



**CYFARFOD BWRDD PRIFYSGOL IECHYD  
STRATEGIC DEVELOPMENT AND OPERATIONAL DELIVERY COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	29 August 2024
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Cluster Integrated Medium Term Plan (IMTP) Monitoring Report
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Jill Paterson, Director of Primary Care, Community and Long Term Care
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Laura Lloyd Davies, Cluster Development Manager

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Er Gwybodaeth/For Information

**ADRODDIAD SCAA**

**SBAR REPORT**

**Sefyllfa / Situation**

Historically there was a contractual requirement for GP Practices to participate in the development of Cluster level Integrated Medium-Term Plans (IMTPs).

With the introduction of The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023 in October 2023 the contractual requirement has changed.

**Cefndir / Background**

There are seven Primary Care Clusters in Hywel Dda University Health Board (HDdUHB) working across the three Counties, namely:

- Amman Gwendraeth Cluster (AG), Llanelli Cluster (LL) and Tywi Taf Cluster (2Ts) in Carmarthenshire
- South Ceredigion Cluster (SC) and North Ceredigion Cluster (NC) in Ceredigion
- South Pembrokeshire Cluster (SP) and North Pembrokeshire Cluster (NP) in Pembrokeshire

Each Cluster has historically had an IMTP, however as these were due for refresh in 2023/24 and the revised General Medical Services Regulations were issued to support the implementation of the Unified Contract, Plans on a Page (POP) were developed as a high-level summary of the population health needs of each Cluster alongside their priorities and a summary of key projects.

Across the seven clusters, there were 59 projects identified for quarterly monitoring. Progress on Cluster projects is discussed at each quarterly Cluster Meeting and through the monthly Locality Leads meeting.

Part 7, Schedule 3, Paragraphs 17 -19 of The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023 sees the inclusion of GP Collaborative membership, the contribution to Clusters and Collaboratives and Demand and Capacity being included within the core General Medical Services contract. The contract Regulations make provision for GP Collaboratives to contribute to and engage in the development of a GP Collaborative IMTP as

well as contributing to the Cluster IMTP. A process to capture this new requirement is being worked through within the team to ensure that Practices are able to be contractually compliant.

## Asesiad / Assessment

### **Cluster IMTP**

For the period 2021 to 2023 each Cluster produced a detailed three-year IMTP. The Locality Lead and Primary Care Service Manager (PCSM) worked with the Cluster members to assess the local population health need data (provided by Public Health Wales), determined any gap in service and identified Cluster priorities. The IMTP reported on all Cluster projects over that time and were incorporated into the County Plans via the County Locality Managers and County leadership meetings.

In recognising the need to refresh the data whilst considering the revised contractual requirements (for delivery by March 2025) the current Cluster Plan is displayed as a Plan on a Page (*Appendix A*). Each Cluster has worked in conjunction with their respective GP, Optometry and Community Pharmacy Collaborative Leads along with members of the Primary Care Cluster to establish three priority areas that will inform and guide the Cluster in determining future projects and opportunities.

### **GP Collaborative IMTP**

The introduction of the Unified Contract has meant that the contractual requirements, as set out above have changed the required reporting from GP Practices. Each GP Practice (contractor) is required to identify one health care professional who is required to attend at least four meetings of the Collaborative in each financial year. The contractor is also required to contribute relevant information including demand and capacity planning to the Cluster IMTP via the GP Collaborative. They also need to demonstrate how they have engaged in planning and delivery of local services and contribute to delivering specific Cluster determined outcomes. Specifically, the GP Collaborative is required to undertake a Population Needs Assessment of its patients, by analysing current service provision to identify any gaps, then analysing the current numbers and skills of the workforce and their development needs to provide evidence of a Demand and Capacity assessment.

It is proposed that a template is developed for each GP Practice to have their own Plan on a Page, bringing together the key contractual requirements which can then be considered at the Collaborative with an overarching summary of actions and recommendations to be submitted for inclusion in the Cluster IMTP.

### **Cluster Projects**

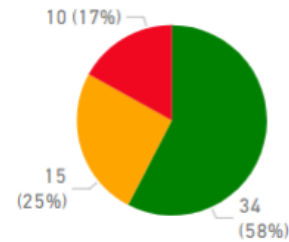
In considering the current Cluster projects the Cluster Data Pack is central to the monitoring of Cluster project progression and is therefore key to future planning and service design (please see Appendix 2: 2023/24 Cluster Project Data Pack). The Cluster Data Pack is presented quarterly at Locality Leads meetings and is available to all Cluster Leads for discussion at Cluster meetings. The data is presented to offer assurance and to clearly demonstrate project success but likewise areas of concern.

In summary 59 projects have been managed and monitored by the Clusters in 2023/24. All seven clusters have engaged in a Trial Without Catheter (TWOC) project, six of the seven Clusters have one or more Mental Health projects ongoing and five of the Clusters have purchased Optom equipment and have a First Contact Practitioner Physiotherapy (FCP) service. Other projects to note are Women's Health Clinics, Persistent Pain, Spirometry and Frailty.

The following information summarises the fifty-nine projects initiated and managed by Clusters and is the final position in Quarter 4 for the last financial year.

### Target

Across the seven Clusters, fifty-nine projects are being regularly monitored. A significant proportion of these (58%, 34 projects) are reporting on target (green) to achieve the identified outcomes.

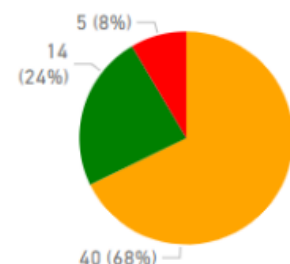


25% (15) of projects are of concern (amber) and 17% (10) of projects are of significant concern (red).

RAG Status	Status Indicates
Red	<p>A red indicator usually means one or more of the following:</p> <ul style="list-style-type: none"> <li>-Significantly off target</li> <li>-A significant forecast overspend against budget of more than 5%</li> <li>-Delays against critical milestones of more than 4 weeks.</li> <li>-Significant problems with quality and expected benefits won't be realised</li> <li>-Significant lack of resources which cannot be resolved by the lead / service</li> <li>-Dissatisfaction or resistance from stakeholders</li> </ul>
Amber	<p>An amber indicator usually means one or more of the following:</p> <ul style="list-style-type: none"> <li>-Within 5% of target</li> <li>-A forecast overspend against the budget of no more than 5%</li> <li>-Delays against critical milestones of more than 2 weeks</li> <li>-Problems with quality, but in the main expected benefits will be realised</li> <li>-Lack of resources which can be resolved by the lead / service</li> <li>-Dissatisfaction or resistance from stakeholders, but this can addressed by the lead /</li> </ul>
Green	<p>A green indicator usually means one or more of the following:</p> <ul style="list-style-type: none"> <li>-On or above target</li> <li>-Forecast expenditure is on budget</li> <li>-Project on plan to complete on time</li> <li>-Quality at expected levels, the vast majority of expected benefits will be realised</li> <li>-No resource problems</li> <li>-Stakeholders engaged and satisfied</li> </ul>

### Trend

24% (14) of the projects have an improving trend (green). 68% (40) of the projects are stable (amber). Only 8% (5) are reported as deteriorating / worsening (red).



The trend and target (RAG) information will be used to plot objectives on a risk grid (see below). This is used to identify where focused performance conversations are needed. For example, those falling within the green areas are progressing well and no attention is needed. However,

those that fall within the red areas should be discussed and assessed to identify what resources / interventions are needed, or indeed if projects should continue if there is no feasibility of achieving their outcomes.

**Risk Grid**

		<b>RAG</b>		
		Green	Amber	Red
Trend	Worsening	-	-	5
	Stable	29	6	5
	Improving	5	9	-

The following have been flagged for attention:

**Red – Worsening**

**IRISi Pilot Domestic Violence and Abuse Training (AG, LL and 2Ts)**

Concerns were raised by the Cluster leads and PCSMs about the delivery of the IRISi service and the impact the service provided to Primary Care staff and patients. Uptake increased following a review of training needs. However no staff received any training in the last quarter. All three Clusters decided to end the project and will not continue with funding.

**Cluster Pharmacist (AG, LL, 2Ts and NP)**

This project has been ragged red primarily as measurement data is not routinely being reported through this monitoring process. Four Clusters employ Cluster Pharmacists in AG, LL, 2Ts and NP who carry out a mixture of Cluster project work and GP Practice based activities. The team is currently undertaking an evaluation of activity and long-term use and this piece of work is expected to impact the role expectations and project delivery positively providing clarity and a consistent approach.

**Red – Stable**

**Singing for Lung Health (Skylarks) (NC)**

Project ended 31st May 2024 due to limited uptake and duration of funding to date.

**Increase Access to Defibrillators Within the Community (NP)**

Unable to order equipment through Oracle due to stocking levels.

**Community Catheter Clinics (NC)**

This NC Cluster project has moved into the red area of concern due to data quality concerns. The measurement data is not routinely collected and the PCSM is working with the project team to amend and ensure adequate monitoring is in place in future.

## Amber

All projects identified as Amber, 15 in total, have had concerns raised and resolutions identified. The projects in this category are in the process of embedding new data collection methods, project staff commencing in post and /or have implemented a change to the service delivery to enable an improvement to the project delivery. Four of the projects in this RAG status are Mental Health services namely, Mind (LL), Connecting Youth, Children and Adults (CYCA) (LL), Jac Lewis Foundation (AG) and Papyrus (2Ts). These services in particular are awaiting the Mental Health service review paper, planned for discussion in September's Locality Leads meeting.

The Cluster Data Pack provides an overview of all Cluster projects, including their aim, most recent update, RAG and Trend status.

## 2023/24 Cluster Financial Position

Each Cluster is allocated an annual budget based on the population size to be utilised on local population needs and service provision. The table below sets out the budget in and the actual spend:

Cluster	23/24 Budget	Final Spend
Amman Gwendraeth	£540,000	£540,000
Llanelli	£462,000	£449,000
Tywi/ Taf	£449,000	£476,000
North Pembrokeshire	£469,000	£325,000
South Pembrokeshire	£418,000	£413,000
North Ceredigion	£330,000	£272,000
South Ceredigion	£353,000	£306,000

## Financial Monitoring

The team has yet to embed financial monitoring within the Cluster Data Pack report. However, Cluster Finance meetings have resumed, and project codes have been shared with Finance colleagues to enable reporting from Quarter 1 2024/25.

## Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the former process for developing the Cluster IMTPs
- **NOTE** the new contractual requirement for the development of GP Collaborative IMTPs and the requirement to engage in the development of Cluster IMTPs
- **NOTE** the process being taken to ensure progress of Cluster projects through the monitoring and evaluation process

**Amcanion: (rhaid cwblhau)**

**Objectives: (must be completed)**

Committee ToR Reference:

Cyfeirnod Cylch Gorchwyl y Pwyllgor:

3.1 Seek assurance on delivery against all Planning Objectives aligned to the Committee (see Appendix 1),

	considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 5. Offer a diverse range of employment opportunities which support people to fulfill their potential 8. Transform our communities through collaboration with people, communities and partners

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Not Applicable
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Cluster Meetings Locality Leads

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	Please refer to paper

<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Please refer to paper
<b>Gweithlu: Workforce:</b>	Please refer to paper
<b>Risg: Risk:</b>	Risks will be assessed as part of the ongoing monitoring of the cluster IMTPs.
<b>Cyfreithiol: Legal:</b>	As above
<b>Enw Da: Reputational:</b>	Hywel Dda University Health Board needs to meet the targets set in order to maintain a good reputation with Welsh Government, together with our stakeholders, including our staff
<b>Gyfrinachedd: Privacy:</b>	Not Applicable
<b>Cydraddoldeb: Equality:</b>	Consideration of Equality legislation and impact is a fundamental part of the planning of service delivery changes and improvements.



# Cluster Plans 2024/25



# Appendix 1



## Amman Gwendraeth



Our goal within the Amman Gwendraeth Cluster is to identify local population needs and innovate to link extant and de novo projects we believe will meet those needs. Providing social prescribers, additional services from third sector agencies and connecting people to Local Authority social care and leisure services will improve the availability and visibility of health and social care infrastructure on our doorstep, leading to acceptable and popular wellbeing opportunities available to all. We aim to connect all four primary care statutory services and integrate and co-ordinate community-based service provision by working with community partners, utilising Welsh Senedd money wisely.

### About our Population

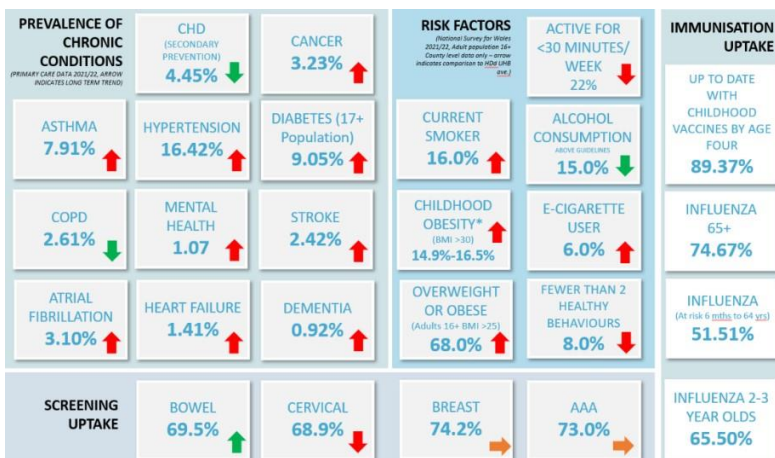


Males – 48.9%  
Females – 51.1%

Aged 65+ – 23.9%  
Aged 85+ – 2.8%



44.3% of people are in very good general health



### About our Services



- 8 GP Practices with 7 Branch Surgeries
- 4 Dental Practices and 0 Orthodontic Practice
- 16 Community Pharmacies
- 5 Optometry Practices
- 1 Community Hospital
- 12 Nursing and Residential Homes
- 1 Community Resource Team

### Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023:

- There were 425,370 GP appointments of which 45% were face to face
- 39% of the appointments were urgent
- There were 3,240 consultations in the PIPs service for common ailments
- 1,752,978 items were dispensed by Pharmacies
- 587 people were seen by the Independent Prescribing Optometry Service



### Cluster Budget (Recurrent)

- Spend for 2023/24 is £537k
- Budget for 2024/25 is £444k



### Cluster Priorities 2023/24

- Improved access to low level – medium Mental Health services for the population that includes CBT, Counselling, EMDR & other psychotherapeutic approaches for adults and younger people.
- Chronic Pain** is a common but extremely complex issue the development of a pathway in primary care to support the biopsychosocial management of persistent pain through pain education and management interventions, working in a multidisciplinary way .
- Dermatology Service** - GPwSI practitioners are able to contribute positively by managing the workload and reduce the burden on mainstream dermatology services through timely access to specialist diagnostic skills and minor surgery for patients presenting with dermatological disease , such as non-pigmented lesions.

### Cluster Priorities 2024/25

- To continue to improve access to mental health services for those with low – medium mental health issues, who would otherwise not meet the criteria .
- The continuation of the **Chronic Pain service** through an MDT approach and , empowering patients to make better lifestyle choices by getting to the root of their pain.
- Develop the **integration of the optometry and pharmacy collaboratives** and ensuring they are being supported at a cluster level. The Cluster would like to support the Optometry collaboratives in funding for new equipment in 2024/25, in particular mobile slit lamps to improve access for patients in the community, which will help to reduce the number of referrals made to Ophthalmology within secondary care, through providing care in Optometric practices.

# Appendix 1



## Llanelli



Llanelli Cluster's priorities are steered towards helping the population become more resilient and concentrate on improving p accessing services less, engaging with their communities more and taking a more active role in their own health and wellbeing including social prescribers, Nurses, Therapists and Counsellors all currently contribute to make Primary Care a more sustain supporting people to have better health and wellbeing throughout their whole lives.

people's health and wellbeing. The ultimate aim will be to have a population needs. The wide varying range of professionals engaged with Cluster projects, able and integrated model. Our aim in the Llanelli Cluster is one of partnership,

### About our Population



Males – 48.5%  
Females – 51.5%

Aged 65+ – 21.8%  
Aged 85+ – 3.0%



44.1% of people are in very good general health

PREVALENCE OF CHRONIC CONDITIONS <small>(PREVALENCE COMPARED TO 2019/2020, UNLESS INDICATED OTHERWISE)</small>		CHD <small>(SECONDARY PREVENTION)</small>	CANCER	RISK FACTORS <small>(Prevalence Survey for Wales 2022/23, Adult Population 20+ - Chronic Health Issues only - services includes comparison to HSE LIME 2021)</small>		ACTIVE FOR <30 MINUTES/WEEK	IMMUNISATION UPTAKE
ASTHMA 7.73% ↑	HYPERTENSION 16.31% ↑	4.03% ↓	DIABETES (17+ Population) 8.62% ↑	CURRENT SMOKER 16.0% ↑	ALCOHOL CONSUMPTION <small>(ALCOHOL RELATED)</small> 15.0% ↓	22% ↓	UP TO DATE WITH CHILDHOOD VACCINES BY AGE FOUR 93.01%
COPD 2.22% ↓	MENTAL HEALTH 1.04 ↑		STROKE 2.39% ↑	CHILDHOOD OBESITY* 16.5%-18.1% ↑	E-CIGARETTE USER 6.0% ↑		INFLUENZA 65+ 79.61%
ATRIAL FIBRILLATION 2.82% ↑	HEART FAILURE 2.82% ↑		DEMENTIA 0.84% ↑	OVERWEIGHT OR OBESE <small>(BMI &gt;25)</small> 68.0% ↑	FEWER THAN 2 HEALTHY BEHAVIOURS 8.0% ↓		INFLUENZA <small>(At risk 6 months to 64 years)</small> 45.43%
SCREENING UPTAKE	BOWEL 66.4% ↑	CERVICAL 64.5% ↓	BREAST 70.5% ↓	AAA 75.6% →			INFLUENZA 2-3 YEAR OLDS 37.76%

### About our Services



- 7 GP Practices with 1 Branch Surgery
- 7 Dental Practices and 1 Orthodontic Practice
- 13 Community Pharmacies
- 5 Optometry Practices
- 1 Hospital (Prince Phillip)
- 1 Community Clinic (Elizabeth Williams)
- 14 Nursing and Residential Homes
- 1 Community Resource Team

### Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023:

- There were 401,776 GP appointments of which 53% were face to face
- 26% of the appointments were urgent
- There were 798 consultations in the PIPs service for common ailments
- 1,953,510 items were dispensed by Pharmacies
- 567 people were seen by the Independent Prescribing Optometry Service



### Cluster Budget (Recurrent)

- Spend for 2023/24 is £446k
- Budget for 2024/25 is £454k



### Cluster Priorities 2023/24

- **Mental Health services** commissioned for adults and children and young people to have timely access to services for low to medium mental health concerns.
- **Dementia** mapping of available services to look to streamline pathways through working with the Memory Assessment Team with the view to exploring what services could be delivered by GP Practices.
- **Domestic Violence and Abuse Training** through working with IRISI to provide education and training to GP Practices that would support the identification of patients and supporting appropriate referral and support to the individuals affected by DVA.

### Cluster Priorities 2024/25

- **Mental Health** services continues to be a priority for the Cluster however due to services being recommissioned 2024/25 will be an opportunity to take stock of what has previously been commissioned and map this across with other Mental Health services to ensure we are commissioning the right services for our patients.
- **Spirometry** testing and reporting through locally accessible clinics with the aim of clearing the current backlog and having no waiting list for future testing.
- **Improving signposting** for patients to support them to take control of their own health and wellbeing using the Cluster websites, improving accessibility to exercise etc. The Cluster aim is to have all care providers working together as an inclusive team to promote self-care and well-being.

# Appendix 1

Tywi Taf works to develop an integrated system of primary, community and social care where patients are able to flow through the sectors as needed during their journey based on pathways for different conditions. We aim to support our local population to remain in their own home; with an emphasis on population wellbeing and community connection by establishing greater links with partner services. We aim for a fully integrated Locality with a greater emphasis on joining up services and focussing on anticipatory and preventative care to improve the support provided for people who use services, their carers and their families to manage their own health and well-being in line with “A Healthier Wales: our Plan for Health and Social Care”

## About our Population

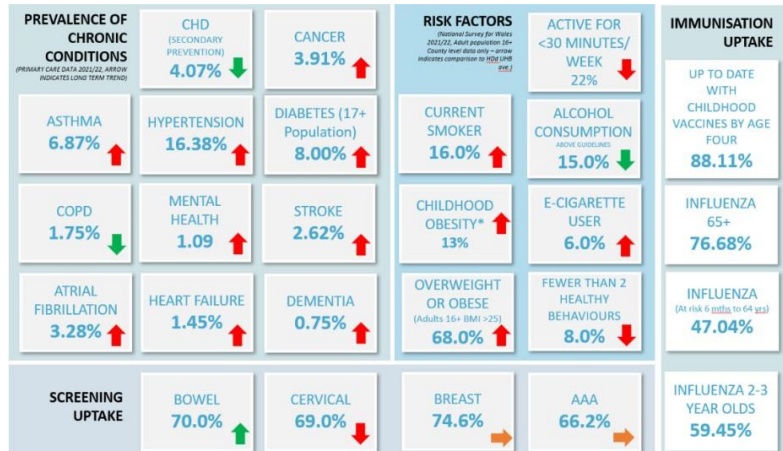


Males – **49.0%**  
Females – **51.0%**

Aged 65+ – **26.4%**  
Aged 85+ – **3.2%**



**46.7%** of people are in very good general health



## About our Services



- 8 GP Practices with 2 Branch Surgeries
- 7 Dental Practices and 1 Orthodontic Practice
- 13 Community Pharmacies
- 11 Optometry Practices
- 1 Hospital (Glangwili)
- 1 Community Hospital (Llandoverly)
- 11 Nursing and Residential Homes
- 1 Community Resource Team

## Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023:

- There were **475,372** GP appointments of which **59%** were face to face
- **38%** of the appointments were urgent
- There were **408** consultations in the PIPs service for common ailments
- **1,360,389** items were dispensed by Pharmacies
- **400** people were seen by the Independent Prescribing Optometry Service



## Cluster Budget (Recurrent)

- Spend for 2023/24 is **£475k**
- Budget for 2024/25 is **£435k**



## Cluster Priorities 2023/24

- **Frailty** is the most significant area of increase in patient need within the Health Board and was identified as one of the main challenges for 2Ts. These are the patients most likely to be admitted and re-admitted to hospital. Managing these patients effectively and pro-actively in their own home will enhance their experience of care, improve their outcomes and reduce acute care costs and bed days.
- Improved access to low level, medium **Mental Health** services for the population.
- Enhance and continue to develop **MDT working** within GP Practices. The Locality MDT model is supporting close collaborative working between community and primary care. It is expected that this will have a positive impact on proactive case management for the frailer population within the community.

## Cluster Priorities 2024/25

- **Frailty** is an ongoing priority, and our aim is to reduce emergency admissions and average length of stay in hospital.
- The Cluster are currently enrolled in an **EQUIP** project to identify, co-ordinate, plan and support for people at greater risk of needing **urgent or emergency care**
- The Cluster have recently re-tendered and awarded a contract to **MIND** for their active monitoring services for low to medium **mental health** symptoms.

North Ceredigion Cluster's vision is to provide safe, sustainable, accessible and kind, seamless care and support for our population, in line with A Healthier Wales and the principles of Prudent Healthcare. To ensure the treatment and care we deliver are value based and meeting the needs of the individual.

### About our Population

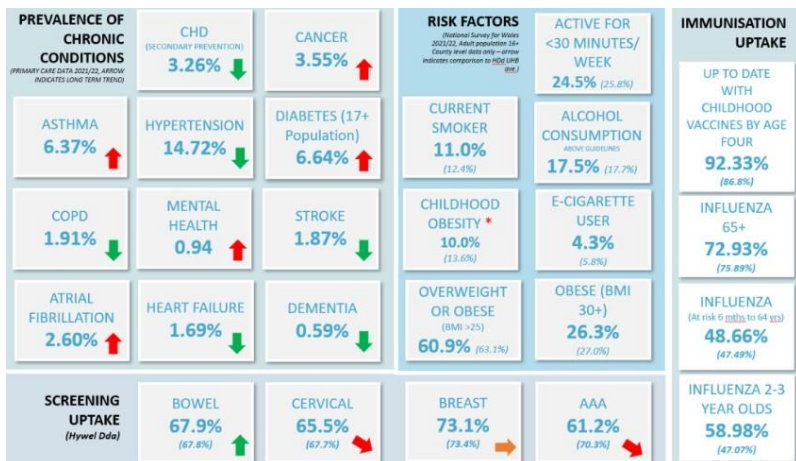


Males – 49.3%  
Females – 50.7%

Aged 65+ – 22.5%  
Aged 85+ – 3.0%



46.6% of people are in very good general health



### About our Services



- 7 GP Practices with 0 Branch Surgeries
- 4 Dental Practices
- 5 Ophthalmic Practices
- 9 Community Pharmacies
- 4 Optometry Practices
- 1 Hospital (Bronglais)
- 1 Integrated Care Centre (Aberaeron)
- 13 Nursing and Residential Homes
- 1 Community Resource Team Aberaeron

### Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023:

- There were 256,618 GP appointments of which 59% were face to face
- 31% of the appointments were urgent
- There were 671 consultations in the PIPs service for common ailments
- 886,943 items were dispensed by Pharmacies
- 227 people were seen by the Independent Prescribing Optometry Service



### Cluster Budget (Recurrent)

- Spend for 2023/24 is £264k
- Budget for 2024/25 is £327k



### Cluster Priorities 2023/24

- PAPYRUS will be working with the cluster for 2 years to deliver **suicide prevention training** to Primary and Secondary care, schools, third sector organisations, and the university.
- A joint cluster project between North/South Ceredigion and 2 Ts, to deliver **Clinical Health Psychology Service** to provide psychological care and treatment for women's health and pelvic health related conditions.
- Technology within healthcare for kidney function/diabetes** using a home test kit and mobile app, patients are able to self-test at home with clinical grade results to test Albumin Creatinine Ratio (ACR) with a ~95% specificity using their smartphone.

### Cluster Priorities 2024/25

- Continuation of the **Clinical Health Psychology Service** to provide psychological care and treatment for women's health and pelvic health related conditions.
- Develop **integration of the Optometry and Pharmacy collaboratives** ensuring they are supported at cluster level. Currently working with PHW to provide training, which optom colleagues will need to increase contractual obligation for focus on holistic health.
- The **Early Intervention Pain Service (EIPS)** has been very successful to date and has gathered excellent patient feedback scores. Double the service's capacity by employing an additional Band 5 Psychologist and admin support.

