

**Cwmtawe Health Cluster**

**Integrated Medium Term Plan**

**(IMTP)**

**Annual Plan 2022 – 2023**

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# 1. CLUSTER OVERVIEW – PLAN ON A PAGE

Cwmtawe Cluster will continue to work closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vison is to achieve a Cluster led transformed model of integrated health and social care for the Cwmtawe Cluster population.

The following provides an at a glance summary of key actions planned by the cluster:

|  |  |  |
| --- | --- | --- |
| [**IMPROVING PLANNED CARE**](#planned) | [**IMPROVING CANCER & PALLIATIVE CARE**](#Cancer) | [**IMPROVING UNSCHEDULED CARE**](#Unscheduled) |
| * Review & reduce prescribing levels of gabapentinoids & protein pump inhibitor * Implementation of Heart Failure Care Plan * Implement Get Ready for Surgery project | * Increase uptake in screening by aligning promotion to access of mobile screening units * Train and utilise volunteers to contact non responders; bowel and cervical screening * promote model developed for Bowel screening Wales (in partnership with PHW) * Promotion of cervical cancer awareness | * Employment of a Frailty Nurse * Employment of Complex Needs Worker * Development of the Virtual Ward |
| [**IMPROVING MENTAL HEALTH & LEARNING DIFFICULTIES**](#Mental) | [**CHILDREN, YOUNG PEOPLE & MATERNITY**](#Children) | [**PREVENTION & REDUCING HEALTH INEQUALITIES**](#Prevention) |
| * Commissioning of Psychological Therapies * Employment of Mental Health Triage & Wellbeing Worker * Develop Mental Health champions in each practice * Improving data collection around suicide ideation | * Work with SNAPP Health Champions to promote vaccinations in schools * Employment of a Cluster Mental Health Triage and Wellbeing Worker * Develop Mental Health champions in each practice * Improving data collection around suicide ideation * Work with SNAPP Health Champions to promote the reasons for vaccination within schools –myth busting | * Deliver a comprehensive cluster flu plan to increase uptake in vaccinations. * Deliver ‘Help Me Quit’ training update practice records to assist smoking cessation * Utilise volunteers to contact non responders; bowel and cervical screening * Improve signposting and services for carers * Cluster to develop clear protocols between all partners |

The plan is actioned using enablers; technological, workforce, communication and engagement, financial. [Click Here](#Drivers)

# 2. FORWARD LOOK

The 20/2021 global pandemic, coronavirus COVID-19, brought with it many challenges for which the cluster had to adapt quickly. By working closely together and collaborating on various elements, we maintained services for the benefit of our communities. We had to set up Covid hubs as part of the wider Swansea Bay health board strategy which we managed to do with the collaborative effort of the three surgeries. This included a weekly rota to manage the hub for any Covid affected patients. Thanks must be given to SCVS for the support provided in the role out of COVID-19 vaccination programme and their support to coordinate volunteers to deliver those clinics.

In addition to this we continued to roll out the virtual ward that was set up in November 2020 and has to date provided immediate access to diagnostic and key health care services, avoiding potential hospital admissions to over 150 patients. To expand its holistic wrap around support it now includes multi-disciplinary personnel and services, including therapies, social services and the voluntary sector through SCVS. This model has been adopted by three other clusters and it has had the backing of the chief executive of the health board and primary care directorate, we are very proud of its ongoing effort and the willingness to make this work.

For the past six months we have seen services especially GP surgeries returning to normal but with added pressures and increased demand. This has had a significant impact on their daily work which I am proud to say they have worked through given the ongoing lack of services elsewhere in the health board. We have had to manage increased complex cases especially those patients that were on the waiting list for outpatient care and investigations.

We have been fortunate that we have developed a mental health hub in the cluster over the past couple of years which with the increased demand for mental health cases during the global pandemic this has benefited both the cluster and patients greatly by providing them with appropriate care in a timely manner. We hope that this will continue and have commissioned an independent evaluation to explore how we can roll this out as best as possible over the coming years. In addition a complex needs worker role has been added to the hub in response to the needs of those living with domestic abuse, substance misuse and associated mental health needs. This is also subject to an independent evaluation and has created much interest with external partners.

Next year we will have the new challenge of beginning to implement the Accelerated Cluster Development programme which aims to align cluster work with regional priorities of all our partners, bringing a new phase to the development of clusters.

