Annex 3

Three Year Cluster Network Action Plan 2017-2020

Western Vale 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 127,592 people living in the Vale of Glamorgan. The population age structure of the Vale of Glamorgan is very similar to the Wales average, with the exception of a slightly lower number of young adults (20-24yrs). The population of the Vale will increase modestly over the next 10 years, by around 1% (1,255 people). However, this masks significant growth in the over 65s category. The Vale has a relatively stable population size which reflects a low net migration rate and roughly equal birth and death rates.

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

Age Group	2019	2021	2026
0-4	-3.2	-3.4	-3.8
5-16	1.4	2.2	-0.3
17-64	-1.6	-2.8	-5.5
65-84	5.9	9.7	19.5
>84	7.1	13.0	36.2
All	0.3	0.6	1.0

Within the Vale of Glamorgan 14% (up to 23.1% in Cardiff) of local areas are among the most deprived in Wales, clustered in the central Vale around Barry, but there are also significant pockets in the Western Vale too. Within the Vale of Glamorgan, men in the most deprived areas can expect to live on average 8 years less than those in the least deprived areas with a healthy life expectancy gap of 21 years. Deprivation leads to lower immunisation uptake, A+E attendance and prevalence of diabetes.

The Western Vale 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 3 practices represented by this cluster:

Eryl Surgery – population 10885 (Llantwit Major, Rhoose & St Athans)

Western Vale Family Practice – population 6877 (Cowbridge)

Cowbridge and Vale Medical Practice – population 10183 (Cowbridge, St Athans & Llantwit Major)

Headline issues for the Vale of Glamorgan (specifically for Western Vale):

- has the largest inequality gap in health inequalities for women who live in the most deprived areas
- higher level of alcohol consumption – particularly by older people living in rural areas
- engaging with harder to reach groups still proves challenging and new innovative ways to reach all of the population needs to be considered at cluster level
- the cluster is at risk of isolating those living in rural areas who find it difficult to access services
- high housing prices which may become unaffordable to local people
- an increased demand for services due to an ageing population – leading to an increased risk of social isolation

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 patients access to GMS services	All 3 GP practices staff Cluster Vale 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 (length and type) being offered across practices 3) Workforce retention and recruitment planning for the future 4) Workflow optimisation training being explored	High
2	Improve Welsh & non-English language provision	All 3 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	Direct access to physiotherapy	All 3 GP practices staff Cluster	1) Quicker access for patients with musculoskeletal problems	1) Discussions/research ongoing with regard to impact of investment 2) Reinstatement of local services in Cowbridge 3) Discussions with Physiotherapy Directorate with regards to waiting list management	Medium
4	Patient Experience and Engagement to be considered in planning	All 3 GP practices staff Cluster	1) Improved patient communication 2) Patient feedback to influence service development &	1) Practices within the cluster are working through how best to engage with patients to support future planning & sustainability	Medium

	services		sustainability		
5	Childhood Immunisation	All 3 GP practices staff Cluster Public Health	1) Improve immunisation in all groups – especially in those children after the first year of life	1) Immunisation uptake at 1 year old is 96.4% (UHB is 95.6%) 2) MMR2 uptake at 4 years old is 88.3% (UHB is 86.8%) 3) Preschool Booster uptake at 4 years old is 86.9% (UHB is 84.9%) 4) Teenage booster by age 16 is 83.6% (UHB is 76.1%) **Increased uptake in all areas from 2016/17 figures**	Medium
6	Influenza Immunisation	All 3 GP practices staff Cluster Public Health	1) Improve immunisation and reduce risk of flu in all ages / risk categories	1) Seasonal flu uptake of >65 years is 73.8% (UHB is 69.0%) 2) Seasonal flu uptake of the at risk group is 53.2% (UHB is 48.3%) **Increased uptake in all areas from 2016/17 figures**	Medium
7	WAG: Tier 1 Performance • 5% of smokers should set a firm quit date • 40% should have quit by 4/52	All 3 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 Eryl Surgery **Western Vale: 14.2% of the registered population smoke – compared with the C&V average of 19.5% and Wales average of 20.5%**	Medium
8	Improve alcohol awareness The Vale is the area of C&V with the highest intake of alcohol	All 3 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