# Appendix 1



## South Ceredigion



Our vision is to continue developing the health & wellbeing of the local population within South Ceredigion utilising the current services whilst developing new and innovative ways of delivering care in our locality. The Cluster aims to grow mental health services and opportunities for people to maintain their health and wellbeing, via the Third Sector, Community and Primary Care contractors.

### About our Population

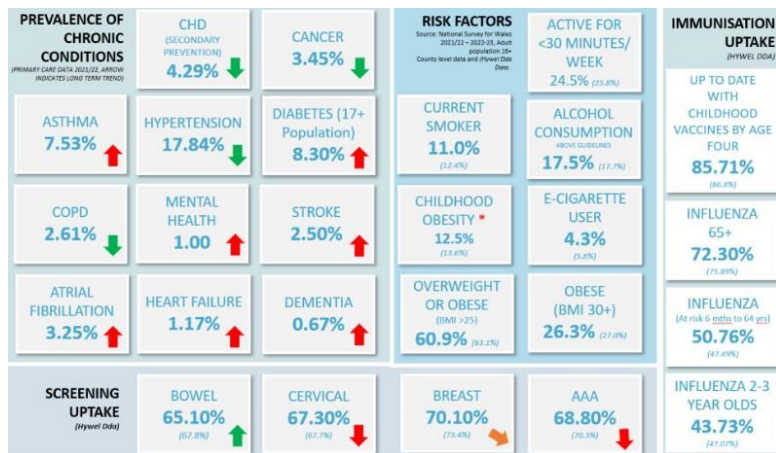


Males – 48.7%  
Females – 51.3%

Aged 65+ – 29.4%  
Aged 85+ – 3.5%



43.2% of people are in very good general health



### About our Services



- 5 GP Practices with 0 Branch Surgeries
- 5 Dental Practices including 1 Community Dental Practice
- 13 Community Pharmacies
- 6 Optometry Practices
- 1 Integrated Care Centre
- 12 Nursing & Residential homes
- Bronglais Hospital serves North & South Ceredigion

### Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023:

- There were 256,618 GP appointments of which 75% were face to face
- 56% of the appointments were urgent
- There were no consultations in the PIPs service for common ailments
- 1,352,653 items were dispensed by Pharmacies
- 40 people were seen by the Independent Prescribing Optometry Service



### Cluster Budget (Recurrent)

- Spend for 2023/24 is £301k
- Budget for 2024/25 is £348k



### Cluster Priorities 2023/24

- A joint cluster project between North/South Ceredigion and 2 Ts, to deliver **Clinical Health Psychology Service** to provide psychological care and treatment for women's health and pelvic health related conditions. It is a 2-year project costing £122,000 p/a between all three clusters.
- **Exercise co-ordinator** within the Cluster Frailty and Chronic Conditions team
- **Pro-active Falls and frailty specialist Physiotherapist** - the recruitment of a Band 6 Specialist Physiotherapist with a special interest in falls and frailty, and a Band 4 physiotherapy assistant practitioner to work alongside General Practice.

### Cluster Priorities 2024/25

- Scale up the **frailty team** to reduce the case load and enable improved access to the large cohort of frail patients across the cluster
- The continuation of the **Clinical Health Psychology Service** to provide psychological care and treatment for women's health and pelvic health related conditions.
- Develop the **integration of the optometry and pharmacy collaboratives** to ensure they are being supported at a cluster level. We are currently working with PHW to provide access to training which optometry colleagues may need as a result to the increased focus on holistic health as part of their new contract regulations.

# Appendix 1



## North Pembrokeshire



The main focus of the North Pembrokeshire Cluster is provide sustainable primary care services to North Pembrokeshire. Our aim is to reduce the reliance on accessing services, encourage greater community engagement, and empower individuals to take an active role in managing their own health and well-being whilst supporting all of primary care to improve access to care. The Cluster projects involve a diverse range of professionals, including Occupational Therapists, Physiotherapists, and Care coordinators, who all contribute to creating a more sustainable and integrated model of Primary Care whilst targeting population health needs such as diabetic foot health.

### About our Population

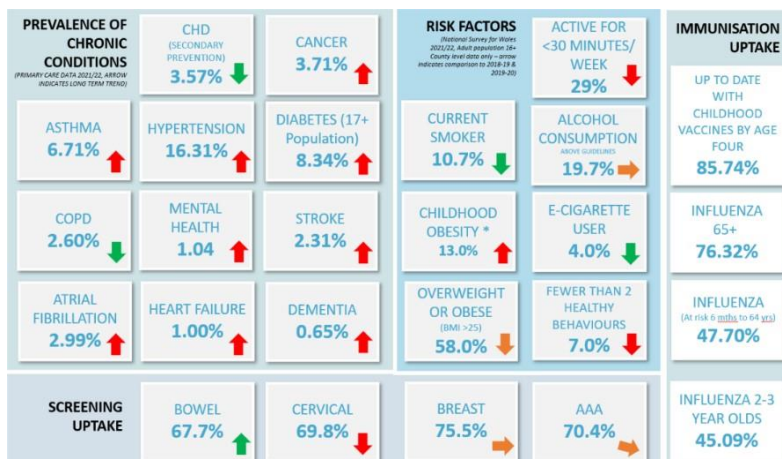


Males – 48.8%  
Females – 51.2%

Aged 65+ – 25.3%  
Aged 85+ – 3.2%



45.1% of people are in very good general health



### About our Services



- 8 GP Practices with 3 Branch Surgeries
- 9 Dental Practices and 0 Orthodontic Practice
- 16 Community Pharmacies
- 9 Optometry Practices
- 1 Hospital (Withybush)
- 5 Community Clinic Health Centre
- 35 Nursing and Residential Homes
- 4 Community Resource Team

### Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023:

- There were 366,905 GP appointments of which 63% were face to face
- 32% of the appointments were urgent
- There were 61 consultations in the PIPs service for common ailments
- 1,551,020 items were dispensed by Pharmacies
- 340 people were seen by the Independent Prescribing Optometry Service



### Cluster Budget (Recurrent)

- Spend for 2023/24 is £394k
- Budget for 2024/25 is £489k



### Cluster Priorities 2023/24

- **First Contact Physiotherapy** service - first point contact MSK FCP service within Primary setting. In keeping with the WG vision delivery care by the right people at the right setting in the right time.
- **Care Co-ordinator MDT** - working to establish robust MDT working across 8 GP Practices.
- **Improving Asthma Management** in primary school aged children – this project is aimed at prevention and early intervention.

### Cluster Priorities 2024/25

- **FCP MSK Physiotherapist** – aim to collect further data from the FCP MSK Physio project to mainstream this longstanding project since 2019.
- **Diabetic Foot Health Project** - Reduce the financial burden for the Health Service in Hywel Dda and reduce the incidence of foot ulcers, and amputations in the long term.
- **Care Co-ordinator MDT** - establish robust MDT working across 8 GP Practices and reduce emergency admissions and average length of stay.

Our vision is to continue developing the health & wellbeing of the local population within South Pembrokeshire utilising the current services while developing new and innovative projects to common problems promoting multidisciplinary working and by working with wider partners and stakeholder in the third sector, therapies, local authority, mental health, children services and pharmacy to have a locality approach. The cluster approach is cradle to grave model approach with all current projects. We aim to support our local population to remain in their own home; with an emphasis on population wellbeing and community connection by establishing greater links with partner services.

## About our Population



Males – **48.6%**  
Females – **51.4%**

Aged 65+ – **27.0%**  
Aged 85+ – **3.3%**



**44.0%** of people are in very good general health

PREVALENCE OF CHRONIC CONDITIONS <small>(PRIMARY CARE DATA 2022/23, ARROW INDICATES LONG TERM TREND)</small>	CHD (SECONDARY PREVENTION) <b>3.95%</b> ↓	CANCER <b>4.65%</b> ↑	RISK FACTORS <small>(National Survey for Wales 2022/23, Adult population 16+ County level data only – data indicates comparison to 2018-19 &amp; 2019-20)</small>	ACTIVE FOR <30 MINUTES/WEEK <b>29%</b> ↓	IMMUNISATION UPTAKE
ASTHMA <b>7.33%</b> ↑	HYPERTENSION <b>19.10%</b> ↑	DIABETES (17+ Population) <b>9.23%</b> ↑	CURRENT SMOKER <b>10.7%</b> ↓	ALCOHOL CONSUMPTION (ANY CONSUMED) <b>19.7%</b> →	UP TO DATE WITH CHILDHOOD VACCINES BY AGE FOUR <b>86.23%</b>
COPD <b>2.35%</b> ↓	MENTAL HEALTH <b>1.09</b> ↓	STROKE <b>2.73%</b> ↑	CHILDHOOD OBESITY + <b>11.5%</b> ↑	E-CIGARETTE USER <b>4.0%</b> ↓	INFLUENZA 65+ <b>73.82%</b>
ATRIAL FIBRILLATION <b>3.76%</b> ↑	HEART FAILURE <b>1.42%</b> ↑	DEMENZA <b>0.84%</b> ↑	OVERWEIGHT OR OBESE (BMI >25) <b>58.0%</b> ↓	FEWER THAN 2 HEALTHY BEHAVIOURS <b>7.0%</b> ↓	INFLUENZA (At risk 6 months to 64 yrs) <b>48.62%</b>
SCREENING UPTAKE	BOWEL <b>68.4%</b> ↑	CERVICAL <b>69.4%</b> ↓	BREAST <b>75.4%</b> →	AAA <b>74.3%</b> ↓	INFLUENZA 2-3 YEAR OLDS <b>53.23%</b>

## About our Services



- 5 GP Practices with 3 Branch Surgeries
- 4 Dental Practices and 1 Orthodontic Practice
- 13 Community Pharmacies
- 5 Optometry Practices
- 0 Hospital
- 2 Community Hospital
- 21 Nursing and Residential Homes
- 4 Community Resource Team (Integrated Localities)

## Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023:

- There were **366,905** GP appointments of which **64%** were face to face
- **32%** of the appointments were urgent
- There were **1,763** consultations in the PIPs service for common ailments
- **1,381,758** items were dispensed by Pharmacies
- **15** people were seen by the Independent Prescribing Optometry Service



## Cluster Budget (Recurrent)

- Spend for 2023/24 is **£422k**
- Budget for 2024/25 is **£393k**



## Cluster Priorities 2023/24

- **Improving Childrens Health** – Improving Asthma in Primary Schools and our Young Mental Health project for under 18 children. These two projects are aimed at prevention and early intervention.
- **Integrated Community Network (ICN)** – Clinical tier affiliated to the current CRT/MDT model. To target our older age population with multi mobilities and frailty. This is proactively addressing unnecessary admissions, with risk stratification model of working.
- **FCP MSK Physiotherapist** –First point contact MSK FCP service within Primary setting. In keeping with the WG vision delivery care by the right people at the right setting in the right time.

## Cluster Priorities 2024/25

- **Spirometry** testing and reporting through locally accessible clinics with the aim of clearing the current backlog and having no waiting list for future testing.
- To **continue** and **develop** existing successful cluster projects, i.e. Intergrated Community Network Youth Project, Improving Asthma Management in Primary Schools.
- **FCP MSK Physiotherapist** - aim to collect further data from the FCP MSK Physio project to mainstream this longstanding project since 2019.

# Cluster Projects Q4 2023/24



# Purpose

The purpose of this document is to provide a quarterly update on progress of cluster projects in Primary Care. This report will be shared with Locality Leads and 6-monthly with the Strategic Development and Operational Delivery Committee (SDODC).

There are 2 reporting styles. The first (which is for older projects) provide an overall assessment of progress and details performance measures and actions. The second (for newer projects) provides an overall assessment and presents data in the form of a dashboard, in addition for the newer projects there is a LOGIC Model Assessment which provides a list of the measures identified from the original proposal, and an assessment based on actual provision of data to fulfil these.

This report report is limited to the data available to us. Primary Care Service Managers (PCSMs) should be contacted for further information relating to individual projects. PCSM contact details are:

- |                     |                     |
|---------------------|---------------------|
| Amman Gwendraeth    | - Gemma Evans       |
| Llanelli            | - Kristy Williams   |
| Tywi / Taf          | - Eleri Davies      |
| North Ceredigion    | - Geraint Scales    |
| South Ceredigion    | - Jackson Reynolds  |
| North Pembrokeshire | - Bethan Merriman   |
| South Pembrokeshire | - Lucie-Jane Whelan |

Pages shaded as follows indicate:

- |      |                                  |
|------|----------------------------------|
| Red  | - Management attention is needed |
| Grey | - Project has ended this quarter |
| Blue | - Project has been extended      |

## Key

RAG Status	Status Indicates
Red	A red indicator usually means one or more of the following: -Significantly off target -A significant forecast overspend against budget of more than 5% -Delays against critical milestones of more than 4 weeks. -Significant problems with quality and expected benefits won't be realised -Significant lack of resources which cannot be resolved by the lead / service -Dissatisfaction or resistance from stakeholders
Amber	An amber indicator usually means one or more of the following: -Within 5% of target -A forecast overspend against the budget of no more than 5% -Delays against critical milestones of more than 2 weeks -Problems with quality, but in the main expected benefits will be realised -Lack of resources which can be resolved by the lead / service -Dissatisfaction or resistance from stakeholders, but this can addressed by the lead /
Green	A green indicator usually means one or more of the following: -On or above target -Forecast expenditure is on budget -Project on plan to complete on time -Quality at expected levels, the vast majority of expected benefits will be realised -No resource problems -Stakeholders engaged and satisfied

Trend Status	Status Indicates
Improving	Objective / Action / Measure has developed / improved since the last update
Stable	Objective / Action / Measure progress is stable
Worsening	Objective / Action / Measure is in a deteriorating / worsening position since the last update

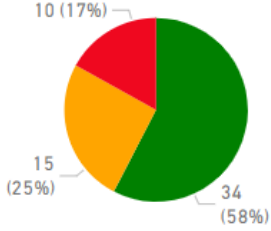
PROMS – Patient related outcome measures  
PREMS – Patient related experience measures

# Overview



**Target**

Across the 7 clusters, 59 cluster projects are being monitored. A significant proportion of these (58%, 34 projects) are reporting on target (green) to achieve the outcomes identified.

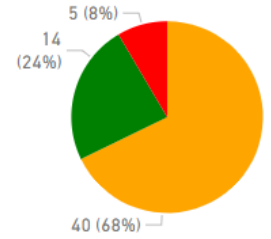


25% of projects (15) are of concern (amber) – see key on previous page.

17% of projects (10) are of significant concern (red) –see key on previous page.

**Trend**

24% of projects (14) have an improving trend (green). 68% of projects (40) are stable (amber). Only 8% of projects (5) are deteriorating / worsening (red).



**Risk Grid**

The trend and target (RAG) information will be used to plot objectives on a risk grid (see below). This is used to identify where focused performance conversations are needed. For example, those falling within the green areas are progressing well and no attention is needed. However, those that fall within the red areas should be discussed and assessed to identify what resources / interventions are needed, or indeed if projects should continue if there is no feasibility of achieving their outcomes.

		RAG		
		Green	Amber	Red
Trend	Worsening	-	-	5
	Stable	29	6	5
	Improving	5	9	-

# Flags

The following has been flagged for attention:

## Red – of concern

**Cluster Pharmacist (AG & NP)** – flagged as measurement data is not routinely being reported through this monitoring process. Matt McGivern is currently undertaking an evaluation of activity and long-term use. 2Ts and Llanelli have also engaged cluster pharmacy staff.

**Community Catheter Clinics (NC)** – data quality concerns – measurement data is not routinely collected.

**Financial Monitoring** - we have yet to embed financial monitoring within this report. However, cluster finance meeting have resumed and project codes have been shared with Finance colleagues to enable report from Quarter 1 2024/25.

## Grey – projects finished

Two projects have completed this quarter. The group should review these projects to ensure a full evaluation is progressed and lessons learned.

- Lifestyle clinic (AG) – project ceased early (Feb 2024) at the request of Dr Frater
- Singing for lung health (NC) – Project concluding as at 31<sup>st</sup> May due to lack of uptake and duration of funding

## Blue – projects ongoing

Ten projects are ongoing, they may have extended past their original completion date due to late starts or are being funded routinely from the cluster budget. They are identified below so the group can determine if this extension is appropriate.

- Dermatology Non-pigmented Lesion Clinic / Diagnostic Uncertainty (AG) – project started in 2019
- First Contact Practitioner Physiotherapy Service (LL, NC, SC, NP & SP) – projects started in 2020
- Mind (LL) – project started in Nov 2018 and was due to end in Mar 2024. However, a 12-month extension has been agreed pending the Mental Health service review
- Family Wellbeing Service provided by Connecting Youth, Children & Adults (LL) – project started in Apr 2019 and was due to end in Mar 2024. However, a 12-month extension has been agreed pending the Mental Health service review
- Early Intervention Pain Service (NC) – project started in 2020
- Frailty Team (SC) – project started in 2019

# New Projects

The following projects have been approved and dashboards will begin development in preparation for ongoing reporting:

## All Clusters

### Amman Gwendraeth

No additional projects approved

### Llanelli

No additional projects approved

### Tywi / Taf

- Extension of 'Delivery of Mental Health services for young people's mental health' (PAPYRUS) – due to start in September 2024
- Carers Co-Ordinator with Carmarthenshire County Council – SLA development

### North Ceredigion

No additional projects approved

### South Ceredigion

- Occupational Therapist relating to frailty – currently being reviewed

### North Pembrokeshire

No additional projects approved

### South Pembrokeshire

No additional projects approved

# Amman Gwendraeth

# Dermatology Non-pigmented Lesion Clinic / Diagnostic Uncertainty

Code	Name
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AG0007 Dermatology Non-pigmented Lesion Clinic / Diagnostic Uncertainty

Baseline	Aim	Update as at	Commentary	RAG	Trend
Skin problems are common and Dermatology clinic waiting lists are long	To improve timely access to specialist diagnostic skills and minor surgery for patients presenting with dermatological disease	Apr 2024	A GP Partner within the Cluster has a special interest in Dermatology and as such, provides a Dermatology service in which all Practices within the Amman Gwendraeth Cluster can refer to directly. After review of data and discussion with Dr Scourfield, most of the referrals come from within the Gwendraeth valley. Skin conditions have crept into the referrals, which isn't the purpose of the service, it is for USC only. Dr Scourfield will tighten up on triage and direct routine referrals / skin conditions to Consultant Connect, to allow him more scope to treat the urgents / USC's. Although the service is working well and preventing referrals into SC, because of a funding cap, we run the risk of two months at the end of the year without service provision, however, with more stringent triage, this should level out. It is time to review this ongoing project with the collaborative.	●	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00047	Number of treatments offered & undertaken.		Mar 2023	Apr 2024	60 patients were referred to the service, but again normal dermatological referrals have crept in, such as acne, cysts & papillomas, which is not the purpose of the service. More stringent triage / rejection is needed.	60	▲	→
M00048	% of skin cancers detected and referred.		Mar 2023	Apr 2024	Not all patients have received their histology result, but so far 16 / 60 patients were confirmed cancer and only one of those required an onward referral to Dermatology.	27.0%	●	↑

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00053	This will service the Cluster population and reduce the burden on mainstream dermatology services	March 2022	May 2024	This quarter the service saw 60 patients who would have otherwise been referred to SC. However, as Consultant Connect is fully up and running, there is a question whether or not these patients would have all been referred into SC and if CC could have supported the GP's in their diagnosis before onward referral. Staffing remains an issue in SC Dermatology with one consultant from SB supporting the whole of HD. Routine referrals are waiting three months to be graded, therefore this service seems to be supporting this objective.	●	→

- Project Start Date: 2019
- Project End Date: Ongoing
- Narrative updated 03/05/2024

Code	Name
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AG0009 Jac Lewis Foundation

Baseline	Aim	Update as at	Commentary	RAG	Trend
We recognise that there is enormous unmet need in patients with low level mental health issues, often presenting as a medical request for help. Children and the sequelae from psychological/emotional trauma are poorly provided for with slow statutory responses to help requests	We want to provide patients and their families with a real and constructive opportunity to receive appropriate mental health help in a helpful timeframe. We wanted more help for children and their families requests	Apr 2024	No option of extension was embedded into the SLA, therefore has to go through procurement. Another provider came forward and scoring is in progress. JLF's SLA expired on the 31st of December and the HB extended at risk for an additional month until the procurement process was complete, however no award was granted. JLF have therefore been extended for a further 6 months in order to keep some service provision and the procurement process will begin again. Their bid was not detailed enough and it is therefore completely possible that another tender may be more successful during the next round. The collab and cluster have been notified of the process and will be engaged in conversations around the needs and expectations from the service.	▲	→

- Project Start Date: 2020
- Project End Date: December 2023, however extended for 6 months until August / September 2024. There will then be a procurement process.
- Narrative updated 03/05/2024

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00052	Number of referrals to JLF		Mar 2023	Apr 2024	Further reduction in referrals, but this is likely to be because we have changed to GP-only referrals.	82	▲	→
M00317	Annual Patient Feedback		Mar 2023	Apr 2024	Patient feedback questionnaires are completed throughout the various therapy programmes provided and are readily available.	100.0%	●	→

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00056	We have successfully commissioned JLF to provide low level and step-up mental health support, psychological interventions, family and play therapy plus EMDR	April 2022	Apr 2024	Complete.	●	→
AC00057	We plan to expand access to this initiative to support the growing need which is not successfully met within NHS mental health provision	April 2022	Apr 2024	JLF will be extended for a further 6/12 and will go through another procurement process. We will work with MH and look at what is already commissioned to avoid duplication of services. Once we go through procurement, We can then re-assess access to the service then.	▲	→

# IRISi Pilot Domestic Violence and Abuse Training

Code	Name
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AG0010 IRISi Pilot Domestic Violence and Abuse Training

Baseline	Aim	Update as at	Commentary	RAG	Trend
-In Wales 11% of women and 5% of men a year experience 'any domestic abuse', while rates of 'any sexual assault' in the last year were also higher for women (3.2%) than men (0.7%). -6.8% of the local population are estimated to have experienced abuse in the last year, 10.3% of the female population, 3.3% of the male population. -In 2016/17, Heddlu Dyfed Powys Police recorded: 4635 incidents of domestic abuse; 69 sexual offences crimes including rape and 405 stalking / harassment crimes. Between March 2013 and April 2017 there have been 9 Domestic Homicides in Dyfed Powys.	To provide an evidence-based intervention that improves the general practice response to domestic abuse. Increase identifications and referrals of and for patients affected by DVA.	Apr 2024	The project is due to expire in June of this year, after a two month extension was granted due to a delayed start. Training uptake remains low with no additional training provided in this quarter. Referral numbers remain extremely low - despite the training and a known increase in domestic violence across Carmarthenshire.	🔴	⬇️

Ref	Measure Description	Update as at	Commentary	Value	RAG	Trend
M00055	Key staff appointed to the promote the programme	Apr 2024	All staff are in post, the team are reaching out to all practices and continue to deliver training.	1	🟢	⬆️
M00056	Number of staff trained in the IRISi Programme	Apr 2024	There have been no further improvements in the uptake of the training of staff and clinicians, despite requests from social prescribers. The service has been unable to host 1:1 training sessions and cannot agree a mutual date for a joint session, so even when clinicians show interest, uptake of training is an issue.		🔴	⬇️
M00057	Numbers of referrals to DVA Services from PC	Apr 2024	5 referrals received for AG in 3 months.	5	🟡	⬆️

Ref	Activity / Project	Update as at	Commentary	RAG	Trend
AC00059	Key staff will be appointed to promote the programme, organise and deliver training in practices, provide ongoing advice for practice teams about DVA concerns, and provide advocacy and support for patient referred from participating practice	Apr 2024	Practices couldnt commit hours and days to this training and as a result didnt engage with the service. A PCSM arranged the training dates and Irisi agreed to condense down which improved the accessibility of their training package. Since this, more admin staff have completed their training and clinicians at least partially trained. The SLA expires in March, but the service have asked to continue until June, as that is when the pilot started. Although the Cluster is currently overspent, the GP collab members were asked if they would continue to fiancially support this project and the answer was no. Referral numbers remain very low even though domestic violence is prevalent in AG.	🔴	⬇️
AC00060	Each practice to receive two clinical sessions lasting two hours each and one reception and admin staff session lasting one hour	May 2024	Since training sessions have been arranged on behalf of Iris, the uptake has much improved, however after 19 months, not all staff have engaged with the training. Zero clinicians received training in the last quarter.	🔴	⬇️
AC00061	Increased referrals into specialist DVA services from primary care: Clinical staff are able to ask, respond to and refer patients, and record DVA in medical records appropriately	Apr 2024	5 in this quarter.	🔴	⬇️

- Project Start Date: March 2022
- Project End Date: June 2024
- Narrative updated 03/05/2024

Code	Name
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AG0011	Lifestyle Clinic
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Baseline	Aim	Update as at	Commentary	RAG	Trend
- Our Cluster has a high prevalence of obesity and prediabetes/T2DM. - Diabetes economic and morbidity costs are very high	To offer practical and evidence-based access to dietary and clinical advice and support to decrease disease burden from obesity	Apr 2024	This project has now finalised as Dr Frater has made the decision not to request to extend the project. The final data poster and patient satisfaction surveys have been received.	●	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00312	Number of referrals received		Mar 2023	Apr 2024	The end of year results have been received and there have been 84 participants in total for the year 2023.	84	●	→
M00313	% of patients with reduced medication		Mar 2023	Apr 2024	30% of the 84 (25 patients) stopped or reduced their medication. 1 in 3 achieved full/partial remission of Diabetes in 6 months.	30.0%	●	→
M00314	Patient feedback		Mar 2023	Apr 2024	Quarterly patient feedback/evaluation forms are received. They are very extensive with very positive feedback and are readily available.	100.0 %	●	→
M00315	Total weight loss of patients currently in the programme (for the quarter)		Mar 2023	Apr 2024	256.5Kg Total weight lost over the year with 29cm average decrease in waist circumference (for the Diabetes group)	257	●	→

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00063	Continue to promote and expand the service and recover following COVID-19 restrictions	April 2023	Apr 2024	Diabetes prevention service and weight management service based on this model.	●	↑
AC00064	To reduce weight in participants and restore self esteem	April 2023	Apr 2024	The Patient Questionnaires collated frequently support restored self esteem and the end of year report shows that out of 84 participants, 256.5 kgs of weight was lost and an average waist circumference of 29cms.	●	→

- Project Start Date: 2021
- Project End Date: March 2024
- Measurement data only available annually.
- This project will now cease in February 2024 at request of Dr Frater.
- Narrative updated 03/05/2024

# Generic Community Occupational Therapy / Physiotherapy Technician

Code	Name
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AG0013 Generic Community Occupational Therapy / Physiotherapy Technician -

