# ***North Cynon Cluster GP Network Action Plan 2017-20***

**NORTH CYNON NETWORK CLUSTER ACTION PLAN 2017-20**

This plan has been developed by the following 4 practices which operate in the North Cynon Cluster Area, through facilitated discussion with the Local Medical Director and Primary Care UHB Locality Management :-

- Hirwaun Surgery
- The Foundry Town Clinic and Aberaman Surgery
- St John's Medical Practice
- Park Surgery

**The Plan** The plan has been informed by the practice development plans produced by practices; public health information on key health needs within the area; information provided by Cwm Taf uHB re current activity/referral patterns; an understanding of our localities baseline services (current service provision) and identification of potential service provision unmet needs. The plan also embraces key UHB priorities for the next three years. The plan details cluster objectives for years 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 plan is by its very nature fluid /flexible and evolving over the next 3 years the plan itself will be reviewed and updated in response to changes in cluster planning. The RAG rating score indicates progress against planned action (Red-future work, Amber- in progress, Green- completed). A number of key principles underpin the plan:

- **Management of variation/reducing harm/sharing good practice:** in acknowledgement of the fact that healthcare must be delivered on the basis of safety, effectiveness and efficiency, the practices have considered and analysed variation in performance and where appropriate have considered steps by which to map standardise practice based on clinical guidelines.

- **Maximising use of Local Cluster Resources**: practices have taken into account the capacity, capability and expertise that exists within primary care, community services and voluntary/third sector services to deliver more care closer to home and reduce unnecessary demands within the acute care services.

- **Promoting integration/better use of health, social care and third sector services to meet local needs:** practices have considered current arrangements/links with RCT Council and the voluntary sector and will also consider any action plans from stakeholders that evolve over the 3 year cycle of this plan.

- **Considering and Embedding New Approaches to Delivering Primary Care**: this includes increased use of technology, new roles and service models considering and embedding new approaches to delivering primary care: this includes increased use of technology, new roles and collaborative working.

- **Maximising opportunities for patient participation**: this includes consideration of models of good practice that exist with within/locality/cluster and nationally and within the rest of the UK.

- **Maximising opportunities for more efficient and effective use of resources**: this includes consideration of current resources, opportunities to utilise current and new services more efficiently and effectively.

**Additional contributors to the plan/potential evolving contributors to the plan subject to evolution of plan**

- Health and social care facilitators.
- Primary care practice managers.
- Practice Nursing and allied health professions representatives.
- Local voluntary sector providers and third sector.
- Relevant secondary care consultants e.g. potentially diabetic and cardiology secondary care teams.
- Prescribing advisers.
- Potential educator partners including third sector TEDS for brief alcohol intervention training, podiatry/local tertiary education providers for foot assessment training for Health care assistants.
- Primary Care Support Unit Nursing advisory expertise/local university school of health care re Health care assistant initiatives and informing community care planning e.g. diabetes.
- Cluster employed pharmacists, & community pharmacists (including those with UHB funded independent prescribing status and involvement in the common aliments pilot scheme).

**Data from the 2016-2017 Welsh Health Survey show that:**

- 20% of adults in Cwm Taf reported drinking more than 14 units a week, compared to 20% for the whole of Wales.
- 21% of adults in Cwm Taf reported being a current smoker with 19% in Wales reported being a current smoker.
- 38% of adults in Cwm Taf reported being active less than 30 minutes a week compared with an all-Wales figure of 32%, further those in CwmTaf reporting that they were active for 150 minutes a week was 45% compared with an all Wales figure of 54%.
- Those respondents classified as overweight or obese in Cwm Taf were 64% the all Wales average was 59%.
- Healthy behaviours – 13 % of adults reported less than two out of five healthy behaviours compared to 10% across Wales where healthy behaviours are 'not smoking, average weekly alcohol consumption 14 units or lower, eating at least 5 portions fruit and vegetables the previous day, having a healthy body mass index, being physically active at least 150 minutes the previous week'.

