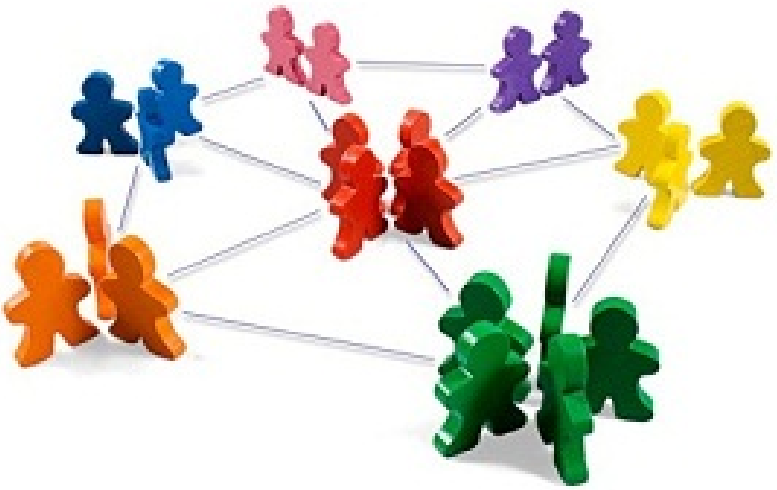
GP Cluster Network Action Plan 2016/17

Amman Gwendraeth Cluster



The GP Cluster Network[1] Development Domain supports GP Practices to work to collaborate to:

- Understand local health needs and priorities.
- Develop an agreed GP 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 development of primary and community services is a key element of all LHB's 3 year service delivery plans.

The Action Plan should be a simple, dynamic document.

The 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.

Each cluster objective should be accorded a RAG (Red, Amber, and Green) rating. This will provide a useful tool to enable the GP Cluster and the LHB to take an overview in terms of the progress of delivery of each objective.

[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

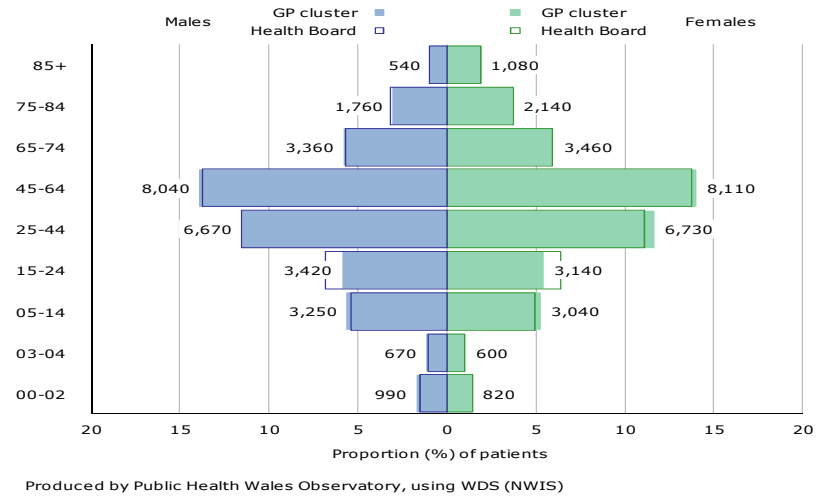
Strategic Aim 1: To understand the needs of the population served by the Cluster Network

The Cluster Profile provides a summary of key issues. Local Public Health Teams can provide additional analysis and support.
Consider local rates of smoking, alcohol, healthy diet and exercise – what role do Cluster practices play and who are local partners. Is action connected and effective? What practical tools could support the delivery of care?

Health protection- consider levels of immunisation and screening- is coverage consistent- is there potential to share good practice?
Are there actions that could be delivered in collaboration- e.g. Community First to support more effective engagement with local groups

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To review the needs of the population using available data	Local Public Health Team Public Health Observatory	On-going	To ensure that services are developed according to local need	**Demography characteristics of Amman Gwendraeth Cluster:** Amman Gwendraeth is one of seven clusters operating within Hywel Dda University Health Board [HB] with a total list size of **57,790.** **Older People:** The percentage of patients of 65+ for Amman Gwendraeth is 21.3% (12,340), which is above the Wales average at 18.7%, and slightly below the HB average at 21.4%. The percentage of patients of 85+ for Amman Gwendraeth is 2.8%, which is above the Wales average at 2.5% and equal to the HB average. **Rurality:** The percentage of patients living in areas classified as rural is **75% (43,330)** and recognised as the 3rd highest cluster in the HB, which is broken down into: **Rural area** (village) showing 57.8% (33,420) which is greater than HB average. **Rural area** (small town) showing 17.1% (9,910), which is slightly less than	