Baseline	Aim	Update as at	Commentary	RAG	Trend
Improved community access to therapies and a desire to prolong safe and independent living matters to patients in our growing older population	To bring basic generic tech skills into primary care to help patients to maintain independent living	Apr 2024	leuan recently attended a GP Collaborative and now reports that his referrals have more than doubled. This is fantastic news for the Cluster and promising to see so many clinicians engaging. leuan has also linked in with the Social Prescribers and the PP Team who are now also referring to him. leuan has revealed that due to the increase in referrals, he is struggling to keep up with the admin and feel it is taking time away from the patients. This has created a small waiting list. Although there is no funding for an additional admin support, he can source this from the admin support team in Physio. However, for this to work, leuan needs to be working from the same spreadsheet as them. We have created a more workable spreadsheet for leuan to use to improve efficiency when entering data.	●	↑

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00319	Reduction of waiting list for patients to be seen by the Generic Tech		Mar 2023	May 2024	As lots of these patient have been added onto a waiting list, leuan hasn't yet been able to see them to understand how many he can prevent from seeing a qualified prac. This should be updated in the next quarter.		●	●
M00318	Number of referrals received		Mar 2023	May 2024	The referrals have dropped significantly in this quarter, however leuan had accrued a waiting list from incresed referrals in the previous quarter. He will therefore use this time to catch up on admin and his waiting referrals.	27	●	↓

- Project Start Date: March 2022
- Project End Date: March 2025
- Narrative updated 03/05/2024

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00068	Work with our colleagues in Local Authority social services to integrate generic OT/physio tech within the community resource team for direct intervention and signposting to agencies interested in promoting well-being of the older adult	April 2023	Apr 2024	Generic tech continues to be proactive and work with the CRT and actively takes patients from their waiting list when his referrals are low. New referral triage system implemented with OT and physio triaging together, re-directing to Tech.	●	→

# Cluster Pharmacist



Code	Name
AG0014	Cluster Pharmacist

Baseline	Aim	Update as at	Commentary	RAG	Trend
Cluster Pharmacist in post, evaluation of change in project focus due to Covid ongoing	Rapid clinically safe reconciliation of discharge medication. Improved governance for repeat prescribing for those patients as seen under the project. Fast access to pharmaceutical advice for General Practitioners. Improved cross sector working	Apr 2024	The Cluster has two part time Cluster Pharmacists. One covering Gwendraeth and one covering Ammanford. They continue to support practices with med reviews, NOAC reviews, patient prescribing safety indicators, medication reconciliation following discharge, DMARD monitoring systems & also supporting the latest QI projects. The Cluster Pharmacists are able to respond to individual practice needs and provide improved oversight in prescribing systems and specific project-based support. The role is currently under evaluation by the HB to standardise their workloads. There has been some resistance from the practices re this, as they feel Cluster-funded pharmacists should be meeting the requirements of the individual practices. The Pharmacists have proved invaluable to some of the practices this quarter with staff shortages in Margaret Street and Tumble surgery, however this role is under review as it is felt that their work should be standardised. This is stable for this quarter.	▲	➔

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
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Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
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- Project Start Date: 2017
- Project End Date: Ongoing
- Measurement data not routinely reported. Matt McGivern is currently undertaking an evaluation of activity and long-term use. Recommendations will be shared with cluster leads from Q1 2024/25.
- Narrative updated 20/05/2024

# Persistent Pain Services



Code	Name
AG0015	Persistent Pain Service

Baseline	Aim	Update as at	Commentary	RAG	Trend
Chronic pain is a complex and common problem often requiring long consultations and skillful negotiation of management plans	Bring specialist pain services knowledge and MDT working into primary care for timely case management and clinician support and learning	Apr 2024	The PPMDT now have a full complement of staff and seem to be making great progress. Referrals into the service have improved in numbers and quality, with very little being rejected, which suggest the clinicians understand what the service is about and the type of patients they can help. The team have recently presented their data to the GP collaborative, which was very well received. The data is very promising. As the project will end in March 2025, our data analyst is supporting with the data to ensure we remain on track for final evaluation, with the intention of proving concept in order to shift funds from Scheduled care budget within SC to PC. The stakeholders seem to be far more engaged. The team continue to work collaboratively with external stakeholders such as our generic Tech, Social Prescribers and Cluster Pharmacists. More improvement needs to be made around MDT work and learning, but this has improved since the last quarter as the team tell us they have far more patient discussions with the clinicians.	●	↑

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00074	Comparison reduction of pain relief medication. Before service started & after implementation of service.		Mar 2023	Apr 2024	79 complex med reviews undertaken. 36 of these had a successful intervention as 14 stopped their meds altogether, 12 patients had their dosage changed and 8 were prescribed a better option. 40 patients were stable on their current plan and 3 patients refused a pharmacist input. 2 patients were prevented from a drug-related error.	7900.0%	●	↑
M00073	Referral numbers to the Persistent Pain Service MDT		Mar 2023	Apr 2024	83 referrals made this quarter, only two rejected with good conversations around the reasoning.	83	●	→
M00075	Patient feedback & assessment of harm reduction techniques used.		Mar 2023		Not yet commenced			

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00074	A multidisciplinary team approach to include expanding the chronic pain service with a physiotherapist, pharmacist and clinical psychologist to meet primary care service need and embed learning	April 2022	Apr 2024	There has been a massive improvement in the service. After consultation with the stakeholders, there is improved communication. The referral pathways has been streamlined. Referrals have increased as a result with very little rejected. Reasons for rejection are shared to allow for learning. The admin is being processed by the SC admin teams / secs, to allow the clinicians more time with the patients. Engagement in the service has improved and the chronic pain w/I's within SC have significantly decreased to around 31 patients for the AG area, which compared to other Clusters, who don't have this service are much higher, proving that this project does prevent referrals into SC. The service are trying to engage in practice MDT's. The team have linked in with other Cluster projects, such as joint clinics with the Social Prescribers, Generic Tech and have participated in Irisi domestic violence training. I have rated a green for this quarter as there has been a slight improvement in MDT working. The team have been able to join onto more practice MDT's and discuss individual patients with clinicians for more joined up working.	●	↑

- Project Start Date: March 2022
- Project End Date: March 2025
- Narrative updated 03/05/2024

Project	Update as at	Commentary	RAG	Trend
Trial without Catheter (TWOC) (AG0017)	May 2024	Recruitment has been successful, but there has been significant delays to date. The band 6 nurse is expected to start in the next month. However, this could be in Pembrokeshire only to start. Practices have set aside funding and are concerned with start up delays.	◆	➔

Approved due to begin: February 2024

Project duration: 1 Year

Project Status: In **Development**

Data quality comments: A draft data collection process has been created, awaiting testing and service to receive SOP approval.

- Project Start Date: February 2024
- Project End Date: February 2025
- This dashboard is **in development** – data collection process is in development and clinics due to begin towards the end of May.
- Narrative updated 17/05/2024

# Llanelli

# IRISi Pilot Domestic Violence and Abuse Training

Code	Name
LL0004	IRISi Pilot Domestic Violence and Abuse Training

Baseline	Aim	Update as at	Commentary	RAG	Trend
<p>- In Wales 11% of women and 5% of men a year experience 'any domestic abuse', while rates of 'any sexual assault' in the last year were also higher for women (3.2%) than men (0.7%).</p> <p>6.8% of the local population are estimated to have experienced abuse in the last year, 10.3% of the female population, 3.3% of the male population.</p> <p>- In 2016/17, Heddlu Dyfed Powys Police recorded: 4635 incidents of domestic abuse; 69 sexual offences crimes including rape and 405 stalking / harassment crimes. Between March 2013 and April 2017 there have been 9 Domestic Homicides in Dyfed Powys.</p>	<p>To provide an evidence-based intervention that improves the general practice response to domestic abuse.</p> <p>Increase identifications and referrals of and for patients affected by DVA.</p>	Apr 2024	Unfortunately this project has not delivered the volume of training expected and referrals into the service have remained low. The project will end 31/05/24 when the contract finishes.	🔴	⬇️

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00006	% of IRISi staff training complete		Mar 2023	Apr 2024	0 staff trained this quarter.	0	🔴	⬇️
M00007	Number of referrals to the IRISi service		Mar 2023	Apr 2024	This has remained stable from the last quarter, but still remains very low for three months when we know domestic violence is prevalent in the area.	4	🟢	➡️

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00010	Each practice to receive two clinical sessions lasting two hours each and one reception and admin staff session lasting one hour.		Apr 2024	This quarter 0 admin staff undertook training and 0 clinicians. Only 2 practices in Llanelli have been fully trained since the start of this project.	🟢	⬇️
AC00011	Increased referrals into specialist DVA services from primary care: Clinical staff are able to ask, respond to and refer patients, and record DVA in medical records appropriately		Apr 2024	There have been 4 referrals this quarter for Llanelli, which is the same as last quarter.	🟢	➡️
AC00009	Key staff will be appointed to promote the programme, organise and deliver training in practices, provide ongoing advice for practice teams about DVA concerns, and provide advocacy and support for patient referred from participating practice		Apr 2024	An Advocate Educator and 2 Clinical Leads are in post.	🟢	➡️
AC00012	Onward referrals from clinicians to specialist DVA service provider enable support for victims and survivors.		Apr 2024	A stable number of referrals this quarter compared to last, but no clinicians or admin staff undertook a training session this quarter.	🟢	➡️

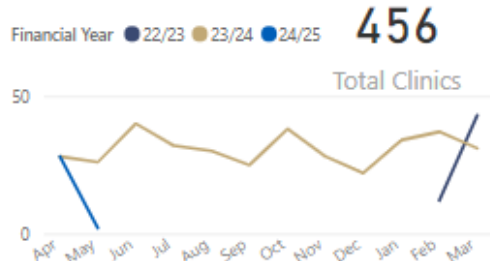
- Project Start Date: June 2022
- Project End Date: May 2024
- Narrative updated 03/05/2024

Project	Update as at	Commentary	RAG	Trend
Physiotherapy MSK project (LL0005)	April 2024	This project is going well and has been discussed at both collab and cluster; GP's are very pleased with the physio output and physio staff are happy in their roles. There is a push across all clusters to get this service mainstreamed. It is beneficial to pts, secondary care and overall is a win for all. The Physio MSK projects were discussed at Locality Leads, John Davies HoS attended to present. As it stands we do not know what the future plan is.	●	➔

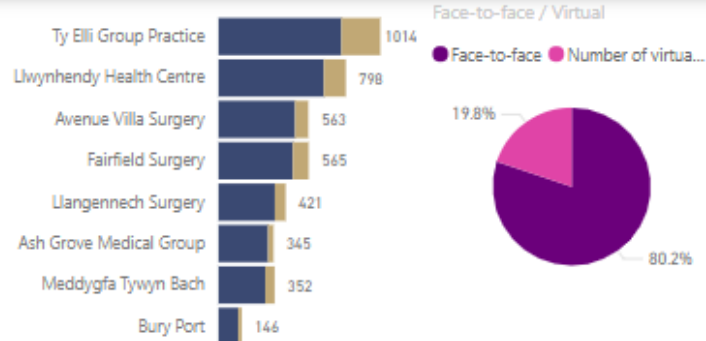
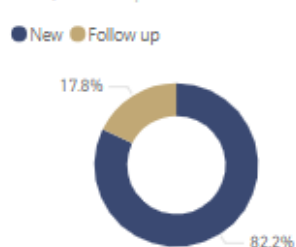
## Appointments

4394 Available  
4777 Booked  
109% Fill %  
580 DNA's

Clinic's Over time



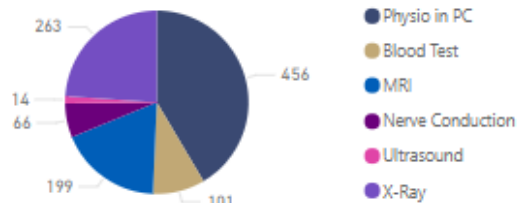
New / Follow up



## Process

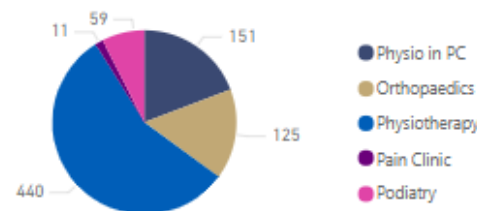
How many investigations were undertaken for new patients?

Investigations (New Patients)



How many patients have been referred?



Onward referrals to other Specialties (New patients)



Data Quality Risk

- Project Start Date: 2020
- Project End Date: Jan 2024, but still ongoing
- Data is being collated, **however as auditable individualised data is not being collected, this has been flagged as a Data Quality Risk.** New methods are being explored. Narberth Surgery (EMIS) & Preseli Practice (Vision) have tested & are currently using their respective templates within the clinical system to provide more robust individualised data - informed by practice managers & FCP's that it is working as expected. **Next step** is to assess and decide data extraction methods to extrapolate template & extraction for all clusters involved within this project. Lucie is in discussions with Jamel Bull (Vision in Primary Care) to establish costs feasibility and costs.
- Kristy is leading on a 'value for money' assessment to support ongoing discussions relating to the ongoing funding of this service.
- Narrative updated 03/05/2024

## LOGIC Model Assessment and Data Source: FCP Physiotherapy Service (NP0017, SP0014, NC0005, SC0003, LL0005)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>• Patient pathways (New/Follow ups) ✓</li> <li>• Referrals to Orthopaedics in secondary care ✓</li> </ul>	 <a href="#">Static Link - FCP Form</a>  <a href="#">SharePoint Link - FCP Spreadsheet</a>
Amended	<ul style="list-style-type: none"> <li>• Patient pathways - Now recording: Onward referrals, investigations ✓</li> <li>• Individualised &amp; auditable data through EMIS &amp; Vision clinical systems !</li> </ul>	<p><b>Key</b></p> <ul style="list-style-type: none"> <li>✓ Data available</li> <li>✗ = Data awaited from service</li> <li>! Data collection in development</li> </ul>
Additional	<ul style="list-style-type: none"> <li>• Clinic fill rates - Clinic appointments available / Clinic appointments booked / DNA's ✓</li> <li>• Face-to-face vs virtual appointments ✓</li> <li>• Referrals to other specialities in secondary care - such as; Pain Clinic, Physiotherapy, Podiatry ✓</li> </ul>	
Measures not being collected		
Data collection under review	<ul style="list-style-type: none"> <li>• Patients receiving same day assessment and advice / demand for GP appointments through re-directing</li> <li>• Waiting times for patients accessing community Physiotherapy services</li> <li>• PROMS / PREMS</li> </ul>	
Unable to collect	<ul style="list-style-type: none"> <li>• Social Prescribing to local voluntary and community sector organisations</li> <li>• Physical activity of local population</li> <li>• Access to local services (carbon footprint)</li> </ul>	

# Mind Llanelli

Code	Name
LL0006	Mind Llanelli

Baseline	Aim	Update as at	Commentary	RAG	Trend
- Mind Llanelli provide appropriate and timely support for those with mental ill health to all 7 General Practices in the Cluster - Due to the pandemic there is a significant population demand for mental health support and counselling identified in the cluster - 136 referrals received April to June 2021 with 84 patients receiving direct counselling with the service.	Continued to provide an equitable service throughout the cluster Keep access and waiting times to a minimum	Apr 2024	The contract ended March 2024 and a 12 month extension was granted by the HB to allow for the full tender and commissioning process. The review of MHS services is still outstanding so the future core provision remains unknown. Llanelli cluster are very satisfied with the service provided by Mind and are in agreement that it needs to continue. A 4% uplift has been requested to cover the cost of living increase, a decision from finance is outstanding, Mind have stated they will have to scale down the current service provision were the uplift denied.	●	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00012	Number of referrals to Mind Llanelli		Mar 2023	Apr 2024	144 referrals received this quarter. Mind remain very much engaged with the cluster and have attended a GP collaborative meeting this quarter. A total of 496 referrals received this year with 4,261 contacts recorded Q2 to Q4.	144	●	↑
M00013	Number of patients positively discharged from Mind Llanelli		Mar 2023	Apr 2022	Project ongoing	434	●	→

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00017	Continue to fund Mind Llanelli for their service until March 2022.		Apr 2024	The service was funded until March 2024 and a 1-year extension granted until March 2025.	●	→
AC00019	Liaise with Health Board's Primary Care Mental Health team on the significant increase in patient referrals following on from Covid-19.		Apr 2024	The MH service review is still outstanding and the HoS for MH has yet to attend a cluster or collaborative meeting. MH representation at meetings is not regular, with a team manager attending just one collaborative meeting and apologies being sent for all cluster meetings this year.	▲	↓
AC00018	Engage with GPs to ensure expectations of the service are realistic and appropriate.		Apr 2024	Mind held a GP collaborative in their building this quarter, the GP's and PM's had a tour of the building and presentation of the service. This service is successfully embedded within Llanelli and appreciated by the cluster and patients.	●	→

- Project Start Date: November 2018
- Project End Date: March 2024. However, a 12-month extension has been agreed pending the Mental Health service review
- Narrative updated 03/05/2024

# Family Wellbeing Service provided by Connecting Youth, Children & Adults



Code	Name
LL0007	Family Wellbeing Service provided by Connecting Youth, Children and Adults (CYCA)

Baseline	Aim	Update as at	Commentary	RAG	Trend
This service is available to children aged 4 to 17 years and works alongside the child's parents/guardians and family offering mentorship and resilience strategies to combat emotional distress.	Continued to provide an equitable service throughout the cluster Keep access and waiting times to a minimum	Apr 2024	The contract ended March 2024 and a 12 month extension was granted by the HB to allow for the full tender and commissioning process. The review of MHS services is still outstanding so the future core provision remains unknown. Llanelli cluster are very satisfied with the service provided by CYCA and are in agreement that it needs to continue. A 4% uplift has been requested to cover the cost of living increase, a decision from finance is outstanding, CYCA have stated they will have to scale down the current service provision were the uplift denied.	●	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00014	Number of referrals to CYCA		Mar 2023	Apr 2024	The total number of referrals for January to March was 25, which is lower than last quarter but remains higher than in Q1 and Q2.	25	●	↓

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00020	Continue to fund CYCA for their service until March 2022.		Apr 2024	The service was funded until March 2024 and a 1-year extension granted until March 2025.	●	→
AC00021	Engage with GPs to ensure expectations of the service are realistic and appropriate.		Apr 2024	The service is well embedded within Llanelli cluster and has close working relationships with the practices. CYCA are due to attend the next collaborative meeting to present and discuss the service with GP's and PM's.	●	→
AC00022	Liaise with Health Board's Primary Care Mental Health team on the significant increase in patient referrals following on from Covid-19.		Apr 2024	The MH service review is still outstanding and the HoS for MH has yet to attend a cluster or collaborative meeting. MH representation at meetings is not regular, with a team manager attending just one collaborative meeting and apologies being sent for all cluster meetings this year.	▲	↓

- Project Start Date: April 2019
- Project End Date: March 2024. However, a 12-month extension has been agreed pending the Mental Health service review
- Narrative updated 03/05/2024

Project	Update as at	Commentary	RAG	Trend
Spirometry (LL0018)	1/22/2024	The projects aim is to provide a spirometry service within the community, delivering accurate and comprehensive spirometry to ensure accurate diagnosis for patients leading to appropriate treatments. After an initial delay in getting the HCSW roles approved at FCG, we have successfully appointed staff and they have undertaken all the required training. There have been ongoing issues with IT allowing access to clinical lists and setting up the spirometers, but this has been resolved and clinics are due to start in March.	●	↑

Project due to begin: March 2024

Project duration: 2 Years

Project Status: **In Development**

Data quality comments: A data collection process is being jointly developed by the providing service and the Health Board.

- Project Start Date: March 2024
- Project End Date: March 2026
- This dashboard is **in development** – spreadsheet is being created to begin data collection processes.
- Narrative updated 03/052024

# Diabetes HCSW [Page 1 of 1]



Project	Update as at	Commentary	RAG	Trend
Diabetes HCSW (LL0019)	May 2024	HCSW is in post as of 15/04/24 and is undertaking basic reviews but still has training to do.	●	➔

Approved due to begin: March 2024

Project duration: 2 Years

Project Status: In **Development**

Data quality comments: Data collection process are currently being jointly developed by the service and health board.

- Project Start Date: March 2024
- Project End Date: February 2026
- This dashboard is in **development** – data collection is being jointly developed by service & health board.
- Narrative updated 08/052024

Project	Update as at	Commentary	RAG	Trend
Frailty HCSW (LL0020)	5/10/2024	HCSW is in post as of 8/04/24 and started independently seeing patients on 29/04/24. She is still undertaking adhoc training for Gait measurement, etc with NERS and her numbers are likely to increase from mid May.	●	➔

Approved due to begin: March 2024

Project duration: 2 Years

Project Status: Yet to begin

Data quality comments: Data capture & development discussion process due to begin week commencing 06/05/2024

- Project Start Date: March 2024
- Project End Date: March 2026
- This project is in its early developmental stages – data collection process are being developed.
- Narrative updated 08/05/2024

Project	Update as at	Commentary	RAG	Trend
Trial without Catheter (TWOC) (LL0021)	May 2024	Patient triage to commence 13th May with the aim of clinics being operational 27th May.	●	➔

Approved due to begin: February 2024

Project duration: 1 Year

Project Status: In **Development**

Data quality comments: A draft data collection process has been created, awaiting testing and service to receive SOP approval.

- Project Start Date: February 2024
- Project End Date: February 2025
- This dashboard is in **development** – data collection process is in development and clinics due to begin towards the end of May.
- Narrative updated 17/05/2024

Project	Update as at	Commentary	RAG	Trend
Optom Equipment (LL0022)	May 2024	Equipment has been delivered to practices, awaiting an update from cluster lead as to whether equipment is being used yet and the name of the practice(s).	●	➔

Approved due to begin: March 2024

Project duration: 2 Years

Project Status: In **Development**

Data quality comments: Data collection process being jointly developed by the service & health board.

- Project Start Date: March 2024
- Project End Date: March 2026
- This project is in its early developmental stages – data collection process are being developed.
- Narrative updated 08/05/2024

Tywi / Taf

# Support Mental Health needs of our population



Code	Name
TT0001	Support Mental Health needs of our population

Baseline	Aim	Update as at	Commentary	RAG	Trend
MIND drop in centers offering mental health support services are only available two days a week in Carmarthen Town, meaning that patients in the more rural areas have to travel at least 30 minutes to access. The Cluster is funding for one year the provision of MIND drop-in Centers in rural areas (Llandovery, Llandeilo, St Clears & Whitland). - Due to the pandemic there is a significant population demand for mental health support	Provision of sustained equitable access to Mental Health Services in rural areas. Provision of MIND Active Monitoring Services to ensure the right support at the right time is available for someone with mild to moderate mental health needs in Primary Care Expand MIND Active Monitoring to 11-18 year olds.	Apr 2024	Two Mental Health support projects commissioned through Cluster. MIND active monitoring for Adults, MIND Active monitoring for children and young people. Both are well established within the cluster.	●	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00077	Number of referrals to the MIND active monitoring of adults 18 +		Mar 2023	Apr 2024	82 Referrals received in Q4	82	●	→
M00079	Patient feedback & assessment of the MIND service		Mar 2023	Apr 2024	92% reporting improvement in Anxiety and Depression	92.0%	●	→
M00080	Number of referrals to the MIND active monitoring of children aged 11-18		Mar 2023	Apr 2024	6 referrals received and 5 assessments already undertaken.	6	●	→

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00076	Continue to fund Mind to provide Active Monitoring sessions for all patients within the cluster	April 2023	Apr 2024	Service has been re-tendered and awarded from Dec 23 for 2y.	●	→

- Project Start Date: Dec 23
- Project End Date: Dec 25
- Project has recently been re-rendered and needs to move to new style Dashboard
- Narrative updated 03/05/2024

# IRIS Pilot Domestic Violence and Abuse Training

Code	Name
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TT0004 IRISi Pilot Domestic Violence and Abuse Training

Baseline	Aim	Update as at	Commentary	RAG	Trend
In Wales 11% of women and 5% of men a year experience 'any domestic abuse', while rates of 'any sexual assault' in the last year were also higher for women (3.2%) than men (0.7%). -In 2016/17, Heddlu Dyfed Powys Police recorded: 4635 incidents of domestic abuse; 69 sexual offences crimes including rape and 405 stalking / harassment crimes. Between March 2013 and April 2017 there have been 9 Domestic Homicides in Dyfed Powys. -Learning from Domestic Homicide Reviews (DHR) identified the need for earlier identification and missed opportunities for signposting victims of domestic violence via GPs.	To provide an evidence-based intervention that improves the general practice response to domestic abuse. Increase identifications and referrals of and for patients affected by DVA. Increase knowledge and awareness and challenge attitudes towards equality and domestic abuse, sexual violence and violence against women	Apr 2024	This project is due to complete in June 2024. Training has not been complete for all practices and therefore referrals have been low. Benefits have not been realised and the project will cease in quarter 2.	🔴	➔

- Project Start Date: June 2021
- Project End Date: June 2024
- Narrative updated 07/05/2024

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00097	% of patient feeling positive after support		Mar 2023	Apr 2024	No data provided		⚪	⚪
M00098	Feedback from newly trained staff		Mar 2023	Apr 2024	No training undertaken.	0.0%	🔴	⚪
M00096	Number of referrals made to DVA services		Mar 2023	Apr 2024	Referrals are low as practices are not fully trained.	3	🔴	⚪

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00090	Provide IRISi training to the whole practice teams in Tywi / Taf via two clinical training sessions 4-6 weeks apart and reception and admin training session. Clinical training will equip clinical staff to identify patients who have symptoms that may indicate DVA.	April 2022	Apr 2024	No Training has been undertaken since Q3.	🔴	⚪

# ACP & Support in Care Homes: Assessments [Page 1 of 4]

Project	Update as at	Commentary	RAG	Trend
Advanced Care Planning (ACP) and Support in Care Homes (TT0019)		To provide additional support in care homes to upskill staff and provide care to prevent admissions to hospital or support discharge from an acute setting. Actively engaging with carehomes and community Hospitals. Currently at Pan cluster stage for vote to extend for 1year.	●	↑

## Assessment Details

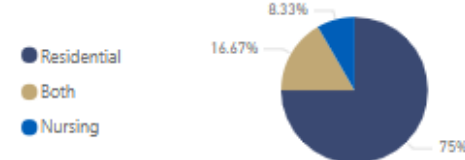
**12**  
No. of Care Homes Assessed

**11**  
No. of Care Homes Reassessed

Assessment by Date



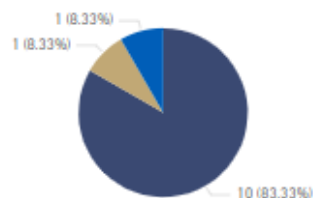
Care Home Type



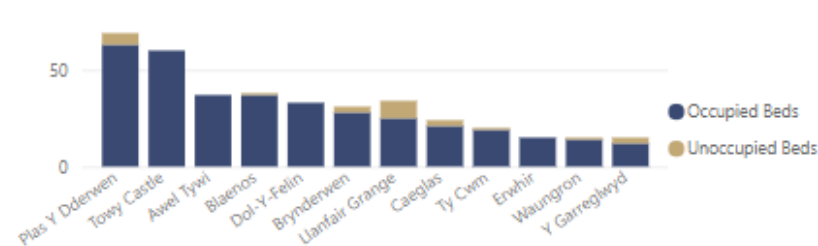
Care Plan Type

● Day to day living ● Day to day living & end of life preferences ● End of life & last wishes care plan

