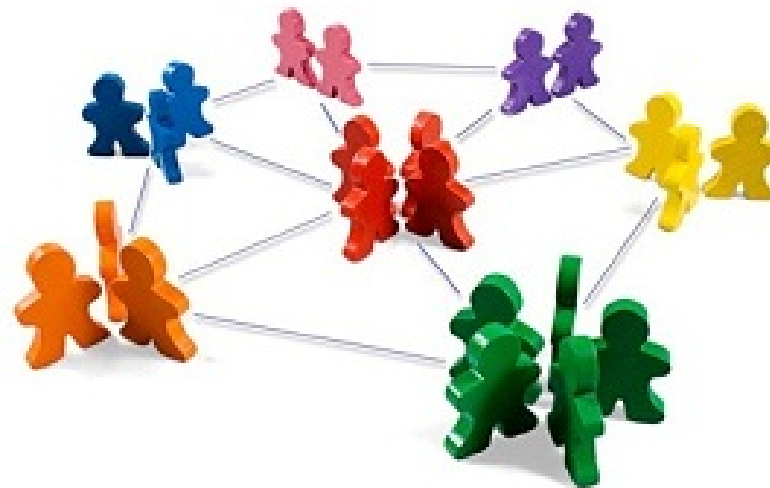
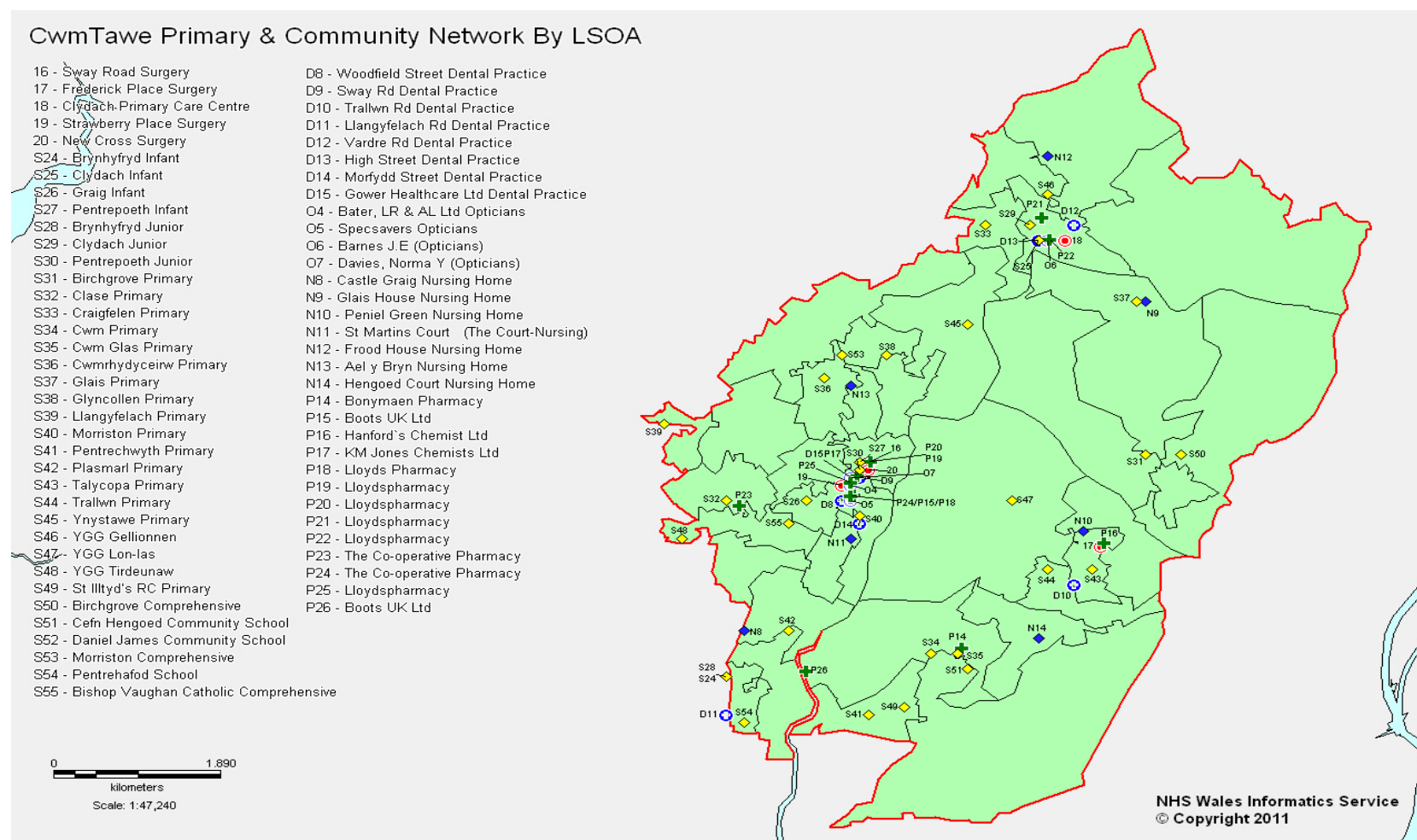


