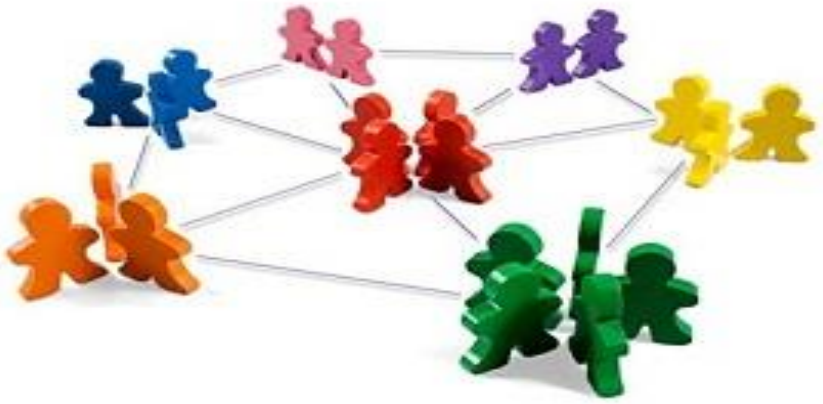
Three Year Cluster Action Plan 2018 - 2021

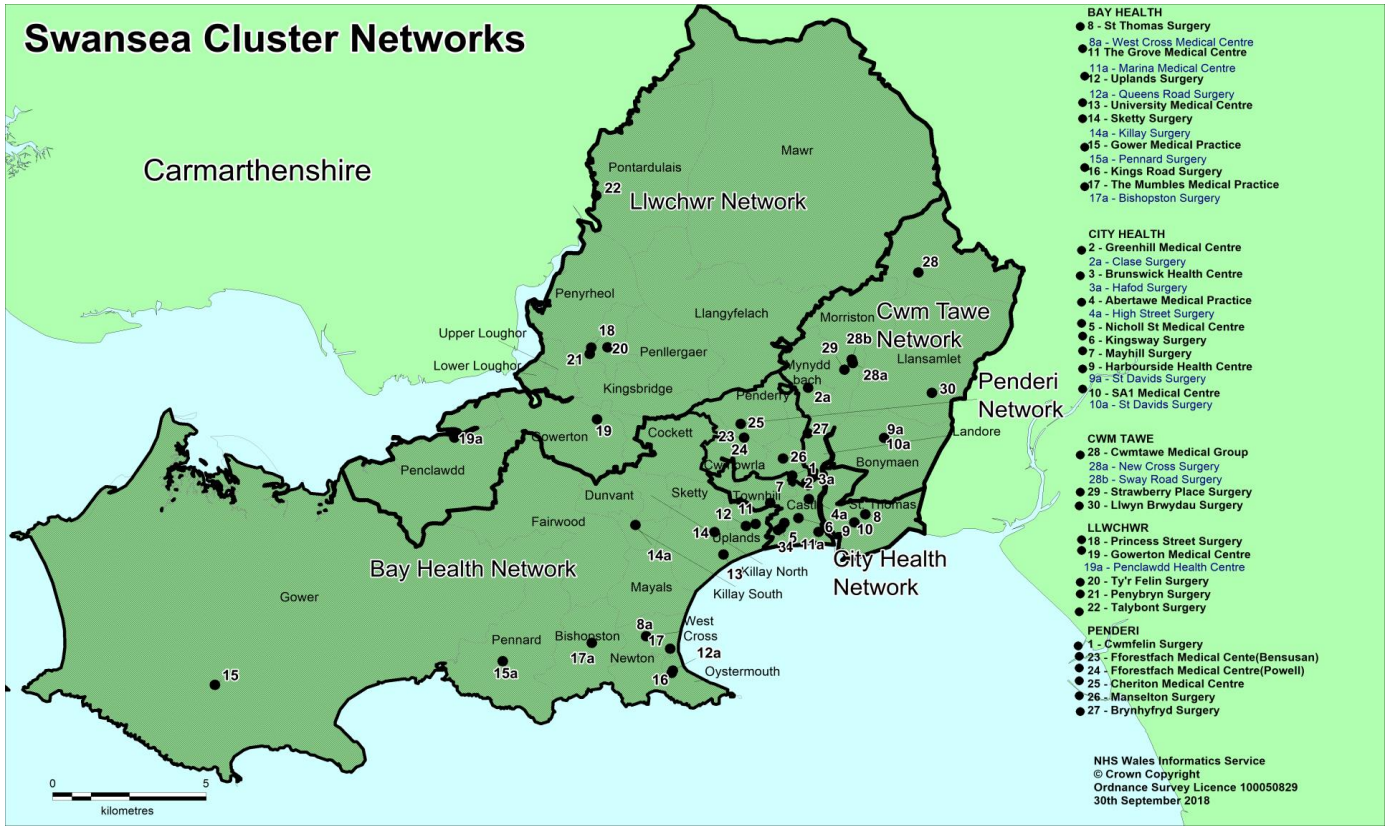
Penderi Cluster



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

1. *Penderi Cluster Overview*

The Penderi Cluster Network is one of five clusters in Swansea, geographically covering Blaenymaes, Portmead, Treboeth, Fforestfach, Ravenhill, Brynhyfryd, Manselton, Gendros and Penlan.



The Penderi Cluster is made up of six general practices working together with partners from key Local Authority Departments such as Social Services and Poverty and Prevention, the Voluntary Sector, Community Pharmacies, Dentists and Optometrists and the wider ABMU Health Board. Practice populations ranging from 2091 to 8334, amounting to a cluster total of 38,122 (July 2018 data).

Clusters across the area have agreed that they 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 t*
- *hat 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.

2.2 Cluster Specific Information

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. Blaenymaes and Portmead schools, (two of the Primary Schools within the Network) have undertaken the study within the last two years, areas of interest are shown below:

	Blaenymaes %	Portmead %	Swansea %
Sedentary Screen time for 2 hours or more a day	41%	38%	31%
5 Portions of Fruit and Veg a day	17%	24%	27%
At least 3 take aways a week	17%	16%	18%
Physically active for 1 hr or more a day	24%	14%	24%
Happy with family	96%	93%	94%
Happy with Life as a whole	94%	81%	91%

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

Information has been collated on a wide range of health needs using the most up to date information available within the Penderi Cluster area in order to support the development of the focus areas for this plan.

