Three Year Cluster Network Action Plan 2017-2020

CARDIFF EAST Cluster

The Cluster Network[1] Development Domain 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 Cluster Network Action Plan should be a simple, dynamic document and should cover a three year period

The Cluster Network Action 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.
This approach should support greater consistency of service provision and improved quality of care, whilst more effectively managing the impact of increasing demand set against financial and workforce challenges.

The action plan may be grouped according to a number of strategic aims.

The three year Cluster Network Action Plan will have a focus on:

(a) Winter preparedness and emergency planning.

[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

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

(c) Service development and liaising with secondary care leads as appropriate.

(d) Review of quality assurance of Clinical Governance Practice Self Assessment Toolkit (CGSAT) and inactive QOF indicator peer review.

This plan has been developed by the 5 practices in the Cardiff East cluster. We serve the second most deprived cluster in Cardiff. The discussion has been facilitated by the community director together with cluster practices, Public health and health board input. The practices are.....

- **Brynderwen (and Minster Rd)**
- **Llanedeyrn Health Centre**
- **Llanrumney Medical Centre**
- **Rumney Primary Care**
- **Willowbrook**

The risk matrix identified most of the practices in the medium risk (amber) category. The factors which put the practices at risk were

- Welsh index of deprivation
- Use of and reliance on locums
- Poor premises
- Increasing GP age
- Workload from nursing homes
- Increasing housing and population

Further information on the demographics of the cluster can be found in the Welsh public health observatory.

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
	Improve the care of patients with **dementia** and their **carers**	GP practices Alzheimer's Society Other relevant 3rd sector organisations	Ongoing	Improved knowledge &support	Annual enhanced dementia reviews Dementia support worker Engagement with Alzheimer's Society The funding for local dementia diagnosis clinics has been withdrawn, unfortunately	
	Improve the care of patients with **diabetes**	GP practices Third sector organisations	Ongoing	Improved knowledge of diabetes and reduced complications. Use video education clips with patients.	Annual diabetes review by practice. All practices are engaged with the community diabetic specialists. Consider using new technology to educate patient's	
	Heart failure	GP practices Secondary care	Ongoing	Improved monitoring and optimisation of treatment reducing mortality and morbidity from heart	Annual medication reviews Improved	

				failure	knowledge of symptoms and when to seek help. Reduced admissions and mortality.	
	Improve access to, and quality of, care to patients presenting with mild to moderate **mental health issues**	GP practices Appoint primary care mental health practitioner Secondary care services Third sector organisations	Ongoing	Patients will be able to see a primary care mental health practitioner. The aim is to improve access to and quality of care for patients with mild-to-moderate mental health issues e.g. anxiety, depression.	Job description agreed and due to interview in Sept 2017. Very slow process	
	Reduce smoking in Cardiff East	Patients Primary care team Smoking cessation Wales team	Ongoing	Improved access to expert smoking cessation counselling and treatment	Electronic referral to smoking cessation team is working well in the cluster	
	Reduce inequalities in health	Primary care team Health board Public health Welsh government	stalled	Improved access to healthy lifestyle and health promotion	Several meetings but little progress	
	COPD	Primary care Secondary care	Ongoing	Patients will have improved access to diagnosis of COPD and to local pulmonary	Local pulmonary rehabilitation program up and running	

				rehabilitation program		
	75th birthday invitation letter from care and repair "Healthy at Home service"	Cluster practices Care and repair organisation	Ongoing	Access to advice on home improvements to improve safety for elderly patients	All practices are engaged	

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
	Reduce DNA rates	Cluster practices	Ongoing	Better access to appointments	Practices advertise DNA rates Some practices Text patient with appointment times. My Health On line	
	All practices to use "my health online"	Cluster practices	2018	Better access to appointments	Achieved	
	Sustainability discussion within the cluster	Cluster practices	2018	Cooperation between practices. Improved access. Improved sustainability	For discussion of cluster meeting	
	E.advice service	Cluster practices Secondary care IT department	2017	Sustainable primary care. Improved quality of	Achieved	

				care		
	Improve capacity of Cardiff GP practices with increasing population	Cardiff practices Cardiff health board Cardiff cancel	2018	Maintain access to primary care	Ongoing	
	Improve skill mix within Cardiff East practices	Cluster practices	2018	To see the right person in the right place at the right time. Awaiting appointment of Mental Health Practitioner. Consider other eg nurse visiting, para-medic visits, physio for MSK	Ongoing	
	Patient's to see the right person in the right place at the right time	Cluster practices Health board Other primary care organisations e.g. optometrist, pharmacist	2018	Sustainable primary care. Improved access. See appropriate person	Cluster has employed a cluster pharmacist and is in the process of appointing a mental health worker. Patient's redirected, where appropriate, to optometry service. Implement minor ailment service in community pharmacies	
	Improve sustainable general practice	Cluster practices	2018	Sustainable general practice	Practices will consider projects	

