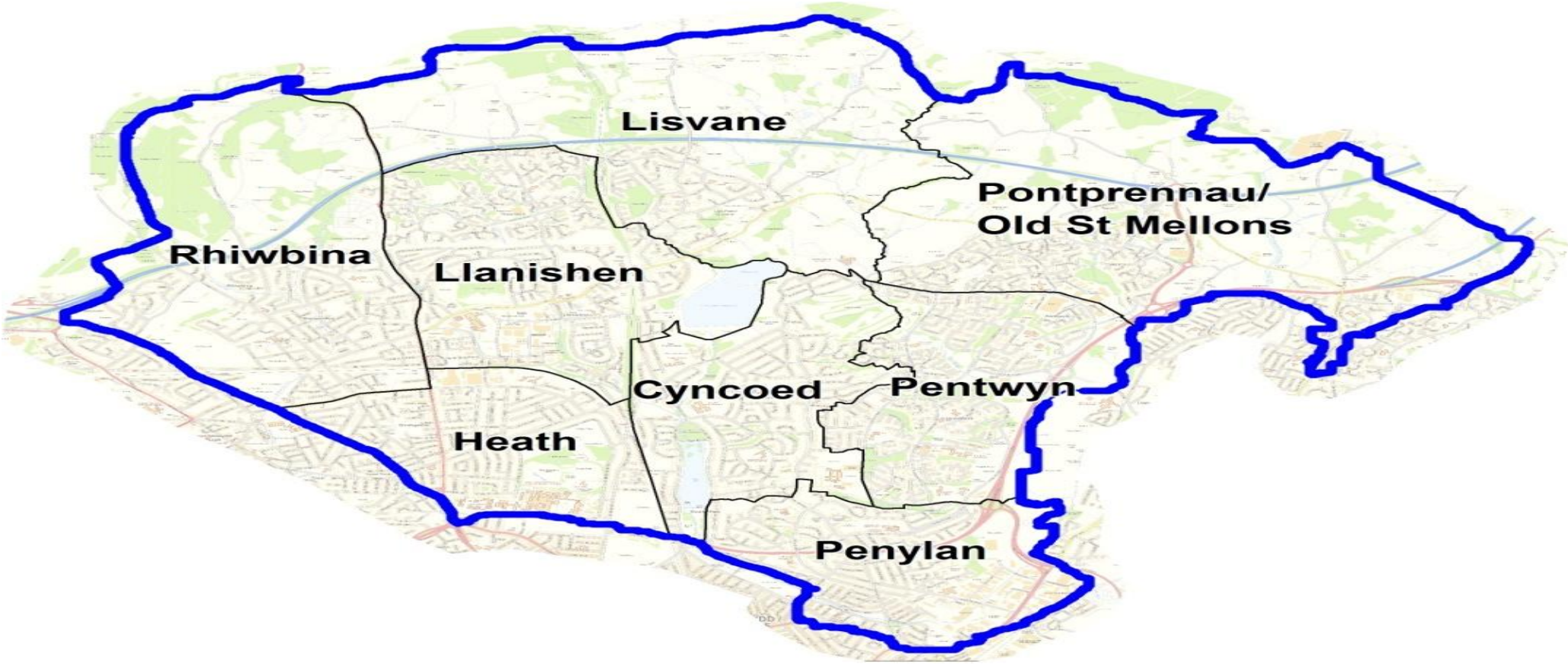
Three Year Cluster Network Action Plan 2017-2020

North Cardiff Cluster



CARDIFF NORTH CLUSTER NETWORK ACTION PLAN

This plan has been developed by the following 11 practices which operate in the North Cluster Area, through facilitated discussion with the Community Director and Locality Manager:-

Cyncoed Medical Centre
Roath House Surgery
Penylan Surgery
St David's Medical Centre
North Cardiff Medical Centre
Birchgrove Surgery
Llanishen Court Surgery
St Isan's Road Surgery
Whitchurch Road Surgery
Crwys Road Surgery
Cathedral View and Llywnbedwr Surgery