Key Population Features

Resident population: 31,900 (Community Area Profile:Source Mid 2016 rounded estimates ONS)

18 Lower Super Output Areas in the cluster areas. Smallest land area but highest population density of the cluster areas in Swansea (Community Area Profile)

32.8% of residents are under 24. (Swansea: 31.3%)

8.7 % of residents are 65-74 (Swansea: 10.4%) and 7.5% are 75+ (Swansea 8.9%)

Nearly 50% of patients are living in the 20% most deprived areas (WIMD 2014 revised)

35.2% of the population live in social rented accommodation from council or RSL/HA). Swansea average is 19.2%. (Swansea Assessment of Local Wellbeing 2017)

Number of people in non white ethnic groups 5.1% .(Swansea average 6%) (Swansea Assessment of Local Wellbeing 2017)

Highest percentage of lone parents in Swansea 16.7% Swansea average: 11.7%. (Community Area Profile 2017)

36.7% of 16-74 year olds are 'economically inactive'. (Swansea: 37%)

35.6% of the population aged 16+ have no qualifications . This is the highest level in Swansea. Swansea average is 23.9%. (Swansea Assessment of Local Wellbeing 2017)

26.3 % of the population have a long term health problem or disability. This is the highest percentage in Swansea. (average is 23.3%.) (Swansea Assessment of Local Wellbeing 2017)

Cluster Features

6 GP Surgeries

4 Dental Practices

8 pharmacies

5 Opticians

9 Primary schools & 2 Secondary Schools

38,122 patients registered- majority of list sizes increasing

High service need for patients living in a care home specialising in mental health and previous drug abuse

Two women's refuges within the network (for women and children who are victims of domestic abuse)

Population & Community Assets

Community Farm located close to Penderi practices.