DRAFT
GP Cluster Network Action Plan 2016-17
Cwmtawe Cluster



Welcome to the Cwmtawe network/cluster plan for 2016/17. The Cwmtawe network based in Swansea is made up of five general practices working together with partners from social services, the voluntary sector, and the ABMU health board. Cwmtawe covers the area of Bonymaen, Clydach, Landore, Llansamlet, Morriston and Mynyddbach and has a registered population of approximately 42,717.

Cwmtawe Network by Lower Super Output area (LSOA)



List Size Structure Changes 2009-2014

	2009	2010	2011	2012	2013	2014	2015	Change 2009-15
Cwmtawe	42,282	42,500	42,720	42,984	42,989	42,983	42,772	490
Swansea	247,106	248,803	249,511	250,780	251,264	252,093	253,520	6,417

Networks aim to work together in order to

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

In order to support the development of the network cluster plan, information has been collated on a wide range of health needs within the Cwmtawe area. The summary below highlights the key points. The health needs information has been taken into account when developing the priorities for this plan.

Cwmtawe network has:

- 8 Dental Practices
- 10 Pharmacies
- 6 Nursing Homes
- 4 opticians
- 26 schools
- An average population of 19.8% above 65 years of age and an average population of 8.6% aged 75 years and above.
- Low student population
- Low ethnic minority patient numbers

- Low asylum seekers numbers
- Deprivation greater than Welsh Average and variable across the area. (Cwmtawe has 23% of patients living in the most deprived fifth of areas in Wales, compared to the Wales average of 20% using Welsh Index of Multiple Deprivation 2011)
- Has the joint highest prevalence of obesity out of Swansea networks
- Has the highest percentage of patients on the Diabetes register amongst Swansea networks

Age-standardised percentage of patients on selected chronic condition registers, GP clusters in ABM UHB, 2015, to indicate the relative burden of recorded disease across clusters having taken age into account,

	Cwmtawe Average	ABMU Average	Wales Average
Asthma	6.8	7.4	6.4
Hypertension	10.7	15.2	11.1
CHD	3.7	3.9	2.6
COPD	1.8	2.2	1.4
Diabetes	6.2	6.1	3.9
Epilepsy	0.9	0.8	0.7
Heart failure	1.1	1.0	0.6

- Has the third lowest rate (20%) of people who smoke in Swansea, however smoking remains the biggest cause of premature death and the Welsh Government has also set a target to reduce the prevalence of smoking to 16% by 2020, with an interim 2016 target of 20%.
 - o 3.4% of Cwmtawe's smoking population made contacts to Stop Smoking Wales (234 contacts), which is the 2nd highest of Swansea networks. *Source: Stop Smoking Wales service data, QOF data 2014-15*

- Has the second highest coverage of cervical screening in Swansea at 80.2 %
- Has the third highest uptake of Bowel Screening in Swansea at 54 %
- Flu Immunisation Uptake (2014-15):
 - o At-risk under 65s:39% - Lowest uptake out of Swansea networks*
 - o Over 65s: 59% - Lowest uptake out of Swansea networks*

*Source: Public Health Wales – Vaccine Preventable Disease Programme, data correct as at 24/03/2015. * Data for Cwmtawe did not include data for Llansamlet Surgery as the data was unavailable for collection.*

There is a significant overlap of registered patients who live in adjoining network areas, particularly Llchwyr.