**Dr Iestyn Davies, Cwmtawe Cluster Lead**

## **2a. SWOT ANALYSIS**

|  |  |
| --- | --- |
| **STRENGTHS**   * Strong leadership by the Cluster Lead * Strong collaborative working relationship between Partners on projects * Developed infrastructure within the cluster * Undertaking decisions and actions for the good of the cluster not just the practice * External funding sources | **WEAKNESSES**   * Consistency in ensuring that the cluster message is relayed back to partner organisation and that their thoughts are fed into the cluster * The delay in being able to mainstream effective projects in order to release funds enabling innovation to continue * The lack of time/resource available in practices and partner organisations for cluster work due to competing demands * Sustainability for schemes beyond the Transformation Fund |
| **OPPORTUNITIES**   * To increase closer working with secondary care * To develop a mental health hub * To further develop Wellbeing within the work of the Cwmtawe Cluster * Training and development for primary care teams to engage with new ways of working and the direction of travel and aims of the cluster * To embed the extended multi-disciplinary team within the Cluster * Transformation Funding * Digitalisation/Modernisation * Improving Access * Appointment of a new cluster lead | **THREATS**   * The inability to re-invest in new projects due to successful ones not being mainstreamed * Reduced allocation of budget by Welsh Government * Change of Government Policy regarding Clusters(ACD) * Increase in list sizes due to housing developments * Number of Nurses due for retirement in the next 5 years. * SBUHB organisational changes * Overwhelming demand due to global pandemic * Health Board bureaucracy as a barrier to decision making * Appointment of a new cluster lead |

# 3. VISION/MISSION STATEMENT

Cwmtawe Cluster aims to be a vanguard within Wales enabling a social model of health and wellbeing, ensuring patients have the maximum possible support to access the mechanisms needed to live a healthy lifestyle.

It will do this by developing a hub of services for its population, involving GP practices, the community themselves and key partners; delivering this collaboratively with a social ethos, ensuring real and tangible benefits for the patients of Cwmtawe Cluster



# 4. STRATEGIC BACKGROUND & PRIORITY AREAS

## **STRATEGIC BACKGROUND**

The Primary Care Model for Wales sets out how primary care will work within the whole system to deliver a place based approach. Our Cluster working is at the core of this to ensure care is better co-ordinated to promote the wellbeing of individuals and communities and will continue to be taken forward through the multi-disciplinary, multi-agency cluster planning teams reflecting all partner contributions.

The Cluster continues to focus resources on delivering the aims and aspirations of the Primary Care Model for Wales and to accommodate the delivery of improvements, our plan is flexible and will be underpinned by ongoing work to develop implementation and performance plans against the stated Goals, Methods and Outcomes Action Plan.

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The 2022/23 Cluster IMTP is developed in alignment with national, regional and local strategic context and to address:

* COVID 19 Resilience
* Ministerial Delivery Milestones
* Local Primary Care Cluster Priorities
* Local Priorities influenced by Health Board IMTP, Regional Partnership Board, National Strategic Programmes and the Primary Care Model for Wales
* NHS Wales Planning Framework
* Framed within the context of the Well-being of Future Generations Act
* Social Services and Wellbeing Act 2014
* NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030

As part of the process to develop this IMTP we have worked closely with Health Board colleagues to integrate with the Health Board IMTPs and planning arrangements, such as delivery plans for Cancer and Mental Health services, and under the context of The Clinical Services Plan (CSP) . The CSP remains the primary roadmap for the long-term delivery of services for our communities and Cluster planning and delivery remains aligned to the four CSP principles:



In Swansea Bay, Primary Care Clusters aim to:

* Work towards the Primary Care Model for Wales
* Prevent ill health
* Develop a range and quality of services in the community
* Ensure services in the community are better co-ordinated
* Improve communication and information sharing between professionals
* Facilitate closer working between community based and hospital services
* Support sustainability of primary care

****Additionally, Cluster work is structured to encompass the Health Board’s overall Organisational Strategy as set out below in summary:

The organisational strategies and priorities of a number of key regional partnerships are also accounted in our planning including:

* Swansea & Neath Port Talbot Wellbeing Plans
* The West Glamorgan Regional Partnership
* The Adult’s Transformation Board
* The Children and Young Adults’ Transformation Board
* The Integrated Transformation Board

**CLUSTER IMTP STRATEGIC PRIORITY AREAS**

During the planning process, SBUHB Cluster leads considered the range of Health Board strategic priority areas, and agreed to focus their Cluster planning on a key range of six priority areas from those:

Improving Unscheduled Care

Improving Planned Care

Improving Cancer and Palliative Care

Prevention and Reducing Health Inequalities

Children, Young People and Maternity

Improving Mental Health and Learning Disabilities and the 7 goals

In addition the Cluster has mapped throughout its GMO Action Plan where work is undertaken which overlaps with the remaining HB Strategic Priority Areas, Ministerial Priorities (July 2021) and addressing the Four Harms of Covid.