Outline of Cluster Population Profile

The Cardiff North cluster has a GP registered population count of 107,230[1] and is the largest cluster in Cardiff in terms of population and land area. The cluster is approximately 40% larger than any other cluster in Cardiff and Vale. Although it is generally perceived to be a less deprived and a generally healthy area, according to most social economic, health and deprivation indicators there are significant pockets of deprivation, including areas of Llanedeyrn and Pentwyn and a part of Llanishen ward known as the "Crystals Estate" (See Welsh Government Tackling Poverty Action Plan – Building Resilient Communities). Approximately 7,000 (7.2%) of Cardiff North residents live in the most deprived decile of deprivation in Wales.

[1] Public Health Wales Observatory

In Cardiff the population is rapidly growing in size, currently projected to increase by 10% between 2016-2026[2]. There will be significant increases in particular in people aged 0-16 and over 65. The number of people aged 65-84 is predicted to rise from 43,155 in 2016, to 53,104 in 2026 (an increase of 23.1%). The number of people aged over 84 in Cardiff is also predicted to rise sharply, from 7,440 in 2016 to 9,417 in 2026 (an increase of 26.6%). Recent estimates suggest that the rise in Cardiff North is predicted to be even higher[3]. Using Daffodil Cymru (2017) and ONS (2016) statistics, it is predicted that in CNC there will be a 53% increase in people aged 65+ between 2015 and 2035 (from 18,762 to 28,631), and an 88% increase in people aged 85+ (from 2,828 to 5,317) between 2015 and 2035. Of people aged over 65 in Wales, two thirds reported having at least one chronic condition, and one third had multiple chronic conditions; and over three-quarters of people aged over 85 in Wales reported having a limiting long-term illness. As CNC has nearly one third of the total population of Cardiff residing in its boundaries this represents a large demographic challenge medically. A detailed modelling exercise was undertaken as part of the Population Needs Assessment for Cardiff and the Vale[2] which suggested that there are 3,550 frail older people in Cardiff North and West locality. This is compared with 1,780 in Cardiff South and East and 2,280 in the Vale localities. The model projected that, based on frailty, demand for services will increase by 25% in Cardiff North and West locality over the next 10 years.

The Public Health Wales Observatory reported that in 2015/16, there were 627 people in CNC on the QOF dementia register, with an estimated 1,230 people remaining undiagnosed. The sharpest increase in numbers of people with dementia is in those aged 80 and over, where prevalence rates are estimated to be 1 in 6. The total number of people aged 65 and over with dementia in Cardiff and the Vale of Glamorgan is predicted to rise from 5,387 in 2015 to 6,849 in 2025[2]. If the same increase of 27% is applied in CNC, the number will rise to 796 people diagnosed, 1,562 undiagnosed.

Diabetes - The number of people registered with a GP practice who had diabetes in 2016 (taken from Audit +) in CNC was 5,223 people (4.9% of the cluster population).

Public health indicators (taken from Public Health at a Glance):-

- 14% of the cluster population smoke (range from 10.3% - 16.6% across the practices). This is lower than the Wales average of 20.5% and the UH average of 19.5%)

[2] Cardiff & the Vale of Glamorgan Population needs assessment, 2017
[3] 'Me, My Home, My Community' Cardiff and Vale of Glamorgan market position statement: Care and Support Services for Older people 2017-2022 Draft, Cardiff & Vale of Glamorgan Integrated Health and Social Care Partnership, 2017

- Immunisation uptake as at June 2017:-

	Cardiff North	C&V UHB
5 in 1 (by age 1)	97.2%	95.6%
MMR2 (by age 4)	88.4%	86.8%
Preschool booster (by age 4)	85.8%	84.9%
Teenage booster (by age 16)	81.6%	76.1%
Seasonal flu over 65s	71.7%	69.0%
Seasonal flu under 65s	50.0%	48.3%