This is the second cluster network development plan that has been produced by the network and it is the aim to further develop it over the coming years. The network will also be regularly monitoring progress against the actions contained within the plan.

Please note!

Green narratives are new actions.

Progress/current positions in red will need to be updated at the meeting.

Strategic Aim 1: To understand the needs of the population served by the Cluster Network

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
1	To provide care for the Frail Elderly population and to reduce the number of falls within network	Review the provision of care provided to Care homes: work with care home to reduce the impact on District Nursing Services and the practice once details of the enhanced service criteria are published Continue to review all patients over 85 years with more than 6 medications Chronic Conditions Nurses to work on the falls assessment and to	GP Practices; CCM team: Chronic Conditions Nurses/District Nurses GPs Voluntary Sector/ Social Services		Improve Community care Improve anticipatory Care and reduce admissions to hospital	Community pharmacist trained to immunise house bound patients reducing demand on District Nurses. Community pharmacist continues to review all patients over 85 with more than 6 medications April 17: Added to the work plan of the Chronic conditions nurses	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
		liaise with the ACT team.				to action	
2	Target increasing obesity levels	To continue to roll out of Weight management programme and review outcomes of the programme Increase referrals to National Exercise Referral Scheme	GPs; Chronic Care Nurses; District Nurses; Admin Staff Weight Watchers Positive Steps to roll out		Improved health for diabetics Better health for those patients with chronic diseases. Improved lifestyle choices leading to a less medicalised model of care Options for patients to self refer Patients to take responsibility of own health care	Cluster agreed to roll out; Weight Watchers providing allocation of vouchers to each practice Still having difficulties with. Contact made and new code and letters issued to practice managers. February17 –there has only been 1 referral to Weight Watchers. NERS attended Jan PLTS in order to increase referrals. Figures to Dec16 suggest that completion is not high for those that do attend.	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
		To develop links with local supermarkets to deliver ad- hoc clinics with involvement from dieticians and fitness advisors, within the supermarket.				To be picked up by C&D manager	
3	Reduce Smoking rates (19% of known smokers for person aged 15 and over with a recorded smoking status within preceding 27 months as at 31 st March 2015)	Review asthmatics that smoke with spirometry to establish if COPD patients. Develop an action plan to ensure that smokers are offered support Continue to signpost patients to stop smoking Wales and community pharmacies To develop a calendar of Stop Smoking Clinics to be advertised both in practices, by GP's and on webs sites.	Practices Admin staff; Community staff	Dec2016 Dec 2016 Ongoing	Healthier lifestyle	Little impact is being had and appears to be a lack of knowledge of when clinics are available. 09/03/17 March 17. New actiondelegated to the practice managers group to action	
4	Improve uptake of Vaccinations and	Flu: target everyone over 65, not only those	Practices; Admin staff;	Jan 2016	Improved health Improved	Flu plan needed to be developed by	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
	Flu Immunisations (Flu uptake aged 65+ 61%, Patients under 65 at risk 38% children aged 2-3 21.3%)	patients for QOF purposes Signpost patients Flu Busters campaign: possibly provide stands in practices Increase the uptake of Fluenz across the practice (adult and child programme). Ensure that a delivery plan is developed Diary note for September to obtain publicity material for Flu campaign to actively distribute within the community. Targeting the under 4's in particular.	Public Health Public Health Wales		immunisation levels	cluster/network 9/16. Public health to provide details of support that can be provided Nov16. Pharmacist now recd training to delivery flu vacs to housebound patients. Issues regarding Pharmacists in the community providing vacs to those that they are not meant to target. Highlighted to contract Manager	
5	To further develop the third sector support project increasing the use	Ensure that links are made with voluntary sector organisations supporting the agreed	GP practices/ Voluntary Sector organisations	Ongoing	Improved support and access to services for the Cwmtawe Network	Grant scheme advertised for counselling	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
