Cluster Network Action Plan 2016-17

(Third year of the Cluster Network Development Programme)

Conwy West Cluster

The Cluster Network[1] Development Programme supports GP Practices to work to collaborate to:

- Understand local health needs and priorities.
- Develop an agreed Cluster Network Action Plan linked to elements of the individual Practice Development Plans.
- Work with partners to improve the coordination of care and the integration of health and social care.
- Work with local communities and networks to reduce health inequalities.

The Action Plan should be a simple, dynamic document and in line with CND 002W guidance.

The Plan should include: -

- Objectives that can be delivered independently by the network to improve patient care and to ensure the sustainability and modernisation of services.
- Objectives for delivery through partnership working
- Issues for discussion with the Health Board

For each objective there should be specific, measureable actions with a clear timescale for delivery.

Cluster Action Plans should compliment individual Practice Development Plans, tackling issues that cannot be managed at an individual practice level or challenges that can be more effectively and efficiently delivered through collaborative action.

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[1] A GP cluster network is defined as a cluster or group of GP practices within the Local Health Board’s area of operation as previously designated for QOF QP purposes

To understand the needs of the population served by the Cluster Network

The Cluster Profile provides a summary of key issues. Local Public Health Teams can provide additional analysis and support. Consider local rates of **smoking, alcohol, healthy diet and exercise – what role do Cluster practices play and who are local partners.** Is action connected and effective? What practical tools could support the delivery of care? Health protection- **consider levels of immunisation and screening**- is coverage consistent- is there potential to share good practice? Are there actions that could be delivered in collaboration- e.g. **Community First** to support more effective engagement with local groups.

No	Objective	For completion by: -	Outcome for patients	Progress to Date
1	To review the needs of the population using available data	Completed annually prior to cluster plan submission.	To ensure that services are developed according to local need	PHW have carried out a review of population needs (to Cluster level) using the Practice Development Plans and Observatory data. PHW reviewed the population needs and identified the following priorities, Life style management (smoking, obesity, and alcohol), Mental Health, Chronic Disease Management including self-managing programmes. Isolation and Loneliness in older people and flu immunisation uptake.
2	To identify additional information requirements to support service development	Completed annually prior to cluster plan submission.	Improved support for service development	Practices engage with their patients via patient forums, patient questionnaire, review referral and access data to inform service development. The following service areas have been identified which could be potentially delivered working in collaboration:

				Pharmacy Services, phlebotomy, Incontinence Nurse, Residential Care Homes patients, Designated Practice Nurse to review e.g. Diabetic Nurse.
3	To consider learning from previous analyses to identify any outstanding service development needs	On-going	Improved access to services, patient care and health prevention.	Conwy West area has a varying population profile including migrant workers in the tourist industry. Increase number of temporary residents during Summer months. Isolated rural populations. Higher older person's population. Delivery of bilingual services, new care facilities demand on GP practice services and needs associated with care of patient with dementia. The cluster has commissioned a community navigator scheme in partnership with the third sector.
4	To develop a plan to contribute to the reduction in prevalence of smoking	Completed	Improved health outcomes Improved quality of life.	Cluster performance against the 5% target for referral to smoking cessation service needs further update. Smoking cessation plan is in place. (please refer to priority 1).
PLEASE NOTE THIS PIECE OF WORK WILL BE SUPPORTED BY PUBLIC HEALTH WALES AND YOUR LOCAL AREA TEAMS				

Cluster Overview – Conwy West

Conwy West comprises of 12 GP practices providing a full range of services. Resilience, sustainability and recruitment issues continue to dominate the concerns of the GP practices across the cluster. Llys Meddyg, Castle Street, Conwy and Lonfa, Glyn y Marl Road, Llandudno Junction have tendered their resignation from the GMS contract. Proposals in relation to Llys Meddyg, are being submitted to the LHB in October 2016. Meddygfa Gyffin, Conwy and Lonfa, Llandudno Junction are working towards merging their practices.

Population needs summary from 2015 Practice Development Plans - Suggested top 3 priorities

- Lifestyle management (smoking, obesity and alcohol)
- Chronic disease management including self management programmes
- Mental health

Specific population features: Emerging themes from all Practices.