Other SBUHB Strategic Priority Areas

* Responding to Covid  (including addressing the four harms of Covid)
* Improving Patient Quality and the 5 Q&S goals
* Improving Planned Care
* Increasing Digital Capability
* Improving primary, community and therapy services

Ministerial priorities refreshed in July 2021:

* A Healthier Wales - as the overarching policy context
* Population health
* Covid - response
* NHS recovery
* Mental Health and emotional wellbeing
* Supporting the health and care workforce
* NHS Finance and managing within resources
* Working alongside Social Care

Clusters have also given consideration to the enablers and programmes in place which will support facilitation of the plan and wider priorities set out above and have set these out at the end of the GMO action plan in section 6 below.

Finally, Clusters have also taken account of the Four Strategic Programme priorities and will continue to address these throughout the year:

- Accelerated Cluster Development;

- Urgent Primary Care;

- Community Infrastructure and

- Mental Well-being

Taking account of these priority areas ensures a robust approach to delivering safe, quality services and improving health population whilst maintaining the lighter touch approach requested for the development of the IMTPs in the annual delivery period prior to the implementation of the national Accelerated Cluster Development Programme. The ACD outline specification discussed nationally is currently being considered by Cluster Leads to identify key requirements and constraints into 2022-23 as an ongoing process, alongside Health Board and Local Authority discussions in the region.

# 5. CLUSTER NEEDS HIGHLIGHTS

An extensive cluster needs profile has been developed for all 8 clusters within the SBUHB. This document is available separately, the content of the needs profile was considered for Llwchwr Cluster with highlights set out below:

## **SUMMARY**

**Carers**: There are 8501 carers in Swansea providing 50 or more unpaid hours of care. Of those 5873 are aged over 50. The projected number of carers is expected to continue to rise

**Disability:** Data from the 2011 census highlighted that percentage of people in Swansea whose day to day activities were limited as 11% or limited a lot as 13%. In 2019 the Swansea Bay area has on average 26.6% of working age people who are EA core or work-limiting disabled, 2% above the Welsh average

**Obesity**: 12% of the Cluster population in 2018 was recorded by GP’s as obese –this was the highest in Swansea.

**Alcohol:** Swansea Bay has the highest proportion of population that drink over the recommended guidelines (21.1%) Swansea 20.8% and the Wales average is 19%. Alcohol specific admissions by men (165) were more than double that of women (303) in Swansea in 20217/18 as were alcohol specific mortality ay 18.9% and 8.2% respectively. Alcohol related mortality in Swansea Bay (14.6% or 58.9 deaths per 100 thousand) is higher than Wales average (12.5% per 100 thousand) and second highest after Cwm Taf Morgannwg (16.8% per 100 thousand).

**Smoking**: attributable admissions, EASR per 100,000 Swansea Bay UHB had 1488 admissions which was above the Welsh average (1427) during 2016/17 to 2018/19. The second highest in Wales. Nearly 6% of all hospital admissions for males and nearly 4% of females were attributable to smoking during this period in SBUHB.

**Cancer:** In 2018 Deaths from Lung cancer were double that of other cancers and deaths from prostate cancer were not far behind.

**Screening:** In 2017/18 the Cwmtawe cluster is below the bowel screening target of 60% at 56.1%. It is below the Cervical screening target of 80% at 73.6% but is over the Abdominal Aortic Aneurysm target of 80% at 84%.

**Vaccinations:** The summary uptake identifies Cwmtawe as performing well, achieving over 95% take up in most areas. The only category under 90% take up was the 3 in 1 teenage booster at 88.1%. ------school vaccinations

**Diabetes:** Diabetes diagnosis and registrations, in the former Abertawe Bro-Morgannwg University Health Board (ABM UHB), area was slightly above the Wales average; 6.21 and 6.03 respectively. Cwmtawe has a higher prevalence of 6.3%

**Heart Failure:** Whilst Cwmtawe (1.8) is only slightly higher than the Wales average (1.1) according to 2018 figures, it has one of the highest levels of recorded diagnosis of heart failure in Swansea Bay UHB along with Upper Valleys. Figures suggest that nationally heart failure rates are continuing to rise.

**Sexual Health:** In 2018/19 The Sexual Health in Wales Surveillance Scheme reports a compares the 6-month period October 2018 to March 2019 which highlights:

* More syphilis (22% increase), gonorrhoea (14%), and first episode herpes (7%)
* Of concern, 76% increase in syphilis diagnoses in people aged less than 25 years
* Fewer new diagnoses of HIV (43%)

Increase was seen in Chlamydia diagnoses in ABM UHB, compared to a Wales decrease of 3%. The biggest increase observed in men (+20%) and men who have sex with men (+83%). The percentage change in chlamydia diagnoses made in ISH clinics from Q4 2017- Q1 2018 to Q4 2018-Q1 2019, by LHB of residence, gender and sexuality identified a 58% overall increase in Gonorrhoea diagnoses in ABM UHB, compared to a Wales increase of 13%. The majority of Health Boards observed an increase in Gonorrhoea diagnoses but none as steep as ABM UHB. The biggest increase observed in men who have sex with men (105%).