**364**  
No. of residents on initial...

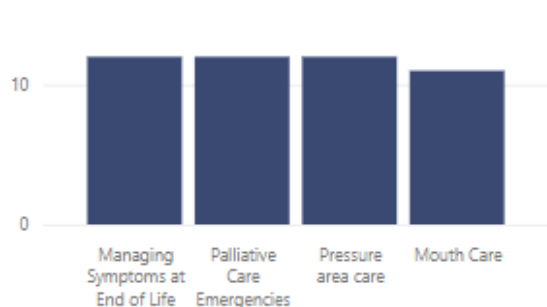


Care Home / Capacity



## Assessment Outcome

Support Areas Identified



Staff Training Requirements



- Project Start Date: June 2023
- Project End Date: May 2024
- There are 3 stages to this project, the 1<sup>st</sup> being assessment of Care Home needs, which completed in August '23. The 2<sup>nd</sup> being support sessions provided to staff, which are still taking place (see page 2 of 4), and the 3<sup>rd</sup> being the outcome (i.e. increase in number of ACP's). Additionally with visits to residents provided directly by the service itself.
- Narrative updated 20/05/2024

# ACP & Support in Care Homes: Support & ACPs Completed [Page 2 of 4]



Project	Update as at	Commentary	RAG	Trend
Advanced Care Planning (ACP) and Support in Care Homes (TT0019)		To provide additional support in care homes to upskill staff and provide care to prevent admissions to hospital or support discharge from an acute setting. Actively engaging with carehomes and community Hospitals. Currently at Pan cluster stage for vote to extend for 1 year.	●	↑

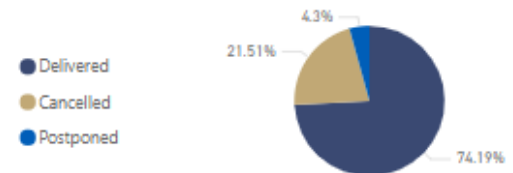
## Session Details

**93** Possible Sessions  
**69** Sessions Delivered

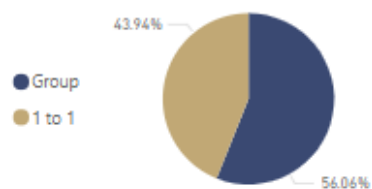
Sessions Delivered Over Time



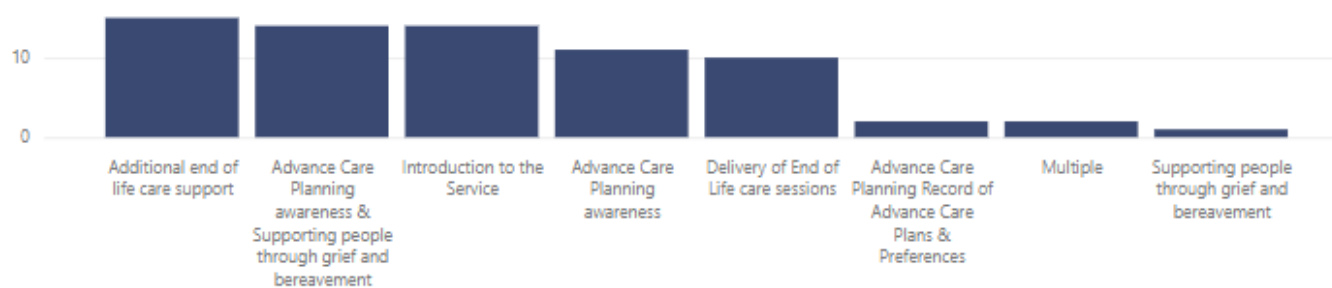
Sessions Status



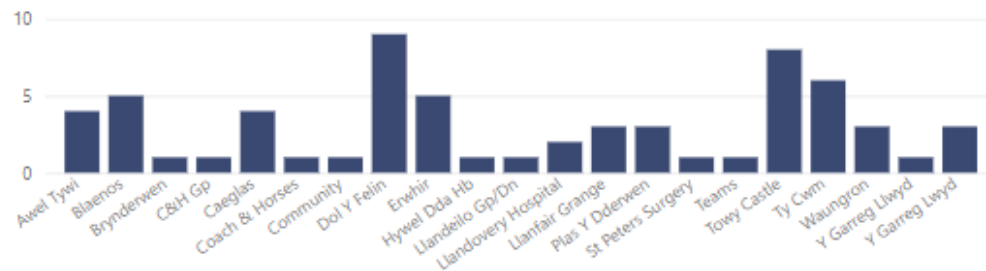
Session Delivery Method



Sessions Types Delivered to Care Homes



Sessions Delivered by Care Home



**68** Staff Attended  
**2.05** Average Session (Hours)  
**109** ACP's completed following training

Number of Residents with ACP's completed following training





**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

# ACP & Support in Care Homes: Service Visits [Page 3 of 4]



**DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG**  
**SAFE | SUSTAINABLE | ACCESSIBLE | KIND**

Project	Update as at	Commentary	RAG	Trend
Advanced Care Planning (ACP) and Support in Care Homes (TT0019)		To provide additional support in care homes to upskill staff and provide care to prevent admissions to hospital or support discharge from an acute setting. Actively engaging with carehomes and community Hospitals. Currently at Pan cluster stage for vote to extend for 1year.	●	↑

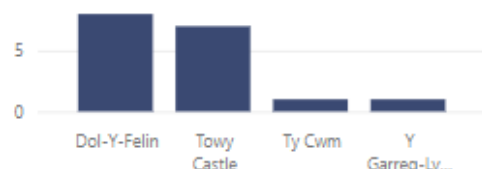
## Service Visit Details

**17**  
Visits to residents

Visits Over Time



Care Homes Visited



Top 10 Clinical Activities

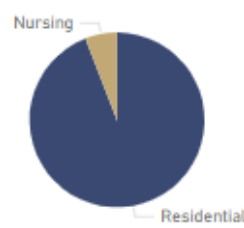
Clinical Activity	Count
Assessment - Initial Assessment	5
Advice/Support - Death and Dying Care Plans	4
Care - Advance Care Plan completed	3
Assessment - Reassessment	1
Care - Advance Care Plan updated	1
Care - Death and Dying Care Plans completed	1
Care - Oral	1
Signposting - External - SALT	1
Signposting - External - Dietician	1
Signposting - External- SALT	1
<b>Total</b>	<b>19</b>

**69**  
Average Visit Duration (mins)

Visit Type

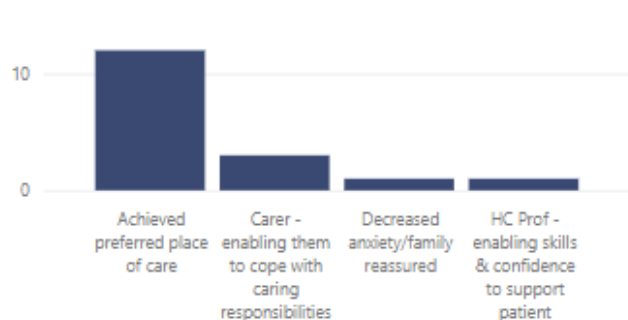


Care Home Type

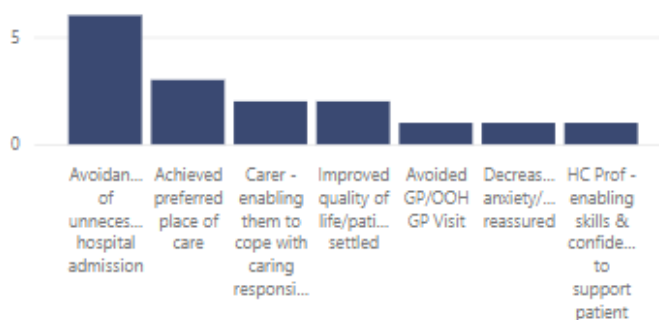


**52**  
Total Count of Clinical Activities

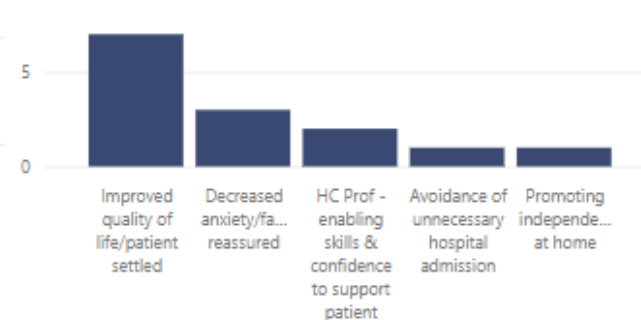
Primary Impact Outcome



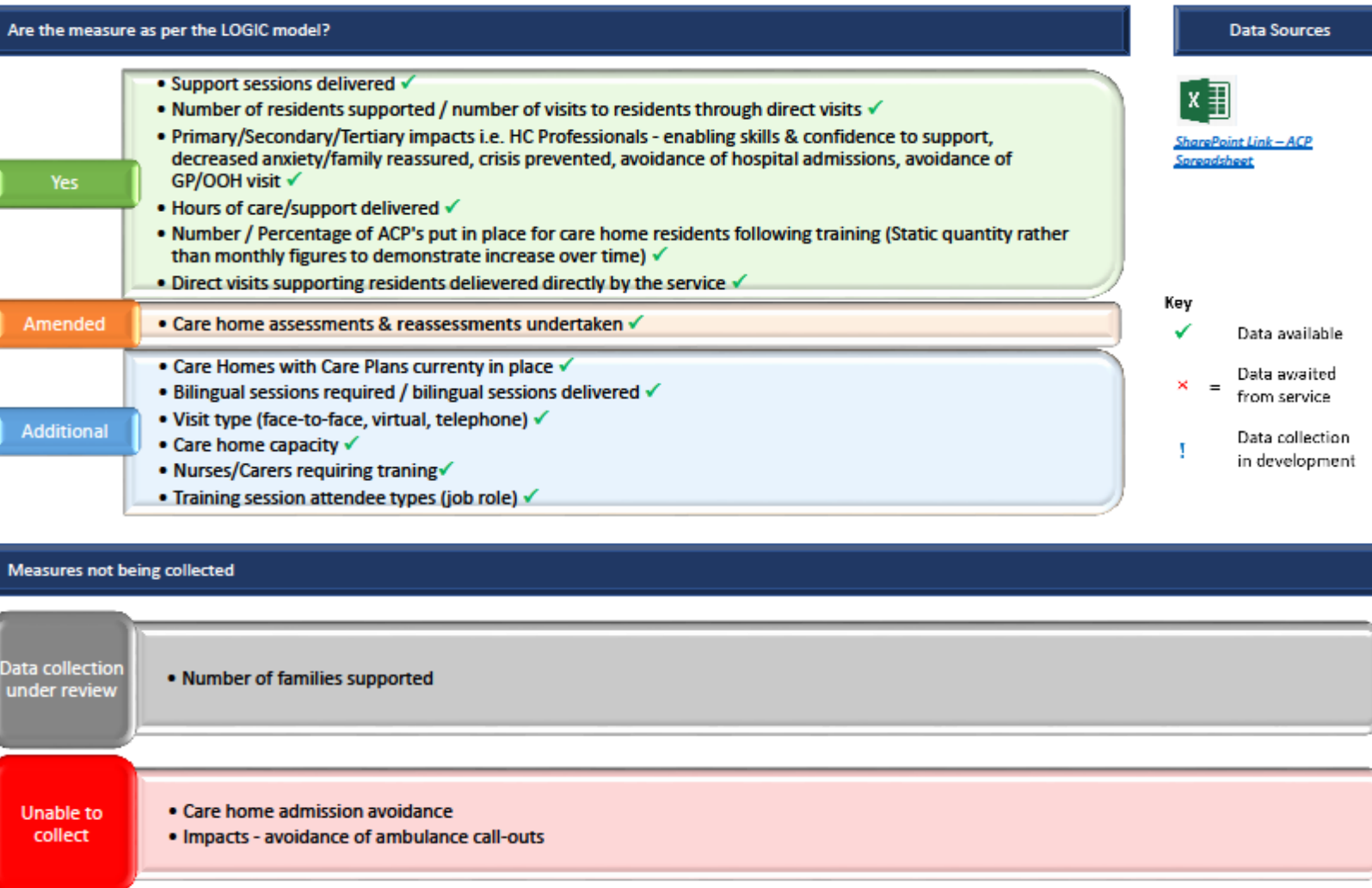
Secondary Impact Outcome



Tertiary Impact Outcome



## LOGIC Model Assessment and Data Source: Advanced Care Planning and Support in Care Homes (TT0019)



Project	Update as at	Commentary	RAG	Trend
Trial without Catheter (TWOC) (TT0021)	May 2024	Recruitment has been successful, but there has been significant delays to date. The band 6 nurse is expected to start in the next month. However, this could be in Pembrokeshire only to start. Practices have set aside funding and are concerned with start up delays.	⬇️	➡️

Approved due to begin: February 2024

Project duration: 1 Year

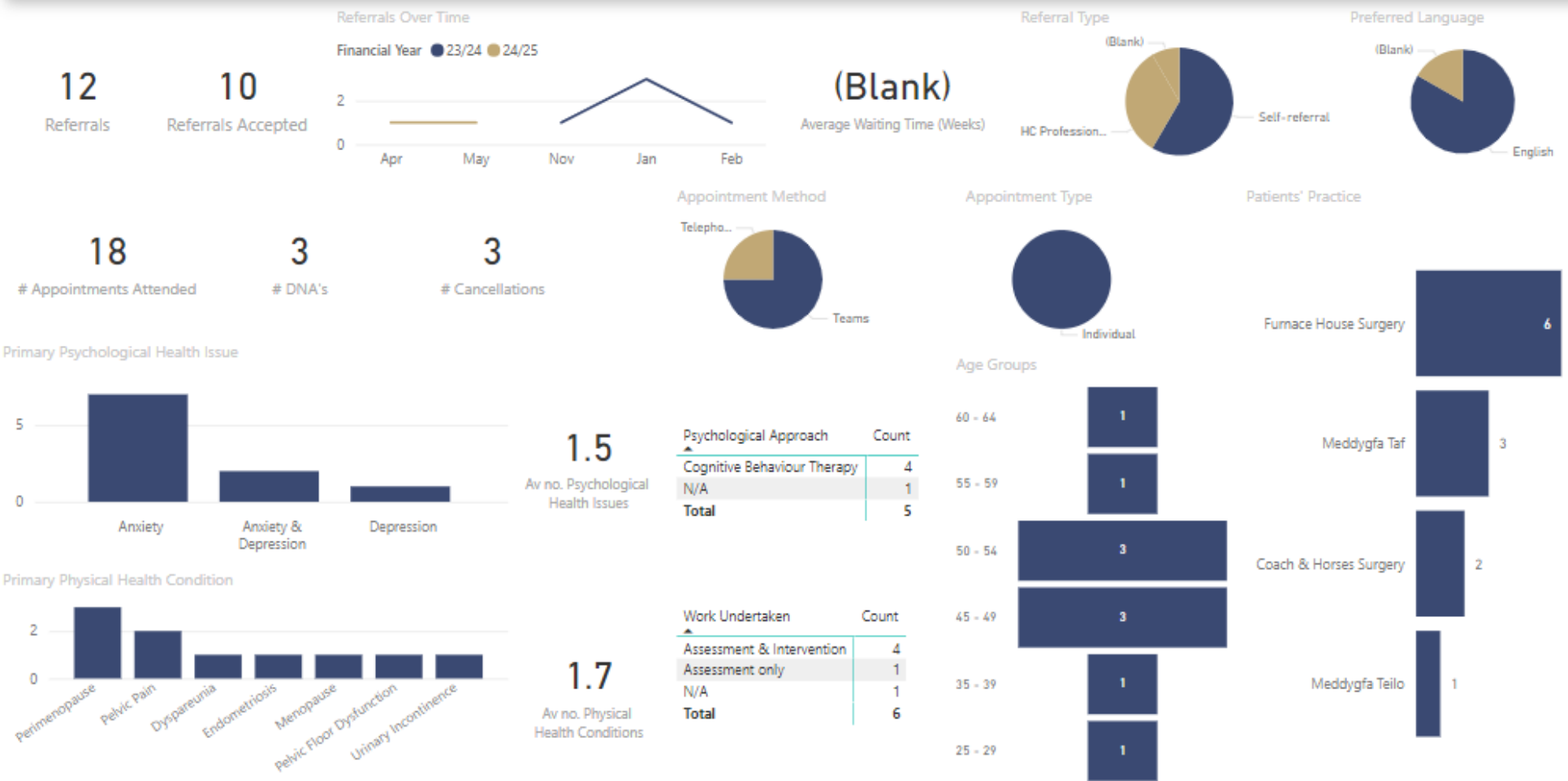
Project Status: In **Development**

Data quality comments: A draft data collection process has been created, awaiting testing and service to receive SOP approval.

- Project Start Date: February 2024
- Project End Date: February 2025
- This dashboard is in **development** – data collection process is in development and clinics due to begin towards the end of May.
- Narrative updated 17/05/2024

# Women's Health Psychological Service [Page 1 of 4]

Project	Update as at	Commentary	RAG	Trend
Women's Health Psychological Service (TT0020)	April 2024	All posts required for the project to start have been successfully recruited into, including the two assistant psychologist posts which received over 90 applications. The project went live for referrals in November 2023 and we have been collecting the data accordingly across the three funding clusters (SC, NC, 2T's). Bethan Lloyd, project lead, presented at the November GP collab for 2T's.	●	➔



- Project Start Date: November 2023
- Project End Date: September 2025
- This dashboard is **in development** - Data is now being collected consistently.
- Awaiting project to conduct follow-up PROMs & PREMS for comparative data and feedback.
- Narrative updated 17/05/2024

## 29

### Responses

#### Patient Health Questionnaire (PHQ)

This easy to use patient questionnaire is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria as "0" (not at all) to "3" (nearly every day). It has been validated for use in primary care.

Average of PHQ-9



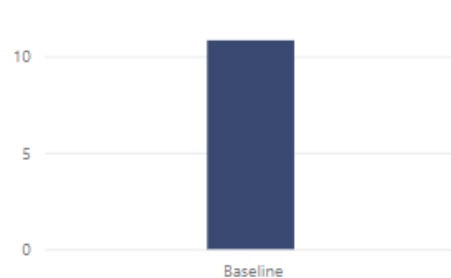
#### Depression severity scale:

0-4:	No depression
5-9:	Mild depression
10-14:	Moderate depression
15-19:	Moderately severe depression
20-27:	Severe depression

#### Generalised Anxiety Disorder (GAD)

This easy-to-use self-administered patient questionnaire is used as a screening tool and severity measure for generalised anxiety disorder (GAD).

Average of GAD-7



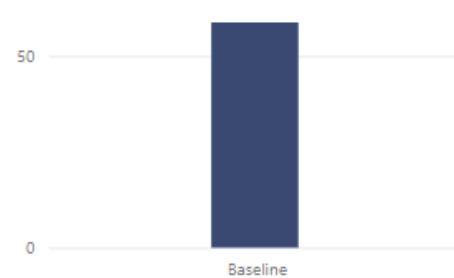
#### Anxiety severity scale:

0-4:	No anxiety
5-9:	Mild anxiety
10-14:	Moderate anxiety
15-21:	Severe anxiety

#### EuroQol Visual Analogue Scale (EQ VAS)

The EQ VAS records the patient's self-rated health on a vertical visual analogue scale where the endpoints are labelled 'The best health you can image' (100) and 'The worst health you can image' (0). The VAS can be used as a quantitative measure of health outcome that reflects the patient's own judgement.

Average of EQ VAS



#### Pain Self-Efficacy Questionnaire (PSEQ)

The Pain Self-Efficacy Questionnaire (PSEQ) is a 10-item questionnaire developed to assess the confidence people with ongoing pain have in performing activities while in pain, 0 being 'not at all confident' & 6 being 'completely confident'.

Average of PSEQ



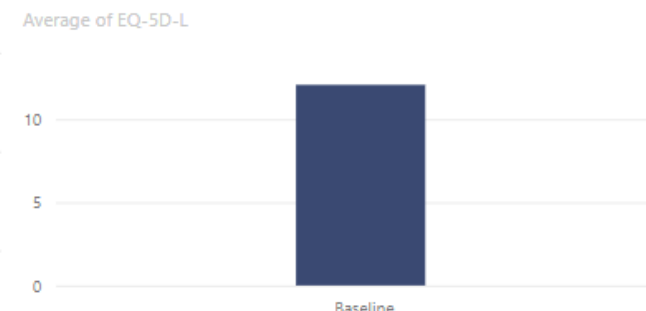
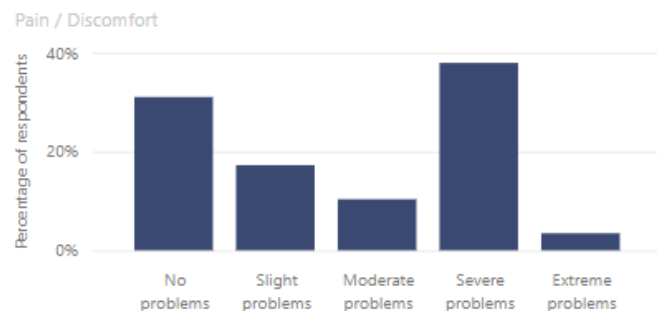
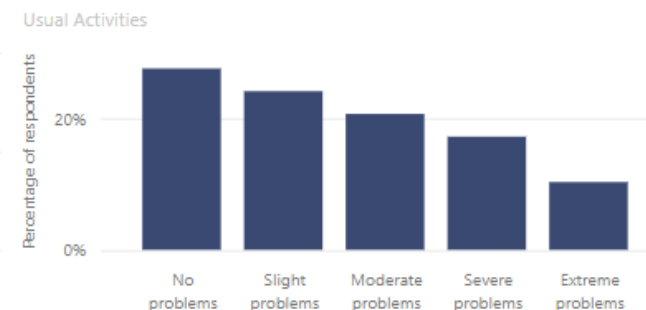
Please note\* these are currently responses from all 3 clusters involved with this project - TT's, North Ceredigion & South Ceredigion.

29

Responses

## EuroQol 5 Level Dimensions (EQ-5D-L)

The descriptive system comprises five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 5 levels: no problems, slight problems, moderate problems, severe problems and extreme problems. The patient is asked to indicate his/her health state by ticking the box next to the most appropriate statement in each of the five dimensions. This decision results in a 1-digit number that expresses the level selected for that dimension. The digits for the five dimensions can be combined into a 5-digit number that describes the patient's health state.



Please note\* these are currently responses from all 3 clusters involved with this project - TT's, North Ceredigion & South Ceredigion.

## LOGIC Model Assessment and Data Source: Women's Health Psychological Service (TT0020, NC0016, SC0014)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>Type of delivery (Face-to-face &amp; remote) ✓</li> <li>Type of sessions (Group &amp; individual) ✓</li> <li>Psychological &amp; Physical health concern/conditions &amp; severity/quantity ✓</li> <li>Referrals, referral type &amp; associated general practice ✓</li> <li>Effectiveness of a psychology service for women's health - PROMS ✓</li> <li>Patient feedback - PREMS ✗</li> </ul>	
Amended		
Additional	<ul style="list-style-type: none"> <li>DNA's / Cancellations / # Appointments ✓</li> <li>Demographics (age groups) ✓</li> <li>Waiting time (time between referral/first assessment &amp; first appointment) ✓</li> <li>Preferred language ✓</li> </ul>	
<b>Measures not being collected</b>		
Data collection under review		
Unable to collect	<ul style="list-style-type: none"> <li>Comparison between new tailored pain management programme vs general pain management programme currently available via secondary care</li> <li>Degree of mental health/emotional distress within this pelvic health population</li> </ul>	

**Key**

- ✓ = Data available
- ✗ = Data awaited from service
- ! = Data collection in development

# North Ceredigion

## Area 43: Counselling services for children

Code	Name
NC0001	To provide counselling services for children ages 13-17 & 18-30yrs

Baseline	Aim	Update as at	Commentary	RAG	Trend
-Patients experiencing mental health and wellbeing issues are referred into existing NHS mental health services'	To provide counselling services for children and adults when they need it.	Apr 2024	The service is operating well across the county of Ceredigion, supported by both South and North clusters. There are monthly reports and meetings in the diaries to discuss progress and evaluate the data reported.	▲	↑

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00135	Reduction in the number of people needing secondary care intervention for deteriorating mental health and well-being		Mar 2023	Apr 2024	Not capturing data at present; will investigate possibility of doing so.		▲	↑
M00137	Patient feedback		Mar 2023	Apr 2024	Not capturing data at present; will investigate possibility of doing so at next monthly catch-up.		▲	↑
M00136	Numbers of people referred into the service		Mar 2023	Mar 2024	Data being shared on a monthly basis regarding referral figures. The data is broken down to indicate which practices have been using the service and which are not engaging. 96 referrals into service since December	84	▲	↑

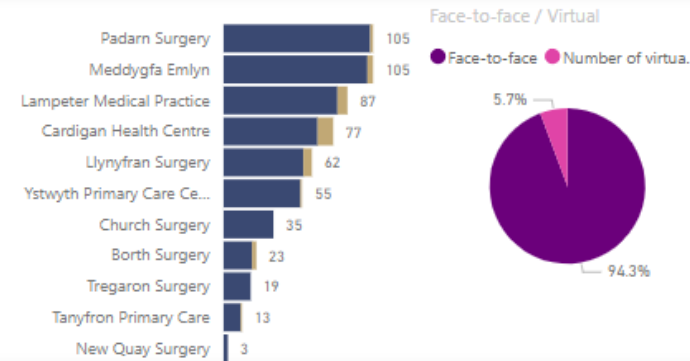
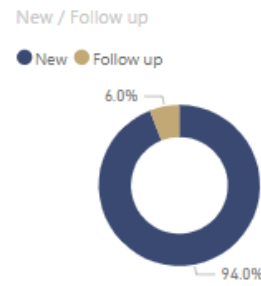
- Project Start Date: November 2023
- Project End Date: November 2025
- Narrative updated 23/02/2024

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00118	Service to commence	April 2023	Apr 2024	The project went live for referrals on Dec 1st via a self-referral model.	●	→
AC00119	Practices and cluster to advertise start of service	April 2023	Apr 2024	Start date highlighted to practices and bilingual promotional materials have been supplied by Area43 and circulated.	●	→
AC00117	Contract awarded	April 2023	Apr 2024	Contract awarded and the project went live for referrals from Dec 1st 2023.	●	→

Project	Update as at	Commentary	RAG	Trend
Continue to deliver Physiotherapy in General Practice (NC0005)	April 2024	One full time FCP in the cluster, employed on an Annexe 21 post. He is continuing to undertake CPD in order to reach necessary milestones within development framework in order to progress his professional capacity, and to be able to undertake the expected range of clinical duties.	▲	↑

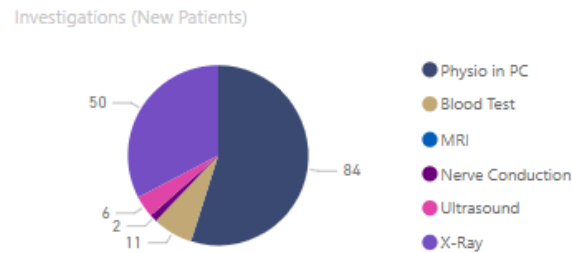
## Appointments

842 Available  
661 Booked  
79% Fill %  
83 DNA's

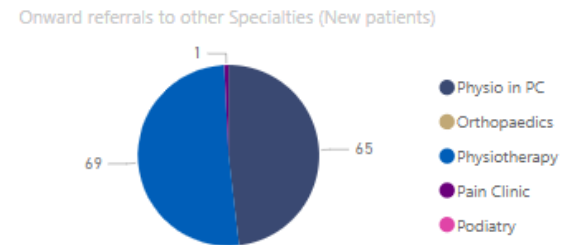


## Process

How many investigations were undertaken for new patients?





