Three Year Cluster Network Action Plan 2017-2020

Cardiff South West Cluster

South West Cardiff Three Year Cluster Network Plan

2017-2020

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

- Lansdowne Surgery
- Woodlands Surgery
- Kings Road Surgery
- St David's Court Surgery
- Greenmount Surgery
- Canna Surgery
- Westways Surgery
- Ely Bridge Surgery
- Caerau Lane Surgery
- Taff Riverside Surgery
- Llandaff fields

Outline of Cluster Population Profile

The Cardiff South West cluster has a population of approximately 66,410 patients registered to its practices (18% of the Cardiff total and 13% of the Cardiff & Vale total population). The cluster has a broadly similar population structure to the Health Board area as a whole, but compared to the Wales averages, it has lower numbers of people of age 65+[1]. There are some areas in the South West cluster that experience high deprivation levels, 60.6% of the cluster population live in the most deprived two-fifths of areas in Wales, compared to 38% in the UHB population as a whole.

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%). In the

[1] Public Health Wales Observatory
[2] Cardiff & the Vale of Glamorgan Population needs assessment, 2017

South West, 12.9% are aged over 65, and 1.7% over 85[3]. Using Daffodil Cymru (2017) and ONS (2016) statistics, it is predicted that in CSW there will be a 53% increase in people aged 65+ between 2015 and 2035 (from 7,191 to 10,973), and an 88% increase in people aged 85+ (from 930 to 1,748) 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. 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 385 people in CSW on the QOF dementia register, with an estimated 460 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. If the same increase of 27% is applied in CSW, the number will rise to 489 people diagnosed, 584 undiagnosed.

Diabetes - The number of people registered with a GP practice who had diabetes in 2016 (taken from Audit +) in CSW was 6.3% of the cluster population.

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

- 24% of the cluster population smoke. This is higher than the Wales average of 20.5% and the UH average of 19.5%)
- Immunisation uptake as at June 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

	Cardiff South West	C&V UHB
5 in 1 (by age 1)	96.3%	95.6%
MMR2 (by age 4)	85.1%	86.8%
Preschool booster (by age 4)	83.4%	84.9%
Teenage booster (by age 16)	77.1%	76.1%
Seasonal flu over 65s	63.3%	69.0%
Seasonal flu under 65s	46.5%	48.3%

- 30.3% 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
- 58.2% adults are overweight or obese in the cluster. 31.1% eat the recommended 5 a day of fruit and vegetables
- The wards of Caerau and Ely have significantly high levels of teenage conceptions
- 28.4% of the cluster population binge drink (ie drink double recommended guidelines on the heaviest drinking day in the previous week). Cluster average is the same as the UHB average of 28.2% and above the Wales average of 26.6%. Highest rate for binge drinking is in Canton area.

- Screening rates in 2015/16 for all Cardiff clusters, with comparisons to Wales and UHB average[4]:-

	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%**

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

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-majority of actions are in place).

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	To increase the uptake of cervical and bowel screening within BME population. In Cardiff South West, uptake is below targets on 4 screening programmes	• Continue with Health Fares in local Mosques • Relevant information will be sourced in languages according to local needs. • An ambassador is being sought to support local information	Practice managers / PHW/Leaders within BME communities	July 2018	Increase uptake of screening in the community by increasing awareness. Early detection and appropriate management earlier, would ensure a healthier population. Additional benefits will be general health promotion e.g. *blood pressure, stroke and general health and well-being.*	A

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
1.2	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
1.2	To increase awareness of local and national health promotion initiatives for patients and visitors to practices.	• Practices will continue to use TV screens to publicise local support services/health events. • The work with Public Health to identify relevant local and national initiatives which are relevant to local population needs. • Use of cluster health and wellbeing group to design and promote events .	Public Health Wales, Lansdowne Surgery	2017-2020	This will support patients in the identification of relevant initiatives with the hope of improving self care and appropriate access to services both alternative and routine.	A
1.3	To increase understanding and to improve primary care referral rate of patients experiencing domestic abuse.	• All the surgeries within the cluster have been trained and continue to refer to a domestic abuse advocate. • The Cluster will continue to seek funding opportunities to continue the project and make it accessible to all patients within the C+V UHB area.	IRIS project	2017-2020	Provision of a responsive service for individuals at risk of domestic abuse	A
1.4a	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 • Practices to work with local pharmacies to boost uptake of immunisations	PMs/ Public Health	2017-2020	More patients receiving vaccinations.	A