**Asylum seekers, refugees and migrants:** In June 2018, Swansea was home to 957 asylum seekers. The figure constantly changes dependant on the political situation. Since the inception of the Syrian Vulnerable Persons Resettlement Scheme in late 2015, Wales had also become home to 854 Syrian refugees, dispersed among every local authority.

Whilst the COVID-19 pandemic has seen the advancement in technology a benefit to a lot of patients to access services it has created a barrier for migrants and asylum seekers which in turn has placed additional pressure on support services such as the Health Access Team. Migrants and asylum seekers usually have very little or no English language speaking skills which has meant the lack of face to face contact due to the pandemic has created a negative impact on accessing health services.

**Students:** Mental health problems. 94% of universities in the UK have experienced a sharp increase in the number of people trying to access support services, with some institutions noticing a threefold increase. According to Unite Students Insight report 2019, the percentage of students who consider that they have a mental health condition has risen, and now stands at 17%. This has risen from 12% in 2016. As in previous years, anxiety and depression – often both – were the most commonly reported conditions.

**Adult prisoners:** 79% of current residents have been in HMP Swansea for under six months. This places the main emphasis of healthcare on the identification and management of immediate health needs. Stays of a short length make it more difficult to pick up on hidden and long-term conditions, particularly those where screening may be infrequent. Giving rise for additional intervention on release. The most common types of disability recorded were mental health problems and unspecified disabilities.

**General prescribing:** Whilst Swansea Bay is on target to meet the 25% reduction, when compared to Wales and England as a Health Board we remain an outlier in terms of overall antibiotic usage. Cwmtawe has seen an increase in the prescription of Gabapentinoids (1.8%) and Protein Pump inhibitors (2.67%)

**Mental Health:** The Public Health Wales, Mental Wellbeing in Wales tool in 2018 identified that in Swansea respondents reported the highest level of low wellbeing. Adults aged 65 and over reported higher levels of wellbeing than younger age groups.

Sense of worthwhile - Swansea local authority had one of the lowest overall rating scores at 81.5.

Low Sense of Anxiety - Swansea being the lowest (60.0) and lower than Wales (62.8). Age groups 55-64, 65-74 and 75+ were more likely to have a low sense of anxiety

High Sense of Happiness - Swansea Bay UHB showed the lowest percentage (72.0) than the rest of Wales and the Wales average (74.7).

**Suicide:** Between 2014 and 2018 the suicide rate for Swansea Bay UHB was 12.3 per 100,000 population, equating to 208 recorded deaths by suicide. This is in line with the Wales average at 12.3 per 100,000. Additional analysis undertaken in early 2019 showed that during 2008-17 suicide rates were higher in males than females in Swansea, which is in line with the national average. Among males, the rates were highest in the 25 – 54 years age group in Swansea. 41% of transgender people reported attempting suicide compared to 1.6% of the general population. There were 28 Suicides in within Swansea Clusters April 2020 - March 2021.

**Dementia:** In Swansea Bay UHB around 5,607 individuals are registered with dementia which is likely to be an underestimate due to symptoms not being recognised and delays in diagnosis.

While dementia usually affects older people it is not an inevitable part of the ageing process (WHO; 2012. Dementia: a public health priority). It may therefore, be amenable to primary prevention, awareness raising to reduce stigma and reducing barriers to early diagnosis and support for cares to reduce the economic burden and improve quality of life.