Parks and Green Spaces including Blaenymaes multi Use Games Area, Penlan Leisure Centre, Ravenhill, Cwmbwrla , Treboeth and Hafod parks

High levels of third sector/external partner involvement in Cluster network

Community Centres (x6)

Libraries (x2)

Major employers in the Cluster: City and County of Swansea (Schools and depots), First Cymru, Cwmdu Industrial Estate, part of Swansea West Industrial Estate

Health Profiles

High levels of patients who smoke 7,420 , 24.7% of the cluster population (PHW Data 2016/17)

Average number of lung cancer cases per annum is 32. This is the highest rate out of the five clusters in Swansea.'Lung cancer incidence is higher in the most deprived areas of all ABMs clusters with with varying deprivation gaps' (CGP Cluster Lung Cancer Profile ABMU HB Sept 2015)

Third highest network for COPD in 2017 956 (6.2%) of patients are on the disease register. (Swansea average: 5.6%)

Uptake for scheduled childhood immunisations by 4 years is 84.5% against the Welsh Government target of 95%

Uptake on Bowel screening 47.4% . Target 60% (PHW Data2016/17)

Uptake on Cervical Screening 75.3% . Target 80% (PHW Data 2016/17)

Uptake on AAA screening 75.9%. Target 80%. (PHW Data 2016/17)

Uptake on Breast screening 71.3%.Target 70% (PHW Data 2016/17)

Flu Immunisation Uptake (PHW Data 2017/18):

Patients 65y and over: 66.6% (ABM 68.2%/ Swansea 67.4%)

Patients under 65y at risk 49.9% (ABM 46.7%/Swansea 46.5%)

Patients under 65y at risk (Respiratory): 52.4% (ABM: 47.2%/ Swansea 47.3%)

Children aged 2&3 Years 45.6% (ABM 49.1%/Swansea 47.4%)

Service demands

Penderi has the second highest proportion of patients attending A&E out of all the Swansea Clusters. Between 1st Sep 2017 and 31st Aug 2018, 11,846 patients attended A&E. Rate 155.88 per 1000 (ABMU HB data)

Between September 1st 2017 and 31st August 2018 the attendance rate for OoH was 92.18 per 1000 people, the highest rate in Swansea.

An average of 18.6 patients per month attended the Help Me Quit Service offered in practices between April 2017 and March 2018. Highest number of attendees (30) was in January

High levels of low level mental health issues evidenced by Social Presecribing initiatives including CAB and Primary Care Children and Family Wellbeing Service and anecdotally by GPs

Penderi Children and Young People Mental Health consultation identified that 75% of respondents needed support for mental health issues before the age of 17, 40% needed support between 12-16 years and 35% needed support under the age of 11

Other Key Influencing Features

Swansea Local Development Plan - 3,175 new homes proposed in cluster area

Hafod Air Quality Management Action Plan declared in Lower Swansea Valley

Public Service Board: Local Wellbeing Plan Focus;

Early Years: Making Sure Children have the best start in Life

Live Well. Age Well-Making Swansea a place to live and age well

Working with Nature-Improving health,supporting biodiversity and rediucing our carbon footprint

Strong Communities-Supporting Communities to promote pride and belonging

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

-Wellbeing of Future Generations (Wales) Act

2.4 Disease Register Information

Disease Register	Penderi Register Total 2018 (%)	Swansea %	ABMU %	Cluster Trend
Cancer	887(2.3%)	(2.7%)	(2.9%)	Practice Variations. Lowest % in Swansea, 2009:1.5%, 2018: 2.3%
Dementia	202 (0.5%)	(0.7%)	(0.7%)	Cluster % decreased in last 2 years. Lowest % in Swansea
Mental Health	430 (1.1%)	(1.1%)	(1.1%)	Practice Variations 2009: 0.9%, 2018:1.1%
Obesity	4148 (10.9%)	(9.1%)	(10 %)	2nd highest % out of Swansea Clusters, 2009 8.8%, 2018: 10.9% (Decrease 2012-2017)
Diabetes	2449 (6.2%)	(5.6%)	(6.4%)	Practice variations but highest % in Swansea, 2009: 5.1%, 2018: 6.4%
COPD	956 (2.5%)	(1.9%)	(2.2%)	Third highest number/cluster in Swansea. Significant practice variations. 2009:2.5%, 2018:2.5%
Epilepsy	330 (0.9%)	0.8%	0.8%	Highest % out of Swansea Clusters
Learning Disabilities	213 (0.6%)	0.4%	0.5%	Highest % in Swansea
Stroke	812 (2.1%)	2.1%	2.3%	Highest % in Swansea