How many patients have been referred?



- Project Start Date: 2020
- Project End Date: Jan 2024, but still ongoing
- Data is being collated, **however as auditable individualised data is not being collected, this has been flagged as a Data Quality Risk.** New methods are being explored. Narberth Surgery (EMIS) & Preseli Practice (Vision) have tested & are currently using their respective templates within the clinical system to provide more robust individualised data - informed by practice managers & FCP's that it is working as expected. **Next step** is to assess and decide data extraction methods to extrapolate template & extraction for all clusters involved within this project. Lucie is in discussions with Jamel Bull (Vision in Primary Care) to establish costs feasibility and costs.
- Kristy is leading on a 'value for money' assessment to support ongoing discussions relating to the ongoing funding of this service.
- Narrative updated 03/05/2024

Data Quality Risk

## LOGIC Model Assessment and Data Source: FCP Physiotherapy Service (NP0017, SP0014, NC0005, SC0003, LL0005)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>• Patient pathways (New/Follow ups) ✓</li> <li>• Referrals to Orthopaedics in secondary care ✓</li> </ul>	 <a href="#">Static Link - FCP Form</a>  <a href="#">SharePoint Link - FCP Spreadsheet</a>
Amended	<ul style="list-style-type: none"> <li>• Patient pathways - Now recording: Onward referrals, investigations ✓</li> <li>• Individualised &amp; auditable data through EMIS &amp; Vision clinical systems !</li> </ul>	<p><b>Key</b></p> <ul style="list-style-type: none"> <li>✓ Data available</li> <li>✗ = Data awaited from service</li> <li>! Data collection in development</li> </ul>
Additional	<ul style="list-style-type: none"> <li>• Clinic fill rates - Clinic appointments available / Clinic appointments booked / DNA's ✓</li> <li>• Face-to-face vs virtual appointments ✓</li> <li>• Referrals to other specialities in secondary care - such as; Pain Clinic, Physiotherapy, Podiatry ✓</li> </ul>	
Measures not being collected		
Data collection under review	<ul style="list-style-type: none"> <li>• Patients receiving same day assessment and advice / demand for GP appointments through re-directing</li> <li>• Waiting times for patients accessing community Physiotherapy services</li> <li>• PROMS / PREMS</li> </ul>	
Unable to collect	<ul style="list-style-type: none"> <li>• Social Prescribing to local voluntary and community sector organisations</li> <li>• Physical activity of local population</li> <li>• Access to local services (carbon footprint)</li> </ul>	

# Set up and deliver Community Catheter Clinics

Code	Name
NC0006	Set up and deliver Community Catheter Clinics

Baseline	Aim	Update as at	Commentary	RAG	Trend
-Project proposal approved. -SLA written. -Patients are not being seen post discharge from hospital in a timely manner	To set up the clinics in Aberaeron and Aberystwyth to serve the whole cluster population. To provide timely checks and intervention	Apr 2024	Catheter clinics working well, with good uptake. Hoping for this to be further supported by joint-cluster TWOC project, but no updates on project development as yet.	▲	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00152	Current average waiting time between hospital discharge and accessing service		Mar 2023	Apr 2024	Will request		▲	↑
M00153	Patient satisfaction (percentage terms) from service		Mar 2023	Apr 2024	Will request		▲	↑
M00151	Number of patients attending catheter clinics		Mar 2023	Apr 2024	This varies on an ad-hoc basis; will request formal reporting		▲	↑
M00150	Number of patients receiving care in the community		Mar 2023	Apr 2024	No consistent reporting - will request.		▲	↑

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00133	Ensure competencies are signed off	April 2023	Apr 2024	Yes - Ystwyth signs off service/HCSW	●	→
AC00134	Ensure supplies are available for service continuity	April 2023	Apr 2024	Supplies provided by Ystwyth as required.	●	→
AC00132	Appoint nurse	April 2023	Apr 2024	Practice nurse appointed.	●	→
AC00135	Identify patients	April 2023	Apr 2024	Ongoing.	●	→
AC00136	Schedule clinics	April 2023	Apr 2024	Office manager scheduling clinics.	●	→
AC00137	Obtain patient feedback	April 2023	Apr 2024	Awaiting specific data.	▲	↑

- Project Start Date: Feb 2022
- Project End Date: Ongoing
- Data Quality - Measurement data is technically available, but difficult to extract and not routinely collected.
- Narrative updated 29/05/2024

# Singing for lung health



Code	Name
NC0014	Singing for lung health (Skylarks)

Baseline	Aim	Update as at	Commentary	RAG	Trend
Cluster has funded a singing lead to provide Singing for Lung Health weekly sessions	To support individuals with lung conditions & breathlessness	Apr 2024	Project is concluding as at 31/05/2024 due to lack of uptake and duration of funding to date.	🔴	➔

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00179	number of patients participating in the group singing		Mar 2023	Apr 2024	Project is concluding as at 31.05.24 due to limited uptake and duration of funding to date.	15	🔴	➔
M00181	Patient satisfaction (percentage terms) from service		Mar 2023	Apr 2024	Excellent, but qualitative feedback only. Project is concluding as at 31.05.24 due to limited uptake and duration of funding to date.	10000.0 %	🟢	➔
M00180	Before Peak flow readings and after peak flow reading of patients breathlessness and lung conditions that impact on patients ability to breath to quantify if the singing groups improve patient breathing and lung capacity		Mar 2023	Mar 2022	Awaiting full evaluation with parts received.	0	🟢	➔

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00154	Engage with singing lead throughout project duration	April 2023	Apr 2024	Project ending 31.05.24 due to limited uptake and duration of funding to date.	🔴	➔
AC00152	Group established	April 2023	Apr 2024	Project ending 31.05.24 due to limited uptake and duration of funding to date.	🔴	➔
AC00153	Support and communicate the needs of the group to the cluster	April 2023	Apr 2024	Project ending 31.05.24 due to limited uptake and duration of funding to date.	🔴	➔

- Project Start Date: March 2023
- Project End Date: May 2024
- Narrative updated 23/02/2024

# Early Intervention Pain Services

Code	Name
NC0015	Psychology in Primary Care - Chronic pain management

Baseline	Aim	Update as at	Commentary	RAG	Trend
Cluster has funded a psychology assistant to work within the pain management team	To support individuals with chronic pain to manage their pain through a bio-psycho-social model	Apr 2024	Early Intervention Pain Service (EIPS) continues to work well, but the cluster is aiming to slightly alter the scope of the project in the hope of amalgamating it with mental health services, physiotherapy services, dietetics, and women's health psychology service, in order to provide comprehensive women's health community hub in Ceredigion.	▲	➔

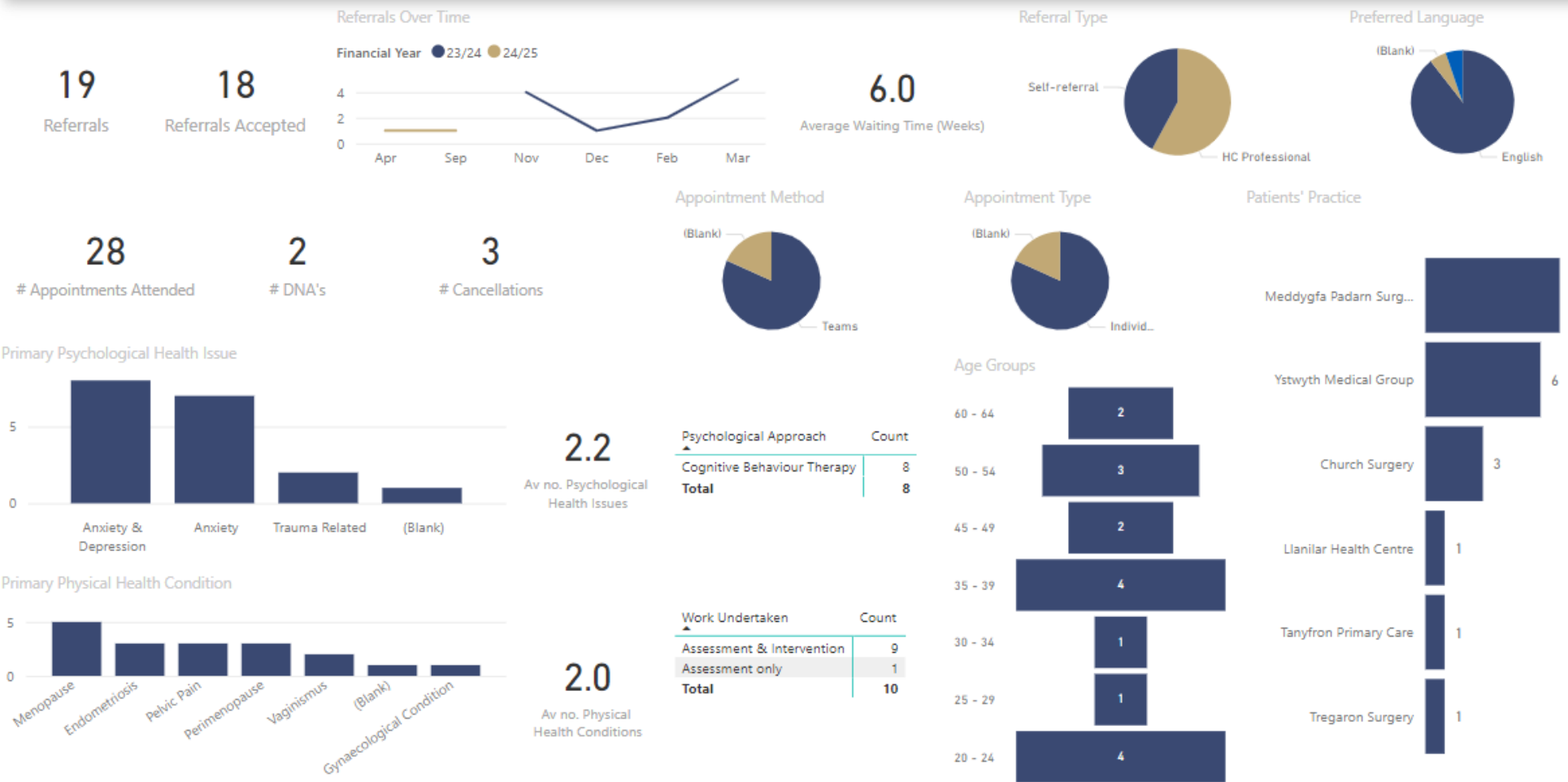
Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00182	Numbers of patients referred to chronic pain management clinic		Mar 2023	Apr 2024	Uptake is working very well with promising outlook. 419 referrals; 40 inappropriate, 379 appropriate	419	▲	⬆️
M00183	patients identified use of pain medication before & after participation on course		Mar 2023	Apr 2024	This data isn't captured - quantified feedback has been collected regarding the patients' moods before and after treatment via EIPS, as well as perceived levels of intervention. All positive.		●	●
M00184	Patient satisfaction (percentage terms) from service		Mar 2023	Apr 2024	Excellent reported feedback from patients/referred individuals.	97.0%	●	➔

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00155	Cluster to identify suitable individuals to attend sessions	April 2023	Apr 2024	Service continues to receive referrals, but currently ensuring that the cluster has adequate exposure to the project and to its benefits. Will be asking the team to attend Collab and Leads meetings in near future.	▲	⬆️
AC00156	Cluster to engage with the psychology assistant	April 2023	Apr 2024	Ensuring further engagement by way of attendance to Collaborative and Leads meetings in the coming quarter.	▲	⬆️

- Project Start Date: 2020
- Project End Date: Ongoing
- Narrative updated 26/02/2024

# Women's Health Psychological Service [Page 1 of 4]

Project	Update as at	Commentary	RAG	Trend
Women's Health Psychological Service (NC0016)	April 2024	The service went live for referrals from mid November 2023, with approximately 30 patients having been referred through to date. The three funding clusters; South Ceredigion, North Ceredigion and 2T's have agreed to finance the backfill of maternity leave for the lead clinician to ensure the continuation of the project in Y2. Data will be reviewed at 18-month mark to evaluate possibility of a year's extension to strengthen possibility of mainstreaming.	▲	➔



- Project Start Date: November 2023
- Project End Date: September 2025
- This dashboard is in **development** - Data is now being collected consistently.
- Awaiting project to conduct follow-up PROMs & PREMS for comparative data and feedback.
- Narrative updated 17/05/2024

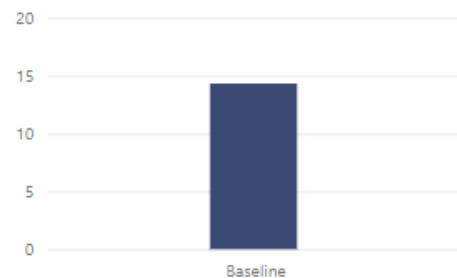
## 29

### Responses

#### Patient Health Questionnaire (PHQ)

This easy to use patient questionnaire is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria as "0" (not at all) to "3" (nearly every day). It has been validated for use in primary care.

Average of PHQ-9



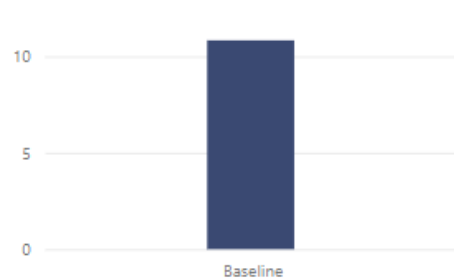
#### Depression severity scale:

0-4:	No depression
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15-19:	Moderately severe depression
20-27:	Severe depression

#### Generalised Anxiety Disorder (GAD)

This easy-to-use self-administered patient questionnaire is used as a screening tool and severity measure for generalised anxiety disorder (GAD).

Average of GAD-7



#### Anxiety severity scale:

0-4:	No anxiety
5-9:	Mild anxiety
10-14:	Moderate anxiety
15-21:	Severe anxiety

#### EuroQol Visual Analogue Scale (EQ VAS)

The EQ VAS records the patient's self-rated health on a vertical visual analogue scale where the endpoints are labelled 'The best health you can image' (100) and 'The worst health you can image' (0). The VAS can be used as a quantitative measure of health outcome that reflects the patient's own judgement.

Average of EQ VAS



#### Pain Self-Efficacy Questionnaire (PSEQ)

The Pain Self-Efficacy Questionnaire (PSEQ) is a 10-item questionnaire developed to assess the confidence people with ongoing pain have in performing activities while in pain, 0 being 'not at all confident' & 6 being 'completely confident'.

Average of PSEQ



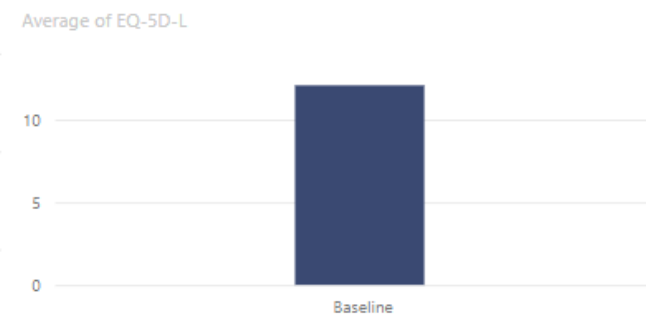
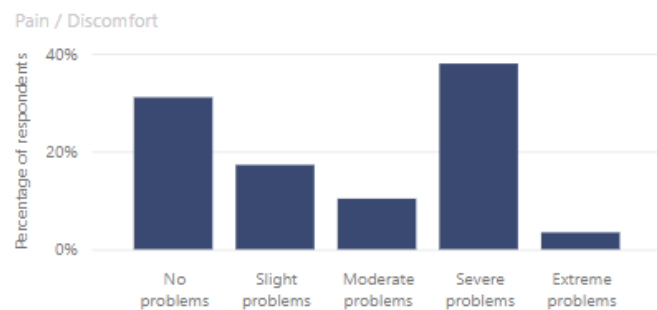
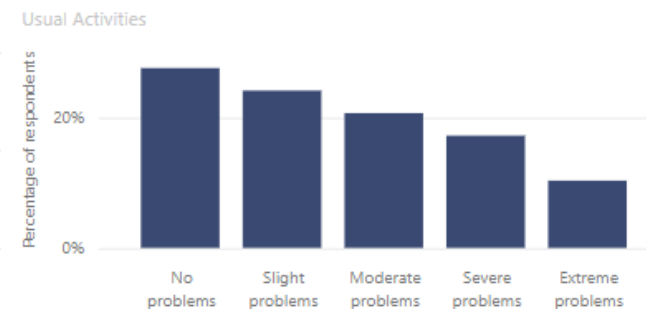
Please note\* these are currently responses from all 3 clusters involved with this project - TT's, North Ceredigion & South Ceredigion.

29

Responses

## EuroQol 5 Level Dimensions (EQ-5D-L)

The descriptive system comprises five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 5 levels: no problems, slight problems, moderate problems, severe problems and extreme problems. The patient is asked to indicate his/her health state by ticking the box next to the most appropriate statement in each of the five dimensions. This decision results in a 1-digit number that expresses the level selected for that dimension. The digits for the five dimensions can be combined into a 5-digit number that describes the patient's health state.



Please note\* these are currently responses from all 3 clusters involved with this project - TT's, North Ceredigion & South Ceredigion.

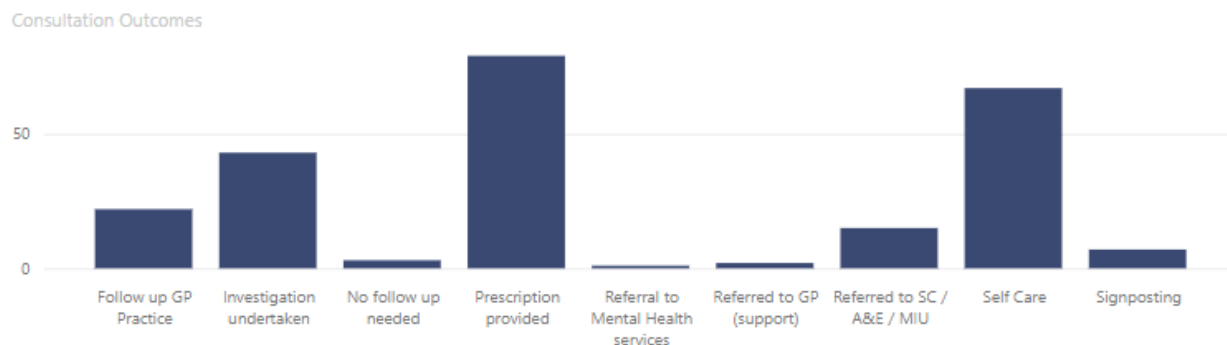
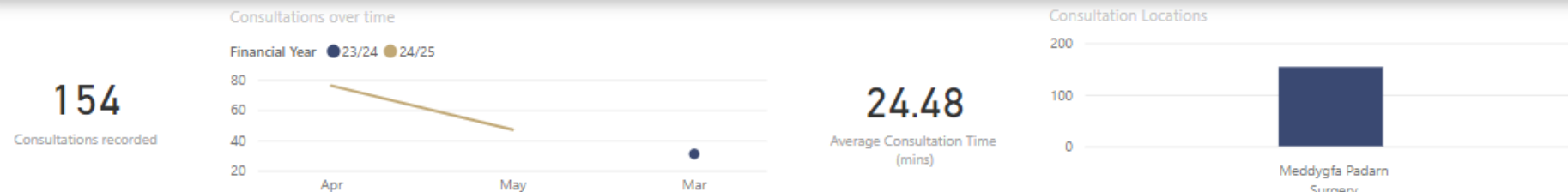
## LOGIC Model Assessment and Data Source: Women's Health Psychological Service (TT0020, NC0016, SC0014)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>Type of delivery (Face-to-face &amp; remote) ✓</li> <li>Type of sessions (Group &amp; individual) ✓</li> <li>Psychological &amp; Physical health concern/conditions &amp; severity/quantity ✓</li> <li>Referrals, referral type &amp; associated general practice ✓</li> <li>Effectiveness of a psychology service for women's health - PROMS ✓</li> <li>Patient feedback - PREMS ✗</li> </ul>	
Amended		
Additional	<ul style="list-style-type: none"> <li>DNA's / Cancellations / # Appointments ✓</li> <li>Demographics (age groups) ✓</li> <li>Waiting time (time between referral/first assessment &amp; first appointment) ✓</li> <li>Preferred language ✓</li> </ul>	
<b>Measures not being collected</b>		
Data collection under review		
Unable to collect	<ul style="list-style-type: none"> <li>Comparison between new tailored pain management programme vs general pain management programme currently available via secondary care</li> <li>Degree of mental health/emotional distress within this pelvic health population</li> </ul>	

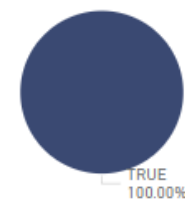
**Key**

- ✓ = Data available
- ✗ = Data awaited from service
- ! = Data collection in development

Project	Update as at	Commentary	RAG	Trend
Physician Associate (NC0017)	April 2024	We are currently developing and testing a monitoring framework in conjunction with the PA Development Manager who has been asked to lead on the work. The project began 2 years ago, and the reporting framework wasn't agreed at that time, so this is a retrospective undertaking which has been more difficult to orchestrate. Nonetheless, we are hopeful that we will have good supporting data in the coming weeks.	▲	↑



Appropriate Patient for PA



- Project Start Date: Apr 2022
- Project End Date: TBA
- The dashboard for this project is **in development** with data capture processes and discussions still taking place with the service.
- Narrative updated 17/05/2024

Project	Update as at	Commentary	RAG	Trend
Trial without Catheter (TWOC) (NC0018)	April 2024	The joint-funded TWOC project operating across all clusters has experienced difficulty in the initial stages, particularly with recruitment and governance issues. These have now seemingly been resolved, and the service is becoming operational by the end of May.	▲	↑

Approved due to begin: February 2024

Project duration: 1 Year

Project Status: In **Development**

Data quality comments: A draft data collection process has been created, awaiting testing and service to receive SOP approval.

- Project Start Date: February 2024
- Project End Date: February 2025
- This dashboard is in **development** – data collection process is in development and clinics due to begin towards the end of May.
- Narrative updated 17/05/2024

Project	Update as at	Commentary	RAG	Trend
Optom Equipment (NC0019)	April 2024	The practices will be receiving their purchased equipment this month, and we will be developing reporting measures at the beginning of June with input from the optometrists.	▲	↑

Approved due to begin: March 2024

Project duration: 2 Years

Project Status: In **Development**

Data quality comments: Data collection process being jointly developed by the service & health board.

- Project Start Date: March 2024
- Project End Date: March 2026
- This project is in its early developmental stages – data collection process are being developed.
- Narrative updated 08/05/2024

# South Ceredigion

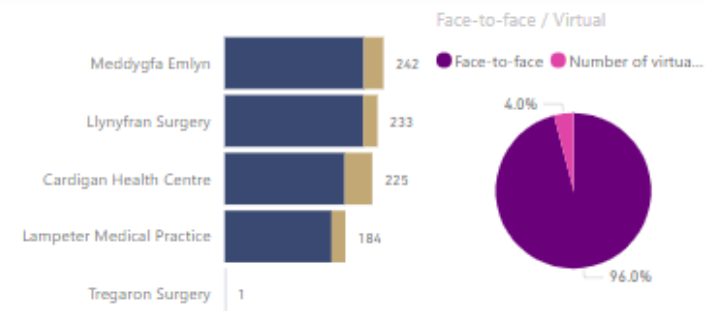
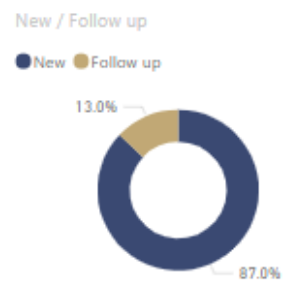
# First Contact Practitioner Physiotherapy Service [Page 1 of 2]



Project	Update as at	Commentary	RAG	Trend
Physiotherapy in General Practice (SC0003)	April 2024	One full time FCP working in the cluster who is clinical 80% of the week, with 20% of time dedicated to admin duties and CPD. Quarterly reports are provided by the physio department and an end of year annual report.	●	➔

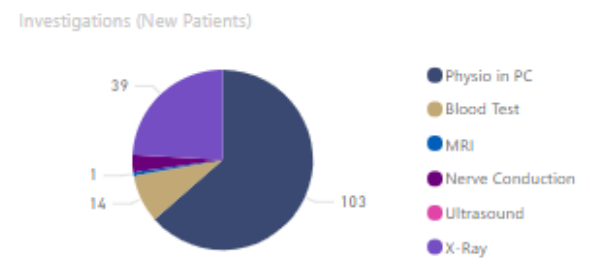
## Appointments

1092 Available  
997 Booked  
91% Fill %  
130 DNA's

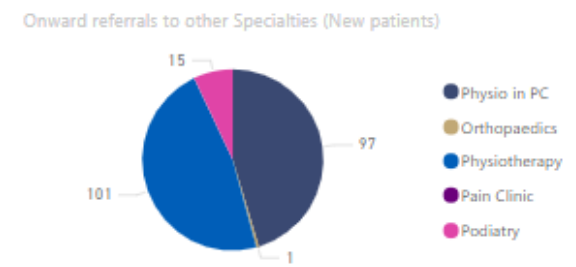


## Process

How many investigations were undertaken for new patients?