- 29.9% of the cluster population meet the physical activity guidelines of 150 minutes per week. 41% report no physical activity on any day in the previous week
- 52.7% adults are overweight or obese in the cluster. 34.4% eat the recommended 5 a day of fruit and vegetables
- The ward of Pentwyn has particularly high levels of teenage conceptions
- 28.5% of the cluster population binge drink (ie drink double recommended guidelines on the heaviest drinking day in the previous week). This ranges between practices from 26.5% and 30.2% . Cluster average is the same as the UHB average of 28.2% and above the Wales average of 26.6%. Highest figures in Penylan, Pentwyn areas.
- Due to high numbers of older people in CNC, there are a high number of people experiencing falls, resulting in hospital admission or attendance at EU.
- Screening rates in 2015/16 for all Cardiff clusters, with comparisons to Wales and UHB average[4]:-

[4] Public Health Wales Screening Division: Cardiff & Vale Primary Care Cluster Update National Screening Programmes

	AAA Target 80%	**Bowel Screening** Target 60%	**Breast Screening** Min.standard 70%	**Cervical Screening** Target 80%
Cardiff East	74.6%	46.0%	64.3%	78.0%
Cardiff North	85.0%	57.3%	71.6%	78.9%
Cardiff South East	67.9%	41.0%	58.9%	65.7%
Cardiff South West	69.3%	45.6%	65.0%	74.7%
Cardiff West	78.8%	56.7%	72.1%	81.8%
Central Vale	78.7%	52.5%	72.3%	78.6%
City & Cardiff South	56.0%	37.9%	51.2%	65.0%
Eastern Vale	79.1%	58.3%	74.6%	82.7%
Western Vale	85.8%	60.5%	74.9%	82.7%
Cardiff & Vale	**77.5%**	**52.5%**	**68.7%**	**76.5%**
Wales	**79.1%**	**54.4%**	**72.5%**	**77.8%**

The Plan

The plan has been informed by the practice development plans produced by practices; GP practice sustainability assessments; sessions held throughout 2016/17 to develop the vision for the cluster; public health information on key health needs within the area; information provided by NWIS and Cardiff and Vale UHB in respect of referral and activity levels; a knowledge of current service provision and gaps within the area and an understanding of key UHB priorities for the next three years. The plan details cluster objectives for years 1-3 (2017/2020) that have been agreed by consensus across practices, providing where relevant background to current position, planned objectives and outcomes and actions required to deliver improvements. The cluster views this plan is a dynamic and evolving document and therefore, the plan itself will be reviewed and updated as required. The RAG rating score indicates progress against planned action (Red-work yet to start, Amber- Some progress made, Green-action has been completed).

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

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
1.1 Screening	Increase response rate for bowel screening	Targeted work with non-responders to screening:- - Request non-responder lists from PHW Screening Services - Letter from Practice to non-responder patients - Utilise Screening Services toolkit to engage with non-responders (due to be published during 2017) - Flag non-responder clinical record for opportunistic reminders - Host awareness raising days	Practice managers / PHW	July 2018	Increased uptake of screening opportunities, early identification and treatment if required	R
1.2 Alcohol	Reduce high rates of alcohol consumption amongst the cluster population	• Practices to proactively engage with Alcohol Awareness Events • Utilise ABI training:- - Use scratch cards, wheels and beakers where appropriate in consultations - Include Audit C questions on new patients for Promote Alcohol Awareness Week and Dry January	PMs/ Public Health	2017-2020	Decreased alcohol consumption so lowered risks of alcohol-related health conditions, accidents, domestic violence and social problems.	A
1.3 Older People	Utilise falls risk assessment tools for early intervention and falls prevention	- Establish Cluster Pathway for appropriate management of falls across primary, community, council and voluntary sector home care services	Cluster GPs / Public Health/ Third Sector	2017-2020	Decreased risk of falling, improved strength and balance. Lowered fear of falling.	A
1.4 Dementia	Cluster to become part of the Dementia Friendly neighbourhood	- Practices to engage in relevant training - One practice from the cluster to take a lead on working with partners in developing North Cardiff Cluster as Dementia Friendly Neighbourhood - Enhance interaction with Dementia Liaison Worker	PMs / Public Health / Neighbourhood Partnership	2017-2020	Better support for patients with dementia, at any stage	A

