	March 2019	Practices better aware pf training available to them and teams enabling them to work more prudently		

Strategic Aim 3: Planned Care - to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface.

Our three year focus:

- Cancer: Provide a more rapid access to services for patients. Ensuring all healthcare professionals are aware of existing pathways and have a high index of suspicion with patients presenting with atypical symptoms in order to make use of Rapid Diagnosis Centre
- Diabetes: transforming care for patients with Type 2 Diabetes, ensuring comprehensive care in place as a cluster, with a focus on delivering the early implementation of the National Enhanced Service for the ABMU Health Board
- To improve care for patients with Dementia

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
3.1	In partnership with SCVS, HB and Cluster develop support for people living with dementia and their carers, including - Provide training/awareness raising to potential groups which those living with dementia could access to improve their wellbeing. - Provide training to primary care staff to enable them to become a dementia friendly general practice	SCVS HB	October 2019	Individuals understand the steps they can take to reduce their risk or delay the onset of dementia Staff within primary care have the skills to help them identify people with dementia and to feel confident and competent in supporting individuals needs post diagnosis The third sector groups have the skills to identify people with dementia and to feel confident and competent in supporting	Work with Admiral nurses working in the Llwchwr area to develop support mechanisms for cares of those with dementia	

				individuals needs post diagnosis Individuals affected by dementia and their carers report an improvement in their health and well being.		
3.2	**Diabetes:** Continued participation in the National Diabetes Audit Providing diabetes care closer to home Uptake of the DES – Gateway module	GP practices/MDT	March 2019	Reduction in ED attendances for Hypoglycaemia Reduction in Amputations Reduction in hospital length of stay/bed days Reduced duplication across primary & secondary care Improved self-management by patients	Business case submitted for approval to Investment Benefit Group	
3.2	**Cancer**: To reduce the time to diagnosis in patients with non-specific symptoms but with the potential to have a serious underlying problem	GP	March 2019 and ongoing	Ensuring all healthcare professionals are aware of existing pathways and have a high index of suspicion with patients presenting with atypical symptoms in order to make use of Rapid Diagnosis Centre	Dr. Heather Wilkes from the Rapid Diagnosis Centre has presented at the Cluster meeting	

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management. To address winter preparedness and emergency planning

Our three year focus:

- Analyse patterns of low attendance at A&E for Llwchwr patients, variance, reasons to share good practice
- Promoting Choose Well Programme and Common Ailments Scheme

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
4.1	Undertake research into why Llwchwr has the lowest rates of A&E attendance, compare with other areas, develop services to improve performance and share findings	Practices/Support Manager/	Sept 2019	Better understanding of unnecessary attendance Reduce unnecessary variation between practices	Work not yet commenced	
4.2	Work to educate patients, and/or implement new processes to address inappropriate types of calls and attendances	Support Manager HB	March 2021	A reduction in unnecessary attendances	Work not yet commenced	
4.3	Identify the type of inappropriate contacts with OOH from cluster patients and take action to address	C&D Manager HB	March 2019	A reduction in unnecessary calls from Llwchwr patients to OOH service	Work not yet commenced	

Strategic Aim 5: To develop the Cluster as a structure for delivery of identified priorities.

Our three year focus:

- Identify cluster specific benefits and scope potential for more formal collaboration
- Ensure Cluster has a greater voice in shaping Health Care in the locality and health board area.
- Identify key service areas the cluster would like to become a leader in providing

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
5.1	Identify the suitability of an appropriate method of formal collaboration to develop wellbeing for the cluster and seek cluster ratification Establish a working group to develop and implement if required	Cluster Lead Lead GPs PMs, HB	Dec 2019	Best support possible in place for Cluster practices, enabling better and continued access for patients. Cluster members able to deliver and provide clarity regarding roles and responsibilities.		
5.2	Allocate protected time and headspace for innovation for cluster leadership roles	Cluster Lead Lead GPs PMs, HB	Ongoing, commencing Jan 2019	Cluster programmes able to be delivered more quickly, time for cluster lead to further consider strategic direction.	Cluster Lead allocated ½ day per week to deliver all cluster work.	
5.3	Establish clear cluster accountability mechanisms for agreed work programmes	Cluster Lead Lead GPs PMs, HB	May 2019	Cluster programmes delivered more rapidly, with engagement.	Lack of clear resource/capacity for implementation.	
5.4	Establish business planning cycle for cluster to prioritise cluster projects and planning spend	Cluster Lead Lead GPs PMs, HB	March 2019	More vigorous approach to delivering cluster strategic direction and minimising likelihood of slippage, ensuring most effective use of funding.	In place on an ad hoc basis in relation to cross cluster issues.	
5.5	Establish Cluster communications strategy, identifying key stakeholders to influence to maximise impact, including sharing best practice delivered in Bay Health	Cluster Lead Lead GPs PMs, HB	June 2019	Strategic stakeholders aware of key cluster programmes. Cluster members better aware of outcome from	Comms made on opportunistic basis eg via WG comms scheme through Health Board.	