***The areas of concern identified by the cluster through this analysis of our cluster populations' health status are therefore: OBESITY/OVER WEIGHT STATUS, PROBLEMATIC ALCOHOL USAGE, RATES OF CURRENT SMOKERS, LOWER LEVELS OF PHYSICAL ACTIVITY***

## Strategic Aim 1: to understand the needs of the population served by the Cluster Network

| No | Objective | Key partners | completion by: - | Outcome for patients | Progress to Date | RAG Rating |
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| 1 | To understand and highlight actions to meet the needs of the population served by the Cluster Network | Local Public Health Team Public Health Observatory | April 2020 | To ensure that services are developed according to local need | Initial analysis complete<br>Continuing to liaise with Public Health Wales to present to the Cluster regular updates. |  |
| 1a | Pilot Obesity Scoping measures to | UHB: Dietetics/ EPP. | April 2020 | Effective identification of and targeting of existing | Building on previous work from the last Cluster Plan current work includes representation on the obesity steering group | |

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| | reduce the levels of obesity in our cluster Representation on steering group for development of obesity pathways | Public Health.<br><br>Third Sector Local authority: Leisure Centre<br><br>NICE approved weight loss programme | | health promotion for weight reduction at those identified as obese. Collaborative developmental work with the UHB to develop an Obesity Pathway with specific emphasis on tier two interventions | which will inform further actions. Developmental work is in progress to integrate the Educating Patient Programme with the wider dietetics education programme.<br><br>Slimming World Vouchers scheme has been explored and identified as an investment option for any funding slippage.<br><br>St John's is involved in an obesity research project (October 2018)<br><br>Proposed Community Pharmacy scheme to record weight and card stamp/ & BP and return to Practice. | |
| 1b | Effective linking with 3rd Sector | Interlink Care Co-Ordinators, Care & Repair, MIND, Representation at Cluster meetings. | March 2020 | Engaging with the 3rd sector to seek funding for innovative schemes to improve patient care/public health measures/social wellbeing | Continued joint projects with third sector. Social prescribing initiatives. Re commissioning Of MIND Active Monitoring Intervention for 2018/19 Partnership work with Age Connect to develop a North Cynon based community Hub. | |
| 1c | Address Five Key lifestyle behaviours of the | Public Health Wales | All cluster practices<br><br>March 2019 | Staff awareness of key public health messages and signposting patients | MECC complete.<br><br>Lifestyle Champion training complete. | |

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| | population of CYNON VALLEY effecting the clusters population health: smoking, alcohol, physical activity, diet and immunisation/ screening | Practice Staff<br><br>Practice Managers<br><br>Community Pharmacists | | to helpful resources and services. | Explore Care Navigation training to facilitate sustainability via workforce development, prudent healthcare and social prescribing.<br><br>Development of a system to identify in house patients over/due health screening programmes – all Practices have consented to share practice level data for learning purposes<br><br>Active links with the 'reducing cancer inequalities in Cwm Taf' group. | |
| 1d | **Older People/ Management of General Frailty/ Maintaining Independent living** | Care & Repair Rhondda Cynon Taf Ltd | April 2020 | Maintain independence in a safe home environment with access to reliable advice and maintenance for the older members of our cluster | The Virtual Ward operating across the Cluster includes the targeting of frail older people and uses a Whole Systems Approach to Advanced Care Planning.<br><br>Active engagement with Community Co-Ordinators<br><br>Active engagement with Care & Repair with several aspects to the scheme including urgent adaptations to facilitate hospital discharge. Overall this aims to maintain | |

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| | | | | | independent at home and via adaptations minimise falls and self care difficulties. GP's can refer to this service.<br><br>The Warmer Homes 'Boilers on Prescription' pilot operating from the Virtual Ward at St John's Medical Centre.<br><br>Completion of a five month pilot of a Community Nurse Home Visiting Service to include frailty and falls assessment. |  <br>  |

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| 1e | Further areas may be identified during 3 year cycle of cluster plan | To be considered by the cluster if time/resources allow | Ad hoc /no time scale | Improvements in care delivered | Potential RCGP dementia practice based all staff training.<br><br>Domestic abuse 3rd sector state agencies improvements in interactions/advertising help availability.<br>IRIS training completed on a UHB wide and successfully implemented and maintain profile of the service.<br>Funding for the continuation of the IRIS scheme has been secured until March 2021. |  <br>  |