- Varying population profile including migrant workers working in tourist industry
- Increase number of temporary residents during Summer months increase demand on GP practice services, some practices geographically located in resort areas receive 'passing trade'
- Isolated rural populations
- High older persons population; living in own home or nursing/residential care.
- Delivery of bilingual service identified
- 'New' care facilities increase demand on GP practice services
- Needs associated with care of patients with dementia

This may be important for identifying opportunities for collaboration with other practices, community teams or voluntary sector organisations: Emerging themes from all Practices.

- Some close geographically located practices meet together (within their cluster) (Llandudno/Penrhyn Bay) as practices identify similar areas increasing demands
- Several practices identify the following service areas which by working together as practices could be delivered differently -
    - Pharmacy services
    - Demands on District nursing service suggestions for Practices to work together to establish phlebotomy service (to reduce demand on District nursing service)
    - Incontinence nurse to support the District nurse service
    - Patients of more than one GP practice are resident in residential/nursing homes – care of these patients could be delivered differently by 1 GP working across practices.
    - Designated Practice nurse to review diabetic patients

POPULATION NEED

	Conwy West	BCU HB	Ref
Total list size	Approx 62,730 (increase of 0.9% between 2005 and 2014)		GP Cluster profiles BCUHB (2013 Public Health Wales NHS Trust)
% of patients 65 +	23.9% (15,010)	20.4%	
% of patients 85+	3.6% (2,250)	2.8%	
% patients living in the most deprived fifth of areas in Wales	5.1% (3,220)	12.7%	
% patients living in areas classified as rural	67.7 (42,460)	49.6%	
Asthma	6.2%	6.6%	
Hypertension	16.8%	15.7%	
CHD	4.6%	4.2%	
COPD	2.4%	2.4%	
Diabetes	4.9%	4.9%	
Epilepsy	0.8%	0.7%	
Heart Failure	1.1%	1.0%	
Flu ; uptake 65+		68.7%	Seasonal Influenza in Wales 2015-6 Annual report
Flu ; under 65+		49.3%	
Smoking (Cluster performance against 5% target)	2.7%	4.1%	BCUHB – Central Area Smoking Cessation Profiles July 2016
At least 30 minutes moderate exercise on five or more days in the previous week	28.6%	29.2%	GP Cluster profiles BCUHB (2015 Public Health Wales NHS Trust)
Adult obesity (BMI 25+)	57.8%	57.8%	
Heavy (binge) drinking on the heaviest day in the past week	25.2%	26.1%	
Older people living alone	33.6%	32.8%	

POPULATION NEED (Priority 1 – Smoking Cessation)					
Priority 1	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Smoking Cessation	There are over 10,400 adults recorded as smokers by Conwy West Practices. Smoking is linked to social class and accounts for a high proportion of the inequalities in health outcomes. Quitting smoking offers better improvement to healthy life expectancy than almost any other medical or social intervention. Patients are 4 times more likely to quit if they access support from specialist services. NICE guidance is that 5% of adult smokers should be treated every year. This is now a Health Board Tier 1 target, with 40% quit rate. In Conwy West Locality, 285 smokers accessed services last year. To meet the target, this needs to be 520.	Increase demand for specialist smoking cessation services Develop an integrated smoking cessation service across the Cluster Offer timely and appropriate support for all adult smokers who wish to make a quit attempt Ensure tailored interventions and equity of access and outcomes for specific groups, such as pregnant women, manual workers, people with mental health problems and socioeconomically disadvantaged communities.	• Review progress against targets at Cluster meetings • All Practices to ensure all staff implement BCUHB smoking cessation pathway. including direct e-referral from GP practices to SSW to ensure that the smoker has an opportunity to discuss his/her smoking cessation options • Practices to consider signing up to the Smoking cessation audit LES • Share smoking cessation data: referrals to specialist services, numbers of treated smokers and quit rates • Work in partnership with SSW / PHW / WG and BCUHB pharmacy to provide an improved quantity and quality of services. • Encourage any in house services to provide a similar standard to specialist providers and monitor outcomes. • Publicise the social media Quit for Them campaign.	Cluster Leads with PHW & BCUHB pharmacy	February 2017 February 2017 February 2017 February 2017 February 2017 February 2017 February 2017