2.5 Antibiotic Prescribing Levels

Items Apr 17 - Mar 18	Items Apr 16 - Mar 17	Items % Variation	Items Difference
25,474	25,978	-1.94%	-504

(With regard to antibiotic prescribing levels nationally there was a 2.2% reduction for the period noted in the table above)

3. ***Strengths Weaknesses, Opportunities and Threats (SWOT) Analysis Penderi Cluster***

Cluster SWOT Analysis

Strengths

Investment in innovative projects

Open to new ideas and an 'upstream' approach

Comprehensive approach to PLTS

Strong links with Third Sector and other external partners

Development of key Social Prescribing initiatives (Child and Family Wellbeing Service, Carers Helpdesks, Asylum Seeker Support, CAB Outreach service)

New practice developments in area eg: Brynhyfryd

Recognising of cluster population needs and taking a preventative approach to support these

Weaknesses

Lack of time to develop initiatives

Substantial Cluster- wide sustainability issues

Staff working to full capacity

Difficulty regarding recruitment and retention of GPs

Difficulty sourcing locums

No 'body' with which to draw in additional funds- no ability to expand rollout

Opportunities

Further develop social prescribing/support within the network

Re-evaluation of use of limited resources
Further strengthen links with third sector organisations and external partners

Share with other clusters/develop mutually beneficial links

Improve communication across the cluster

Use mobile technology to help patients manage conditions

Support key practice issues: high levels of mental health issues/substance misuse/asylum seekers and speakers of other languages

To support staff/GP resilience via PLTS

To further enhance MDT across Cluster to support sustainability

Threats

Proposed housing developments in the network area leading to an additional 3,175 houses being built

Potential list closures could impact negatively on other practices

18/19 QoF may result in lower levels of engagement in Cluster work

GP retirement and recruitment issues

Staff shortages in other areas eg: Central Hub

Staff morale and wellbeing

Cluster work programmes dependant on continuation of Welsh Government annual funding

4. ***Cluster Vision***

In May 2018, the Penderi Cluster 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 Penderi area and its practices.

> ***"The members of the Penderi Cluster have a vision to care for the unique health and wellbeing needs of its patients and citizens in the most effective way possible. In recognition of its particular population needs, it will also work together to create an innovative culture of enabling long term change by taking a preventative approach to tackling ill health and its contributing factors".***

5. ***Penderi 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 Penderi 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:

- To deliver services based on **specific population health and social care needs** in the cluster which has the **highest deprivation levels in Swansea** to inform the planning of services in the network.
- In recognition that Penderi has high levels of deprivation the health and wellbeing focus areas for 2018-21 are: **Children and Families/Obesity and Diabetes and Smoking**
- The focus areas will be addressed by further developing and expanding **preventative work programmes** and improving **health literacy** based on patient feedback to support key patient groups/vulnerable patients.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
1.1	**Obesity:** Develop resources that can be used with parents	GPs Practice Managers ABMU HB	March 2019 and ongoing	Reduced levels of obesity in children and young people resulting in greater wellbeing		
1.2	Consider delivering talks to parents on healthy eating/physical activity in community/school settings	TBC	March 2020	Preventative approach, early intervention,	Links with parents and schools need to be enhanced	
1.3	Develop a 'resource pack' that can be used to effectively signpost children and young people to services that can help- eg: Hwb Abertawe	SCVS, HB – Primary Care and Mental Health Units, Practice Managers	July 2019	Clinicians able to signpost or refer to the most appropriate service. Patient able to access support suitable for their needs in a timely fashion.	Requirement for clarity on services available.	
1.4	Consider developing cluster initiatives to support increasing physical activity levels	All Cluster members	July 2019	Clinicians able to refer to more timely closer to home services.	Proposal has been put to the Cluster by Cwmfelin Medical Centre on increasing Physical Activity levels in children and	