**Strategic Aim 2: To ensure Sustainability of Core GP Services and Access Arrangements that Meet Reasonable Need of local patients including any agreed collaborative arrangements.**

Cluster practice members have considered this area already in their individual Practice Development Plans, with a range of access and sustainability issues considered including number of GP appointments provided, hours of services, inappropriate use of A+E, unscheduled admissions +GP Out of Hours services by patients, DNA rates, Promoting use of technology such as My Health on Line/Texts messaging and use of new technology. In addition to practices individual development plans in this area those areas of common interest across the Cluster are identified in this section.

| No | Objective | Key partners | For completion by: - | Outcome for patients | Progress to Date | RAG Rating |
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| 2a | I.T. Greater use of My Health Online to improve appointment access; and prescription services in accordance with WAG planning | Individual cluster Practice Managers | March 2020 | In the cluster there is varying patient Increase practice uptake of technology to improve access Promotion of My Health Online to improve appointment access; and prescription services and drive forward | Individual practices are engaging with the process and promoting Particularly repeat prescription management, plan is to promote this and ultimately consider practice appointment management re this process.<br><br>Promote shared working and consistency of approach across the Cluster.<br><br>Explore evaluation of Merthyr Cluster GP web investment for possible development within North |  |

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| | | | | WAG planning | Cynon<br><br>Patient engagement in the process. | |
| 2b | To develop local workforce development plans | LHB<br><br>Skills for Health<br><br>WEDS<br><br>Deanery.<br><br>Schools of Nursing.<br><br>Professionals represent ative Organisations . | March 2020 | Service modernisation to meet changing needs.<br>Ensure sustainability of local services.<br><br>Timely service delivery by a multi – skilled multi – agency workforce | Within the cluster there are increasing reports of recruitment difficulties with a GP retirement time bomb. ***Actions***<br>• Discussion around collaborative working in the Cluster following up the workforce planning meeting to explore options for collaborative GP networks, shared staff and GP rota for the virtual ward.<br><br>• Consider collaborative winter planning models<br>• The role of an Occupational Therapist in General Practice is being piloted at a Cynon Practice on a twelve month secondment. This explores multi – skilled general Practice Teams. The skills of the OT are also being shared across four local Practices as part of the extended Virtual Ward. This secondment is to |  <br>  |

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| | | | March 2018<br><br>March 2020 | | become a permanent post with additional posts to follow in 2018.19.<br>• Advanced Emergency Practitioners are attached to the virtual ward and are being evaluated as part of the Bevan Exemplars scheme.<br>• . OOH & Cross cover |  <br>  |
| 2c | **Interface**<br>Limited use of technology to support interface between primary and secondary care Establish more virtual consultation processes with Secondary | Medicine Clinical Board/ LHB/<br><br>Specific Directorate. | March 2020 | Maximise opportunities to improve interface with secondary care specialist. | We already have an e-mail cardiology consultant led Q&A service for GP's which often provides the expertise to avoid referral/further investigation. This beacon service could be expanded including designated consultants per practice/cluster. A directory would need to be created nhs email address coverage would need to be optimised, e-mail receipts would be required and a clinical governance robust system would need to be in place. |  |

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| | Care Services | | | | Integration of primary care clinical system within secondary care via VISION Anywhere<br><br>Explore models for consulting secondary care – possibly Cardiff model – portal, click speciality; ask query; then receive advise.<br><br>Explore IT links with the pathology service.<br><br>Develop pilot DVT pathway between secondary and primary care. | |

**Strategic Aim 3: Planned Care- to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface.**

| No | Objective | Key partners | For completion by: - | Outcome for patients | Progress to Date | RAG Rating |
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| 3a | Review of Enhanced Service provision across the | Cwm Taf GP's with the required skill set<br><br>Primary | March 2020 | Local rapid provision of procedure without the need to attend hospital freeing up capacity in | The Cluster have already scoped enhanced service provision now need to identify practitioners willing to engage in providing networked services. |  |