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
1.4b	Improve childhood immunisation rates specifically pre-school.	• Reduce the cluster wide variation 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
1.5	Meeting needs of LGBT people	• A pilot study has assessed awareness among primary care staff in the cluster about transgender issues. • An awareness training session is planned and IT support to help in supporting the needs of patients	Public Health Wales, Cardiff and Vale UHB, Stonewall Cymru, Unique Transgender, VIPC	September 2018	To help transgender people in the community to access primary care services	R
1.6	To support the needs of patients with dementia through early diagnosis and support for carers	• Dementia awareness training to be undertaken in all practices within cluster	Public Health Wales, Third sector partners,		Improved support for patients and their families	A

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
1.7	To reduce smoking rates amongst ethic minority groups	• Continue to promote referrals to Smoking Cessation clinics in the local area. • Smoking advice and smoking cessation support will be offered to all known smokers by several methods including multilingual posters. • Develop information for TV screens to advertise the smoking cessation clinics. • Clinical staff will also advice patients of the new service during routine consultations as and when it becomes available	Llandaff Fields Medical Practice, Public Health Wales, VIPC	2017-2020	Increased opportunities to access support by which to stop smoking	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 improve access to Long acting reversible contraception for patients within the cluster. To improve access to condoms for young people	• Following an initial inter-practice practice referral pilot, the cluster is aiming to identify another practice by which to extend the scheme • Promotion of C Card scheme	Woodlands Surgery, Public Health, community sexual health clinics	March 2019	Improve access to LARC Services closer to home Improved access to contraception	A
2.2	To provide better access to minor surgery procedures for patients where their usual registered GP does not provide this service.	• An interpractice agreement has been set up for Minor Surgery. The next phase will be to work with cluster and LHB to create standard referral template • A pilot hub will be set up in one practice, with dedicated GP and admin support and a model developed which can be extended to other practices.	INPS, Primary care, information governance lead	March 2019	Better patient access for minor surgery. More minor surgery experience for GPs	A
2.3	To establish a Patient Participation Group within the Cluster	• The cluster has invested in the development of a cluster Health and Wellbeing Reference Group coordinated via a local Voluntary Sector Organisation • This group will meet virtually/physically on a quarterly basis and be used to advise cluster on Practice/Service developments (including advising on access)	GPs/Practice Managers/ACE facilitator	March 2018	Patient services provided via GP practices will be improved	A

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
2.4	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 • Investment in IT expertise to ensure Practices maximise use of IT systems/templates • Investment in vision 360 to facilitate collaborative work and deliver care 'closer to home'	Practices/NWIS/Procurement/VIPC	March 2019	Consistency of data entry in patients notes across all practices Efficient GMS services Access to more locally provided services	A
2.5	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 Cardiff Council, 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
2.6	To increase collaborative working opportunities across cluster practices	• To continue to develop the role of the Cluster Management Committee to drive forward evolution of cluster with the aim of ensuring GMS sustainability within the Cluster	GP practices	March 2018	Sustainable GMS provision	A
2.7	Development of a cluster toolkit to support GP recruitment and retention amongst cluster practices	• A submission has been made to the Bevan Foundation to support the development of this project	Bevan exemplar, Bevan Foundation, C+V UHB sustainability Team, PCIC, C+V UHB innovation lead,	March 2018	Improved access to consistent care through a stable workforce. Continuity of care.	R

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
2.8	To support practices in ensuring accurate data recording relating to correspondence and also improve GP retention through management of workload	• The cluster have decided to invest in training for staff in workflow optimisation	Practices	March 2018	Improved access to primary care. Reduction in variance between cluster practices in how they record patient data	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.

No	Objective	• Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
3.1	To sustain and extend Integrated Paediatrics clinics, providing better access to Paediatricians for patients Learning opportunities for GPs Reductions in referrals	• Clinics have been established in one cluster hub taking referrals from one other practice. The system will be extended to 2 other hubs taking referrals from a total of 4 or 5 other practices. This will be facilitated by the use ot the Vision 360 system	Consultant Paediatricians Cluster IT support, Hub clinics at Woodlands Surgery and Canna Surgery,	March 2019	Reduced waiting time for paediatric outpatient appointment. Reduced travelling times and costs. More convenient for families. Increased confidence in GP for on-going management.	A