					young people. Cluster to consider this proposal	
1.5	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 interventions able to access	Lack of local information around children and young people obesity and contributory lifestyles	
1.6	Links with specialist consultant in Paediatrics re advice/clinical input linked to childhood diabetes	Cluster, Chris Bidder	Dec 2018	Cross system input into most effective interventions available within Primary Care. More consistent provision for patients.	Working links have been made with Paediatric Consultant who has attended PLTS sessions and offered support/advice on individual cases as appropriate.	
1.7	Monitor referrals to Primary Care Children and Family Wellbeing Team regarding issues linked to diet and obesity and look at effect of intervention on reducing obesity	PCCFS lead, BSM, PHW	Ongoing 2019	Enhanced use of delivery of PC Children and Families Service		
1.8	**Smoking**: Encourage patients to attend stop smoking clinics	GPs Practice Managers PHW	March 2019 and ongoing	Reduced levels of smoking across the cluster (from 24.7% to 23% by October 2019). Resulting in better health outcomes and wellbeing		
1.9	Practices to hold 'Help Me Quit' Clinics on a regular basis				'Help Me Quit' Service is available in some practices across the network.	
1.10	Publicise service at key points of the year eg: New Year/January campaigns	PHW/Cluster	Jan 2019, 20 and 21			
1.11	**Health Literacy:** - Health Literacy questionnaire and focus group to be undertaken during 2018/19 by SCVS to inform planning going forward into 2020 and 2021	SCVS	March 2019	Improved Health Literacy among patient population. Following patient feedback changes to be made with regard to communication of information (both written	SCVS drafting questionnaire to gather patient feedback on what could be done differently to help improve health literacy. Questionnaire will be used with existing groups in the Cluster linked to Social Prescribing	

				and verbal) to patients. Resources and new ways of working will be co produced resulting in improved self care and better understanding of health conditions and how to manage them	network ie: Carers/ Parents/ Asylum Seekers and Refugees	

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:

- Expand and **pilot MDT developments** to meet workforce needs of the Cluster. **Implement sustainable, evidence led, robust MDT for the cluster by 2021**
- Explore **collaborative working arrangements** eg: sharing workflow information
- Establish a cluster **social prescribing programme** to alleviate pressure on core services

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
2.1	Develop **collaborative working** arrangements and share information across practices eg workflow Cluster to set aside time to discuss and consider sustainability of practices moving forward	GPs Practice Managers ABMU HB	March 2019 and ongoing	Improved shared understanding of Cluster sustainability issues. Cluster to agree best use of shared resources to ensure sustainability of all network practices Robust plans in place across cluster to meet sustainability needs	Cluster have agreed to meet before Christmas 2018 for a 'time out' session to discuss planning and ideas linked to sustainability going forward	
2.2	**Expand MDT** across the Cluster -*Introduction of pilot physiotherapy initiative in 2018/19*	GPs Practice Managers	March 2019 – March 2021	Cluster to pilot on site physiotherapy sessions	Cluster has agreed to progress Physiotherapy pilot. HB currently supporting sourcing	