POPULATION NEED (Priority 2 – Vaccination and Immunization)					
Priority 2	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Vaccs and Imms	Vaccination is highly cost effective. Childhood uptake is good but is drifting down. Adolescents and young people at risk of measles. Children up to date by age 5: Some large families fail to engage in the vaccination & immunizations processes which impacts negatively on target figures.	Improve childhood vaccination uptake to above 95% at age 5 for whole Cluster population	Review progress against targets at Cluster meetings: • Consider data re inequalities in uptake of childhood immunizations • Review flu vaccination season • Review planning for Flu vaccination season • Explore opportunities with wider partners e.g. midwifery and psychology to improve uptake in the outlying patient groups. • Consider text reminders across all Practices	Cluster Leads with support from PHW	March 2017 Ongoing

POPULATION NEED (Priority 3 - Lifestyle Management)					
Priority 3	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Lifestyle managem ent	Many long term conditions can be prevented, delayed or better managed by the choices people make in life. Helping people make positive changes involves skills that all primary care staff can use and improve. These interventions are among the most cost effective health care interventions, especially if linked to other services and community assets.	Develop and implement a planned approach to appropriate interventions.	Identify priority staff cohorts (i.e. those who have the opportunity to have conversations about health behaviour change with people they are in contact with) Explore navigation training for appropriate staff. Work in partnership with PHW colleagues to explore intervention opportunities. Provide monitoring information as requested, to evaluate impact.	Cluster Leads with support from PHW	March 2016

POPULATION NEED (Priority 4 – Isolation and Loneliness)					
Priority 4	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Isolation & Loneliness	Conwy West significant older population many of which are living on their presenting issues around isolation and loneliness. People experiencing isolation and loneliness is impacting on GP appointments.	Reduce isolation & loneliness in cluster communities Reduce demand on GP appointments brought on by isolation and loneliness issues	Explore partnership opportunities with stakeholders including Local Authority and third sector. The cluster has funded a community navigator pilot scheme in partnership with the third sector, which commenced in September 2016.	Cluster leads Age Connects North Wales Central	On-going On-going

ACCESS **(to ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients)**					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Sustainability of Primary Care services	All but one of the Conwy- West practices report an increase in practice list sizes. Increase in demand GP and nurse recruitment issues present resilience issues across the Cluster Availability of locums Age profile of GP's High workload Frailty, dementia, social isolation end-of-life Temporary Residents (TR's)	Risk assess Primary Care services across Cluster Mitigate risks	Cluster workshop has taken place to explore the perceived risks Identify immediate risks Mitigate risks through cluster collaboration, strong partnership links with Central Area Management Team and the LHB Investment in management support for the Cluster Employment of Cluster Pharmacist. Incorporate stakeholder assistance in addressing frailty, dementia, social-isolation and end-of-life matters	Area Team Area Team Area Team Area Team Cluster Leads Cluster Leads	Completed On-going On-going Completed On-going On-going

	Rural and transportation New Housing Developments Proposed new housing developments will impact on primary care services, lack of details re timescales to plan for future demand. Cluster needs to understand the impact of these new proposed housing developments across the cluster.	Avoid unsustainable future demand.	High numbers of TR's present seasonally; a cluster/sub-cluster approach to this issue may alleviate imbalance and mitigate impact upon specific practices. Explore concept of rural sub-cluster of Practices. Engage with stakeholders in respect of rural and transport issues. Link with Local Authority and developers. Regular review at Cluster Network meetings.	Cluster Leads Cluster Leads Area Team/ Cluster Lead	On-going On-going On-going
Improve patient choice access & to services	"My Health on Line" Patients choice	Improved on line access.	Practices will be encouraged and supported to adopt all functionalities of "My Health on Line". Ensure hardware and software is appropriate. Promote "My Health on Line" across cluster communities.	Cluster Coordinator Cluster leads & support from NWIS	On-going On-going