	of voluntary sector services by the Cwmtawe network population	network priority areas where possible. Ensure that up to date information on voluntary sector services is displayed in GP practices, e.g. information stands, notice boards. Provide opportunities for third sector organisations to attend Protected Learning Time Sessions with GPs and non clinical staff SCVS to map Third sector provision against network priorities To review arrangements in relation to third sector organisations attending	/ SCVS GP practices supported by SCVS GP practices supported by SCVS GP practices supported by SCVS GP practices supported by SCVS	Ongoing Dec 2016 Ongoing	Population Improved knowledge of non medical methods of care	services. Dec16 No bids recd for the scheme. Agreed to extend the submission date to 31Dec and widen the age range. Panel to sit 3rd week in January17. Dec16. Mental Health approached to sit on the panel and advise. –no response. Panel to sit week commencing 16th Jan to review bids. Feb2017. 3 providers shortlisted and New Pathways selected- awaiting	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
		GP Practices and agree a way forward for the network. To trial a small grant scheme within the network area, with a specific focus on counselling. To trial for use on social prescribing project for patients experiencing low level mental health issues	GP practices supported by SCVS		Prudent health care for the patients	commencement date Dec16. Patient wellbeing questionnaire developed and to be facilitated by SCVS in January. Jan17. Results to be presented to Cluster to discuss solutions to issues arising. March17: Agreed preferred model of a link worker to refer patients to for social issues. Referred to Practice managers	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
						group to develop needs in partnership with SCVS.	
6a	To increase the use of the Healthy City Directory within the network	To continue to promote the use of the Healthy City directory within practices and to patients.	NHS Direct/Health Board/SCVS/ Voluntary Sector organisations	Ongoing	Network population more informed on available health and well being services leading to increased usage.	Ongoing use of and promotion of Healthy City Directory An event to be held at Forge Fach promoting Mental Health Services To be incorporated into the social prescribing project	
6b	To obtain patient and carer views on network services and priorities programme	To contribute to the success of patient/ carer participation group within the network area in line with the Community Voices programme Develop targeted	SCVS/GP Practices/Health Board	Ongoing	Responsive services taking into account service user and carer feedback.	Patient Participation Group established in Cwmtawe. Review of the group currently being undertaken by CVS See action 5.	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
		questionnaires to specific patient groups Pilot: PPG to be supplemented with questionnaires and focus groups targeting specific cohorts of patients. Cohort to be considered by Cluster.				Patient needs questionnaire being developed. Feb2017 Wellbeing questionnaire issued. Over 200 responses were received. Analysis being completed by SCVS. To be presented at March Cluster panel. March2017. Funding for PPG due to expire end of June 2017. Not effective for Cwmtawe in present format. Pilot to developed prior to funding expiring.	
7	Rollout of the Bowel	Pro-actively contact		Nov16-	Improved early	Conclusions of the	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
	Screening project subject to evaluation	patients to increase uptake of screening		March 17	detection of cancer	pilot were that it is possible to increase bowel screening participation using GP endorsement in ABMU, and that this must be balanced with opportunity costs of the intervention before deciding whether it is rolled out. Recommendations include follow up work with bowel screening Wales and sharing of information found with GP clusters who participated	

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

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
1	Review of patient demand and access arrangements across the community network	Undertake review in partnership with the Primary Care Foundation “managing access and urgent care in general practice”	Practices Primary Care Foundation	March 2016	Services developed to reflect local need in line with capacity to deliver safe and effective services	Cluster network agreed to defer date to collect work July 2017 -4 out of 5 practices agreed to undertake the review. Awaiting dates Nov16 Primary care Foundation data collection has taken place. Review meeting 12 January. Outcome: limited benefits to be had as most practices had already moved to the triage system. To be address via a communication plan	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
2	Assess potential list size increase with growth of further housing developments	Continue discussions with Local Authority Planning Department	Primary & Community Services Delivery Unit (Swansea) Local Authority Planning Department	Ongoing	Avoid difficulties in accessing GP appointments due to higher demand	Network representative at HB/LA meeting 15 th Aug 2016 HB work to identify key areas that this will affect	

