Three Year Cluster Network Action Plan 2017-2020

Cardiff West 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 Plan will have a focus on:

[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

(a) Winter preparedness and emergency planning.

(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 (CGPSAT) and inactive QOF indicator peer review.

In 2015 there were estimated to be 357,160 people living in Cardiff. The population is growing rapidly in size, currently projected to increase by 10% between 2016-26, significantly higher than the average growth across Wales and the rest of the UK. An extra 35,000 people will live in and require access to health and well-being services.

The Cardiff population is relatively young compared to the rest of Wales, with the proportion of infants (0-4yrs) and young working age population (20-39yrs) significantly higher than the Wales average. This reflects, in part, a significant number of students who study in Cardiff. There will be significant increases in particular in people aged 0-16 and the over 65s.

Table: Projected percentage increase in population of Cardiff (source: StatsWales (2014-based projections))

Age Group	2019	2021	2026
0-4	1.1	3.8	11.7
5-16	6.4	10.3	16.0
17-64	1.5	2.5	5.4
65-84	5.7	9.5	23.1
>84	7.2	12.5	26.6
All	2.7	4.6	9.8

Cardiff has the third highest proportion of the most deprived local areas out of all local authorities in Wales, behind Blaenau Gwent and Newport, with over 1 in 6 (17.6%) people in Cardiff living in these areas. For young people under 18, this proportion rises to nearly a quarter (23.1%). Many of the more deprived areas are in and around south Cardiff, contrasting with the northern half of the City.

Within Cardiff, men in the most deprived areas can expect to live on average11 years less than those in the least deprived areas. For healthy life expectancy the gap is even wider, with 24 fewer years of healthy life experienced by men in the most deprived areas.

The Cardiff West Cluster covers affluent and deprived areas and it is recognition of these inequalities that the cluster will focus on – reflecting on the differing community needs at a neighbourhood and locality level and across the 8 practices represented by this cluster:

Whitchurch Village Practice

Llwyncelyn Practice

Bishops Road Medical Centre

Llandaff North Medical Centre

Danescourt Surgery

Radyr Medical Centre

Llandaff & Pentrych Surgery

Fairwater Health Centre

Headline issues for the Cardiff (Specifically for Cardiff West)

- Cardiff has the fastest projected population growth compared with all major British cities apart from London – putting pressure on the city's physical and social infrastructure and public services.

- LDPs in place currently determine a need in for more health services and the growth of the city's older population will mean greater demands on these services – no health care provisions currently planned
- Inequalities exist even between cluster practice populations
- Housing remains relatively unaffordable in Cardiff
- Retention and Recruitment issues across all practices – all staff groups

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

No	Objective	Key partners	Outcome for patients	Progress to date	RAG Rating
1	Maintain improved patients access to GMS services	All 8 GP practices staff Cluster N/W Locality offices & team PCIC District Nurses Third Sector Local Authority	1) Improved flexible access to GP's 2) Improved & direct access to other primary care services 3) Less points of contact / hand-offs 4) Improved patient experience	1) Practices already improving working practices to maximise service provision, such as making the availability of on-line booking, updated websites, standardised telephone messaging, text reminders 2) Increase in GP sessions being offered across practices 3) Practice boundaries being re-negotiated 4) HCA positions being considered across various practices 5) Consideration being given to expand one Practice branch site to accommodate extra GP's and patients (Bishops Road)	Medium
2	Improve Welsh & non-English language provision	All 8 GP practices staff Cluster PCIC	1) Improved quality of access to patients 2) Patients being able to communicate in the language of their choice	1) In touch screens being checked for multi-lingual capacity 2) Language line is available 3) Promotion of Welsh language training through the UHB	Low
3	Provide all cluster practices with Dermatascopes	All 8 GP practices staff Cluster	1) Improved quality of pictures sent for diagnosis of skin conditions will result in more accurate diagnosis for patients 2) Quality of patient care & experience improved	1) Discussions/research ongoing with regard to impact of investment. 2) Links with Secondary Care to purchase equipment similar to scheme offered for telederm cameras for all practices	Medium