How many patients have been referred?



- Project Start Date: 2020
- Project End Date: Jan 2024, but still ongoing
- Data is being collated, **however as auditable individualised data is not being collected, this has been flagged as a Data Quality Risk.** New methods are being explored. Narberth Surgery (EMIS) & Preseli Practice (Vision) have tested & are currently using their respective templates within the clinical system to provide more robust individualised data - informed by practice managers & FCP's that it is working as expected. **Next step** is to assess and decide data extraction methods to extrapolate template & extraction for all clusters involved within this project. Lucie is in discussions with Jamel Bull (Vision in Primary Care) to establish costs feasibility and costs.
- Kristy is leading on a 'value for money' assessment to support ongoing discussions relating to the ongoing funding of this service.
- Narrative updated 03/05/2024

Data Quality Risk

## LOGIC Model Assessment and Data Source: FCP Physiotherapy Service (NP0017, SP0014, NC0005, SC0003, LL0005)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>• Patient pathways (New/Follow ups) ✓</li> <li>• Referrals to Orthopaedics in secondary care ✓</li> </ul>	 <a href="#">Static Link - FCP Form</a>  <a href="#">SharePoint Link - FCP Spreadsheet</a>
Amended	<ul style="list-style-type: none"> <li>• Patient pathways - Now recording: Onward referrals, investigations ✓</li> <li>• Individualised &amp; auditable data through EMIS &amp; Vision clinical systems !</li> </ul>	<p><b>Key</b></p> <ul style="list-style-type: none"> <li>✓ Data available</li> <li>✗ = Data awaited from service</li> <li>! Data collection in development</li> </ul>
Additional	<ul style="list-style-type: none"> <li>• Clinic fill rates - Clinic appointments available / Clinic appointments booked / DNA's ✓</li> <li>• Face-to-face vs virtual appointments ✓</li> <li>• Referrals to other specialities in secondary care - such as; Pain Clinic, Physiotherapy, Podiatry ✓</li> </ul>	
Measures not being collected		
Data collection under review	<ul style="list-style-type: none"> <li>• Patients receiving same day assessment and advice / demand for GP appointments through re-directing</li> <li>• Waiting times for patients accessing community Physiotherapy services</li> <li>• PROMS / PREMS</li> </ul>	
Unable to collect	<ul style="list-style-type: none"> <li>• Social Prescribing to local voluntary and community sector organisations</li> <li>• Physical activity of local population</li> <li>• Access to local services (carbon footprint)</li> </ul>	

# Area 43 Online Counselling Service

Code	Name
SC0009	Area 43 Online Counselling Service for 16 – 25 year olds

Baseline	Aim	Update as at	Commentary	RAG	Trend
To provide short term, online remote access to professional counselling services for young people aged 16 – 30 years old in the South Ceredigion GP cluster area.	Area 43 provide an ongoing service which is supported by all five practices	Apr 2024	The service is operating well across the county of Ceredigion, supported by both South and North clusters. There are monthly reports and meetings in the diaries to discuss progress and evaluate the data reported.	●	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00323	No. of referrals to Area 43 Online Counselling Service		Mar 2023	Apr 2024	Data being shared on a monthly basis regarding referral figures. The data is broken down to indicate which practices have been using the service and which are not engaging. Only 12 referrals from SC but assured there is capacity for more appointments if the demand picks up locally.	12	●	→
M00324	Patient feedback		Mar 2023	Apr 2024	I have received a feedback document with a summary of responses from 40 patients (across Ceredigion as a county). The feedback was very positive but a common theme amongst patients was that they would have liked more sessions.	40	▲	↑
M00325	Reduction in the number of 16 – 25 year olds needing secondary care intervention for deteriorating mental health and well-being		Mar 2023	Apr 2024	Not capturing this data		●	●

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00278	Encourage & facilitate engagement from Practices within the Cluster to maintain/increase referral numbers.	April 2023	Apr 2024	The GP collaborative agreed on a self-referral model in the November meeting, which was upheld by cluster. Area43 have circulated bilingual promotional materials for collab groups to encourage referrals.	●	→
AC00279	PCSM to arrange regular catch-ups with Area 43 & Cluster to receive regular evaluation reports.	April 2023	Apr 2024	Monthly meetings are in place with the project lead at Area43 to review the monthly data reports that are submitted to us. The time is used to evaluate progress and discuss any areas of concern or opportunities to improve the service.	●	→
AC00280	Cluster to involve the Cluster Communications Officer in the promotion of this project to help raise its profile and to maintain/increase referral numbers.	April 2023	Apr 2024	Looking to complete in the next quarter with a view to increasing referral numbers in the South.	▲	→
AC00281	Newly appointed GP Collaborative Lead to facilitate discussion at next GP Collaborative meeting around potential procurement of project on a County-wide level.	April 2023	Apr 2024	This has been completed and county-wide provision of Area43 is being delivered.	●	→

- Project Start Date: November 2023
- Project End Date: November 2025
- Expecting a quarterly update on monitoring from Area 43 at the end of February.
- Narrative updated 24/05/2024

# Frailty Team

Code	Name
SC0010	Frailty Team

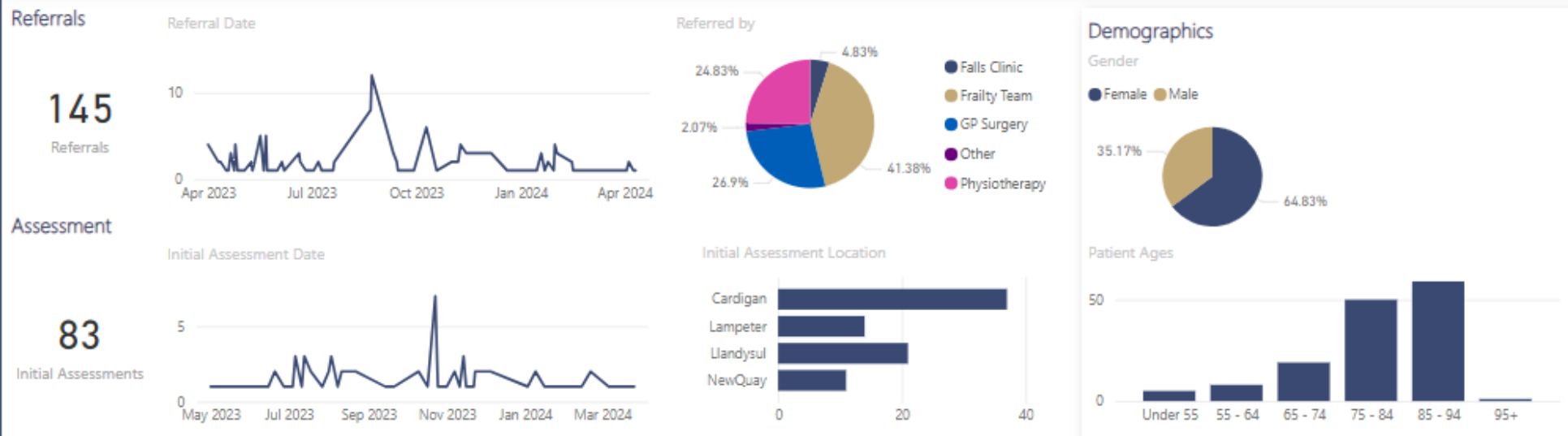
Baseline	Aim	Update as at	Commentary	RAG	Trend
The Frailty team provides a full Frailty nursing assessment which includes a physical, psychological, medical and social review. The assessment also comprises of a cognition assessment in conjunction with a mood and well-being element. A recent innovation is screening each new patient referred for AF using a handheld ECG monitor. Health issues are identified early so that they can be dealt with proactively to prevent a crisis and unwanted hospital admissions. Patients are encouraged to self-manage their conditions to improve outcomes and long-term goals. The Frailty and Chronic Conditions Nurses also signpost or refer patients to other agencies who may be able to help address specific issues, in addition to providing information, education and support to patients, care staff, families and volunteers on managing frailty concerns and other chronic conditions.	Frailty Team continue to accept referrals from all 5 practices via regular practice based MDT meetings. Both B7 Frailty Nurses now permanent staff members	Apr 2024	The project continues to deliver a much needed service in the locality. Two band 7 specialist nurses and one band 3 HCSW covering the South Ceredigion cluster (we will be going out to advert in May for a second HCSW to support the team after approval at pan cluster). Tom Baxter has provided valuable support to the team in streamlining the data capture process to help quantify the unseen work being completed and we have quarterly data reviews. The team have agreed to being using the friends and family feedback forms from next month to obtain more PREMS.	●	→

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00326	No. of referrals to Frailty Team		Mar 2023	Apr 2024	As expected following the data review and discussions with the team.	81	●	→
M00327	Patient feedback		Mar 2023	Apr 2024	Friends and family questionnaire being used on a monthly basis as confirmed with Tom in previous data review meeting.		●	→

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00282	PCSM to meet regularly with Frailty team staff.	April 2023	Apr 2024	Individual monthly 1:2:1 meetings with frailty team staff. Approximately one in person group meeting per month in Cardigan. We also meet as part of our South Ceredigion cluster which the band 7 nurses both attend and update on the frailty service.	●	→
AC00283	Team to produce regular evaluation reports.	April 2023	Apr 2024	The team record the data relating to visits, referrals, types of details and project involvement (NERS) on an excel sheet. We have met with Tom Baxter to streamline this process and ensure relevant data is being captured in the most efficient way. Our frailty HCSW also has her own data capture form which is specific to her cluster funded role.	●	→
AC00284	Patients to be referred via Cluster-funded Practice-based MDT meetings.	April 2023	Apr 2024	Patients are being referred via the cluster funded practice-based meetings and these are being recorded in the Shared drive excel.	●	→
AC00285	PCSM to submit business case for part-time HCSW support for Frailty Team.	April 2023	Apr 2024	Recruited and started in post in April 2023.	●	→

- Project Start Date: November 2019, however, data analytical support commenced November 2023
- Project End Date: Ongoing
- This dashboard is in **development**. However, there **hasn't yet been an assessment of a Logic model**.
- Narrative updated 24/05/2024

Project	Update as at	Commentary	RAG	Trend
National Exercise Referral Scheme (NERS) (SC0012)	April 2024	NERS is running steadily within the cluster, operating from 4 fixed sites across South Ceredigion and are currently running their classes in a residential home for the first time, delivering the sessions within the patients home without the need for them to travel. Positive feedback was received from the GP collaborative in February. The project lead for NERS sends monthly data reports to myself which feed into a PowerBI dashboard developed by Tom.	●	➔



- Project Start Date: April 2022, but delayed to April 2023
- Project End Date: April 2025
- Narrative updated 21/05/2024



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

# National Exercise Referral Scheme: PROMS & PREMS [Page 2 of 3]



Project	Update as at	Commentary	RAG	Trend
National Exercise Referral Scheme (NERS) (SCD012)	April 2024	NERS is running steadily within the cluster, operating from 4 fixed sites across South Ceredigion and are currently running their classes in a residential home for the first time, delivering the sessions within the patients home without the need for them to travel. Positive feedback was received from the GP collaborative in February. The project lead for NERS sends monthly data reports to myself which feed into a PowerBI dashboard developed by Tom.	●	➔

PROMs / PREMs

83

Initial Assessments

37

16 Week Reviews

13

32 Week Reviews

Total Sessions

10

32

Age Categories

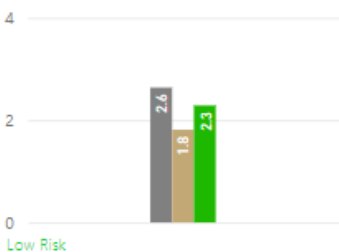
All

Gender

All

FRAT

High Risk



The Falls Risk Assessment Tool (FRAT) is a short questionnaire to determine an individuals' falls risk. Low score = low risk // High score = high risk.

EQ5-D Assessment

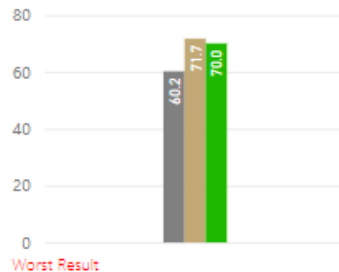
Low Quality



The EQ5-D is a self-assessment questionnaire to measure an individuals' general quality of life. Low score = high quality // High score = low quality.

EQ5-D VAS Assessment

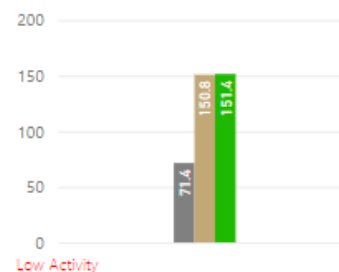
Best Result



The EQ5-D Visual Analogue Scale (VAS) is a self-assessment tool to measure an individuals perceived health. 100 being best imaginable health // 0 being worst imaginable health.

SPAQ

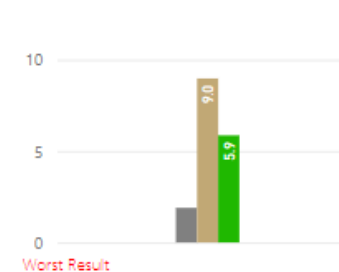
High Activity



The Scottish Physical Activity questionnaire (SPAQ) is a tool to investigate how active a person is, day to day. Low score = low activity // High score = high activity.

Sit2Stand Assessment

Best Result

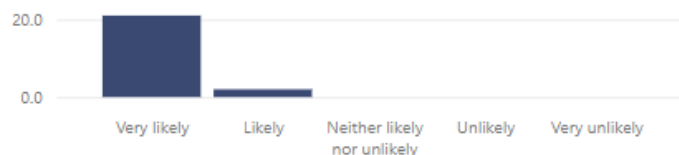


The Sit2Stand tool is a basic physical assessment of the number of times a patient can sit to stand within 30 seconds.


Key

- Baseline
- 16 Week Review
- 32 Week Review

Would you recommend this class to friends or family?

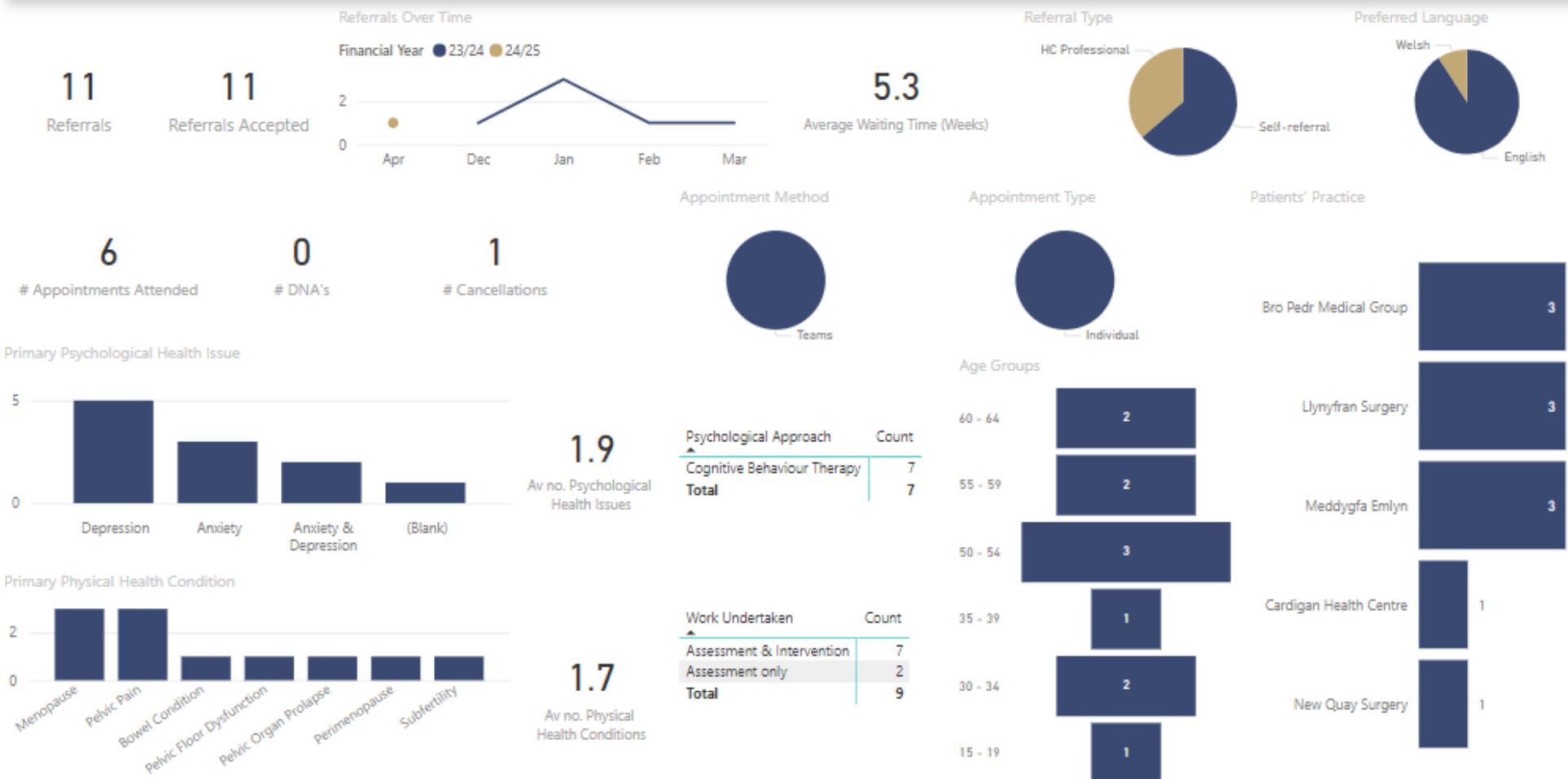


## LOGIC Model Assessment and Data Source: National Exercise Referral Scheme (SC0012)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>Physical assessment - Sit to stand measure ✓</li> <li>PROMS (EQ5D, EQ VAS, SPAQ) ✓</li> <li>Gender ✓</li> <li>PREMS ('Recommend to Friends or family?') ✓</li> </ul>	 <a href="#">SharePoint Link – NERS Spreadsheet</a>
Amended	<ul style="list-style-type: none"> <li>Engagement in falls prevention initiatives - Now recording: Falls Risk Assessment scores ✓</li> </ul>	<b>Key</b> ✓ = Data available ✗ = Data awaited from service ! = Data collection in development
Additional	<ul style="list-style-type: none"> <li>Referral numbers &amp; referral Team ✓</li> <li>Age range ✓</li> <li>Assessment location &amp; date ✓</li> <li>Attendance ✓</li> </ul>	
Measures not being collected		
Data collection under review	<ul style="list-style-type: none"> <li>Engaging hard to reach patients (Geographically)</li> </ul>	
Unable to collect	<ul style="list-style-type: none"> <li>Unplanned hospital admissions due to falls &amp; Associated injuries</li> <li>Reduction of pressure on physiotherapy services</li> <li>BMI / Blood Pressure</li> </ul>	

# Women's Health Psychological Service [Page 1 of 4]

Project	Update as at	Commentary	RAG	Trend
Women's Health Psychological Service (SC0014)	April 2024	The service went live for referrals from mid November 2023, with approximately 30 patients having been referred through to date. The three funding clusters; South Ceredigion, North Ceredigion and 2T's have agreed to finance the backfill of MAT leave for the lead clinician to ensure the continuation of the project in Y2.	<span style="color: green;">●</span>	➔



- Project Start Date: November 2023
- Project End Date: September 2025
- This dashboard is **in development** - Data is now being collected consistently.
- Awaiting project to conduct follow-up PROMs & PREMS for comparative data and feedback.
- Narrative updated 17/05/2024

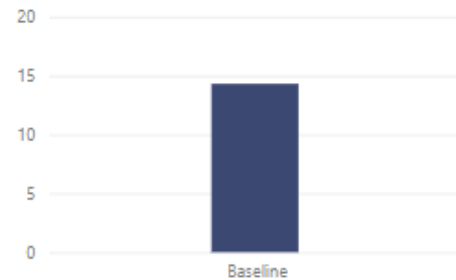
## 29

### Responses

#### Patient Health Questionnaire (PHQ)

This easy to use patient questionnaire is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria as '0' (not at all) to '3' (nearly every day). It has been validated for use in primary care.

Average of PHQ-9



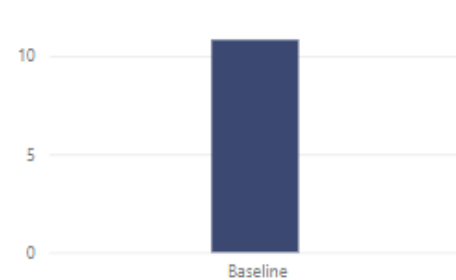
#### Depression severity scale:

0-4:	No depression
5-9:	Mild depression
10-14:	Moderate depression
15-19:	Moderately severe depression
20-27:	Severe depression

#### Generalised Anxiety Disorder (GAD)

This easy-to-use self-administered patient questionnaire is used as a screening tool and severity measure for generalised anxiety disorder (GAD).

Average of GAD-7



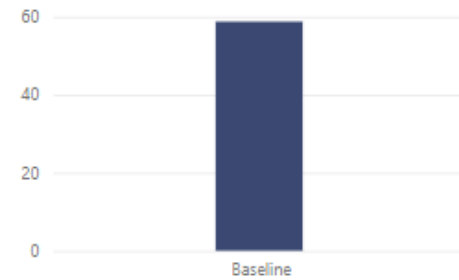
#### Anxiety severity scale:

0-4:	No anxiety
5-9:	Mild anxiety
10-14:	Moderate anxiety
15-21:	Severe anxiety

#### EuroQol Visual Analogue Scale (EQ VAS)

The EQ VAS records the patient's self-rated health on a vertical visual analogue scale where the endpoints are labelled 'The best health you can image' (100) and 'The worst health you can image' (0). The VAS can be used as a quantitative measure of health outcome that reflects the patient's own judgement.

Average of EQ VAS



#### Pain Self-Efficacy Questionnaire (PSEQ)

The Pain Self-Efficacy Questionnaire (PSEQ) is a 10-item questionnaire developed to assess the confidence people with ongoing pain have in performing activities while in pain, 0 being 'not at all confident' & 6 being 'completely confident'.

Average of PSEQ



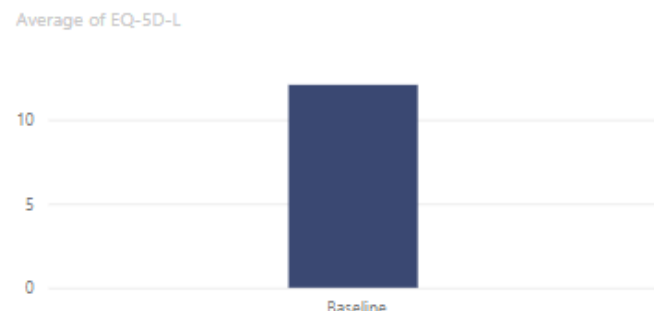
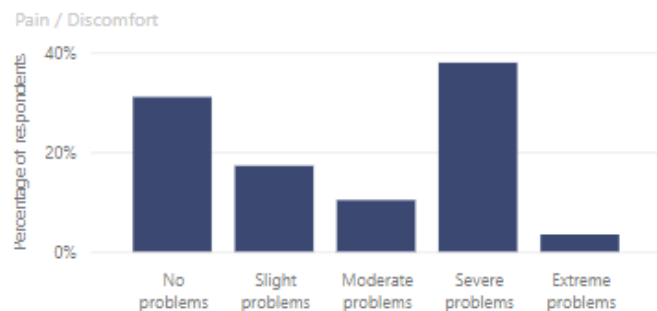
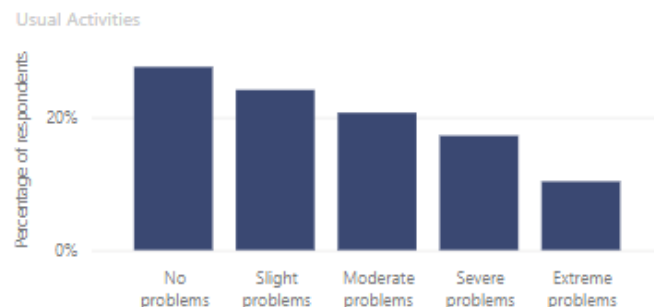
Please note\* these are currently responses from all 3 clusters involved with this project - TT's, North Ceredigion & South Ceredigion.

29

Responses

### EuroQol 5 Level Dimensions (EQ-5D-L)

The descriptive system comprises five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 5 levels: no problems, slight problems, moderate problems, severe problems and extreme problems. The patient is asked to indicate his/her health state by ticking the box next to the most appropriate statement in each of the five dimensions. This decision results in a 1-digit number that expresses the level selected for that dimension. The digits for the five dimensions can be combined into a 5-digit number that describes the patient's health state.



Please note\* these are currently responses from all 3 clusters involved with this project - TT's, North Ceredigion & South Ceredigion.

## LOGIC Model Assessment and Data Source: Women's Health Psychological Service (TT0020, NC0016, SC0014)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>Type of delivery (Face-to-face &amp; remote) ✓</li> <li>Type of sessions (Group &amp; individual) ✓</li> <li>Psychological &amp; Physical health concern/conditions &amp; severity/quantity ✓</li> <li>Referrals, referral type &amp; associated general practice ✓</li> <li>Effectiveness of a psychology service for women's health - PROMS ✓</li> <li>Patient feedback - PREMS ✗</li> </ul>	
Amended		
Additional	<ul style="list-style-type: none"> <li>DNA's / Cancellations / # Appointments ✓</li> <li>Demographics (age groups) ✓</li> <li>Waiting time (time between referral/first assessment &amp; first appointment) ✓</li> <li>Preferred language ✓</li> </ul>	
<b>Measures not being collected</b>		
Data collection under review		
Unable to collect	<ul style="list-style-type: none"> <li>Comparison between new tailored pain management programme vs general pain management programme currently available via secondary care</li> <li>Degree of mental health/emotional distress within this pelvic health population</li> </ul>	

**Key**  
 ✓ = Data available  
 ✗ = Data awaited from service  
 ! = Data collection in development

# Trial without Catheter [Page 1 of 1]

Project	Update as at	Commentary	RAG	Trend
Trial without Catheter (TWOC) (SC0015)	May 2024	The project has been funded since 19th Feb 2024 and the first clinic is scheduled for 28/05/24.	▲	↑

Approved due to begin: February 2024

Project duration: 1 Year

Project Status: In **Development**

Data quality comments: A draft data collection process has been created, awaiting testing and service to receive SOP approval.