No	Objective	• Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
1.5a Vaccinations	Increase flu vaccination uptake through sharing good practice and reducing variation amongst practices in the cluster	• Practices in cluster to share current approaches to flu immunisation to identify best practice • Cluster to arrange to utilise allocated cluster funding to increase access to flu immunisation • Practices to work with local pharmacies to boost uptake of immunisations	PMs/ Public Health	2017-2020	More patients receiving vaccinations.	A
1.5b	Improve childhood immunisation rates specifically pre-school.	• Reduce the cluster wide variation (range 51 – 91%) through collaborative working; sharing of best practice; operational changes including improved access with change of clinic times & text reminders	PMs/ Public Health	2017-2020	More patients receiving vaccinations.	A

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	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
2.1	To increase the number of practices with active Patient Participation Groups	• Sharing of best practice and collaboration between cluster practices and PPGs to support further PPG development	GPs/Practice Managers/ PPG leads	September 2018	Patient services provided via GP practices will be improved	A
2.2	To maximise use of IT and improve collaboration and operational efficiencies across Cluster Practices and partner organisations	• Improved administrative efficiency through sharing of best practice and investment in appropriate administration / workflow solutions • The cluster to continue to work with UHB on improvements to current IT system (EMIS)	Practices/NWIS/Procurement	2020	Pts will have local access to GMS services	A

No	Objective	• Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
2.3	To maximise use of community assets (voluntary sector, council services) and wider primary care services to provide appropriate signposting and alternative service provision	• Continued collaboration with dental, optometry and other allied health professionals • Increased engagement with CCC Locality and Preventative Services • Cluster to maximise use of TV screens and DEWIS	Local Voluntary sector organisations/GP Practices	2020	Patients will be supported to chose wisely and access support from local appropriate agencies	A
2.4	To improve availability and affordability of clinical workforce	• To consider standardisation of terms and conditions for medical and nursing workforce	GP practices	2020	Maintaining responsive access to GP	R
2.5	To increase collaborative working opportunities across cluster practices	• Cluster to create a designated Management Committee to drive forward evolution of cluster • Given size of cluster and continued growth of population consider with PCIC options to change size, boundaries and make-up of cluster • Cluster to continue discussions regarding the merits of federation status in terms of supporting GP sustainability, recruitment and retention.	GP practices	March 2018	Sustainable GMS provision	R

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	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
3.1	To ensure improved detection, diagnosis and effective management of patients with AF	• Cluster wide engagement in the "Stop a Stroke" campaign	Secondary Care Consultant/ Cluster Pharmacists	2020	Effective patient diagnosis and treatment	A
3.2	To ensure effective management of patients with Heart Failure	• To continue development and expansion of community cardiology clinics and increased knowledge and utilisation of Heart Failure Pathway • To collaborate with Heart failure Specialist Nurse to improve the knowledge and skills of practice nurses and understanding of HF management and monitoring	GP Cardiology Champion / Secondary Care Consultant	March 2018	Effective patient diagnosis and treatment	A

No	Objective	• Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
3.3	To develop a "Suspected GI Malignancy Pathway"	• To identify a lead clinician within the Cluster • To engage with leads in secondary care to consider existing pathways and deficiencies	GP Gastro Champion and Lead Community Director / Secondary Care Consultant / LMC	March 2019	Effective patient diagnosis and treatment	R
3.4	To improve care pathways for patients with mental health conditions	• To replicate model of quarterly CMHT Link Worker meetings across all cluster practices • To develop local pathways to ensure appropriate physical health monitoring of patients receiving specific medicines	GP MH Champion and Lead Community Director / Secondary Care Consultant / CMHT Management Team	March 2019	Effective patient diagnosis and treatment	R
3.5	Obesity and prevention of diabetes	• to support reduction in obesity and people at high risk of diabetes by referring identified individuals to dietetics	Public Health and Dietetic Lead	March 2020	Effective patient prevention, diagnosis and treatment	R