					the HB average. **Urban area** showing 24.9% (14,390) which is less than the HB average. Current projections indicate that the increase in the proportion of older people will be greater in rural areas. This will have a significant impact on local service needs and support systems across health and social care. As well as having an older age structure, the population in rural areas is by definition more dispersed leading to difficulties in respect of access to, or the provision of, services, with travelling distances for patients in some rural villages to Prince Philip Hospital / Glangwili Hospital taking more than an hour. There is a dependency on reliable public transport or own transport. **Deprivation -** next most deprived showing 51.2% (29,580), which is twice as great as the HB average. The link between deprivation and poor health is well recognised. People in the most deprived areas have higher levels of mental illness, hearing and sight problems, and long-term conditions, particularly chronic respiratory diseases, cardiovascular diseases and arthritis. **The age and sex** composition of the cluster's patients is an important determinant of the level of need for health care. Older persons are disproportionately affected by chronic conditions. The Welsh Health Survey reported that 82% of respondents aged 65 years and over suffered from a chronic condition, of which 54% suffered from two or more. **Male:** 65yrs-84yrs slightly older than HB average. However, the cohort of people between 15yrs and 24yrs is younger than HB average. **Female:** 25yrs-64yrs slightly older than HB average. 15yrs to 24yrs is younger than HB average.	

					The % of patients by age and sex breakdown  Produced by Public Health Wales Observatory, using WDS (NWIS) **Action**: Update data once published from Public Health Wales	
2	To identify additional information requirements to support service development	Practices/ HB	Improved service delivery for patients	Improved Support for service development	**Public transport** - has been raised as a concern in the cluster, especially in the rural villages. The geographical area covered by the cluster is 3,294km2.	

Modelled percentage of patients living within specified driving times to their registered main practice in Amman/Gwendraeth GP cluster, 2012

Time band (Minutes)	Number registered	Percentage
Less than 5	20,650	35.7
5 or more, less than 10	24,930	43.1
10 or more, less than 15	9,740	16.9
15 and over	2,400	4.2
*Unmatched postcode	70	0.1
Total†	**57,790**	

Produced by Public Health Wales Observatory, using WDS (NWIS), MapInfo Drivetime

*Postcode could not be matched to an area of residence and therefore could not be classified or drivetime was not available

†Total does not include counts of <5, totals may not match due to rounding

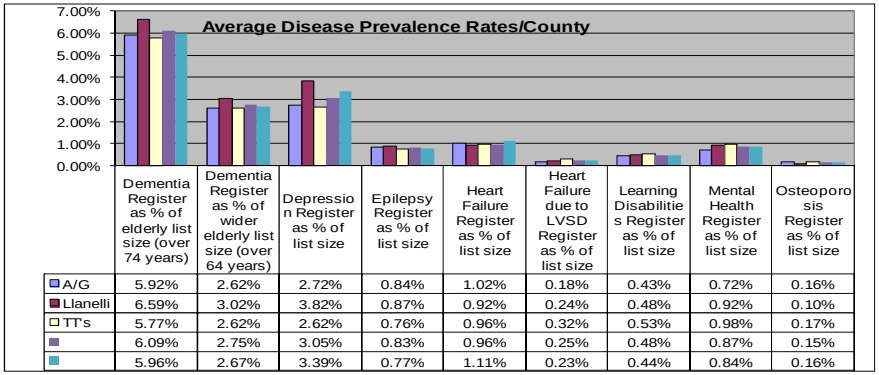
Action: In 2014/15, the Cluster worked with Peter Llewellyn, Assistant Director of Strategic Partnership to develop improved transport links in the cluster. Peter has worked with Aman Tawe Partnership to map out services against surgery locations and times checking for gaps and work is still on-going with Transport Group Wales. On receipt of any reports from Peter detailing the findings, practices are to address any issues raised.
Support volunteer recruitment for DANSA and other car services such as the RVS e.g. stalls at surgeries and community venues/Active Inclusion project. Marketing strategy to discuss at meeting particular for car schemes (additionally support for so called 'hard to reach' patients).

IT Infrastructure

Telehealth – Diabetes Telehealth facility demonstrated at a PT4L session in May 2015.