WORKFORCE					
Important Note: Each Practice has submitted practice specific plans to detail what will be done in order to meet any practice specific workforce needs e.g to cover a period of maternity leave, recruit to a specific vacancy. The table below refers to matters that can be taken forward at a Cluster level and/or require HB input.					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
GP Recruitment	Low numbers of GP's qualified available to fill 'partner' roles or salaried positions There is also a shortage of locum GP to cover.	Improve numbers of GP's available The Cluster has identified localised, shorter-term solutions such as collaboration at sub-cluster level to provide resilience in services (e.g. Conwy town practices working together to identify solutions to Conwy town issues, also reflected in Llandudno)	Already a recognised issue that Welsh Government and LHB's are conscious of. Improvement in such numbers is a long-term objective that the Cluster can have little impact upon directly. Continue to develop and explore sub-cluster sessions and the federation concept to identify localised solutions	WG and LHB Area Team & Cluster Team	On-going On-going
Staff Training	Lack of training provision – Availability of Primary Care specific training presents difficulties at practice level	Improve access to and availability of training for Primary Care	Identify Cluster training needs and providers to address the need.	Cluster Leads	November 2016

	Insufficient time available for training – Much of existing PET time is actually utilised for the QP process.		Cluster has agreed to fund primary care workforce training at cluster level. Develop a cluster workforce training strategy Liaise with OOH and PCSU to explore appropriate alternatives	Cluster Leads Cluster Leads	March 2017 March 2017
Ensure workforce is appropriate to demand	Increased population with the new housing developments. Please refer to access section.		Please refer to Access Section		

REFERRAL MANAGEMENT AND CARE PATHWAYS					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Information flow from secondary care	Lack of information provided to primary care by secondary Lack of primary care access to secondary care admissions information	Improve communication between secondary and primary care	Liaison with relevant secondary care leads to address information flow Establish access to admissions information	Area Management Team	March 2017
Patient referral from secondary care to primary for re-referral & prescriptions	Consistent referrals of patients from secondary to primary care, impacting significantly on GP resource	Reduce/eliminate referrals of patients to Primary Care where referral to other sources may be made directly Reduce/eliminate need to refer to GP for prescribing matters	Encourage direct referral between secondary care specialities Explore prescription issues and address gaps	Area Management Team	March 2017
Consolidation of pathways	A maze of pathways exists, which GP's find difficult to locate or identify. A centralised repository of pathways is not comprehensive	Reduce confusing/conflicting pathway sources and develop simple and effective access to pathways	Establish effective and accessible centralised point to access established pathways	Area Management Team/ Cluster leads	March 2017
Improve referral mechanisms	WCP and WCCG under-utilised	Encourage wider utilisation of the portal and gateway	Explore and engage with LHB IT/Informatics to	Area Management /	March 2017

	Mapping of specialist GP services within the cluster. Efficient cross-sector referral process	Making greater use of skills available within the cluster Maximise communication with stakeholders	establish wider embracement of the portal and WCCG Mapping of specialist GP services. Engagement with SPOA management. Explore the possibility of designing a single referral form	Cluster Leads Cluster Leads Cluster Leads Cluster Leads Cluster Leads	March 2017 March 2017 March 2017 March 2017
Increased capacity in primary MH Counselling	Lack of capacity in counselling services for Tier 0 and Tier 1 patients to access psychological therapies	Improve choice and access for patients. Improve health and well-being	Primary MH counselling has been commissioned from cluster funds which will be reviewed.	Cluster lead	March 2017

UNSCHEDULED CARE **(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, co-ordination of care ad effectiveness of risk management)**					
Priority	The issues	Aims and objectives	How will this be done?	Named Lead	Time Scale
Patient and Information flow to Primary care and community care.	Lack of respite & short-stay care	Improve availability of respite & short-stay care	Engagement at Area Management level and with partners, such as CCBC & the Independent sector	Area Management Team	March 2017
	Access to UC / sec care admissions data	See ‘Referral Management & Pathways’ above	See ‘Referral Management & Pathways’ above		
	Attendance & discharge reports – such information continues to be slow or non-existent, which presents risks to on-going management of patients in the community	Improve data flow to Primary Care	Continued dialogue with unscheduled care providers.	Area Management Team	March 2017