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| | Cluster with a view to greater networking to ensure equitable service provision. | Care Directorate LHB<br><br>Individual Practice Managers | | secondary care. | The recruitment of a Care Home ANP to deliver the DES on behalf of the Cluster Practices is being progressed Autumn 2018. An ANP was successfully recruited in December 2018 |  |
| 3b | CYNON CLUSTER PILOT to improve early cancer diagnosis in patients with non specific symptoms but clinically there is a strong suspicion of an underlying malignancy | WAG<br>UHB:<br>Acute /speciality physicians<br>Patient participation groups<br>Radiology<br>3rd sector charities (Tenovus MacMillan)<br>Cancer nurses<br>Bath University | April 2018 | Earlier detection and diagnosis of cancer.<br>Improved survival rates.<br>One stop shop for tests and scans and investigations. | Pilot due to start in July 2017<br><br>A number of North Cynon GPs have become involved in the delivery of this service which has been rolled out to include the other Cluster areas to accept referrals. The evaluation of this project is ongoing. |  |

**Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management to address winter preparedness and emergency planning.**

| No | Objective | Key partners | For completion by: - | Outcome for patients | Progress to Date | RAG Rating |
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| 4a | Scope Welsh Medium primary care Consultation availability | GP practices in first instance UHB Welsh Language team | April 2019 | Improvements to the availability of Welsh medium primary care consultation | We are already aware that language line can be employed to facilitate Welsh Medium Consultations. Following on from the Welsh Language Commissioners reports "My Language My Health", "More Than Just Words" and the key message of aiming for widespread availability of the "active offer" of a Welsh Language consultation. We will initially scope practice level availability. After this we will involve our UHB Welsh Language team re training/recruitment /translation/signage/literature opportunities. |  |
| 4b | Virtual Ward Pilot | The MDT GPs; Community Nursing; Service; Third Sector – Care & Repair, Interlink; | March 2019 | Ability to stay at home. Holistic care co-ordination. Reduction in unplanned admissions. | A virtual ward model initiated by a Cynon Practice has been identified to host a team of Advanced Emergency Practitioners and an Occupational Therapist. Patients are identified for the 'Virtual Ward' due to frailty and multiple and complex health and social care needs |  |

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| | | Pharmacist; Nurse Practitioner; Social Services; Practice Manager.<br><br>Occupational Therapist. | | | The pilot has been extensively evaluated and is continuing into 2018.19 and extending to include all North Cynon Practices.<br><br>Throughout 2019.20 the model will become embedded in the Cluster as an established way of working with sophisticated IT systems and associated governance agreements in place. |  |
| 4c | Remote Working | NWIS<br>INPS<br>EMIS | March 2019 | Continuity of service provision and care. | Accessing the clinical system from romote locations<br>VISION anywhere & 360<br>Telephone triage |  |
| 4d | Links with Primary Care Partners | Community Pharmacy Community | March 2019 | Appropriate care | Utilising positive relationships with Primary Care Partners to ensure a robust primary care service delivery in times of pressure. |  |

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| | | Optometry<br>Community Dentistry | | | Representation of Primary Care providers at Cluster meetings. | |
| 4e | Cluster wide ANP Winter pressures Team | INPS<br>NWIS<br>EMIS<br>All Practices | March 2018 | Efficient and targeted service provision. | The commissioning of a Home Visiting Service is being considered by the Cluster for the winter period to be staffed by either Paramedics, Advanced Nurse Practitioners or Occupational Therapists or a combination of all. This would pioneer a Cluster wide initiative facilitated by VISION 360.<br><br>This service was redesigned to be a Community Nurse Home Visiting Service and operated between November 2017 and march 2018 inclusive.<br><br>Number of Patients seen = 400<br><br>Number of GP appointments saved = 152 |  |
| 4f | Practice collaborative approach to Business Continuity Planning | All Practices | March 2019 | Continuity of service provision and care. | Use of ‘buddy practice’ and ‘network’‘agreements to ensure business continuity in times of pressures. Use of Significant Event Audits to review the circumstances where emergency plans have been invoked. |  |