	in Wales				
9	To ensure patients have a low risk of falls Falls should not be an inevitable part of ageing Prevention includes • Exercise • Strength and Balance • Sight testing Medication management	All 3 GP practices staff Cluster Public Health Community Services UHB	1) 66/1000 people in C+V will fall and 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 4) In Western Vale there were on average 27 admissions with a diagnosis of hip fracture after falling	1) Cluster funding to be used to provide longer/improved reviews for the elderly 2) OTAGO strength and balance classes 3) Frop-Com screening tool	Medium
10	To improve patients attendance at all screening programmes	All 3 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 = 85.8% (target 80%) 2) Bowel screening = 60.5% (target 60%) 3) Breast screening = 74.9% (target 70%) 4) Cervical screening = 82.7% (target 80%) http://www.screeningforlife.wales.nhs.uk	Medium
11	Promotion of Physical Activity 'Sit Less, Move		1) Physical activity for at least 60+ mins every day (children and young people)	1) Only 28.3% of adults in Western Vale 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

	More & More Often'		2) 150 mins per week for adults – moderate to intense levels 3) 150 mins per week with 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	Improve medication reviews through a Cluster Pharmacist	All 3 GP practices staff Cluster PCIC Pharmacy	1) Timely medication checks for patients 2) Patients seeing reduction in medication they are taking 3) Polypharmacy reviews	1) Cluster Pharmacists employed; 3rd year. 2) Cluster Pharmacists objectives & work plan being reviewed, to be agreed & communicated – PADR completed July 2017 3) GP capacity has been realised 4) Pharmacist being up skilled through training to support sustainability – flu immunisation, home visits.	Medium
2	Workforce Planning across practices and cluster to be undertaken	All 3 GP practices staff Cluster PCIC Secondary Care UHB Third Sector	1) Patient safety considered 2) Continuation of access 3) Improved patient experience	1) Consideration and introduction of 'research' opportunities 2) Streamlining of admin processes – workflow optimisation companies attending the cluster meeting – July 2017 3) Workforce planning being monitored in all practices 4) Sustainability a major factor in all 3 PDPs	High
3	Mitigate the cost of the increase in living wage	All 3 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
4	Agree and sign off of cluster terms of reference	All 3 GP practices staff Cluster	1) Patient will not see visible difference to services	1) Cluster currently drafting TOR for agreement and sign-off to support the 3year cluster plan	Medium
5	Counselling Services	All 3 GP practices staff Cluster PCIC	1) Equitable access to counselling services 2) Enabling improved and faster access to	1) Consideration of discussions with CMHT regarding reinstatement of equitable counselling services across all 3 practices	Medium

		CMHT LMHPSS	community counselling services		
6	ECAS Services	All 3 GP practices staff Cluster Vale Locality offices and staff PCIC ECAS	1) Changes in ECAS need to ensure that equitable access is maintained for all patients in C&V irrespective of base location	1) Relocation of the ECAS service from Barry to Llandough is a threat on the accessibility to patients in Western Vale	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 3 GP practices Cluster Vale 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	Medium
2	Implement & follow agreed ACS pathways	All 3 GP practices Cluster		1) Templates written 2) Templates have been adapted for use in individual surgeries 3) GPs informed & reminded to use	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 vaccination provision	All 3 GP practices staff Cluster District Nurses Cluster Pharmacist Vale Locality offices & team PCIC Pharmacy	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	1) Western Vale have a high uptake for all areas of eligible flu patients 2) Successful flu campaigns to be re-run annually 3) Practices to review individual data and to focus on any area outside the cluster/locality/UHB average levels	Medium
2	Disaster recovery & business continuity plan	All 3 GP practices Cluster Vale 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 3 cluster GP practices to mitigate risk if a disaster was to occur	High
3	Better use of clinical staff / clinical skill mix	All 3 GP practices staff Cluster Vale 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 and length of time for these appointments being implemented supported by cluster funding	Medium

4	Review of patients access to A&E	All 3 GP practices staff Cluster Vale 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	Low
5	Continue to coordinate and communicate with OOH service	All GP practices Cluster PCIC OOH	1) Safe transfer of patients	1) Communication ongoing	Medium
6	Working with WAST for an improved MDT working approach	All GP practices Cluster PCIC WAST	1) Improved access to Primary Care services for the housebound patient 2) Improved working relationships with WAST 3) Decreased pressure loads on Secondary Care/A+E 4) Reduction in Winter Pressures workload	1) Short 3/12 trial of 'Cluster Paramedic' working carried out – February-March 17 2) Excellent data shown for reduction at Secondary Care/A+E level 3) Lead GP and Emma Lewis working together with WAST to extrapolate Primary Care data to identify benefits	Medium
7	Continue to coordinate and communicate with ABMU – crossborder issues	All GP Practices Cluster CD PCIC ABMU	1) Safe discharge and OPD communication of patients from UHB attending AMBU services	1) Regular meetings with AMBU – Vale Locality and CD 2) Two way conversation encouraged to highlight and resolve crossborder issues	High
8	Prescribing	All 3 GP	1) Safer medication	1) Discussions as to Repeat Batch Prescribing for Practices	Medium