					which focus on sustainability and apply for funding from the cluster	
	To share good practise within the cluster	Cluster practices	Ongoing	Sustainable general practice	Practices were share could practices with each other in cluster meetings	
	Social prescribing	Cluster practices Communities first Third sector organisations	Ongoing	Use of local projects to improve health and well-being	Excellent engagement from practices. **Unfortunately, the funding for communities first has been withdrawn**	
	Excellent primary care premises	Cluster practices Health board estates department Welsh government	Ongoing	Excellent primary care premises	Some of the practices in the cluster are at physical capacity and some practices are barely fit for purpose	

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
	ACS pathways	Cluster practices and health board	Ongoing	To provide consistently high quality care to patient's	Ongoing	
	Care pathways	Cluster practices Health board Secondary care	Ongoing	To provide consistently high quality care to patient's	Ongoing	
	Regular SEA meetings within practices	Cluster practices	Ongoing	To provide high quality care to patient's and to learn when things go wrong	Particular focus on new cancer diagnosis and end-of-life care	

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
	Respond quickly to emergencies	Cluster practices and other	Ongoing	Improved quality of care for emergencies	Regular CPR training and	

		organisations as appropriate			emergency training	
	The patient is to have access to urgent (same day) clinical assessment and management	Cluster practices	Ongoing	Improved satisfaction and access to urgent clinical assessment and management	Ongoing	
	Acute illness service within practices	Cluster practices	Ongoing	Access to the appropriate health care professional when needed	Skill mix within practices for example health care assistant, minor illness nurse, GP	
	Provide high quality Eye care to patient's	Cluster practices Optometrists	Ongoing	Access to the appropriate health care professional when needed	Sign post patients to optometrist	
	Provide high quality dental care to patient's	Cluster practices Community dentists		Access to the appropriate health care professional when needed	Sign post patients to dentist	
	Provide high quality advice for self-management of minor illness	Cluster practices Daily pharmacists	Ongoing	Ability of community pharmacists to offer advice on the management of self limiting minor illness and to provide over-the-counter remedies	Sign post patients to community pharmacists. Due to start in late 2017?	
	Patients to attend emergency department when appropriate rather than primary care	Cluster practices Health board Secondary Care	Ongoing	Attend emergency department for appropriate emergency care	Sign post patients to emergency department when	

					appropriate	
	Respond quickly to request for advice from a para-medic at a patients home	Cluster practices	Ongoing	Appropriate management of illness at appropriate place. Respond to telephone request from para-medic within 15 minutes	Achieved.	
	Winter pressures	Primary care team	Ongoing	Improved access for acute illness in the busy winter period. Consider limiting annual leave, shifting routine work e.g. annual reviews away from winter months, use cluster sustainability money to increase capacity.	For discussion at cluster meeting	
	Reduce demand from residential and nursing homes, especially in Winter	Cluster practices, UHB, residential homes, CRT	Ongoing	Increase knowledge of residential home staff in managing minor illness and what needs an urgent, emergency or routine review	Ongoing	

Strategic Aim 5: Improving the delivery of dementia; mental health and well being; cancer; liver disease, COPD, (delete as appropriate)

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
	Improve the care of patients with dementia and their	GP practices Alzheimer's Society	Ongoing	Improved knowledge &support	Annual enhanced dementia	

	carers	Other relevant 3rd sector organisations			reviews Dementia support worker Engagement with Alzheimer's Society The funding for local dementia diagnosis clinics has been withdrawn, unfortunately	
	Improve access to, and quality of, care to patients presenting with mild to moderate **mental health issues**	GP practices Appoint primary care mental health practitioner Secondary care services Third sector organisations	Ongoing	Patients will be able to see a primary care mental health practitioner. The aim is to improve access to and quality of care for patients with mild-to-moderate mental health issues e.g. anxiety, depression.	Job description written and awaiting verification by health board. Very slow process	
	Improve diagnosis and management of liver disease	GP cluster practices	Ongoing	Improved diagnosis and management of liver disease	Educational liver disease and follow health board guidance	
	COPD	Primary care Secondary care	Ongoing	Patients will have improved access to diagnosis of COPD and to local	Local pulmonary rehabilitation	

				pulmonary rehabilitation program	program up and running	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating

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
	Completing the clinical governance and information governance to acute	Cluster practices	2018	Improve quality of care	Ongoing	

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating

	Research	Cluster practices. PICRIS	On going	Access to participation in research projects	Some practices are involved	