TARGETING THE PREVENTION AND EARLY DETECTION OF CANCERS (Refer to National Priority Areas CND 006W)					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Access to diagnostics	Colonoscopy Endoscopy	Improve access to colonoscopy/endoscopy	Examination of anonymised cluster data and liaison with secondary care.	Cluster Leads	March 2017
Increase awareness to patient screening	1 Unawareness of screening services so low uptake 2 Awareness of such services but low uptake 3 Some screening programmes are better than others.	Clarification of uptake of screening services, to identify issues Improve uptake and awareness of services	Examine at cluster level, numbers of patients accessing cancer screening services Work with screening providers	Cluster Leads	March 2017
Information flow from secondary care	A wide-number of different forms/questionnaires has significant impact upon GP time/availability	Minimise use of differing forms/questionnaires – encourage use or development of single forms	Engagement with senior secondary care leads, including oncology, to encourage improved communication.	Cluster Leads	March 2017
Individual case reviews	To identify trends in deficiencies in services		Review progress of the 2015 (SEA findings) action plan. [redacted] has previously attended the Cluster Network meeting	Cancer Research/GP Primary care	Quarterly

IMPROVING THE DELIVERY OF END OF LIFE CARE (Refer to National Priority Areas CND 007W)					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Information flow from secondary on deaths	Information from secondary care to primary care relating to patient deaths is sporadic	Improve information flow	Engagement with senior secondary care leads	Area Management Team	March 2017
EoL plans Communication	Care Homes WAST DNACPR forms complexities Improved recording of Patients' wishes Continued good practice re anticipatory drugs Continue development of communication with palliative care teams Clarify role of End of Life Coordinator.	Improve communication between various partners to ensure compliance with EoL plans and wishes. Improve patient and carer knowledge in relation to EoL / palliative matters.	To ensure consistent, cross-sector/agency communication and processes, relevant partner leads to be identified Consider engagement through County EoL Priority Group (Conwy Outcome Group 7) Engagement with relevant Lead to explore opportunities to reduce complexities Examine existing coordination roles and schemes to explore opportunities.	Cluster Leads Cluster Lead	March 2017 March 2017

MINIMISING THE HARMS OF POLYPHARMACY (Refer to National Priority Areas CND 008W)					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Improved communication from secondary care	Changes to medication by secondary care is not consistently communicated with the GP	Improved communication with secondary care	See 'Referral Management & Pathways' above		
Improved IT systems	Group recalls e.g. pre-diabetes & methotrexate users	Increased efficiency and patient focus	Mapping gaps in existing provision. Liaison with IT to improve system	Cluster Leads	March 2017

PREMISES PLAN					
Important Note: Each Practice has submitted practice specific plans to detail what will be done in order to meet any practice specific needs relating to premises. The table below refers to matters that can be taken forward at a Cluster level and/or require HB input.					
Issue	**Why?**	**What will be done at Cluster Level**	**How will this be done? (Practice; GP Cluster; Health Board)**	**Named Lead**	**Time Scale**
Lack of cluster primary care estates strategy	To ensure fit-for-purpose premises and future sustainability of premises	Development of appropriate strategy Engagement with LHB, Area Management and cluster support	• Cluster • Health Board	Area Management Team	March 2017

CLUSTER NETWORK ISSUES					
Issue	**Why?**	**What will be done?**	**How will this be done? (Practice; GP Cluster; Health Board)**	**Named Lead**	**Time Scale**
Explore collaboration opportunities at sub-cluster level	Improve resilience of primary care services	Establish sub-cluster meetings (also & previously referred to as pods)	Liaison with relevant practices and partners	Cluster Leads	March 2017
Suspension of Locality Leadership Team	Lack of attendance by partner agencies and lack of clarity of role against the background of evolving county wide partnership arrangements	Re-establish multi-agency partnership arrangement pertinent to the cluster.	Negotiation and liaison with Area Management Team and stakeholders. Consider development of the CPPB coordination group.	Cluster Lead & Area Team	December 2017

LHB Issues ***(in addition to any issues raised above requiring Health Board input)***					
Issue	**Why?**	**What will be done?**	**How will this be done? (Practice; GP Cluster; Health Board)**	**Named Lead**	**Time Scale**
There are some premises that are not fit for purpose	Inability to maintain or expand service provision	Development of cluster focus Estates strategy	• Area Management Team / PCSU.	Area Management Team/PCSU	On-going
Lack of agility / flexibility in LHB to facilitate cluster funds	BCU HB bureaucracy	Continued lobbying with LHB	• Discussion at high level meetings	Area Management Team/PCSU	On-going
Planning for future developments	Increased demand on services.	Raise with PCSU & Area Management Team	• Support for PCSU to scope and model demand on primary care based on additional housing developmens.	Area Management Team/PCSU	On-going