- Project Start Date: February 2024
- Project End Date: February 2025
- This dashboard is **in development** – data collection process is in development and clinics due to begin towards the end of May.
- Narrative updated 17/05/2024

Project	Update as at	Commentary	RAG	Trend
Optom Equipment (SC0016)	May 2024	The equipment is currently being set up by the practices, following recent delivery, ready for use with patients.	▲	↑

Approved due to begin: March 2024

Project duration: 2 Years

Project Status: In **Development**

Data quality comments: Data collection process being jointly developed by the service & health board.

- Project Start Date: March 2024
- Project End Date: March 2026
- This project is in its early developmental stages – data collection process are being developed.
- Narrative updated 08/05/2024

# Joint Pembrokeshire

# Primary School Respiratory Review: Assessment Details [Page 1 of 4]

Project	Update as at	Commentary	RAG	Trend
Pembrokeshire Primary School Asthma Review / Respiratory Asthma Pharmacist (NP0018)	May 2024	The project is delivered on the second cluster area within the primary schools.	●	➔

## Assessment Details

192

Children

313

Consultations

1.6

Consultations per child

3.6

Average no. of relievers in past 12 months

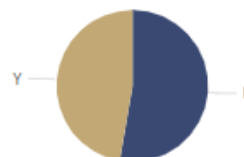
OOH/A&E in last 2 years



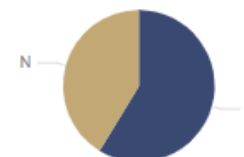
Passive smoker



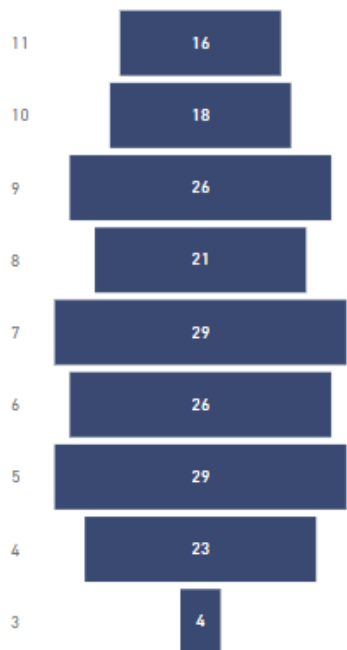
Oral Prednisolone in last 2 years



Antibiotics for chest in last 2 years



## Ages



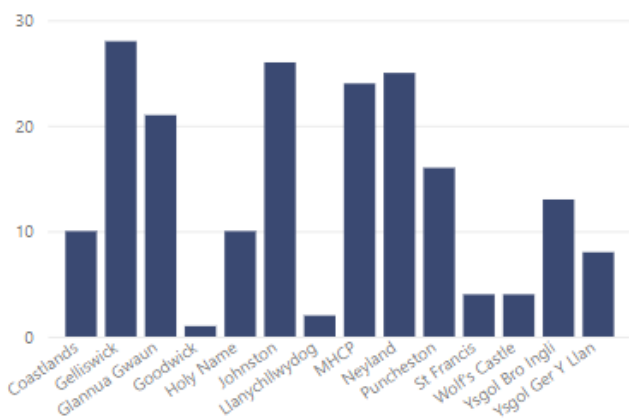
64.8%

Average adherence to preventer

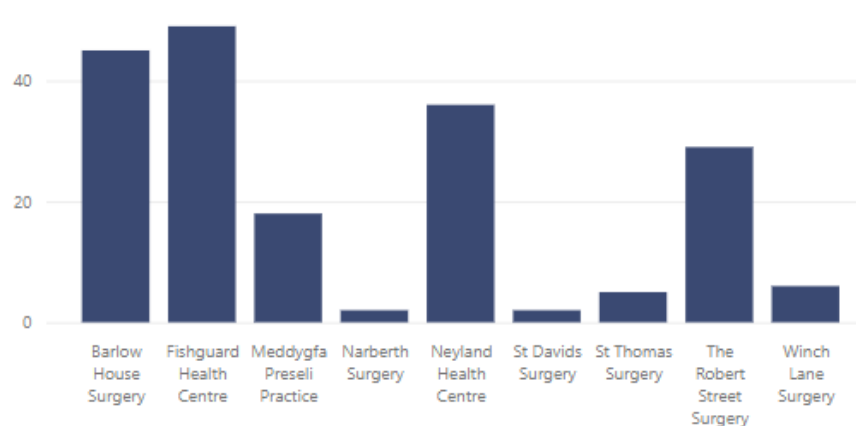
69.2%

Respiratory reviews in last 12 months (With Asthma / Suspected Asthma)

Patients by School



Patients by GP Surgery



- Project Start Date: September 2023
- Project End Date: August 2025
- Data is being collected consistently – awaiting service to complete further respiratory assessments and send through updated data.
- Termly timetable for school visits:
  - Autumn 23: Milford Haven
  - Spring 24: Fishguard / Bro Gwaun
  - Summer 24: Pembroke
  - Autumn 24: Haverfordwest
  - Spring 25: Preseli
  - Summer 25: Tenby
- Narrative updated 20/05/2024

## Outcome Details

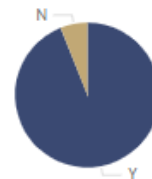
**54.7%**

Change to treatment in line with guidelines

**39.7%**

Change from MDI to PDI (Age 6+)

NHS Wales app info given



**115**

Inhaler technique critical errors pre demo

**0**

Inhaler technique critical errors post demo

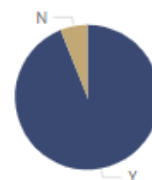
**4**

Adult referrals to smoking cessation

**8**

Referrals to secondary care

Action plan issued

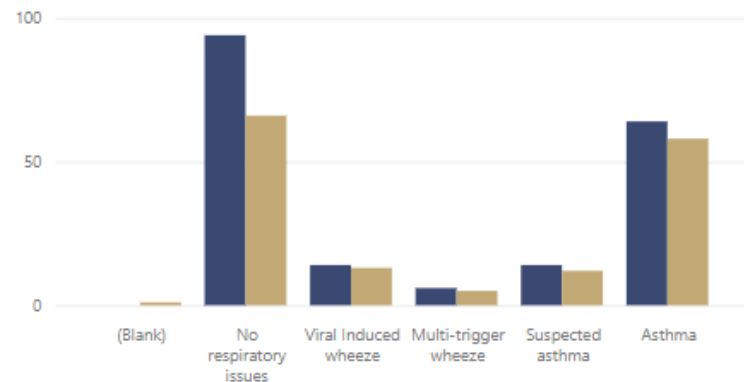


**59**

Changes to diagnosis

Existing Diagnosis vs Diagnosis after second consultation

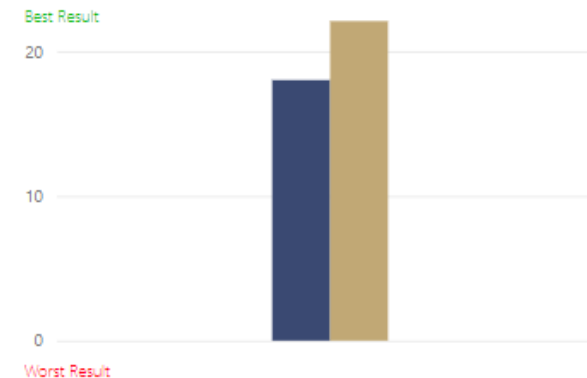
● Existing Diagnosis ● Diagnosis after second consultation



The Childhood Asthma Control Test (C-ACT) is a widely used questionnaire to measure asthma severity in young children aged 4 to 11 years. It helps assess how well a child's asthma symptoms are controlled.

The Childhood Asthma Control Test (C-ACT)

● Average C-ACT initial consultation ● Average C-ACT follow up consultation





## LESSONS IN ASTHMA

Dave Edwards; [dave.edwardspharmacist@gmail.com](mailto:dave.edwardspharmacist@gmail.com)

### PATIENT CASE STUDY – LIAISING WITH PAEDIATRIC LONG TERM CONDITIONS CNS

#### 1. Patient Details

- I** 8-year-old boy, seen in Holy Name Catholic Primary School with dad in February.  
Dad gave history of repeated A&E and hospital admission since he was 18 months old. Admitted to GGH in April 2021. Discharged with no secondary care follow up documented on the system.  
He has been issued with two courses of oral prednisolone since October 2023.  
His adherence with his preventer inhaler is less than 70%.  
With this history, he should have been followed up by secondary care following his admission.  
The two courses of oral prednisolone should have triggered a referral by primary care.

#### 2. Details of the Intervention/Service/Treatment Received

- I** In my consultation, I changed his inhaler in line with All Wales Guidelines and stressed the importance of adherence. Patient lives in two homes, I arranged the follow up appointment with mum so I could have the same conversations with her.  
I contacted Ingrid Phillips, Paediatric Long Term Conditions Nurse, by email. She agreed that he should have been seen in secondary care and saw him in clinic within a month.  
Ingrid did not change my regime, but she did say that she would be looking at their pathways to ensure that the system ensures that all high-risk patients especially post HDU/ITU are followed up by the consultant.



#### 3. Comparison to usual/old pathway

- I** Two opportunities for this high-risk patient to be seen or referred to secondary care were not taken.  
I referred him and he was seen within a month.  
Ingrid is looking at their pathways to stop a repeat.

#### 4. Patient Outcomes

- I** The high-risk patient was seen by secondary care within a month. His condition can now be monitored and managed in an appropriate setting.

#### 5. Impact

- I** This patient is high risk, he should be managed by experts in secondary care.  
One of the main risk factors for a life-threatening asthma attack is having had one previously, this patient is in that category. Being managed in secondary care will reduce his risk of another attack.

#### 6. Stakeholder Feedback

- I** I had an email from Ingrid thanking me for the referral and highlighting the missed opportunities for this patient to be seen in secondary care. In it she also said she would be looking at their pathways to stop a repeat.

## Data Quality Assessment of LOGIC Model: Pembrokeshire Primary School Respiratory (NP0018, SP0015)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>PROMS - Childhood Asthma Control Test (CACT) ✓</li> <li>Improved inhaler technique post demo ✓</li> <li>Changing from MDI to DPI (Switch 6) ✓</li> <li>Smoking adults quantities with children with respiratory complications &amp; smoking cessation referrals ✓</li> <li>Action plan issued ✓</li> <li>NHS Wales App information provided ✓</li> </ul>	
Amended	<ul style="list-style-type: none"> <li>Early diagnosis &amp; also including change in diagnosis post consultations ✓</li> <li>Adherence to preventer medication ✓</li> <li>Reduction in A&amp;E attendances, school days lost &amp; GP appointments for acute exacerbations potentially reflected in Patient / Parent feedback and Case studies ✓</li> </ul>	
Additional	<ul style="list-style-type: none"> <li>NHS Number &amp; Date of Birth ✓</li> <li>Number of consultations ✓</li> <li>GP Practice &amp; School ✓</li> <li>Referrals to secondary care ✓</li> <li>OOH / A&amp;E visits, antibiotics &amp; oral prednisolone for chest in past 2 years ✓</li> <li>Respiratory Reviews in past 12 months ✓</li> </ul>	
<b>Measures not being collected</b>		
Data collection under review	<ul style="list-style-type: none"> <li>Reduction in A&amp;E attendances &amp; bed days in hospital overnight stays</li> </ul>	
Unable to collect	<ul style="list-style-type: none"> <li>Reduction in premature death</li> </ul>	

**Key**  
 ✓ = Data available  
 ✗ = Data awaited from service  
 ! = Data collection in development

# Partners for the Journey (Mind and CAB)



Code	Name
PX0017	Partners for the journey

Baseline	Aim	Update as at	Commentary	RAG	Trend
		Apr 2024	Project supported by both Pembrokeshire Clusters and RIF Funding continues to deliver support from both Mind and CAB. We are having monthly meetings with the team as working group.	●	➔

Ref	Measure Description	Update as at	Commentary	Value	RAG	Trend
M00336	Total number of clients helped	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	189	●	➔
M00337	Clients seen by Citizens Advice	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis. They have seen a rise of need especially within certain areas of Pembrokeshire	115	●	➔
M00338	Clients seen by Mind	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	74	●	➔
M00339	Number of clients worked with collaboratively	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	27	●	➔
M00340	Total number of clients whos issues were resolved (Citizens Advice)	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis. They have seen a rise of need especially within certain areas of Pembrokeshire	74	●	➔
M00341	% of clients whos issues were resolved (Citizens Advice)	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	64.4%	●	➔
M00342	Total number of clients with Benefit & Tax Credit Queries	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis. They are see a lot of activity within the system	85	●	➔
M00343	Total number of Benefit and tax queries resolved	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	68	●	➔
M00344	% of cases benefit and tax cases resolved	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	80.0%	●	➔
M00345	Total number of clients with Debt Queries	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	21	●	➔
M00346	Total number of Debt queries resolved	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	4	●	➔
M00347	% of cases Debt cases resolved	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	19.0%	●	➔
M00348	Value of income gained	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	£55,783	●	➔
M00349	Value of Debt written off	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	£42,150	●	➔
M00350	Total number of clients MIND referred to Active Monitoring	Apr 2024	The project continues to operate at full capacity and is supporting the patient population in the cost of living crisis	10	●	➔
M00351	% number of Mind clients seeing an improvement in their well being measures (comprising of SWEMWBS, PHQ9 & GAD7)	Apr 2024	100% for PHQ9, 100% GAD7, 100% SWEMWBS	100.0%	●	➔

- Project Start Date: 2020
- Project End Date: Apr 2025
- Narrative updated 20/05/2024

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
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# North Pembrokeshire

# Cluster Pharmacist



Code	Name
NP0001	Cluster Pharmacist

Baseline	Aim	Update as at	Commentary	RAG	Trend
Cluster Pharmacist in post, evaluation of change in project focus due to Covid ongoing	Rapid clinically safe reconciliation of discharge medication. -Improved governance for repeat prescribing for those patients as seen under the project. Fast access to pharmaceutical advice for General Practitioners. Improved cross sector working	Apr 2024	Band 8a Cluster Pharmacist is currently on sickness leave and unsure of return date.	🔴	⬇️

Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00361	Patient discharge summary reviews undertaken			May 2024	Awaiting Data, pharmacist currently off sick		🔴	⬇️
M00362	Number of Intermediate Care MDT meetings supported			May 2024	Awaiting Data, pharmacist currently off sick		🔴	⬇️
M00363	Clinical upskilling activity undertaken to increase capacity in Community Pharmacy			Apr 2024	There are currently 2 Pharmacists within the Cluster that are in the process of completing their IP training.	2	🟢	➡️

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00173	Presentation to the Cluster on findings	April 2023	May 2024	The cluster pharmacist has not presented findings at a cluster meeting and is currently on leave of absence.	🔴	⬇️
AC00174	Evaluation of project to date	April 2023	May 2024	Currently with Dr Dew for comments	🟡	⬇️
AC00175	Consider development of the current project to increase Pharmacist support and capacity.	April 2023	May 2024	Currently with Dr Dew for comments	🟡	⬇️
AC00176	Explore the potential to develop additional support for targeted patients identified as high risk during the discharge process	April 2023	Jan 2024	Cluster Pharmacist will now be based in South Pembrokeshire Hospital twice a week to support with discharge planning and MDTs targeting high risk patients	🟢	➡️

- Project Start Date: 2017
- Project End Date: Ongoing (Permanent employment)
- Measurement data not routinely reported. Matt McGivern is currently undertaking an evaluation of activity and long-term use. Recommendations will be shared with cluster leads from Q1 2024/25.
- Narrative updated 20/05/2024

# Improved Multi-disciplinary Team working through employment of Care Co-ordinators



Code	Name
NP0003	Improved Multi Disciplinary Team working through employment of Care Co-ordinators

Baseline	Aim	Update as at	Commentary	RAG	Trend
- 4 Care Co-ordinators recruited who commenced in role during May & June 2021. - MDT meetings re-established in all eight GP Practices. -Expanded MDT membership being developed	To improve lines of communication between the community hubs (Intermediate Care Team and Integrated Community Team) and General Practice and support the continued development of joint Community and Primary Care models of working. To understand ways of working in both General Practice and the Community; bringing together these, to promote a new level of understanding and share purpose in all of the multi-disciplinary roles across Primary and Community Care. Care Co-ordinators will be encouraged to form a strong relationship with their counterparts in the Intermediate Care Hub to improve and enhance the patient journey and to bring professionals together to speed up the responses to patient need.	Apr 2024	The Care Coordinators continue to work across the 8 practices across the Cluster and monthly MDT meetings are operating sufficiently.	●	→

Ref	Measure Description	Update as at	Commentary	Value	RAG	Trend
M00212	Number of MDT meetings	Apr 2024	MDT meetings occurring in all 8 practices, some monthly, others fortnightly	36	●	↑
M00213	Number of patients referred into service	Apr 2024	There has been a decline in the quantity of referrals received by the service in the past three months. As mentioned above, the majority of referrals still originate from GPs, but there has been a rise in referrals from Clinical Nurse Specialists.	225	◆	↓
M00216	Patient recorded outcomes of improvements	Apr 2024	Meeting with care coordinator 21/05/24 to discuss extracting this data		●	●
M00364	Attendance by professionals at MDT meetings	Apr 2024	Currently attendance by professionals at the MDT meetings is stable.	144	●	→

- Project Start Date: 2022/23
- Project End Date: August 2024
- Narrative updated 20/05/2024

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00178	To liaise with Social Services, Secondary Care, Primary Mental Health teams, Community Connectors and other Third Sector providers.	April 2023	Apr 2024	MDT meetings within the Cluster encompass all specified services and have strong representation. Continuous monitoring of the services in attendance is conducted, with connections forged with Heads of Service to tackle any arising concerns.	●	→
AC00179	To provide a single point of contact for GPs in identifying and co-ordinating appropriate care for vulnerable patients. The co-ordinator will manage a case load for the Practice and feedback where appropriate – this will be a task and finish process.	April 2023	Apr 2024	Care Coordinators serve as the primary point of contact within each practice, overseeing a caseload and ensuring that the necessary services are present at MDT meetings to facilitate comprehensive care for patients who are vulnerable.	●	→
AC00180	To support GPs and their patients by arranging for the right professional to support them, at the right time, helping to ensure a consistency of approach; specifically, although not exclusively, around patients in their own homes, the frail and elderly.	April 2023	Apr 2024	Risk stratification efforts are beginning throughout the Cluster. Utilising this tool for proactive care planning will help prioritise the frail and elderly without limiting the flexibility to tailor data searches for various patient groups to be discussed at MDT meetings.	●	→
AC00181	To help facilitate the multi-disciplinary processes in Primary Care, and where necessary implement new groups of multi-agency professionals – encouraging the submission of referrals, assisting with the organising and administrating meetings, monitoring caseloads and ensuring feedback to clinicians.	April 2023	Apr 2024	Fresh teams have been assembled for activities that had not been attempted before using an MDT working method. Care Coordinators aid in the coordination and management of meetings. They participate in broader groups like Frequent Attenders to guarantee that the appropriate patients are reintroduced to practice MDTs for deliberation.	●	→
AC00287	To provide a single point of contact for GPs in identifying and co-ordinating appropriate care for vulnerable patients. The co-ordinator will manage a case load for the Practice and feedback where appropriate	April 2023	Apr 2024	Care Coordinators serve as the primary contact person within each practice, managing a caseload and ensuring that the necessary services are presented at MDT meetings to facilitate comprehensive care for patients in need.	●	→

# Increase access to defibrillators within the Community

Code	Name
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NP0011 Increase access to defibrillators within the Community

Baseline	Aim	Update as at	Commentary	RAG	Trend
Cluster proposal approved to purchase defibrillators to be held in Community Optometry Practices	Each Primary Care Optometry Practice within the North Pembrokeshire Cluster will be equipped with an Automated External Defibrillator with up to 4 people from each practice attending hands-on basic life support / CPR training event which includes use of AED's.	Apr 2024	Order placed on Oracle for defibrillators is unable to be fulfilled due to lack of stock. We have been unable to facilitate training for the items as we are awaiting delivery	🔴	➔

- Project Start Date: Apr 2024
- Project End Date: Sep 2024
- Narrative updated 20/05/2024

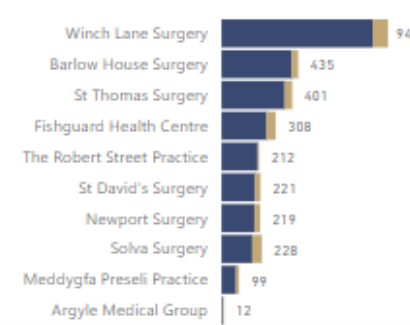
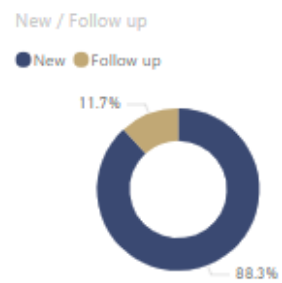
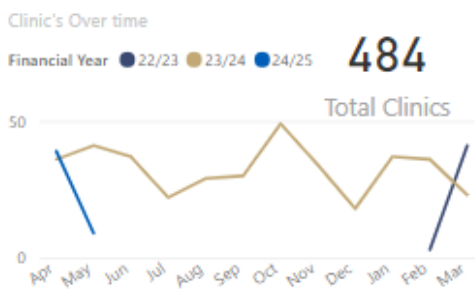
Ref	Measure Description	Target	Target Date	Update as at	Commentary	Value	RAG	Trend
M00240	Purchase of Defibrillators for Primary Care Optometry Practices via Procurement		Mar 2023	Apr 2024	0 training sessions delivered to staff as items have not been delivered	0	🔴	➔
M00241	Training for staff		Mar 2023	Apr 2024	0 training sessions delivered to staff as items have not been delivered	0	🔴	➔

Ref	Activity / Project	Due Date	Update as at	Commentary	RAG	Trend
AC00202	Purchase of Defibrillators for Primary Care Optometry Practices via Procurement	April 2022	Apr 2024	Unable to order through Oracle due to stocking levels	🔴	➔
AC00203	Training for staff	April 2022	Apr 2024	0 training sessions delivered to staff as items have not been delivered	🔴	➔
AC00204	Communication to the public on the availability of the defibrillators	April 2022	Apr 2024	Unable to communicate information to public as defibs have not been received and training has not taken place	🔴	➔

Project	Update as at	Commentary	RAG	Trend
First Contact Practitioner Physiotherapy Service (FCP) (NP0017)	April 2024	Full team of Physiotherapists working across the 8 practices.	●	➔

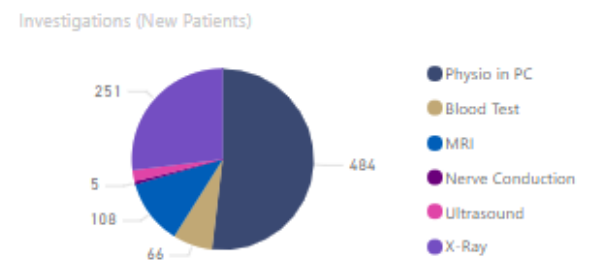
### Appointments

3672 Available  
3296 Booked  
90% Fill %  
289 DNA's

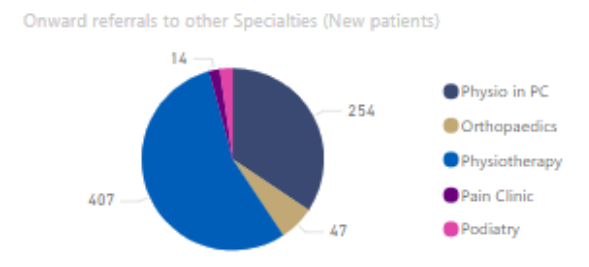


### Process

How many investigations were undertaken for new patients?





How many patients have been referred?



- Project Start Date: 2020
- Project End Date: Jan 2024, but still ongoing
- Data is being collated, however as auditable individualised data is not being collected, this has been flagged as a Data Quality Risk. New methods are being explored. Narberth Surgery (EMIS) & Preseli Practice (Vision) have tested & are currently using their respective templates within the clinical system to provide more robust individualised data - informed by practice managers & FCP's that it is working as expected. **Next step** is to assess and decide data extraction methods to extrapolate template & extraction for all clusters involved within this project. Lucie is in discussions with Jamel Bull (Vision in Primary Care) to establish costs feasibility and costs.
- Kristy is leading on a 'value for money' assessment to support ongoing discussions relating to the ongoing funding of this service.
- Narrative updated 03/05/2024

Data Quality Risk

## LOGIC Model Assessment and Data Source: FCP Physiotherapy Service (NP0017, SP0014, NC0005, SC0003, LL0005)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>• Patient pathways (New/Follow ups) ✓</li> <li>• Referrals to Orthopaedics in secondary care ✓</li> </ul>	 <a href="#">Static Link - FCP Form</a>  <a href="#">SharePoint Link - FCP Spreadsheet</a>
Amended	<ul style="list-style-type: none"> <li>• Patient pathways - Now recording: Onward referrals, investigations ✓</li> <li>• Individualised &amp; auditable data through EMIS &amp; Vision clinical systems !</li> </ul>	<p><b>Key</b></p> <ul style="list-style-type: none"> <li>✓ Data available</li> <li>✗ = Data awaited from service</li> <li>! Data collection in development</li> </ul>
Additional	<ul style="list-style-type: none"> <li>• Clinic fill rates - Clinic appointments available / Clinic appointments booked / DNA's ✓</li> <li>• Face-to-face vs virtual appointments ✓</li> <li>• Referrals to other specialities in secondary care - such as; Pain Clinic, Physiotherapy, Podiatry ✓</li> </ul>	
Measures not being collected		
Data collection under review	<ul style="list-style-type: none"> <li>• Patients receiving same day assessment and advice / demand for GP appointments through re-directing</li> <li>• Waiting times for patients accessing community Physiotherapy services</li> <li>• PROMS / PREMS</li> </ul>	
Unable to collect	<ul style="list-style-type: none"> <li>• Social Prescribing to local voluntary and community sector organisations</li> <li>• Physical activity of local population</li> <li>• Access to local services (carbon footprint)</li> </ul>	

Project	Update as at	Commentary	RAG	Trend
Trial without Catheter (TWOC) (NP0019)	May 2024	Clinics will be operational from the 27th May 2024.	●	➔

Approved due to begin: February 2024

Project duration: 1 Year

Project Status: In **Development**

Data quality comments: A draft data collection process has been created, awaiting testing and service to receive SOP approval.

- Project Start Date: February 2024
- Project End Date: February 2025
- This dashboard is **in development** – data collection process is in development and clinics due to begin towards the end of May.
- Narrative updated 17/05/2024

Project	Update as at	Commentary	RAG	Trend
Optom Equipment (NP0021)	May 2024	Equipment has been delivered and the Optom Cluster Lead will be distributing to the NP Opticians	●	➔

Approved due to begin: March 2024

Project duration: 2 Years

Project Status: In **Development**

Data quality comments: Data collection process being jointly developed by the service & health board.