4	Direct access to physiotherapy	All 8 GP practices staff Cluster	1) Quicker access for patients with musculoskeletal problems	1) Discussions/research ongoing with regard to impact of investment.	High
5	Development of the cluster locality health and well-being hub at Whitchurch Hospital	All 8 GP practices staff Cluster N/W Locality offices & team PCIC Secondary Care UHB District Nurses Third Sector Local Authority Welsh Government	1) Improved patient experience 2) Availability of secondary care in their own locality 3) Integrated Health & Social Care approach to Health & Well-being of the local population	1) Cluster is already aware of UHB's BIG2 programme of work to develop locality Health and Well-being hubs 2) UHB has submitted first round of funding application to Welsh Government	High
6	Patient Experience and Engagement to be considered in planning services	All 8 GP practices staff Cluster	1) Improved patient communication 2) Patient feedback to influence service development & sustainability	1) Practices within the cluster are working through how best to engage with patients to support future planning & sustainability	Medium
7	Childhood Immunisation	All 8 GP practices staff	1) Improve immunisation in all groups –	1) Immunisation uptake at 1 year old is 98.4% (UHB is 95.6%)	Medium

		Cluster Public Health	especially in those children after the first year of life	2) MMR2 uptake at 4 years old is 92.9% (UHB is 86.8%) 3) Preschool Booster uptake at 4 years old is 90.8% (UHB is 84.9%) 4) Teenage booster by age 16 is 80.3% (UHB is 76.1%)	
8	Influenza Immunisation	All 8 GP practices staff Cluster Public Health	Improve immunisation and reduce risk of flu in all age / risk categories	1) Seasonal flu uptake of >65 years is 72.8% (UHB is 69.0%) 2) Seasonal flu uptake of the at risk group is 48.9.2% (UHB is 48.3%)	Medium
9	WAG: Tier 1 Performance • 5% of smokers should set a firm quit date • 40% should have quit by 4/52	All 8 GP practices staff Cluster Public Health Help Me Quit Community Pharmacists	1) Smokers are 4 times more likely to quit smoking with support 2) Quitting smoking at any age has immediate and positive benefit to health	1) Help Me Quit – 0800 0852219 Email, telephone, fax, online referral 2) SSW groups are currently running in some surgeries Agreed specific areas to target: • Online staff training @ http://www.ncsct.co.uk **Cardiff West: 15.1% of the registered population smoke – compared with the C&V average of 19.5% and Wales average of 20.5%**	Medium
10	Improve alcohol awareness The Vale is the area of C&V with the highest intake of alcohol in Wales	All 8 GP practices staff Cluster Public Health	1) Reduce alcohol intake by improving awareness 2) Education regarding alcohol abuse	1) 44% of patients drink over recommended guideline levels 2) 26% of population in C+V binge drink (double recommended levels) •	Medium
11	To ensure patients have a	All 8 GP practices staff	1) 66/1000 people in C+V will fall and	1) OTAGO strength and balance classes 2) Frop-Com screening tool	Medium

	low risk of falls Falls should not be an inevitable part of ageing Prevention includes • Exercise • Strength and Balance • Sight testing Medication management	Cluster Public Health Community Services UHB	subsequently attend the A+E department each year 2) 5,724 people attended A+E in 2016 after falling – 1,500 were admitted 3) 407 hip fractures were reported in 2014/15 – main cause was after a fall		
12	To improve patients attendance at all screening programmes	All 8 GP practices staff Cluster Public Health	1) To access up to date data regarding cluster patient attendance 2) To work with Public Health and Screening Wales to increase attendance	1) AAA screening = 78.8% (target 80%) 2) Bowel screening = 56.7% (target 60%) 3) Breast screening = 72.1% (target 70%) 4) Cervical screening = 81.8% (target 80%) http://www.screeningforlife.wales.nhs.uk	Medium
13	Promotion of Physical Activity 'Sit Less, Move More & More Often'	All 8 GP practices staff Cluster Public Health	1) Physical activity for at least 60+ mins every day (children and young people) 2) 150 mins per week for adults – moderate to intense levels 3) 150 mins per week with	1) Only 29.1% of adults in Cardiff West have more than 150 mins of weekly physical activity (C&V level is 30%) 2) 41% of adults in C&V report undertaking no exercise or physical activity •	Low