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	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
4.1	To scope the potential to develop a cluster urgent care service	• To develop cluster service model • To work with UHB Planning and PCIC Head of Primary Care to establish location opportunities	PCIC Head of Primary Care / UHB Planning Lead for Primary Care	2020	Improved access to services	A

No	Objective	• Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
4.2	To identify alterative models to deliver services to housebound patients.	• To scope the wider use of allied health care professionals in delivering GMS in the home (where appropriate). • To work with social care services to establish appropriate signposting and referral • To work with Community Pharmacy, Dentistry and Optometry to provide improved services.	Local Authority lead for Locality Working and Preventative Services / Voluntary Sector / Dental / Optometry / Community Pharmacy leads	2020	Improved access to services	A
4.3	To expand the capacity of the Primary Care Nurses for Older people Team	• To confirm outcomes and cost benefit of the PCNOP team • To incorporate the PCNOP role into core UHB funding	PCIC SMT / Director of Finance	2019	Improved access to services	A
4.4	To continue to encourage patients to chose well and seek alternative services by which to maintain their health and wellbeing	• To consider use of standardised answer machine messages to suit the time of year • To promote use of self management apps and use of QR codes	Choose Well Promotion Team	March 2018	Improved patient education and access to services	A
4.5	To improve winter preparedness and efficient use of resources	• To provide voluntary sector transport for frail patients so as to reduce the demand for house calls • To improve education of patients to ensure prudent use of health resources (TV screen messages, public health campaigns).	Voluntary Sector (eg VEST and Good Neighbour Schemes)	March 2018	Improved patient education and access to services	A

Strategic Aim 5: Improving the delivery of cancer and COPD as National Priorities

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
5.1	Ensure appropriate clinical management of pts with COPD	• A quality improvement project (including 3 smalls tests of change) will be conducted to ensure delivery of safe, cost effective and prudent health care • Any data captured/results will be shared across practices • All practices will conduct a review of their current COPD register including coding and recording of COPD consultations, prescribing and referrals, this will improve the accuracy of diagnosis and treatment of COPD patients across the cluster.	GP Practices	March 2018	Patients with COPD will be provided with high quality care	A
5.2	Ensure the appropriate clinical management of patients with cancer- lung, ovarian, colorectal, gastroesophageal and pancreatic cancers.	• A quality improvement project (including 3 smalls tests of change) will be conducted to ensure delivery of safe, cost effective and prudent health care • Cluster practices to utilise Cancer Decision Tool	GP Practices	March 2018	Patients with COPD will be provided with high quality care	A

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

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	Rag Rating
6.1	Ensure the appropriate clinical management of patients with Atrial fibrillation	• Practices will conduct a review to identify pts who have undiagnosed or who are not coded correctly as having AF	GP Practices	March 2018	Patients with AF are treated appropriately	A

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	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG rating
7.1	The aim is to identify effective systems linked to the Welsh Government Health Care Standards 2015 which support the delivery of health care in Cardiff North and sharing them consistently across the cluster.	• All practices will share their achievement in all 45 matrices of the Clinical Governance Self-Assessment Toolkit, this will then be collated to facilitate a systematic review over the next three years of all of the matrices	GP Practices	2020	Patients receive high quality care delivered via a sustainable model of GMS	A

Strategic Aim 8: Other Locality issues

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
8.1	To increase GMS capacity and infrastructure to meet the population growth associated with the Local Development Plan	• CD and GP/PM leads to continue discussions with UHB Planning Dept and PCIC • Cluster to develop and support expressions of interest from cluster practices who may wish to provide for this growth • Cluster to engage in development of Hub@Maelfa	CD /Locality Manager/PCIC/ UHB Planning Department	2020	The ensure all residents within Cardiff North have access to GMS/relevant support services to meet population needs	R