## **LOCALITY KEY FACTS**

* + The Cwmtawe Cluster serves a (GP registered) population of 42,067 (as at 01.04.2021) and is the third smallest cluster by registered population in the Health Board Area. (Source – NHS Wales Shared Services Partnership)
  + It is 1 of 5 clusters within the county of Swansea.
  + Of the 20% most deprived LSOAs in Wales, 17 are within Swansea, with 9 found within the Cwmtawe Cluster (Source - <https://www.swansea.gov.uk/wimd2019>)
  + This cluster contains 36 LSOAs. (Source -https://www.swansea.gov.uk/communityareaprofiles)
  + The Cluster geographically covers the wards: Bonymaen, Clydach, Landore (part), Llangyfelach (part), Llansamlet, Morriston, Mynyddbach (part) (Source Cwmtawe– IMTP)
  + A journey from Mynyddbach to Bonymaen by road would take 14 minutes and cover a distance of 4.5 miles. (Source - Google Maps)
  + There is 1 hospital within the Cwmtawe Cluster; Morriston Hospital
  + Based on the projected population growth in Swansea, provided in section 2, there is a forecast of 6.94% increase in population between 2018 – 2043. Based on the resident population in the Cwmtawe cluster area of 58,489 (Source --Population projections by local authority and year (gov.wales)) this could increase to 61,548
  + The Cwmtawe Cluster has approximately 10,940 resident people over the age of 65 years and over (18.7%) which is lower than the Welsh average of 21%. (Primary Source – Mid 2018 Population estimates (Source: Small area population estimates (2018), ONS) Secondary Source - Cluster IMTP
  + The Cluster area has 3 GP practices (2 of which operate a branch practice).
  + The locality has 12 community pharmacies. (Source – Cluster IMPT 2020 – 2023)
  + There are 7 dental practices that offer NHS treatment and 5 optometric practices. (Source – Cluster IMPT 2020 – 2023)
  + There are;
* 4 Dual Registered Care Homes
* 0 Dementia Care Homes • Residential Care Homes
* 0 Local Authority Homes
  + According to the 2011 Census 11.4% of people aged 3 years and above in Swansea are able to speak Welsh
  + There is 1 pharmacy in the Cwmtawe Cluster where spoken languages in addition to English, Welsh is noted as well as Punjabi and Urdu.
  + According to Swansea Council Local Development Plan (2010-2025) it is estimated that a minimum of 1,465 homes will be built in the Cwmtawe Cluster.

# 6. ACTION PLAN – Goals, Methods, Outcomes (GMO)

Our plan is a flexible plan which will be underpinned by ongoing work to develop implementation and performance plans against the stated Goals, Methods and Outcomes Action Plan.

**KEY:**

**Addressing Ministerial Priorities**

⯁ A Healthier Wales – as the overarching policy context

⯁ Population Health

⯁ Covid Response

⯁ NHS Recovery

⯁ Mental Health and Emotional Wellbeing

⯁ Supporting the Health and Care Workforce

⯁ NHS Finance and Managing within Resources

⯁ Working Alongside Social Care

**Strategic Priority Areas**

🞿 Responding to Covid

🞿 Improving Patient Quality and the 5 Q&S goals

🞿 Improving Staff Experience

🞿 Improving Unscheduled Care

🞿 Improving Planned Care

🞿 Increasing Digital Capability

🞿 Improving Cancer and Palliative Care

🞿 Prevention and Reducing Health Inequalities

🞿 Children, Young People and Maternity

🞿 Improving primary, community and therapy services

and the 6 priorities Primary and Community

🞿 Improving Mental Health and Learning Disabilities and the 7 goals

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| --- | --- | --- | --- |
| 1. IMPROVING PLANNED CARE | | | |
|  | **GOALS** | **METHODS** | **OUTCOMES** |
| 1.1 | To achieve prescribing targets by reducing prescriptions for gabapentinoids and protein pump inhibitor (subject to the national shortage of alternatives being resolved)  🞿🞿🞿⯁ | Review patients currently prescribed gabapentinoids and protein pump inhibitor which have increased 1.8% and 2.4% respectively. | Reduction in prescribing levels  Gabapentinoids by 4%  Protein Pump Inhibitors by 6% dependent of national shortage of alternatives being resolved |
| 1.2 | Heart Failure: Implementation of the Swansea Bay Primary Care Heart Failure Care Plan  🞿🞿🞿🞿🞿🞿⯁⯁ | Co –production of 12 monthly care plans with patients experiencing heart failure, through patient activation for behaviour change. To include smoking, exercise and dietary advice plus signposting to British Heart Foundation resources’. | 100% of patients to have documented care plan  10% reported Increased personal confidence in managing their condition  10% of patients have increased reported importance of self-management and behaviour change  Patient questionnaires to provide level of behaviour change |
| 1.3 | To improve patient experience for those patients on secondary care waiting lists  🞿🞿🞿🞿🞿🞿⯁⯁⯁ | Implement the Get Ready for Surgery Project:   * Optimising patients for planned surgery/treatments enabling healthier lifestyle choices. | Novel project testing hypothesis  Improved patient outcomes while they wait for surgery  Enhance recovery following treatment/surgery. Improve the overall wellbeing of the patient  Reduce demand on health care  Improved patient experience whilst they wait for surgery |

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| 2. IMPROVING CANCER & PALLIATIVE CARE | | | |
|  | **GOALS** | **METHODS** | **OUTCOMES** |
| 2.1 | Cancer prevention  ⯁⯁🞿🞿 | To promote model developed for Bowel screening Wales (in partnership with PHW)  Aligning promotion to access of mobile screening units from PHW  Promotion of Cervical Cancer during Awareness week (January 2022)  Training volunteers in screening services awareness | Number of non-responders contacted  Social media hits and shares  Increase in the uptake of Bowel and Cervical screening.  Number of volunteers trained and deployed |