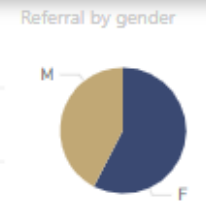
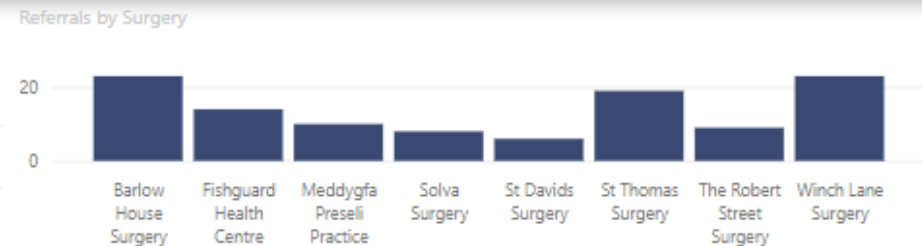
- Project Start Date: March 2024
- Project End Date: March 2026
- This project is in its early developmental stages – data collection process are being developed.
- Narrative updated 08/05/2024

Project	Update as at	Commentary	RAG	Trend
Advanced Care Planning (ACP) (NP0022)	May 2024	Project finished on the 31st March 2024, we have secured as collaborative working big lottery funding to secure advanced future care planning for additional three years within Pembrokeshire. We are going to continue working with Paul Sartori but we will not be supporting with funds moving forward.	●	➔

**118**  
Referrals

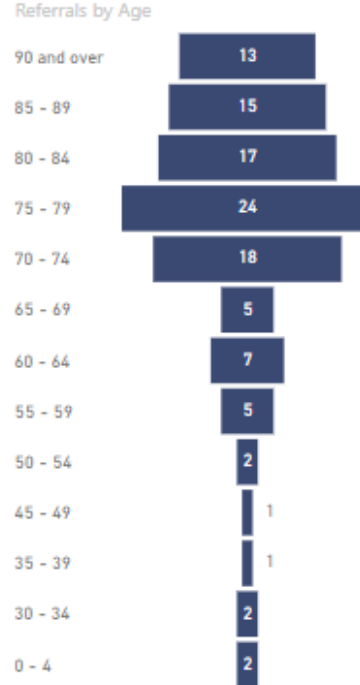
**548**  
Total Contacts

**30.54**  
Average Time per Contact (Mins)

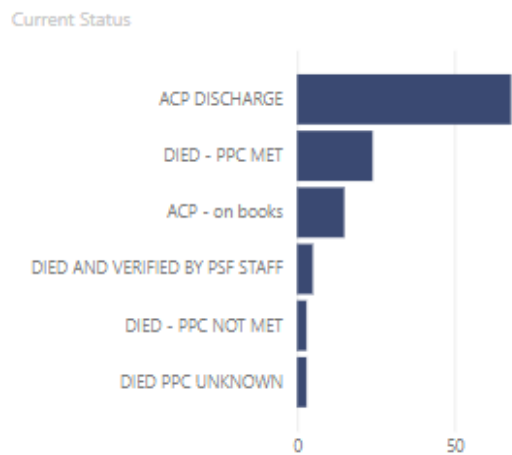


Outcomes

Outcomes	Count
Statement of Wishes and Care Preferences	26
Advanced Decision to Refuse Treatment	24
ACFP discussion	17
ACFP -declined referral	9
Died during ACP process	9
Drafted documents - add further outcome	8
LPA advice / information provided	8
Deteriorating condition-inappropriate to continue	7
ACFP Information only sent	6
Liaison with-add further outcome /free text	6
Do Not Attempt Cardio-Pulmonary Resuscitation	4
Died before ACP contact	3
Failed contact attempts	3
Re-referral -Revised documentation	3
Planner/family completed own ACP	2
Record of Best Interest Decision	2
Drafted documents	1
Mental Capacity Assessment	1
Referral to other - add further outcome /free text	1
<b>Total</b>	<b>140</b>



Contact Location	Count
HOSP (ACUTE) - NHS	11
NHOME - OTH	46
OTHER LOCATION	1
PT HOME	436
RES CARE - LA	8
RES CARE - OTH	20
UNKNOWN	16
WGH ACU	6
WGH WARD 10	4
<b>Total</b>	<b>548</b>



- Project Start Date: April 2023
- Project End Date: March 2024
- Data has been provided recently by the service and a dashboard is now in **development**.
- Narrative updated 20/05/2024

## Data Quality Assessment of LOGIC Model: ACP – Paul Sartori (NP0022 & SP0016)

Are the measure as per the LOGIC model?

Data Sources

Yes	<ul style="list-style-type: none"> <li>• Number of referrals &amp; ACP's completed ✓</li> <li>• Impact of ACP service for clients - feedback ✗</li> <li>• Reduce impact on GP's &amp; other health professionals !</li> <li>• Patients remaining in their preferred place of care ✓</li> </ul>
Amended	
Additional	<ul style="list-style-type: none"> <li>• GP Practice ✓</li> <li>• Patient Identifiable data + age / gender ✓</li> <li>• Visits / meetings per service user ✓</li> <li>• Visit duration ✓</li> <li>• Potential cost saving due to ACP being met !</li> </ul>

**Key**

- ✓ = Data available
- ✗ = Data awaited from service
- ! = Data collection in development

Measures not being collected

Data collection under review	
Unable to collect	<ul style="list-style-type: none"> <li>• Reduce hospital admissions, emergency response calls &amp; meds</li> </ul>

# South Pembrokeshire

# Cluster Youth Resilience Project

Code	Name
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SP0004 Cluster Youth Resilience Project Children aged 8 to 18 years of age

Baseline	Aim	Update as at	Commentary	RAG	Trend
<p>Youth Project is established since October 2020 and the team is consists of 0.60 WTE Team Leader B7 RMN 1WTE Band 6 RMN 1 WTE Youth Worker (funded by the Local Authority) We are working with partnership with Local Authority, Mental Health and Child Health.</p>	<p>ExamThe service would be a resilience based therapeutic service for children and young people. The service will be systemic and would support extended family members to help the child recover from emotional distress, "A Family Wellbeing Service" "Early intervention and prevention for children and young people in improving resilience and wellbeing: 85% by March 2022 The focus of the support will be the child, but the support offered will need to be mirrored in the home environment to ensure the child receives reinforced messages to improve wellbeing. The service would need to provide individualised package of support focussing on the stress triggers that impact on the child's wellbeing. Collection of data and case stories</p>	Apr 2024	Project is fully supported by the 5 GP practices and the project is also working with stakeholders of Mental Health, Childrens Services and Education and School Services within Pembrokeshire County Council. We are currently updating our reporting template and we are currently working through data reporting complications as we are changing our reporting template with the Primary Care Data Team.	▲	↑

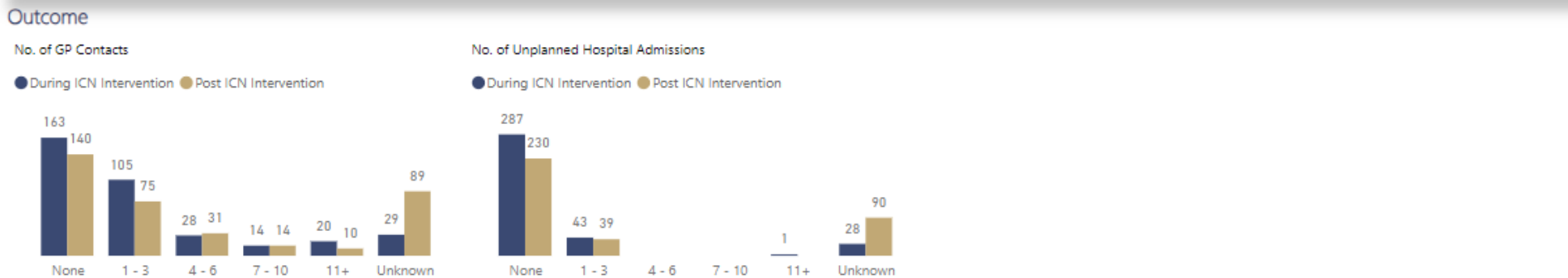
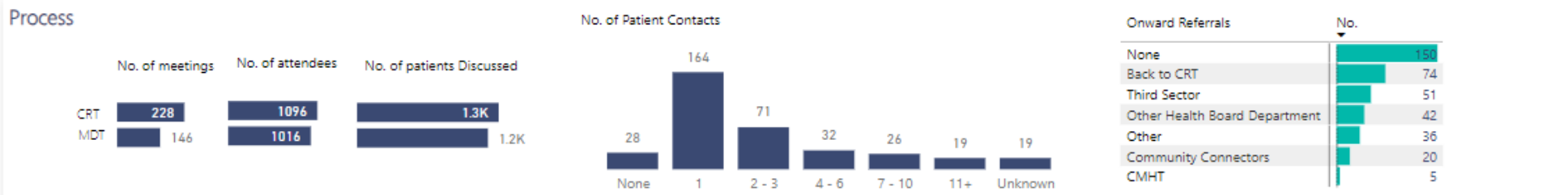
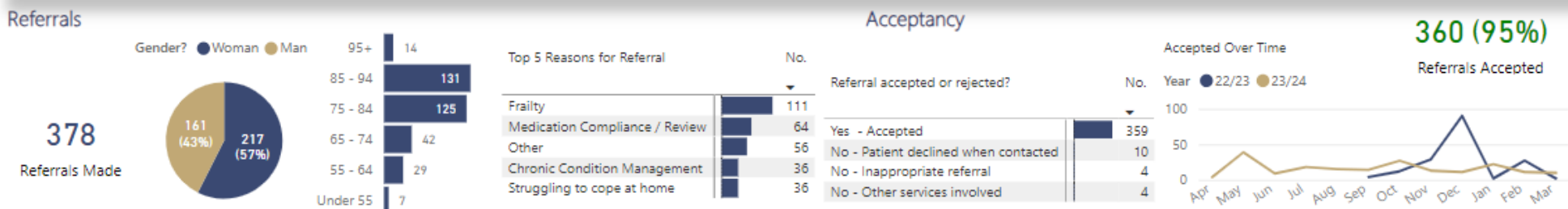
Ref	Measure Description	Update as at	Commentary	Value	RAG	Trend
M00266	Every intervention a feedback summary will sent to referring agency (Clinical Systems)	Apr 2024	Every patient seen has a feedback intervention form set to the clinical system and the Mental Health Team	100.0 %	●	→
M00267	A quarter report will also be produced to show outcomes and trends in referrals.	Apr 2024	Referrals to other places as well for support 1 x patients to CAMHS direct, 2 x Patients to School MDT, 5 x patient referred to Family Support, 3x Youth services, 3 x Neurodevelopmental Team, 1 x College Counsellor, and 7 patient's referred to Koot. 1 to attend Parent partnership support and 3 x EHW	100.0 %	●	→
M00268	Number of children & young adults referred to service	Apr 2024	10 patients ended support during this period. 52 number of services users still supported through this reporting period as ongoing.	55	●	→
M00269	Diagnosis trends	Apr 2024	Main Concern of referral - Anxiety, school based Anxiety, Low Mood, Suicidal Intention, OCD, Behaviour, bullying, Family Dynamics, ADHD, ASD, Social Communication, Anger, Functional Impairment, Alcohol, Eating Difficulties, Refugee, Mental Health, Emotional Dysregulation, sleep management	73.0%	●	→
M00270	Therapies used	Apr 2024	1 x MARF referrals made	25	●	→
M00271	Patient evaluations & feedback	Apr 2024	We have case studies as well	4	●	→
M00272	Impact assessment on SC services	Apr 2024	No referrals direct into social services using additional resources to support families and children.	0.0%	●	→

Ref	Activity / Project	Update as at	Commentary	RAG	Trend
AC00229	Every intervention a feedback summary will sent to referring agency (Clinical Systems)	Apr 2024	All referrals are being sent back to clinical systems on EMIS & Vision. Ongoing	●	→
AC00230	Improving communication with Education and schools	Apr 2024	Relationships have been form with all the local schools in South Pembrokeshire cluster area from Primary and secondary schools.	●	→
AC00231	A quarter report will also be produced to show outcomes and trends in referrals.	Apr 2024	We are capturing the data on the quarterly reports are being set but we are currently working with the primary Care data team to be more streamlined with our data achievement across the whole system.	▲	→
AC00232	Liaise with Health Board's Primary Care Mental Health team & Local Authority Education Department on the significant increase in patient referrals following on from Covid-19	Apr 2024	Relationships have been form with all Stakeholders with the project and it is working well with positive feedback	●	→
AC00233	Next Steps funding opportunities	Apr 2024	This project is funded for 2 years	●	→
AC00234	Fully evaluate counselling and low level mental health projects	Apr 2024	The project is funded for 2 years	●	→

- Project Start Date: July 2023. However, data analytical support commenced December 2023.
- Project End Date: July 2025
- A new style dashboard will be developed for this project for Q4 reporting. A Logic assessment will also be developed.
- Data has been provided by local authority regarding Youth workers, but not by the Primary Mental Health Team.
- Data quality concerns – though we expect this to be rectified in early June
- Narrative updated 28/05/2024



Project	Update as at	Commentary	RAG	Trend
Cluster South Pembrokeshire Integrated Community Team Building Capacity (SP0009)	April 2024	A well establish team with a mix of clinical and non-clinical staff groups. All 5 GP practices have CRT and MDTs in place and linking in with e proactive Care Planning and linking in with Frequent Attenders meetings within Pembrokeshire the whole seamless approach to supporting the patient. We have purchase a risk stratification tool kit which was previous used in Swansea bay for the cluster to be able to link into the CRT/MDT working and the ICN project for over 65+.	●	↑



- Project Start Date: August 2022
- Project End Date: September 2024
- Additional nursing PROMS data capture has been implemented. This will be available to demonstrate by following quarter.
- Psychology & Med optimise data is also now available with dashboard pages in development.
- Risk Stratification Toolkit purchased to support ICN and CRT working. Dashboard to be updated to include relevant data.
- Narrative updated 03/05/2024

## LOGIC Model Assessment and Data Source: Integrated Community Network (SP0009)

Are the measure as per the LOGIC model?

Data Sources

Yes

- Case Stories - Number of referrals / reason for referral / onward referrals ✓
- PROMS (Psychology & Pharmacy) ✓
- PREMS !



[SharePoint Link – ICN Spreadsheet](#)



[SharePoint Link – IMTP Spreadsheet](#)

Amended

- Cluster maturity through enhanced system working, co-ordination & collaboration - Now recording: quantity of CRT & MDT meetings, attendees and patients discussed ✓
- Unscheduled care admission from care homes - Now recording: unplanned hospital admissions ✓

Additional

- Number of patient contacts / number of GP contacts ✓
- Gender & Age ✓

**Key**

- ✓ = Data available
- ✗ = Data awaited from service
- ! = Data collection in development

Measures not being collected

Data collection under review

- Immunisations & vaccination rates (further discussions need to be had to understand whether it will be part of core GMS service vs cluster funded implementation)

Unable to collect

- Number of people with a Stay Well plan
- WAST attendances to Care Homes

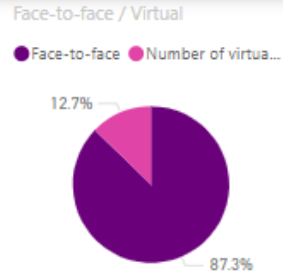
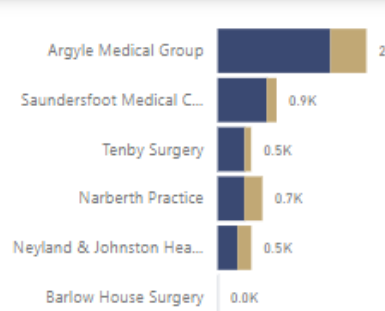
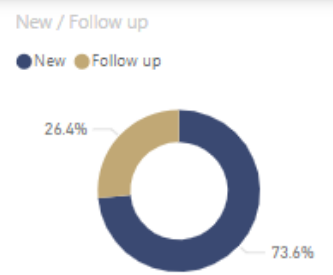
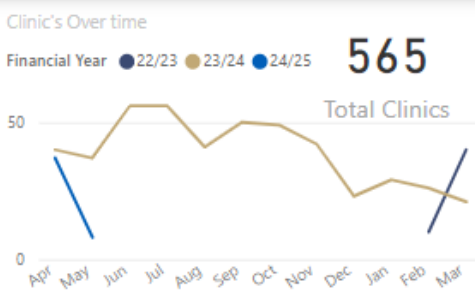
# First Contact Practitioner Physiotherapy Service [Page 1 of 2]



Project	Update as at	Commentary	RAG	Trend
First Contact Practitioner Physiotherapy Service (FCP) (SP0014)	April 2024	The service is operating at a reduction of 20% we have backfill some of the previous physio FCP hrs with additional FCP hrs from North Pembrokeshire part time FCP roles this will continue until July 24. We have recruit to the vacant role and the FCP Physio will be starting with us in July 24.	▲	➔

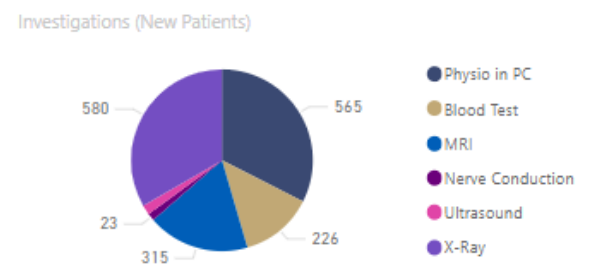
## Appointments

5026 Available  
4957 Booked  
99% Fill %  
329 DNA's

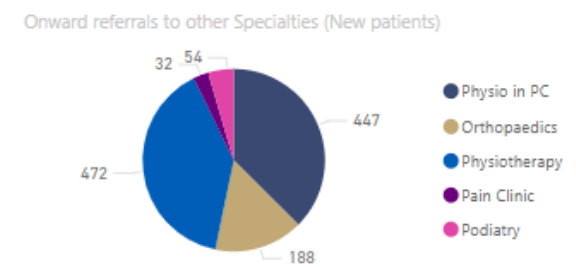


## Process

How many investigations were undertaken for new patients?





How many patients have been referred?



- Project Start Date: 2020
- Project End Date: Jan 2024, but still ongoing
- Data is being collated, **however as auditable individualised data is not being collected, this has been flagged as a Data Quality Risk.** New methods are being explored. Narberth Surgery (EMIS) & Preseli Practice (Vision) have tested & are currently using their respective templates within the clinical system to provide more robust individualised data - informed by practice managers & FCP's that it is working as expected. **Next step** is to assess and decide data extraction methods to extrapolate template & extraction for all clusters involved within this project. Lucie is in discussions with Jamel Bull (Vision in Primary Care) to establish costs feasibility and costs.
- Kristy is leading on a 'value for money' assessment to support ongoing discussions relating to the ongoing funding of this service.
- Narrative updated 03/05/2024

Data Quality Risk

## LOGIC Model Assessment and Data Source: FCP Physiotherapy Service (NP0017, SP0014, NC0005, SC0003, LL0005)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>• Patient pathways (New/Follow ups) ✓</li> <li>• Referrals to Orthopaedics in secondary care ✓</li> </ul>	 <a href="#">Static Link - FCP Form</a>  <a href="#">SharePoint Link - FCP Spreadsheet</a>
Amended	<ul style="list-style-type: none"> <li>• Patient pathways - Now recording: Onward referrals, investigations ✓</li> <li>• Individualised &amp; auditable data through EMIS &amp; Vision clinical systems !</li> </ul>	<p><b>Key</b></p> <ul style="list-style-type: none"> <li>✓ Data available</li> <li>✗ = Data awaited from service</li> <li>! Data collection in development</li> </ul>
Additional	<ul style="list-style-type: none"> <li>• Clinic fill rates - Clinic appointments available / Clinic appointments booked / DNA's ✓</li> <li>• Face-to-face vs virtual appointments ✓</li> <li>• Referrals to other specialities in secondary care - such as; Pain Clinic, Physiotherapy, Podiatry ✓</li> </ul>	
Measures not being collected		
Data collection under review	<ul style="list-style-type: none"> <li>• Patients receiving same day assessment and advice / demand for GP appointments through re-directing</li> <li>• Waiting times for patients accessing community Physiotherapy services</li> <li>• PROMS / PREMS</li> </ul>	
Unable to collect	<ul style="list-style-type: none"> <li>• Social Prescribing to local voluntary and community sector organisations</li> <li>• Physical activity of local population</li> <li>• Access to local services (carbon footprint)</li> </ul>	

Project	Update as at	Commentary	RAG	Trend
Advanced Care Planning (ACP) (SP0016)	May 2024	Project finished on the 31st March 2024, we have secured as collaborative working big lottery funding to secure advanced future care planning for additional three years within Pembrokeshire. We are going to continue working with Paul Sartori but we will not be supporting with funds moving forward.	●	➔

**104**  
Referrals

Referrals over time

Financial Year ● 23/24



**433**  
Total Contacts

Contacts over time

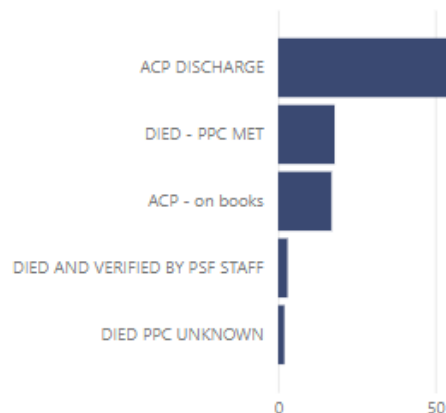
Financial Year ● 23/24



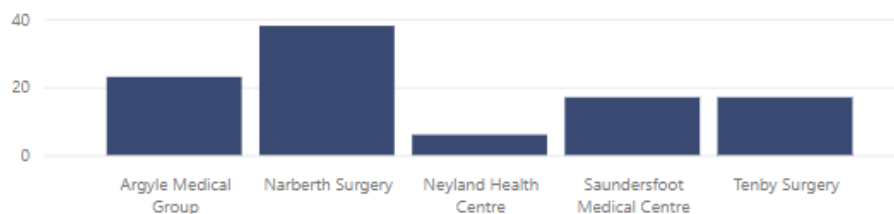
**32.86**  
Average Time per Contact (Mins)

Current Status

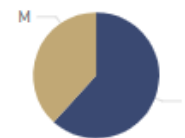
Contact Location	Count
NHOME - OTH	20
OTHER LOCATION	1
PT HOME	362
RES CARE - OTH	45
SPH SUNDERLAND WARD	2
UNKNOWN	3
<b>Total</b>	<b>433</b>



Referrals by Surgery

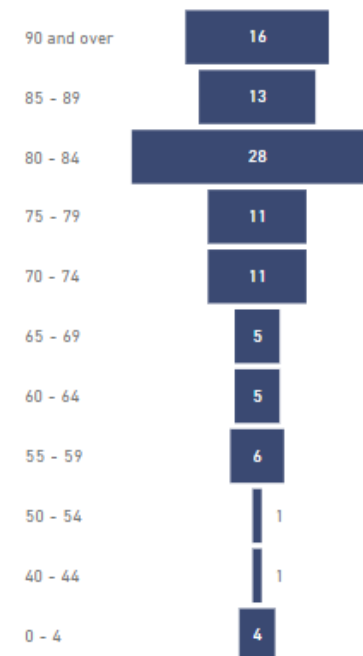


Referral by gender



Outcomes	Count
Advanced Decision to Refuse Treatment	30
Statement of Wishes and Care Preferences	25
Do Not Attempt Cardio-Pulmonary Resuscitation	15
AFCP discussion	14
LPA advice / information provided	8
Deteriorating condition-inappropriate to continue	6
Died during AFCP process	4
Mental Capacity Assessment	4
Re-referral -Revised documentation	4
Died before AFCP contact	3
Planner/family completed own AFCP	3
Record of Best Interest Decision	3
AFCP -declined referral	2
Referral to other - add further outcome /free text	2
AFCP Information only sent	1
Drafted documents - add further outcome	1
Liaison with-add further outcome /free text	1
<b>Total</b>	<b>126</b>

Referrals by Age



- Project Start Date: April 2024
- Project End Date: March 2027
- Data has been provided recently by the service and a dashboard is now in **development**.
- The cluster funding (Apr-23 to Mar-24) has now ended. However, this project is continuing via lottery funding for the next 3 years in Pembrokeshire. Therefore, we will continue to monitor and work collaboratively with Paul Sartori.
- Narrative updated 28/05/2024

## Data Quality Assessment of LOGIC Model: ACP – Paul Sartori (NP0022 & SP0016)

Are the measure as per the LOGIC model?		Data Sources
Yes	<ul style="list-style-type: none"> <li>Number of referrals &amp; ACP's completed ✓</li> <li>Impact of ACP service for clients - feedback ✗</li> <li>Reduce impact on GP's &amp; other health professionals !</li> <li>Patients remaining in their preferred place of care ✓</li> </ul>	
Amended		
Additional	<ul style="list-style-type: none"> <li>GP Practice ✓</li> <li>Patient Identifiable data + age / gender ✓</li> <li>Visits / meetings per service user ✓</li> <li>Visit duration ✓</li> <li>Potential cost saving due to ACP being met !</li> </ul>	
<p><b>Key</b></p> <ul style="list-style-type: none"> <li>✓ = Data available</li> <li>✗ = Data awaited from service</li> <li>! = Data collection in development</li> </ul>		
Measures not being collected		
Data collection under review		
Unable to collect	<ul style="list-style-type: none"> <li>Reduce hospital admissions, emergency response calls &amp; meds</li> </ul>	

Project	Update as at	Commentary	RAG	Trend
Optom Equipment (SP0017)	May 2024	Equipment has been delivered and the Optom Cluster Lead will be distributing to the SP Opticians	●	➔

Approved due to begin: March 2024

Project duration: 2 Years

Project Status: In **Development**

Data quality comments: Data collection process being jointly developed by the service & health board.

- Project Start Date: March 2024
- Project End Date: March 2026
- This project is in its early developmental stages – data collection process are being developed.
- Narrative updated 20/05/2024

Project	Update as at	Commentary	RAG	Trend
Trial without Catheter (TWOC) (SP0018)	May 2024	Clinics will be operational from the 27th May 2024.	●	➔

Approved due to begin: February 2024

Project duration: 1 Year

Project Status: In **Development**

Data quality comments: A draft data collection process has been created, awaiting testing and service to receive SOP approval.

- Project Start Date: February 2024
- Project End Date: February 2025
- This dashboard is in **development** – data collection process is in development and clinics due to begin towards the end of May.
- Narrative updated 17/05/2024