Strategic Aim 3: Planned Care- to ensure that patients needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
1	Streamline access to Outpatient Departments and other services	Increase staff training and awareness of advice lines Audiology clinics commence Strawberry place 30th Sept. Continue with Rheumatology clinics Maximise usage of electronic referral templates	All practices Rheumatology GP Practices	Ongoing	Improving patient flow	Advice lines proving useful with good response rates. Feb2017 Audiology clinics are working well and are fully subscribed. Increase in number of clinics has been requested. Has been visited by the Health Minister	
2	PMS Plus – Respiratory Prescribing: to be considered on a network basis	To undertake a range of prescribing initiatives as required to improve respiratory prescribing	GP's within networks/ support from Medicines Management to be determined on	Mar 2015 and ongoing	Improvement in patient symptom control	Medicines management to assist all practices in completing All practices have agreed to	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
		CCN with specialist knowledge in respiratory medicine has been appointed. It is intended that this will be targeted and outcomes feed back to the cluster	practice level			undertake PMS Plus Feb2017 PMS plus to be extended for another year	

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

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
1	Reduce inappropriate visits/frequent users	Continue to explore increasing the use of telephone triaging Signpost patients to Third Sector /Voluntary services Promote greater understanding of A&E appropriate attendances using a patient questionnaire	Practices	Ongoing	Increase consultation activity for more appropriate patients Appropriate consultations for medical need, not medical want	To be raised at the next practice managers meeting Posters placed in reception rooms 'Ring 111' 'Access' leaflets	

		Monitor A&E attendances during core hours and inappropriate OOH contacts in core working hours and develop a communications/info awareness plan e.g choosing well or radio campaign Target frequent users groups Utilise 111 service when operational and ensure staff and patients are aware of there service. Access leaflet to be developed and to be placed in practices.				to be developed and placed on reception desk – to be developed as part of a communications plan March 2017. Leaflet developed and awaiting signoff by cluster April leaflet not signed off – further development needed.	
2	Reduce hospital admissions	Use of discharge summaries Proactive care; Anticipatory care Use of pathways Use of email advice lines Use of telephone advice lines Signpost to other community-	Secondary care Primary Care Community Care	Ongoing	More appropriate streamlined c are	Anticipatory care pilot to commence mid to end October Pilot now delayed until jan/feb17	

		based options (more amenable to patient) Refer to ACO/ACR Take up of the anticipatory care pilot.				Jan 17. Rollout now on hold pending decision from Alex Howells and Vicky Warner on direction of the project	
3	To engage as an early adopter in anticipatory care to work with people at most risk of losing independence	To act as the early adopter for anticipatory care, establishing systems to: - Identifying those most vulnerable of losing their independence - Identify care coordinator and care plan systems Develop effective means of communication	Community Hubs/older peoples mental health services	Before March 2016 (Cwmtawe next on roll-out)	Early identification of those patients most vulnerable of losing their independence. Care coordinator and care plan systems will assist those patients most at risk.	As above	
4	To improve antimicrobial stewardship	Antibiotic audit at all practices	Medicines management team	Ongoing quarterly monitoring trends	Reduced resistance. Reduced c.diff. Increased knowledge and empowerment to self care	Discussed at all annual practice prescribing visits. Cluster level data to be shared at forthcoming cluster meeting.	
5	Reduce prescribing of antibiotics.	Purchase of CRP machines by practices	GP practices	August 2016	Increased knowledge and confidence to self care and reduce	Once training has been provided in September the machines will be	

					disease resistance.	released for use. Nov16 Machines now being used by 4 of the 5 practices Evaluation not being undertaken Consistently. Where the machines are being used there is reasonable refusal to prescribe antibiotics. However it will be difficult to provide any conclusive data on a cluster level due to inconsistent data provided.	
6	National Chronic Kidney Disease Audit	To review the outcomes of the audit within the cluster To be scheduled for a PLTS session and outcome from the discussions to be brought back to the cluster for any actions to	GP practices		Increased knowledge and understanding, improving patient care	Audit Report issued January17	

		be considered.					
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Strategic Aim 5: Improving the delivery of end of life care

