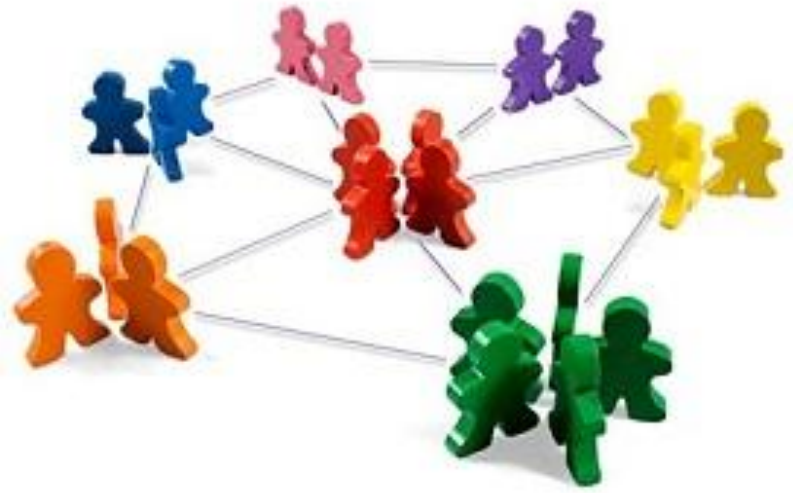
Three Year Cluster Network Action Plan 2017-2020

City and South Cluster



Cardiff City and South

This is the second Network plan that has been produced by the Cluster and once again this plan has been developed at Cluster level across the following seven practices:

- Cardiff Bay Surgery
- Saltmead Medical Centre
- Dr Tiwari – Grangetown Health Centre
- Dr A Anwar
- Clare Road Medical Centre
- Grange Medical Practice
- Butetown Medical Practice

This plan builds on and compliments the individual Practice development Plans and sustainability assessments.

Outline of Cluster Population Profile

The area covered by the Cardiff City and South cluster includes the wards of Butetown and Grangetown and extends north to include the City Centre, which is part of the ward of Cathays. The area demographic information indicates that the City & Cardiff South group had a usual resident population of 34,535 persons on Census Day 2011, which is 10.0% of the Cardiff total. This is an increase of 12,071 persons, or 53.7% from the 2001 Census estimate. City & Cardiff South Neighbourhood Partnership area covers 1,143 hectares (8.1 % of the Cardiff total), with a population density of 30.2 people hectare, compared with a Cardiff average of 24.7 people. There were 15,520 households with at least one usual resident in City & Cardiff South in 2011. This accounts for 10.9 % of the Cardiff total. This is an increase of 6,334 from the 2001 Census count. The average household size in City & Cardiff South is 2.2 people. According to the 2011 Census of population, 63.8 % of residents in the City & Cardiff South neighbourhood were of white ethnicity. This was lower than the Cardiff average of 87.4%. Non-white, including all categories of mixed ethnicities accounted for 36.2 % of residents, compared with 15.3% for Cardiff.

The population of South Cardiff has been growing rapidly and this trend is expected to continue, with a greater proportion of younger people and children and a smaller proportion of older people than other areas of Cardiff and Wales. 21.8% of our patients are aged 0-15 and 4.9% are over 75. It should also be noted that life expectancy across this area of Cardiff is lower than that of residents in more affluent areas of Cardiff and Vale.

The area has a range community facilities and services, including the newly developed Youth Pavilion, and Community Centre. The @Loudoun Development incorporates a Cultural and Media Centre, also a Community Hub and library alongside health services. The Channel View Leisure Centre provides a focus for sports and recreation activities. The Butetown Employment Support and Training Centre (BEST) has been established to provide a range of opportunities for tackling economic inactivity through the delivery of training, job searches, support, etc

The Plan

The plan has been informed by the 7 practice development plans; public health information on key health needs within the area; a knowledge of current service provision and gaps within the area and an understanding of key WG and UHB priorities for the emeregcing primary care model for the next three years. The plan details service plans for years 1-3 (2017/2020), providing where relevant background to current position, planned objectives and outcomes and actions required delivering improvements. The cluster views this plan is a dynamic and evolving document and therefore, the plan itself will be reviewed and updated as required.

A number of key principles underpin the plan:

- Winter preparedness and emergency planning.

- Access to services, including patient flows, models of GP access engagement with wider community stakeholders to improve capacity and patient communication.

- Service development and liaising with secondary care leads as appropriate e.g. Diabetes
- Review of quality assurance of Clinical Governance Practice Self Assessment Toolkit (CGSAT) and inactive QOF indicator peer review

- Maximising use of Local Cluster Resources: practices have taken into account the capacity, capability and expertise that exist within primary care, community services and voluntary/third sector services to deliver more care closer to home and reduce unnecessary demands within the acute care services.

- Promoting integration/better use of health, social care and third sector services to meet local needs

- Considering and Embedding New Approaches to Delivering Primary Care: this includes increased use of technology, new roles and service models considering embedding new approaches to delivering primary care: this includes increased use of technology new roles

- Maximising opportunities for patient participation: this includes consideration of models of good practice that exist with within/locality/cluster and nationally and within the rest of the UK.

- Maximising opportunities for more efficient and effective use of resources: this includes consideration of current resources, opportunities to utilise and current and new services more efficiently and effectively

It should also be noted that a key objective in 2017 is to ensure that the Cluster matures and operates in a more business like way and will shortly be developing terms of reference for the Cluster. This will ensure that decision making is appropriate, enable sound governance and support the ongoing and sustainability of primary care services.