			strengthening exercises on 2+ days for those over 65yrs of age		

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	Outcome for patients	Progress to Date	RAG Rating
1	Increase the use of the Social Prescribing methodology to support the cluster in becoming a 'Well-being cluster'	All 8 GP practices staff Cluster Third Sector N/W Locality offices & team Pharmacy Local Authority	1) Better choice & control for the patient 2) Patient experiences less 'hand offs' 3) Patient sees the right person at the right time 4) Alternative approach to medication prescribed	1) Practice by practice staff are being introduced and up skilled in well-being/signposting/triage training, possibly through PDSA cycles ahead of cluster wide roll-out 2) One practice already working with Wellbeing4U 3) Signum Health pilot explored; patients being encouraged to use Signum Health for self management guides 4) Working on the possibility that NHS Choices can be embedded into practice websites 5) DEWIS Cymru/Wales Wellbeing information directory up and running in the region 6) Local authority Independent Living Services direct line is live	High
2	Improve medication checks through a Cluster Pharmacist	All 8 GP practices staff Cluster PCIC Pharmacy	1) Timely medication checks for patients 2) Patients seeing reduction in medication they are taking	1) Cluster Pharmacists employed; 2nd year. 2) Cluster Pharmacists objectives & work plan being reviewed, to be agreed & communciated 3) GP capacity has been released 4) Pharmacist being up skilled through training to support sustainability	Medium
3	Shared cluster workforce - apprentices	All 8 GP practices staff Cluster		1) Discussions/research ongoing with regard to impact of training, investment and long-term viability of apprentices	High
4	Workforce Planning across practices and	All 8 GP practices staff Cluster	1) Patient safety considered 2) Continuation of access	1) Cleaning contracts are being considered in one practice 2) Employment of HCA being undertaken across	Medium

	cluster to be undertaken	PCIC Secondary Care UHB Third Sector	3) Improved patient experience	several practices 3) Consideration and introduction of 'research' opportunities underway in several practices 4) Streamlining of admin processes underway in one practice 5) Several practices have identified 'ageing' workforce as an issue which increases the sustainability of the practices	
5	Mitigate the cost of the increase in living wage	All 8 GP practices staff Cluster PCIC		1) Cluster is aware of increase & starting to have the conversation on how to mitigate to support the sustainability of the practices	High
6	Agree and sign off of cluster terms of reference	All practices Cluster	1) Patient will not see visible difference to services	1) Cluster currently drafting TOR for agreement and sign-off to support the 3 year cluster plan 2) Funding to back-fill practice managers time to cluster development to be considered	Medium
7	Support the possibility of collaborative working within the cluster and/or locality	All practices Cluster PCIC	1) Continuation of quality health care provision for patients	1) Meetings with PCIC underway on how best to share resources / work collaboratively 2) CHC aware of issues and support practice requirements	High

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	Outcome for patients	Progress to Date	RAG Rating
1	Appropriate and timely referrals and increased prevalence of care pathways	All 8 GP practices Cluster N/W Locality offices & team PCIC District Nurses CMH team Health Visitors Secondary Care Third Sector Local Authority	1) Improved timely diagnosis and referral 2) More conditions managed in the community 3) Earlier discharge 4) Less time spent in hospital 5) Care closer to home 6) Better patient experience 7) Patients better informed of process	1) Recognised pathways and guidelines agreed 2) Patients data being audited 3) Increase in correct coding 4) CRRU education seminar pilot undertaken successfully; cluster agreed to repeat seminar 5) Dementia – maintaining Dementia Friendly Status work done in previous years 6) Peer Reviews 7) Diabetes	High
2	Implement & follow agreed ACS pathways	All 8 GP practices Cluster		1) Templates written 2) Templates have been adapted for use in individual surgeries 3) GPs informed & reminded to use	Medium
3	Consider the setting up of a micro suction	All 8 GP practices Cluster	1) Ear syringing services being offered to the patients	1) Ear Syringing services not being funded by GMS 2) Discussions ongoing with ENT to link in with their idea of a Community Service	High

	service			3) Private run service for cluster patients – commissioning of services	
4	Community Heart Failure Clinics	All 8 GP Practices North West Locality practices Cardiology	1) Better recognition and diagnosis of patients with heart failure 2) Reduction of cardiology waiting lists	1) Engagement with the Community Cardiac Heart Failure Clinic 2) Improved pathway for diagnosis and management of patients with Heart Failure	Medium