				use of time and resources.		
5.6	Ensure Cluster compliant with GDPR for Cluster based/delivered activity	Cluster Lead Lead GPs PMs, HB	March 2019	All staff will receive GDPR training	Training resource to be identified	
5.7	Review of cross cluster IT, Estates infrastructure to meet aims	Cluster Lead Lead GPs PMs, HB	Dec 2019	Better use of current resources across the cluster	Clear understanding of resources to be considered in planning of services.	
5.8	Implement mobile technology to support Cluster working	Cluster Lead Lead GPs PMs, HB	Dec 2019	Delivery of services effectively and efficiently using modes of technology		
5.9	Enable practice and team time to collate and set out data for external evaluation	Cluster Lead Lead GPs PMs, HB	March 2019	Demonstration of effectiveness of Cluster programme. More prudent commissioning of services.	Practices identifying time within current constraints.	
5.10	Develop potential for planning cluster spend across 3 year period	Cluster Lead Lead GPs PMs, HB	Ongoing	To have clear aims, objectives and vision of areas in which Llwchwr wish to implement change and develop existing services to enable planning and resource identification	Cluster vision set, priority areas of focus. 18-24 mth spend plans in place.	
5.11	Integration and Partnerships • Draw up a code of Conduct between cluster partners and organisations • Understand local assets and how to access local services	Cluster Lead Lead GPs PMs, HB	May 2019	Cluster partners understand their respective roles Patients and citizens aware of local assets and benefits to them of their use	Code of Conduct required. Local assets not extensively utilised on a Cluster basis	

Strategic Aim 6: Other Cluster and area specific issues

Our three year focus:

- Atrial Fibrillation: A focus on uptake of screening and awareness raising amongst patients and professionals
- Identify and access additional funding and resources for the Cluster

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
6.1	**Funding:** Work to obtaining money from the Windfarm and other funds to establish and support community projects within the Llwchwr Cluster Network Identify and secure additional funding streams	Members of the Network Cluster Lead Lead GPs PMs, HB	Ongoing	New and existing community projects receiving funding within the Llwchwr Network External funding available for the cluster to deliver services meeting its identified priorities	Initial meeting has taken place to stimulate ideas and identify potential groups and projects. Guidance to be released in the New Year with funding being allocated in February 2019 Little leverage of additional funding and resources currently done.	
6.2	Develop 3-4 key Cluster project proposals to meet Cluster aims, ready to further develop into funding bids	All	March 2019	Cluster better enabled to access additional funds	Windfarm funding projects discussed	
6.3	**Atrial Fibrillation** Put more screening in the community to identify patients early (most common cause for Stroke and TIA) to enable patients to reduce #s of strokes	All	Sept 2019	More at risk patients identified and treated earlier, avoiding TIAs and admission to Hospitals		

6.4	Support the mainstreaming of services via the business case application process through 'Balancing the System – shifting resources from secondary to primary care' for: Mental Health Services for Tier 0 Pharmacist Provision Physiotherapy on a Cluster basis	Cluster Development Managers, Cluster Lead	Oct/Nov 2018	Services mainstreamed and Cluster funds released where relevant	Pharmacy outline case summarised for consideration by ABMU Strategy and Finance Depts. Physiotherapist preferred option model being costed	
6.5	To ensure that all clinicians are familiar with existing diabetic pathways to achieve early intervention and diagnosis management	Practices/HB	Oct/Nov	Patients are seen and treated in the correct and a timely manner		
6.6	To develop a calendar of funding opportunities	All ABMU	Ongoing to March 20121	Funding opportunities are maximised		

6. Cluster Finance Statement

Finance

Llwchwr Cluster has a financial allocation from the Welsh Government of £146,185. In addition Clusters have access to other funding streams such as through the Health Board delivered PMS+ scheme.