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| 3. IMPROVING UNSCHEDULED CARE | | | |
|  | **GOALS** | **METHODS** | **OUTCOMES** |
| 3.1 | Development of integrated Community Care through provision of complex case management in order to maintain independence and prevent unnecessary hospital admissions.  🞿🞿🞿🞿⯁⯁⯁⯁ | Employment of a Frailty nurse (2-year contract). To deliver the frailty framework to cluster practices. | Novel project testing hypothesis  To support care management of 150 patients plus via virtual wards.  Identification of 30% of patients classified as frail.  Improved partnership approaches to care.  Support reduced hospital admissions. |
| 3.2 | Increase MDT with a focus on patients experiencing DV, substance misuse and poor mental health  🞿🞿🞿🞿🞿🞿🞿⯁⯁⯁ | Employment of a Complex needs worker (2 year contract) | Novel Project –testing Hypothesis. Independent evaluation being undertaken.   * Evidence reduced demand on GP’s with an ambition of 30% * Better support for patients to take responsibility for their own health –outcome surveys * All complex needs patients to receive support tailored through co-production * Improved access to other sources of support Number of referrals to other agencies * Identification and quantification of ‘hidden’ cause of poor physical and mental health issues. Initial assessments. * Improved identification of safeguarding issues * Proof of concept identified and supports concerns raised by partners via Safer Swansea Partnership |
| 3.2 | Development of integrated Community Care through provision of  a virtual ward within the cluster.  🞿🞿🞿🞿🞿⯁⯁⯁⯁⯁ | Development of a cluster virtual ward | 150 patients seen/supported within virtual wards per annum from the 2 practices participating.  83% of patients seen within VW have received improved access to diagnostic services  Evaluation to be undertaken by QI team |

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| 4. IMPROVING MENTAL HEALTH & LEARNING DIFFICULTIES | | | |
|  | **GOALS** | **METHODS** | **OUTCOMES** |
| 4.1 | Improved access to low intensity and high intensity psychological therapies to improve access to Mental Health  Improve prevention and self-care  🞿🞿🞿🞿🞿🞿🞿⯁⯁⯁ | Commissioning of Psychological therapies | * Support achievement of maximum wait for high intensity psychological therapies of 26 weeks and 56 day wait for other therapies. * Rapid access to psychological therapies * 81% of patients seen will have improved patient outcomes – articulated in year-end report * Numbers of patients receiving support |
| 4.2 | Timely Access to Mental Health services within Primary Care  🞿🞿🞿🞿🞿🞿⯁⯁⯁ | Employment of a Cluster Mental Health Triage and Wellbeing Worker | Novel Project testing hypothesis   * Achievement of a cluster model for mental health services in primary care * Patients with mental health needs, are referred for the right service at the right time. Case studies in quarterly reporting * Patients already known to secondary mental health services receive a step up/ step down provision. Method of measurement to be determined * Increased MDT and options for referral * Reduction in demand for appointments with GP’s of patients with poor mental health |
| 4.3 | Suicide prevention:  Improved patient outcomes for patients with suicidal ideation  🞿🞿🞿🞿🞿🞿🞿⯁⯁ | To collate accurate data via a new practice coding template to inform service development  Development of front line Mental Health Champions within each practice | Testing hypothesis  % of Staff feel equipped to interface with patients with suicidal ideation and have a specific point of reference for advice.  The cluster has accurate patient data for those at risk of suicide resulting in improved patient outcome |

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| 5. CHILDREN, YOUNG PEOPLE & MATERNITY | | | |
|  | **GOALS** | **METHODS** | **OUTCOMES** |
| 5.1 | Refer to mental health psychological therapies above 4.2 |  |  |
| 5.2 | Refer to suicide prevention work 4.3 |  |  |
| 5.3 | Refer to flu actions below 6.1 |  |  |
| 5.4 | Refer to plans to boost teenage 3 in 1 jab below 6.4 |  |  |