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
1	To improve the delivery of end of life care	To identify deaths occurring between 1st Jan 2016 and 31st Dec 2016 An appropriate clinician to have weekly contact with Nursing Homes to identify DNACPR Improve communication between GP's and support team so that patients are identified at an early stage and added to the palliative care register	GP practices	Statement to be provided March 2017	Improved care for patients	Discussions have taken place with the following points noted: - Need to identify patients for the palliative list. - To review lists regularly - To engage with Ty Olwen - To conduct split palliative care meetings End of Life Care template completed and shared with network to improve practice documentation	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
2	To improve prognostic indications in the delivery of the end of life care	Implementation of a prognostic indicator system across all practices e.g. traffic light system as suggested by the Gold Standards Framework	GP practices	June 2017			

Strategic Aim 6 : Targeting the prevention and early detection of cancers

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date/Current Position	RAG Rating
1	To target the prevention and early detection of digestive, lung and ovarian cancers	To carry out significant event analyses To summarise learning and actions to be shared with the cluster and LHB To share analyses and progress with the network and	GP practices	Statement to be provided March 2016	Better prevention and earlier detection of cancers for our patients	SEA undertaken	

		wider Health Board Forge closer working relations with Health Board colleagues in particular radiology					
2	Efficient referrals	Review and refresh care pathways	GP practices Secondary Care		Appropriate and efficient referrals	Update needed at meeting Jan 2017 Referral pathway improved	

Strategic Aim 7: Minimising the risk of poly-pharmacy

Objective	Action	Key partners	For completion by: -	Outcome for patients	Progress to date/current position	RAG Rating
Polypharmacy						
To progress polypharmacy issues identified in previous cluster network plan	To progress polypharmacy issues identified in previous cluster network plan	Medicines management team and Practice Teams	Ongoing	Improved prescribing and mechanisms for polypharmacy review	Ongoing work in practices also supported by the Medicines Management team	
To ensure appropriate use of the pharmacist and	Work with medicines	Medicines management	Ongoing	Improved access to better	Cluster Pharmacist appointed as well as	

technician resources (cluster and non-cluster funded) to reduce risks from polypharmacy and improve other aspects of medicines management	management team to deliver and ensure appropriate training, support and indemnity arrangements	team and Practice Teams		pharmaceutical care	other support from Health Board Medicines management team Work ongoing to clarify roles, training requirements and indemnity arrangements	
To engage in the Prescribing Management Scheme (PMS) and PMS+ respiratory schemes (which contain polypharmacy elements)	Undertake a range of prescribing initiatives to improve: respiratory, antibiotic, pain management prescribing and yellow card reporting	GPs Practice Nurses Medicines Management team	PMS 16/17 – by March 17 (some Dec 16 deadlines) PMS +respiratory – by Nov 17	Improved medicines management including polypharmacy Investment in other service areas for patient benefit	Discussed at all annual practice prescribing visits Practices engaged and making progress Medicines management team supporting where possible Scheme to be extended for another year	
Improvement/maintenance against national prescribing indicators	Consider and review practice and network data for national	Practice teams Medicines management team	Ongoing within 16/17	Improve prudent prescribing leading to better health outcomes and reduced	Discussed at all annual practice prescribing visits Work ongoing with	

	indicators			polypharmacy	the Medicines Management and Big Fight team	
The Big Fight – Improving Antimicrobial Stewardship. To improve antimicrobial stewardship through appropriate use of antibiotics	Implement mechanisms to ensure appropriate use of antibiotics (see also PMS 2016-17)	Practice team Big Fight Team Medicines management team	Ongoing with monitoring of trends See also PMS 16-17 for deadlines: Dec 16: • Overall antibiotic use and choices • Acute Cough Audit • Improvement Plan March 17: • Evidence of patient engagement activities	Reduced antimicrobial Resistance Reduced C.Diff Increased knowledge and empowerment to self care	Discussed at all annual practice prescribing visits. Development of cluster level data available on GP portal	