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
3.2	To improve waiting times for Cardiology through deliver f Community Cardiology Clinics	• To establish Community Cardiology Clinics in conjunction with secondary care Specialists.	GPWSI cardiology, Consultant Cardiologist, Heart Failure Nurse	March 2019	Reduced waiting times for patients. Local service provision	A
3.3	To support the development of a new model for multi disciplinary clinics for the holistic care of people with long term conditions.	• To work with secondary care specialists to develop a community based clinics for patients with multiple ling term conditions	Westway Surgery, N+W Locality Team, INPS	March 2020	Reduce Primary care referral waiting times. Reduce number of appointments per patient with integrated service. Reduce patient travel times and distances	R
3.4	Implementation across the Cluster of repeat dispensing scheme ensuring that patients are ordering only the medication they require	• The system has been set up across the cluster. • Audit and spot checks and all practices • Identify any issues around operation of the scheme • Provide guidance and training on issues identified • Liaise with community pharmacies to ensure all aware of policy • Use data obtained by University students who are evaluating project	Cluster pharmacists, community pharmacists, Canna Surgery	September 2018	Ensure consistent repeat prescribing across cluster Enhanced patient safety by reducing stockpiling of medication Reduction in waste/over prescribing	A

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
3.5	Cluster Pharmacists to support GPs through holistic medication reviews and quality improvement activities related to cluster prescribing objectives	• The role of the pharmacists will be enhanced through the development of independent prescriber training for one of the pharmacists who has not completed the course	Cluster Pharmacists, UHB prescribing advisors. Ely Bridge Surgery	March 2019	Improved patient safety through enhanced medication reviews, significant event analysis and quality improvement related to prescribing. Improved patient access through reduction in GP appointments to undertake medication reviews.	R
3.6	To ensure consistency in respect of laboratory testing for Vitamin D based on clinical guidelines across all practices within SW Cardiff Cluster (and C&V UHB).	• The guideline for this has been approved by 'Medicine Management Group of C&V UHB and presented to the cluster. • The use of the guideline will be audited and improvements made based on the results.	C+V UHB prescribing advisors, cluster pharmacists, Cluster IT support.	March 2019	Safe patient care	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	Palliative Care	• Use of Cardiff and Vale Palliative Care tool kit and the reporting system to identify patients for the register, monitor and manage patients and provide better end of life care planning.	GP Practices	March 2018	Increase number of patients on palliative care register and provide better end of life planning and reduce inappropriate hospital admissions	A

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

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
5.1	To encourage GPs to use the CDS tool to increase earlier diagnosis of cancer. The CDS tool allows easy access to local pathways and the Nice guidelines. It has an alert to pick up patients at a risk of 3% or more of 5 common cancers. It has a reporting system within it to enable monitoring and audit.	Development completed and tool released Training needed for all clinicians using the tool, and to check the each clinician has easy access through the vision settings	INPS, Macmillan Lead GP	March 2018	Increased diagnosis of cancer at an earlier stage. Better tracking of patient s on the USC pathway, GPs more confident with local referral pathways and NICE guidelines.	A

No	Objective	Actions Required	Key partners	For completion by: -	Outcome for patients	RAG Rating
5.2	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	Cluster pharmacists, VIPC, Primary Care team,	March 2018	Patient receive safe and effective 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	Social Prescribing: A new time credit based model for social prescribing to be established within the cluster	There are strong links with existing social prescribing resources within the local community. The Cluster has been awarded an innovate to save grant to complete the R+D phase of a new time credit based model of social prescribing which will start in September 2017	SPICE, Grow Cardiff, ACE, NESTA, Cardiff University	March 2018	Improvement in mental health and well being, physical health (physical exercise, healthy eating), improved resilience within the community	R
6.2	Grow Well gardening project:	Funding has been secured to allow the initial pilot to be extended into and R+D phase to assess potential benefits and cost savings	Grow Cardiff, NESTA, Cardiff University,	March 2018	Improved health and wellbeing through participation in the gardening project	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	Information Sharing within cluster	• An information sharing agreement for the cluster has been developed and is awaiting approval from the UHB	Cardiff and Vale Locality team, Primary Care, UHB IT department, UHB clinical governance team	September 2017	Ensure patient safety whilst maintaining patient confidentiality	A
7.2	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 SW 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, Primary Care Team	2017-2020	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	Development of Hub@Parkview	• A project group has been set up which meets regularly • Business Case to be developed by May 2018	UHB/Cluster/ Voluntary Sector/Cardiff Council	March 2018	A holistic well being resource for the community with the emphasis on wellness and preventative health care	A
8.2	A large number of new housing developments are proposed which will impact on cluster GP practices. A clear plan for how to support the development of GMS services in line with population increase is needed.	• Initial meetings have been held with Estates and Planning team at UHB	C+V UHB, Welsh Government, Cardiff Council	2017-2020	Access to GMS services for newly registered patients moving to new housing developments in Cardiff and Vale	A