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	Outcome for patients	Progress to Date	RAG Rating
1	Flu vaccinations & community days	All 8 GP practices staff Cluster District Nurses Third Sector Community Transport N/W Locality offices & team PCIC Pharmacy Podiatry Form 6 students	1) Promotion of preventative service 2) More patients vaccinated 3) Promotion of self care and increase in patients education 4) Engagement in staying healthy activities 5) Release of GP capacity resulting in better access to those in need 6) Patients better informed of other community activities	1) Met & agreed draft plan with DN team to hold 2 community flu days 2) Agreed to invite all over 65 & their carers 3) Venues being sourced 4) Transport solutions being considered for housebound patients where necessary 5) Discussions ongoing to hold children's under 4 fun morning nasal flu session 6) Collaboration underway with Third and community sector to be part of the events	Medium
2	Disaster recovery & business continuity plan	All 5 GP practices Cluster N/W Locality offices PCIC	1) Continuity of access and care	1) Disaster recovery and business continuity plans currently being reviewed, agreed and updated in practices and agreed to be shared across the cluster 2) Discussion underway to create a support network among the 8 cluster GP practices to mitigate risk if a disaster was to occur	High
3	Home 1st	All 8 GP practices staff	1) Seamless, early hospital discharge for	1) Continue to utilise ART and CRT services for patient discharge	Low

		Cluster District Nurses Third Sector N/W Locality offices & team Pharmacy Local Authority	patients 2) Reduction in the re-admittance of patients to hospital		
4	Better use of clinical staff / clinical skill mix	All 8 GP practices staff Cluster N/W Locality offices & team	1) Release of GP capacity 2) Increased access to those in need	1) Discussions underway to review the skills of practice nurses and HCA 2) Up skilling of staff and training being considered 3) Increase in minor illness appointment slots being implemented in some practices 4) Utilising cluster Pharmacist skills 5) Cluster funding for extra community nurse time	Medium
5	Review of patients access to A&E	All 8 GP practices staff Cluster N/W Locality offices & team Secondary Care	1) Patients access appropriate timely healthcare 2) Patients avoid hospital admission 3) Patients remain at home where possible	1) Practices individually are continuing to raise awareness to patients of when it's appropriate to use different medical services; Pharmacy, OOH A&E, 999 2) Good relationships with District Nursing Team, Acute Response Team and ECAS	Medium
6	Continue to coordinate and communicate with OOH service	All GP practices Cluster PCIC OOH	1) Safe transfer of patients	1) Communication ongoing 2) Reinstate special notes – discussions with Jane Brown/Helen Earland	Low
7	Prescribing	All 8 GP	1) Safer medication	1) Sharing of protocols for Repeat Prescribing Policies	Medium

	Issues	practices Cluster Pharmacist PCIC prescribing team	management for all patients 2) Improved management of patients medications 3) Improved safe prescribing	and Medicines Reconciliation 2) Creation of a Cluster Pharmacist Policy to be used by all practices within the cluster – ensuring a robust lone-worker protocol 3) Cluster Prescribing Meetings – sharing data and working together to improve overall prescribing 4) Practices considering employment of a Prescribing Clerk and appropriate training	
10	Antibiotic Prescribing	All 8 GP practices Cluster Cluster Pharmacist PCIC Prescribing Team	1) Reduced antibiotic prescribing across all practices 2) Use of appropriate antibiotics as per locality Microguidance	1) Cluster/Practice and individual prescriber information to be distributed at prescribing visits 2) European Antibiotic Awareness Week starting 13th November 2017 3) Practices to have at least one Prescribing Lead to promote good prescribing to staff and patients – practice organised promotional events 4) Regular pharmacist attendance and feedback at Cluster Meetings	Medium

Strategic Aim 5: Improving the delivery of the agreed nationally agreed pathway priorities