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| 6. PREVENTION & REDUCING HEALTH INEQUALITIES | | | |
|  | **GOALS** | **METHODS** | **OUTCOMES** |
| 6.1 | To Reduce Hospital admissions of patients with Flu  🞿🞿🞿🞿🞿⯁⯁⯁ | Deliver a Cluster plan of action to address Flu to compliment individual practice plans including, promotion of self-care, vaccination clinics, communications, continued use of flu champions for to increase uptake of influenza vaccinations; practices to share ‘best practice’ | * Contact made with 75% of non-attenders * Increased uptake from target groups by 4% from most recent data and to reduce gap in uptake amongst practices * Support reduction in hospital admissions due to influenza |
| 6.2 | Continue to increase work to reduce smoking  🞿🞿🞿🞿🞿⯁⯁ | Promote “Help Me Quit” through Comms via Social Media, Facebook, Twitter  Deliver Help Me Quit training practice staff in providing support –Brief intervention training  Practices to cleanse their records in ensuring that patients have an up to date record of their smoking status and referred to “Help Me Quit” accordingly | * Support reduction in numbers of smokers * Support reduction in respiratory illnesses * Increase in referrals to the Help me quit project by 10% |
| 6.3 | Improved uptake of the screening programmes particularly for   1. Bowel screening 2. Cervical Screening   🞿🞿🞿🞿⯁⯁ | Utilise volunteers to contact non responders working in partnership with Public Health Wales | Contact 60% of non- responders.  Testing hypothesis- Improved screening rates by 15% for bowel screening and 5% for cervical screening |
| 6.4 | To improve uptake of the 3 in 1 teenage booster vaccination  🞿🞿🞿🞿⯁⯁ | Work with SNAPP Health Champions to promote the reasons for vaccination within schools –myth busting | Project funding pending-measures to be developed  Increase in uptake of childhood vaccinations |
| 6.5 | Safeguarding:  Better management of patients with complex needs and Improved ability of professions to act with clear communication routes  🞿🞿🞿🞿🞿🞿⯁ | Cluster to develop clear protocols between all partners | Safeguarding protocols are in place between all partners |
| 6.6 | Raise awareness of Carers and support their needs  🞿🞿🞿🞿🞿🞿🞿  ⯁⯁⯁⯁ | Signposting to appropriate services for new carers  Consideration of carers’ needs in commissioning and development of cluster based services  Cluster services developed demonstrate they undertake an impact assessment for carers | • Staff are able to identify and support carers effectively as Practices are able to demonstrate a 28% increase in carers on practice records  • New carers understand what it means to be a carer  •Carers become valued as expert partners in care and are included in conversation and decision making leading to co-production of a carers impact assessment to be used within the cluster  •Improved staff knowledge and training by 80% of practices within the cluster have completed the GP accreditation scheme |

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| 7. ACTION PLAN ENABLERS | | | |
| Technological | **Workforce** | **Communication & Engagement** | **Finance** |
| The use of My Health | Continual employment of a Cluster Commissioning & Development Manager to provide the cluster with the resources to achieve its goals | My Surgery App | Seek opportunities for both external and multi – agency funded projects to maximise cluster funds |
| Ask my GP | Cluster Project & Admin support | Primary and community communications officer delivering e-media, and press advertising campaigns | Financial allocation is £260,040.00 |
| E consult | Other workforce working within the cluster:  LMPHSS; Social prescriber: LACs, ONA | Co-production of complex needs worker and Heart failure care plan | Reimbursement from the academic fellowship scheme. |
| My Surgery App | Bluestream E learning platform |  | Mental health delivery group for social prescriber and for mental health triage post |
| Bluestream E learning platform | Academic Fellow - Workforce & Organisational Development  New ways of working |  |  |
|  | Induction pack for new cluster staff |  |  |
|  | Emergency plan – resilience and response |  |  |

# 7. GOVERNANCE ARRANGEMENTS

The Cluster members meet 5 times a year at formal Cluster Board meetings, to plan and review progress and strategic direction related to the Cluster IMTP and to routinely address: Cluster Plan and associated planning actions, Cluster Spending Plan, Risk Register Update, Sustainability and Finance. Declarations of interest are addressed as standing items. GP Practices are permanent members of the Cluster.



Welsh Government and Health Board allocated Cluster Funds are spent and allocated in accordance with Swansea Bay University Health Boards Standing Financial Instructions. Non-Welsh Government funds are administered on behalf of the Cluster by Swansea Council for Voluntary Service in accordance with agreed Cluster and funding body policies and procedures.

## **MEMBERS**

The core membership of the Primary Care Cluster shall comprise of representation from all local services involved in health and social care within the cluster area and shall include:

* Cluster Lead (Chair)
* Representation for each GP Practice. In Cwmtawe Cluster there will be representation from 3 GP Practices. This will include as a minimum a GP and will also extend to Practice Manager.
* One representative from Community Pharmacy - to represent all community pharmacies within the cluster
* One representative from Dental - to represent dental services within the cluster
* One representative from Optometry - to represent optometry services within the cluster
* Primary, Community & Therapies Services Senior Manager
* Cluster Development Manager
* Nominated representative for Adult Nursing and Childrens Nursing
* Medicines Management Representation
* Nominated representative for Therapies; two members to represent the breadth of therapies services
* Representation from Mental Health
* Third Sector / Community Voluntary Service

# 8. CLUSTER ASSETS PROFILE

Primary Care Estate is used to support the development and implementation to community based clinics e.g. spirometry and counselling clinics

## Key Community Assets

* Extensive green space e.g. Lliw Reservoir, Swansea Vale Nature Reserve, Primrose Park, Morriston Park.
* Active Community and Voluntary Organisations.
* Rugby Club
* Leisure Centres
* Libraries
* Community Hubs

The Major employers within the cluster are City and County of Swansea; The Mond Nickel Works; DVLA; DWP; HSBC and Land Registry.