	Issues	practices Cluster Pharmacist PCIC prescribing team	management for all patients 2) Improved management of patients medications 3) Improved safe prescribing	2) Sharing of protocols for Repeat Prescribing Policies and Medicines Reconciliations 3) Cluster Prescribing Meetings – sharing data and working together to improve overall prescribing 4) Practices considering employment of a Prescribing Clerk and appropriate training	
9	Antibiotic Prescribing	All 3 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
10	Community Cardiac Defibrillators	All 3 GP practices Cluster Cowbridge First Responders WAST	1) Increase in number and spread of Cardiac Defibrillators across the Western Vale Locality	1) Cluster funding donated to 4 local fundraising groups to finance the procurement of a Cardiac Defibrillator in these areas http://www.nhsdirect.wales.nhs.uk/LocalServices/?s=DefibrillatorLocations	Low

Strategic Aim 5: Improving the delivery of dementia, cancer & COPD

No	Objective	Key partners	Outcome for patients	Progress to Date	RAG Rating
1	Review & improve the recognition & diagnosis of cancer	All 3 GP practices staff Cluster Secondary Care Vale 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 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
3	Continuation of the work of the Cluster Memory Clinic	All 3 GP practices staff Cluster Lead GP – Dr Mark Townend	1) Faster access to diagnosis 2) Increasing Dementia population numbers 3) Patients & carers get earlier access to support	1) Working with UHB to discuss reinstatement of these Primary Care Clinics 2) Nurses to be trained in MOCA questionnaires – CPET May 2017 3) Referral process for patients to be seen within the cluster to be discussed	Medium

4	Creation of a Dementia Friendly Community	All 3 GP practices staff Cluster Third Sector Public Health	1) A greater awareness of those diagnosed with Dementia 2) Community partnership working	1) Working with Public Health to create a Dementia Friendly Community in Western Vale 2) Practices are on the steering committee for this project 3) All practices have agreed to work together to make this a success 4) Initial consultations with the Innovation team regarding moving Dementia patients OPA out of hospital settings 5) Dementia Workshops being organised	High
8	Working more closely with the REACT team	All 3 GP practices staff Cluster REACT team		1) Discussion with REACT regarding monitoring and reviewing antipsychotic prescribing 2) Cluster Pharmacist to access support from the REACT Pharmacist to carry out this work 3) Consideration of targeted Specialist Reviews for certain patients in Primary Care – satellite surgeries	High

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	Admission Avoidance	All 3 GP practices staff Cluster Secondary Care	Improved and safe management of patients with aortic valves	1) Cluster is considering how to improve interface between cluster and secondary care 2) Discussions as to how best to audit this group of patients 3) Working out what are the 3 tests of change that the Cluster are hoping to demonstrate with this work	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 3 GP practices staff Cluster		1) Dementia and COPD clinical areas to be discussed at a midpoint (September) and end of year (March) cluster level meeting 2) Other retired QOF areas to be discussed if issues are identified at practice or cluster level	Medium
	Clusters to have access to a Clinical Governance Support team	Community Director PCIC		1) Community Director to maintain communications with the Clinical Director regarding the employment of LHB funded Clinical Governance Support	Medium

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 3 GP practices staff Cluster Vale 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	Medium
2	To provide a consistent and equitable phlebotomy service across the cluster	All 3 GP practices Vale Locality offices & team PCIC DN services Phlebotomy Directorate	1) Equitable access to phlebotomy services for all cluster patients, including the housebound	1) District Nurses auditing the work carried out by the new phlebotomist posts working with them 2) Consideration in the future as to where the housebound phlebotomy service should sit 3) Ongoing discussions for a cluster based phlebotomy working service	Low
3	Consider the setting up of a micro suction service	All 3 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 3) Private run service for cluster patients – commissioning of services	Medium