No	Objective	Key partners	Outcome for patients	Progress to Date	RAG Rating
1	Review & improve the recognition & diagnosis of cancer	All 8 GP practices staff Cluster Secondary Care N/W Locality offices & team Third Sector	1) Improved early cancer diagnosis 2) Improved patient care 3) Improved referral process	1) QI toolkits had been developed to improve the early diagnosis of cancer 2) Improvement plan to be agreed 3) Continue to work with 'Blue Bay' on achieving agreed goals 4) Agreed toolkits to be installed in all cluster practices 5) Early intervention / support for those patients diagnosed with cancer study ongoing	Medium
2	Improve the accuracy of read coding for COPD patients, ensuring appropriate prescribing and referrals	All 8 GP practices staff Cluster Secondary Care	1) Better diagnosis and Readcoding for all COPD patients 2) Improved access for support and exacerbations 3) Improved self care 4) Improved medication and treatment regimens	1) Agreed to develop peer review system 2) Continue to work with 'Blue Bay' on achieving agreed goals 3) Evaluation of access to training and education closer to home study in progress before roll out to the whole cluster 4) Commissioning of additional Nurse sessions over the winter period being considered by the cluster	Medium
3	Increase COPD patient self help / education	All 8 GP practices staff Cluster	1) Patients has improved insight into their condition 2) Better self management of condition 3) Patient requires less GP appointment time	1) Patient self help and education sessions been piloted in a cluster surgery 2) National COPD audit outcomes being reviewed - outcomes & learning to be shared	Medium

4	Pilot a Cancer Wellbeing service with Macmillan	All 8 GP practices staff Cluster Third Sector N&W Locality	1) Increased and better informed access to supporting & wellbeing information for patients	1) Funding sought in partnership with Macmillan to pilot project 2) GP identified to progress work	High
5	Develop follow up for non responders to AAA, Cervical, Bowel & Breast screening	All 8 GP practices Cluster	1) Improved screening rates should mean earlier diagnosis for patients 2) Improved patient care	1) Low rates of attendance for bowel screening especially – working with Bowel Screening Wales to pilot alternative methods of encouraging patients attendance for screening 2) Discussion with Public Health regarding obtaining Practice Level data	Medium

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

No	Objective	Key partners	Outcome for patients	Progress to Date	RAG Rating
1	Improve the diagnosis of dementia	All 8 GP practices staff Cluster Secondary Care N/W Locality offices & team Third Sector	1) Improved access to support	1) Toolkits developed 2) Agreed to develop cluster quality improvement plan & peer review 3) Continue to work with 'Blue Bay' on achieving agreed goals 4) Cluster working towards becoming a virtual Dementia Friendly organisation	Medium
2	Continuation of the work of the Cluster Memory Clinic	All 8 GP practices staff Cluster	1) Faster access to diagnosis 2) Patients & carers get earlier access to support	1) Cluster decision made to support the trained Cluster GP to continue with this work following successful pilot. 2) Referral process for patients to be seen within the community to be set-up 3) Promotion of the local dementia cafe ongoing	Medium
3	Introduction of practice Dementia Champion	All 8 GP practices staff Cluster Third Sector	1) Better identification, management and care of Dementia patients	1) Cardiff West is already awarded 'Working Towards Dementia Friendly' status	Medium

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	Outcome for patients	Progress to Date	RAG Rating
1	Cluster peer review system to be developed	All 8 GP practices staff Cluster		1) Collaborative working to identify best working practices 2) Sharing workload across practices	Medium
2	Clusters to have access to a Clinical Governance Support team	All 8 GP practices PCIC		1) Clinical Director in discussion with PCIC and CDs regarding funding of a Clinical Governance support team to be utilised by all clusters as needed	High

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	Outcome for patients	Progress to Date	RAG Rating
1	Mitigate the risks associated with the local development plan which will see a vast increase in the local population of the cluster	All 8 GP practices staff Cluster N/W Locality offices & team PCIC Secondary Care Local Authority	1) Continuity of high level quality care within the cluster	1) Cluster workforce plan 2) Communication with PCIC regarding estates and boundaries 3) Communication with local authority 4) Cluster task & finish group identified 5) Rejection of application to redraw practice boundaries being challenged 6) Consideration being given to adding clinical space/rooms in some practices 7) List growth of practices being regularly monitored	High
2	Secondary care interface	All 8 GP practices staff Cluster Secondary Care PCIC		1) Cluster is considering how to improve interface between cluster and secondary care – within Dementia services	HIgh
3	IT development	All 8 GP practices staff Cluster IT provider PCIC	1) Better IT documentation in clinical notes 2) Easier access and completion of templates and policies enabling safer care for patients	1) Procurement of IT services for the 2nd year running 2) Utilising the PCIC funded Blubay service in conjunction with the services offered from the IT service team	Medium