# 9. CLUSTER WORKFORCE PROFILE

**Cwmtawe Cluster Multi-Disciplinary Team Workforce Staff Outlined for 2022-23**

One of the most effective ways identified to deliver services to meet Cluster priorities is through the employment of Cluster based MDT. This includes a huge range of professions and areas of expertise, with some working closely together to achieve the demands and capacity of the Cluster needs.

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| **Role** | **WTE** | **Outcomes / Impact** |
| Commissioning and Development Manager | 0.2 | Cluster Lead Support in delivery of IMTP  Project commissioning and development,  Oversight of cluster based staff  Project management oversight  Supports cluster lead with strategic direction  Development of joint funding bids with partners as required by projects developed |
| Project and Administrative Support Officer | 0.9 | The 15 Cluster members are supported.  Increased resources available to cluster  Development and Implementation of Cluster IMTP  Cluster projects developed and implemented (as determined by the cluster) effectively with robust monitoring, evaluation and reporting  Clear feedback to Cluster members and Health Board  Timely access for cluster to relevant information to inform improvements for health population and service delivery  Increased partnership working and partnership projects  Informed and briefed Cluster Lead  Provision for increased patient engagement  Research function to the cluster to support efficacy during project development |
| Social Prescriber | 0.5 | Provides support to patients with:  long-term conditions  Low level poor mental health  lonely or isolated  Social needs which affect their wellbeing |
| Frailty Nurse | 1.0 | Reduction in overall rate of falls,  Increase in uptake of flu vaccinations,  Reduction of admissions into secondary care,  Improved outcomes of those who have been discharged from hospitals,  Improved quality of care and clear pathway created for those who are frail,  Reduced demand for GP appointments and easier access to primary care services within the community,  Greater data relating to ACP and DNA CPR requests,  Ability to link in to the carers centre, virtual ward and other pathways available within the cluster – streamlining the approach and improving care across the board. |
| Cluster triage and wellbeing role | 0.5 x2 | 80% of patients report an improvement in their wellbeing.  80% of patients access appropriate mental health support in a timely manner.  10% reduction in antidepressant prescriptions.  20% reduction in frequent attendance at GP practices.  10% reduction in referrals to secondary care. |
| Complex Needs Worker | 1.0 | Meaningful interventions to address identified issues regarding domestic abuse, mental health and/or substance misuse  Work with colleagues as an advocate for patients with complex needs across the Cwmtawe Cluster area.  Use a ‘Team Around the Family’ approach to lead and broker staff in specialist roles and from partner organisations to ensure effective outcomes.  Strengthen and develop links and pathways with other services including but not exclusively private sector landlords and specialist providers to increase collaborative learning.  Work closely with local relevant services to ensure that communications are clear and people who need help are identified at the earliest opportunity.  Help people to maintain their independence, health and wellbeing through innovative interventions that fully recognise and incorporate each person’s strengths.  Promote empowerment and resilience for individuals with complex needs. |
| Occupational therapist | 1.0 | Providing preventative and early intervention within primary care, will support patients to self-manage their health conditions and keep individuals independent, safe and confident within their homes and communities. Ultimately, aiming to reduce unnecessary general practice contacts, hospital admissions, releasing professional capacity and most importantly improving patient outcomes. |

# 10. CLUSTER FINANCIAL PROFILE

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| **BUDGET 22/23 Subject to alteration** | |  |
| WG allocation 22/23 | **£260,040.00** |  |
| Brokerage from 21/22 | **TBC** |  |
| PMS+ Monies/Other income | **TBC** |  |
| **Total available for 22/23** | **£ 260,040.00** |  |
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| **PLANNED SPEND as at March 2022** |  |  |
| **Project** | **Projected Actual Spend** |  |
| Cluster Comm & Dev Manager | £12,000.00 |  |
| Project & Admin support 2yr post commence Feb 2021 | £39,454.00 |  |
| Bluestream training | £3,332.00 |  |
| Frailty nurse | £50,750.00 |  |
| VISION 360 | £3,939.00 |  |
| Complex needs worker 2 year contract | £37,300.00 |  |
| Cluster Triage and Wellbeing worker role | £37,263.00 |  |
| Counselling | £37,500.00 |  |
| Training cluster staff | 1,000.00 |  |
| **Total** | **£222,538.00** |  |

The cluster are also in the process of scoping out potential for delivery of GP fellowship scheme; Whole Family Approach to Health Project; and contribution towards a communications resource during 2022/23.