		ABMU HB		with remaining cluster funds	Physiotherapists who might be able to deliver sessions.	
2.3	**Continue to expand and further develop Social Prescribing initiatives** to alleviate pressure on core services and adopt an 'upstream' approach *-Children and Family Wellbeing Service* *-Carers* *-CAB* *-Asylum Seeker Support* *- Other links and initiatives to be developed eg: Community Farm* *-Links with HWB Abertawe* *-Develop Social Prescribing links with Cluster Pharmacist for onward referral of patients* *-Enhance links with Local Area Coordination Programme*	GPs Practice Managers SCVS ABMU HB	March 2019 – March 2021	Preventative approach strengthened by further development of social prescribing network across the cluster. This will result in increased levels of wellbeing and contribute to an improvement in low level mental health issues across the cluster	SCVS is holding meetings to allow Penderi Social Prescribing initiatives to meet and discuss service offered and cross refer patients as appropriate. Cluster pharmacist to develop referrals to Social Prescribing for patients seen. SCVS planning to develop a 'ready reckoner' for all social prescribing initiatives that are delivering across the cluster that can be used by GPs as an aide memoire of what is available when seeing patients.	

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:

- **Reduction in antibiotic prescribing** with particular reference to UTIs
- To continue to **promote screening** with patients as appropriate
- To develop **positive working links with Paediatrics** to help raise awareness of specific clinical issues related to children and young people and **improve communication with secondary care**

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
3.1	Reduction in Antibiotic Prescribing: Cluster Pharmacist to initiate reduction in antibiotic prescribing across all practices with a focus on prophylactics	Cluster Pharmacist GPs	March 2019 and ongoing	Reduction in prophylactic prescribing levels resulting in better outcomes for patients and cost savings, long term stewardship of antibiotics	Comparing the years 16/17 and 17/18 antibiotic prescribing levels have reduced (1.94%). There is a need to further reduce this level. In the same period, nationally antibiotic prescribing levels fell by 2.2%	
3.2	Deliver PLTS on reduction of antibiotic prescribing (prophylactics)-link to be made with Avril Tucker	BSM	Nov 18/Jan 19			
3.3	Link with ED Clinicians over prescribing of antibiotics to reduce tendency for them to be the first option		May 2019	Antibiotic prescribing rates reduced at ED point of access, reduction in ongoing P Care prescribing as a result	Penderi has high rates of OoH and A&E attendances. GPs report that antibiotics prescribed in A&E and OoH on a more regular basis.	
3.4	Practices and Clinicians to play an active role in promoting screening opportunities to patients through: -Up to date relevant information easily accessible -Promotion on practice web sites and TV screens -Link with PHW on best way to follow up on non-attendees	Practice Managers GPs	March 2019 and ongoing	Screening widely promoted and information visible across all practices resulting in higher levels of patients engaging with screening services. Increased early intervention resulting in better patient outcomes.	Screening opportunities are widely promoted across the Cluster. Based on PHW figures for 2016/17 screening engagement rates are below target	
3.5	To develop positive working links with Paediatrics -Develop e-mail advice line for fast expert guidance when appropriate -Consultant to attend Penderi PLTS sessions on a regular basis to update on relevant issues pertinent to Children and young people eg: Childhood Diabetes, Addisons disease etc	Cluster Lead GPs Practice Managers	March 2019 and ongoing	Easy and quick access to expert advice for Penderi GPs with regard to Paediatric concerns. GPs updated on clinical pathways and current clinical data and information regarding paediatrics	Paediatric Consultant to attend a future session to deliver clinical input on Addison's Disease.	

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:

- Continue to educate patients in how to manage **self-care** and identify the most appropriate place to receive treatment
- To **reduce any inappropriate use of A&E and GP OoH** by Penderi Patients,with a focus on attendance by children and young people
- Ensure advanced cluster planning takes place related to '**winter preparedness'** including flu vaccinations and immunisations

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
4.1	**Develop educational approach to inform patients on when to access A&E and OoH:** Develop practice leaflets that can be shared with patients and cascaded via Midwives/Health Visitors/Social Prescribing networks/Colleagues in A&E for onward distribution	GPs Practice Managers	July 2019	Patients aware of when to contact A&E and OoH. Contacts to these services will be appropriate	Penderi has high rates of A&E and OoH attendances.	
4.2	Further research and understand data linked to frequent attendees by linking with A&E		June 2019 and ongoing	Reduction in numbers of patients attending A&E and engaging with OoH service.	As above	
4.3	Target young families with regard to self-care via leaflets/resources and talks to be delivered to family/parenting groups and in schools/E-bug school programme re: minor illnesses		Sept 2019	Reduction in numbers of patients attending A&E and engaging with OoH service.	As above	
4.3	To ensure effective planning is in place for the winter season to ensure continual increase in uptake of Flu Vacs and advanced promotion of self care	GPs Practice Managers	Sept /0ct 2018 and ongoing	High levels of patients including older and housebound patients,at	Cluster Flu Vaccination Figures based on PHW Data 2017/18 included in Health Profile section	