Strategic Aim 8: Deliver consistent, effective systems of Clinical Governance

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current	RAG Rating
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						Position	
1	Maintain and improve safe and robust systems within the practice	Continue use of CGPSAT toolkit for 2015-16 Use of Significant Event Analysis to highlight themes and trends - Each practice to bring one SEA to each cluster meeting Continue with effective PLTS programme	GP Practices	Ongoing Discuss at cluster meetings Network PLTS sessions held every 2 months	Improve service	CGPSAT submission by 31 st March 2016	
2	Development of E-prescriptions project	Undertake a cost benefit analysis of implementing E-prescriptions for Patients, Practices and Pharmacists Visit an English practice to look at good practice and the implications of implementation within the practice Report back to the Cluster Network on findings	GP practices Health Board Pharmacists	January/February	Improved service for patients Reduced demand on GP's and practice staff	Project development meeting taken place 07/09/16 Project deferred Med management wish to pilot another project regarding prescriptions with Cwmtawe instead Project pilot allocated to Bridgend.	

						Possible that Cwmtae may be involved in some way.	
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strategic Aim 9: Other Locality issues

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
1	To evaluate the benefit of having 2 chronic conditions nurses employed by cluster	To establish key roles and responsibilities for the CCNs to enable evaluation to take place. To establish work plan reflective of cluster needs Compile an evaluation of progress quarterly to be reported to the cluster	GP Practices	March 2018	Better care within the community Improved access	PLTS session on their role in the cluster and what practices want at end of march 17.	
2	To increase counselling services to young people	Allocate funds to contract service provision via the voluntary sector. Review progress quarterly on the impact/benefit to patients.	GP practices Voluntary Sector		Improved access to service Better Patient Care	Specification to be drawn up. Potential for joint working with another Cluster network Grant scheme advertised via SCVS	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
						Jan17. 5 Bids received and sent to panel in advance of evaluation on 31 January Feb2017 Shortlisted 3 and requested presentation from them. New pathways awarded the Grant –letter to be issued to them. Awaiting start date	
3	Expand INR service (increase capacity)	Development/expansion of service to be explored	Health Board	3months	Better patient care within community Safer/higher quality/more convenient care setting	£0.5million awarded to ABMU for roll out of Swansea INR model Service not yet expanded as national specification awaited. However ABMU has received additional funds to expand the service for 2016/17. Current service continues to operate effectively.	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
						Jan 17. Project direction in process of being reviewed before moving forward Paper to Board –awaiting outcome. March2017- Paper deferred.	
4	Sustainability of general practice	To raise issues relating to the need for additional investment into primary care highlighting increased expenses, e.g. Superannuation costs	GPs Health Board Welsh Government	ASAP	More sustainable model of general practice	Discussed by network at 1st cluster meeting To continue to be raised at a national level Feb2017 Appointment of CCN's, grants for counselling and proposals for Social prescribing. Employment of a part-time Commissioning and Development Manager. To remain on Cwmtawe Risk Register	

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to date/Current Position	RAG Rating
5	Workforce development	Review PLTS arrangements Establish a directory of training available for non-clinical staff. E.g. customer care training Each practice to organise a PLTS session. Social prescribing to be presented Jan 17	GP's Health Board Training Providers SCVS	Ongoing	Improved patient care from experienced and knowledgeable staff.	To be moved forward at cluster practice managers meeting –Topics need to be identified. List of PLTS sessions held across the clusters sent to Practice Managers. Practice managers each organising a PLTS March 2017. SCVS to develop a directory of training available within the community to be distributed to clusters.	