Strategic Aim 1: To understand and highlight actions to meet the needs of the population served by the Cluster Network

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
1	To proactively work with the local community to educate and improve immunisation and vaccinations rates across the Cluster.	Public Health Colleagues Benchmark with other UK health providers to assess the level of compliance of other inner city, high ethnicity populations and consider areas of good practice.	October 2017 to March 2018	• Improved education and understanding of the importance of immunisation against diseases among the community • Early detection and diagnosis of Cancer • Improved outcomes • Improved health and wellbeing	• Discussed and agreed at Cluster meeting July 2017. • Public Health Consultant Lead has been approached to support this work	AMBER

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To understand workforce profile across the Cluster and develop a workforce profile to ensure that patients are seen by the most appropriate member of staff.	Workforce Colleagues	Oct to Dec 2017	Better access to services Reduced waiting times Improved clinical outcome		RED
2	To work with partner organisations to ensure the social issues of the populations are supported as an alternative to seeking medical advice/care.	Wellbeing Co-ordinators	Ongoing	Improved wellbeing Better understanding of ways to address social issues		
3	To consider best approach to working with the high ethnic population and overcoming the language issues, high demand, high consultation/ DNA rate To explore possible solutions or service development for this segment of the			Appropriate use of urgent slots/high consultation rate		

	population across the Cluster in order to reduce the burden of lengthier appointment slots for patients					
4	To Audit & assess increase in demand within surgeries and cluster network. Collaborative working across cluster in order to sharing good practice To make use of interpretation services in order to reduce DNA rates. Make use of the wellbeing team to tackle frequent flyers and educate patients.		.			
5	To work with Primary Care to avoid unnecessary Re-registrations that are unique to this population – related to multiple occupancy housing which is common among BMR groups.	SSWP		Reduction in unnecessary re registrations. Continued access to GP practice	Agreed at Cluster meeting July 2017.	RED

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. To highlight improvements for primary care/secondary care interface.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To ensure that all pathways are reviewed and followed appropriately	Secondary Care Leads	March 2018	○ Appropriate referrals to secondary care ○ Early diagnosis ○ Improved outcomes		Amber
2	To work with secondary care colleagues to further embed the Community Diabetes Model across the Cluster	✚ Secondary Care Consultants ✚ Diabetic Specialist Nurse		✚ Better engagement ✚ Improved communication ✚ Improved self-help	✚ DSN appointed and objectives agreed.	Amber
	Working with Dietetics team to provide healthy eating courses specifically targeting BME groups.				✚ Courses ongoing	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Improve Signposting for patients			• Access to the most appropriate services. • Reduction in wasted appointments	Training has been arranged for reception staff	Amber
2	To work across the Cluster to ensure that patients with the greatest clinical need are prioritised, and that appropriate sign-posting (choose well) is used to direct patients to the most appropriate health professional for their need.	• Wellbeing co-ordinators • 3rd sector groups • Neighbourhood partnerships	Ongoing	• Improved wellbeing • Better understanding of ways to address non-medical issues • Improved self help • Avoidance of unnecessary GP appointments		Amber
3	To utilise the skills of the Cluster based staff to see and treat patients in their own	• Frailty Nurse • Cluster		• Reduced need for GP visits • Hospital admission		Amber

	home	Pharmacist		avoidance Early warning for patient declining health Medication reviews		
4	To promote the importance Flu vaccinations within the Community	Community Pharmacists		Less respiratory illness		Amber
5	To continue to work with WAST colleagues at Cluster level.	WAST colleagues are invited to Cluster meetings				Amber

Strategic Aim 5: Improving the delivery of dementia and cancer;

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To improve the management of patients with Dementia across the Cluster. To have consistent pathways across the Cluster and support services across cluster Work with PHW to determine prevalence in cluster	The Dementia Delivery Plan has enabled Dementia support workers available to each Locality and work is ongoing to up skill GPs in early diagnosis.		• Access to support services • Early diagnosis • Support for carers and families • Signposting	• Toolkit has been assessed and agreed. • Discussed at Cluster meeting in July 2017.	Amber
2	To improve the management of patients with cancer across the Cluster.			• Early diagnosis • Better prognosis • Early intervention		Amber

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority – Pre Diabetes.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To proactively assess the risk of pre-diabetes across the Cluster.	Patients		• Reduced risk of developing diabetes • Better informed • Weight reduction • Improved health and wellbeing	• Clinical Lead identified.	Amber
	To take forward a key project to screen patients that are deemed at high risk of developing Diabetes					RED
	To educate patients on the benefits of healthy eating in particular BME groups where prevalence is high.				• Courses have commenced	Amber

Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and Information Governance. To include actions arising out of peer review Quality and Outcomes Framework (when undertaken)

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Strengthen quality assurance in relation to clinical governance and assurance on specific indicators designated as "inactive" QOF	Primary Care team	Sept and March each year.	Appropriate and consistent care provided	Discussed at Cluster meeting and schedule agreed.	

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To review the inequitable workload associated with Nursing Homes To agree referral criteria	Nursing Homes management	December 2017	Improved access	Discussed at Cluster meeting July 2017	RED
2	To understand clinical recruitments issues and proactively consider new	WOD	December 2017	Sustainable GP services	Discussed at Cluster meeting July	RED

	approaches to overcome difficulties.				2017 Workshop arranged for August 2017	