	- *Practices to host flu parties* - *Vacs for Housebound patients to continue* - *Publicity/self care info for patients including myth busting* - *Consider other methods and channels of publicising/promoting the benefits of the flu vacs*			risk patients and children immunised against flu. Patients 'health literate' with regard to myths surrounding flu and actively seeking flu vacs.		

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

Our three year focus:

- Enable **cluster to reach full maturity** against key criteria below
- Expand opportunities for **innovative partnership working** to effectively and innovatively support patient needs
- **Access potential external funding streams** to bolster existing cluster funds
- Consider benefits to cluster of becoming a **formal collaborative entity**

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	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	May 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.	Cluster experiencing high levels of sustainability issues with need to maximise cluster ability to support practices.	
5.2	Allocate protected time for Lead GPs to further develop innovative ideas and to ensure cluster actions are met	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, including main GP lead for Early Years flagship programme, additional capacity required.	

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 deliver 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 Penderi Cluster	Cluster Lead Lead GPs PMs, HB	June 2019	Strategic stakeholders aware of key cluster programmes. Cluster members better aware of outcome from use of time and resources.	Communications made on opportunistic basis eg via WG communications scheme through Health Board.	
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	To be scoped	
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 Penderi wish to implement change and develop existing	Cluster vision set, priority areas of focus. 18-24 mth spend plans in place.	

				services to enable planning and resource identification		
5.11	Identify and secure additional funding streams	Cluster Lead Lead GPs PMs, HB	Ongoing	External funding available for the cluster to deliver services meeting its identified priorities	Little leverage of additional funding and resources currently done.	
5.12	Ensure the Cluster addresses population needs by: - Ensure that the public and service users are involved in the design, planning and co-production of local services and pathways - Undertake continuous benchmarking between cluster practices to address any variation	Cluster Lead Lead GPs PMs, HB	March 2020	Cluster using benchmarking in relation to unscheduled Care, Paediatrics.	Patient panels attempted. Patients not extensively involved in design and delivery of services though feedback from evaluation is taken into account in improving service delivery. Benchmarking commenced in Clinical Priority Areas in 17-18.	
5.13	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:

- To continue to improve **multi agency mental health services for adults children and young people** with a quality improvement approach

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
6.1	**To continue to improve access to mental health services** - Development of 'ready reckoner' for mental health referrals for GPs - Development of pack outlining service provision for use by GPs - Regular meetings of Social Prescribing organisations in the Penderi Network to facilitate cross referrals when appropriate - Give timely and appropriate feedback to mental health services to highlight issues in general practice to facilitate effective solutions	PM's GPs SCVS	March 2019 and ongoing	Easier and faster access for patients to relevant mental health services Patients accessing the right service at the right time GPs comfortable and knowledgeable about local referral routes and mechanisms	SCVS to develop flow charts/pack that can be used by GPs in Primary Care outlining referral routes and sources of support. Pack to be updated on a cyclical basis Cluster able to discuss barriers and possible ways forward following CAMHS presentation. CAMHS developing 'helpline' and developing improved referral timescales to Primary and Secondary CAMHS	
6.2	Create links with City Farm - offering volunteering and wellbeing opportunities for all people in the Network	PMs, SCVS, HB	March 2019	Patients and residents able to benefit from local asset in relation to wellbeing/social isolation.	Local assets not extensively utilised on a Cluster basis	
6.3	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. Cluster Finance Statement

The Penderi Cluster has a financial allocation from the Welsh Government of £171, 472. In addition Clusters have access to other funding streams such as through the Health Board delivered PMS+ scheme.