**Strategic Aim 5 & 6: Improving the delivery dementia; mental health and well being; cancer; liver disease; COPD**
**Improving the delivery of the locally agreed pathway priority**

| No | Objective | Key partners | For completion by: - | Outcome for patients | Progress to Date<br>**The second phase of audit was due to take place in February 2018, the Cluster Clinical Pathways domain was however relaxed in January 2018.** | RAG Rating |
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| 1 | COPD | Cluster Pharmacists | March 2018 | Care review. Appropriate & accurate diagnosis and treatment intervention. | Practice audits completed and discussed in the October 2017 Cluster meeting |  |
| 2. | Liver Disease | Consultant. Path lab. Planning & Delivery Group | March 2018 | Timely diagnosis and treatment. | Baseline audits completed and new pathway commenced 1st October 2017 |  |
| 3. | Cancer | Macmillan. Reducing Cancer inequalities group. Rapid Diagnostics | March 2018 | Reduced wait times for diagnostic investigations via a one stop shop and timely treatment commencement if required. | Module 2 of the Macmillan Cancer Toolkit for GP in Wales completed by Practices. By October 2017 Practices had:<br>• Reviewed current data regarding cancer presentation, referral and incidence.<br>• Reviewed and critiqued current |  |

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| | | Clinic. Screening services. | | Increased awareness of cancer prevention initiatives and access to screening programmes. | practice regarding recognition and referral of cancer, with particular reference to NICE suspected cancer referral guidance, at risk groups, and potential barriers to prompt referral.<br>• Discussed learning points at a Cluster meeting and agreed three changes. | |
| 4 | Mental health | MIND Valley Steps EPP | March 2019 | Reduced wait times for therapeutic interventions. Increased choice of interventions. Integrated pathway approach. | Cluster recommissioning of an Active Monitoring Service from MIND for an additional twelve months until March 2019. Initial meeting in January 2018 following a Co productive model with partners to develop a Cluster pathway. |  |

## Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and information governance. To include actions arising out of peer review of inactive QOF (when undertaken)

| No | Objective | Key partners | For completion by: - | Outcome for patients | Progress to Date | RAG Rating |
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| 7a | Engage with a robust validated clinical | Individual cluster practices | April 2018 | All measures/proposals outlined and assessed in a | Clinical Governance Practice Self Assessment Tool |  |

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| | governance process specifically designed with Cluster planning in mind | Public Health Wales | | validated all Wales clinical governance tool | Information Governance Toolkit. | |
| 7b | Continue to engage with statutory emerging clinical governance obligations | Health Inspection Wales | Ongoing rolling program of inspections. | Clinical governance oversight of their local practice | All Wales Cluster Governance requirements.<br><br>Cluster has a terms of reference. |  |
| 7c | Inactive QOF | UHB | April 2018 | Improved access and uptake of chronic condition care | Cluster peer review took place in September 2017 and actions agreed.<br>Re audit was planned for February 2018 but was cancelled due to the relaxation of QOF in January 2018 |  |

# Strategic Aim 8: Other Locality issues

| No | Objective | Key partners | For completion by: - | Outcome for patients | Progress to Date | RAG Rating |
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| 8b | Development of a foot care assessment programme performed by | Health care assistants<br>Local podiatry department and/or local university | March 2019 | Improvements in provision of practice based feet assessment, freeing up practice nurse time increased job | .<br><br>Foot care assessment programme provider identified. |  |

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| | Practice based Health Care Assistants | school of nursing Local primary care nursing management and nursing representative | | challenge for HCA's (right person right place right time – prudent health care). | | |
| 8c | Medication reviews, smarter working, develop role of pharmacist | Cluster Pharmacists | March 2019<br><br>Extended to March 2020 as service recommissioned. | Improved access. Providing medication reviews: house bound/residential/nursing home patients/improving repeat prescribing processes. Freeing up GP time to see patients. Ultimately by further postgraduate training e.g. independent prescriber status/ minor illness consultations i.e. service expansion with pharmacists embedded in primary care teams with direct patient benefit. | On going training to include prescribing and minor illness.<br>Strategic Fit of this proposal:<br>"Improving access and quality and new ways of working." |  |