Action: If appropriate, a further invitation for a Telehealth update at a

					future cluster meeting. **<u>Wi-Fi</u>** – 6/8 practices in the cluster have Wi-Fi. As part of the refurbishment works at Cross Hands Health Centre, Wi-Fi has been made available which is accessed by Tumble and Penygroes surgeries who work from the Health Centre. **Action**: Further work is required to ensure Wi-Fi is available at all 8 practices. **<u>Video Conferencing Facilities</u>** – to support practices with reduced travel time in rural area. Video conferencing facilities are available in some community halls i.e. Llandybie. **Action:** Amman Tawe Partnership are currently involved in a pilot involving video conferencing. The practice will feedback to the cluster the findings once the pilot phase has been completed. **Chronic Conditions** burden is higher than other Cluster areas in the following categories: Diabetes; CKD; Obesity; Asthma; CHD; COPD; Epilepsy; Hypothyroidism If current trends continue, the number of people living with chronic conditions will increase with people living longer and developing more than one chronic condition. The average disease prevalence rate for patients in the cluster is **13.04%.** The average for Carmarthenshire: **11.02%** and the average for HB: **10.4%.** During the initial cluster meeting discussions, it was agreed that Obesity groups will be developed in the Cluster and support provided from the Public Health team.	



	Dementia Register as % of elderly list size (over 74 years)	Dementia Register as % of wider elderly list size (over 64 years)	Depression Register as % of list size	Epilepsy Register as % of list size	Heart Failure Register as % of list size	Heart Failure due to LVSD Register as % of list size	Learning Disabilities Register as % of list size	Mental Health Register as % of list size	Osteoporosis Register as % of list size
A/G	5.92%	2.62%	2.72%	0.84%	1.02%	0.18%	0.43%	0.72%	0.16%
Llanelli	6.59%	3.02%	3.82%	0.87%	0.92%	0.24%	0.48%	0.92%	0.10%
TT's	5.77%	2.62%	2.62%	0.76%	0.96%	0.32%	0.53%	0.98%	0.17%
	6.09%	2.75%	3.05%	0.83%	0.96%	0.25%	0.48%	0.87%	0.15%
	5.96%	2.67%	3.39%	0.77%	1.11%	0.23%	0.44%	0.84%	0.16%

Cluster Obesity Pathway – recognising it is not the role of the consultant clinic to address this problem pre-op, neither the primary role of the GP, nevertheless it is recognised and accepted the clusters pivotal position in developing local obesity services accessible to the patients well before secondary effects begin to occur and the primary prevention of the effects of obesity is a priority for this GP cluster.

Percentage of GPs and Pharmacies offering weight management services* in each locality

Locality	**% of GPs**	**% of pharmacies**
Llanelli	33%	23.5%
Taf and Tywi (2Ts)	50%	54%
Amman Gwendraeth	62.5%	31%
Ceredigion South	50%	33%
Ceredigion North	37.5%	10%
Pembrokeshire South	66%	31%
Pembrokeshire North	44%	12.5%

					To date, the Level 2 sub-group (Obesity Implementation Group) has undertaken a mapping exercise in relation to current weight management service provision within community and primary health care settings across HDUHB. **Obesity Workshops** held at a cluster meeting using an Assistive Inquiry tool, the following aspirations were raised: Actions raised: o Scope weight management services for the cluster and 'free' classes o Publicity – develop a business card & posters of services o Bariatric Service in cluster o Training in motivational interviewing o Continue the use of Orlistat. o Invite PHW to a CND meeting **Introduction to Motivational Interviewing** Healthcare professions are in the position of trying to help patients to manage their weight. Some strategies are more effective than others and the hallmark approach to accomplish this is MI. The plan of this approach is using an empathetic listening style to enhance patients' self efficiency, motivation, confidence and personal control for behaviour change. An introductory session held during a GP cluster PT4L event on Motivational Interviewing/MI, delivered by a clinical lead dietician. **Food wise For Life Programme** An eight week patient group Food wise For Life programme is available in the cluster at Coalbrook practice; Meddygfa Minafon, Tycroes surgery and at Cross Hands HC which is led by a clinical lead dietician. The programme enables patients referred from the practices to the service to be seen	

					locally. Food wise fits at Level 1 & 2 Obesity pathway: o Adults with a **BMI>25-35** o Evidence based community weight management programme to meet NICE (2006) best practice standards o Enable community based workers across Wales to deliver a standardised quality assured programme. o Developed by Public Health Dieticians in Wales. o Scripted 8 week programme Piloted across 4 areas in Wales (2012 **Lifestyle Development Project** The information from the Obesity workshop was shared with the Public Health Wales [PHW] team who were invited to a further cluster meeting to discuss the possibility of introducing a Lifestyle Development Project to the cluster. The aim it to embed a healthy lifestyle/prevention ethos and practice within primary care, using an advocate model, which is evidence based. All practices in the cluster have identified one enthusiast within their practice to be become a lifestyle advocate; in 2015/16 practices have been asked to identify a further advocate who will be a "Buddy" for the 1st advocate. The "Buddy" will undertake training, provided by PHW. **Action:** Practices to identify a "Buddy" [if required] to undertake the Lifestyle Advocate training and cascade the information within the practice.	

Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients

Consider the National Survey for Wales, local feedback and individual practice analysis.

In the National Survey for Wales 38% of people found it hard to get a convenient appointment – for a number of reasons such as Long wait for appointment ; early morning calls; Appointments not available on the same day ; Difficulty getting through to make the appointment ; Could not book appointment with doctor of choice ; Appointments not available at convenient times.

Is there an accurate measure of demand- if not consider data collection to articulate the scale of action required.

Consider what capacity could be released by minimising system waste- chasing appointments, discharge letters and specialist advice. If that is a significant issue ensure that data is captured to highlight the scale of the problem and include this as an issue to be taken forward by the LHB.

Recruitment and retention- risk in some areas. Ensure risks are recorded and reported. Does this need a local plan to support concerted action? Potential to test new models/roles- are there volunteer practices or potential for roles across the Cluster area that could support the management of capacity.

What potential is there for collaborative working with local partners- Communities First, Third Sector etc

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To review current demand and capacity	Practice /HB	Practice/HB	Services developed to reflect local need	100% of GP practices offering appointments after 5pm on 2 or more days per week 87.5% of GP practices were open for daily core hours, (08:00 to 18:30) or within one hour of the daily core hours, Monday to Friday. **Action** o Extended Hours LES awarded to 2 practices in the cluster. Funding to expand this service to other practices. o Review capacity and demand audit in the cluster. o HB to support one practice to achieve Tier 1 target o GP Access appointment system introduced at 2 practices to support with patient demand. HB to evaluate process in 2016/2017	

<table>
<tr>
<td>2</td>
<td>Establish local data collection systems to monitor trend</td>
<td>NWIS/ Practice /HB</td>
<td>Practice/HB</td>
<td>Capacity more effectively matched to local demand</td>
<td>Action

o Agreed data extraction via clinical audit to give comparative and trend data to inform local planning especially for the ongoing work with the dermatology network/dementia network.
o SAIL databank - 5 practices have signed up. DJ/AJ have met with Suzie Lucas to expand this further in the cluster to support with information available in the cluster.</td>
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<td>3</td>
<td>Recruitment and Retention within General Practice</td>
<td>HB/ Practice</td>
<td></td>
<td>Service modernisation to meet changing needs

Ensure sustainability of local services</td>
<td>The potential of GP retirement in the cluster within the next 5 years is 19.9% as set out below:

<table>
<tr><th></th><th colspan="4">% Potential GP Retirement</th></tr>
<tr><th>Locality</th><th>≤ 1yr</th><th>1 - 3 yrs</th><th>3-5yrs</th><th>Total</th></tr>
<tr><td>Llanelli</td><td>6.3%</td><td>18.2%</td><td>6.3%</td><td>30.8%</td></tr>
<tr><td>Amman Gwendraeth</td><td>5.0%</td><td>10.0%</td><td>5.0%</td><td>19.9%</td></tr>
<tr><td>2Ts</td><td>4.2%</td><td>2.8%</td><td>31.8%</td><td>38.8%</td></tr>
<tr><td>N Pembs</td><td>1.2%</td><td>11.1%</td><td>10.9%</td><td>23.3%</td></tr>
<tr><td>S Pembs</td><td>4.5%</td><td>8.8%</td><td>14.6%</td><td>27.9%</td></tr>
<tr><td>N Ceredigion</td><td>9.2%</td><td>7.1%</td><td>0.0%</td><td>16.3%</td></tr>
<tr><td>S Ceredigion & Teifi *</td><td>8.0%</td><td>8.2%</td><td>23.5%</td><td>39.8%</td></tr>
<tr><td>Hywel Dda</td><td>5.1%</td><td>8.7%</td><td>15.4%</td><td>29.2%</td></tr>
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The potential of Practice Nurse retirement in the cluster within the next 5 years is 34.1% as set out below:

% Potential PN Retirement			
≤ 1yr	**1 – 3 yrs**	**3-5yrs**	Total
0.0%	7.2%	18.6%	25.8%
15.9%	0.0%	18.2%	34.1%
0.0%	20.7%	14.6%	35.3%
12.1%	3.6%	6.4%	22.0%
0.0%	3.6%	10.2%	13.8%
0.0%	39.5%	28.9%	68.4%
9.0%	24.0%	4.0%	37.0%
4.2%	12.8%	12.8%	29.9%

Managed Practice – The cluster has one practice which is managed by the HB following the retirement of a senior GP partner and the inability to recruit further partners. This option was agreed to enable a period of stability for the patients and the practice whilst the future model is more carefully reviewed. The HB can determine the model of care for the population and to ensure the existing clinical and administrative workforce thereby reducing vacancies.

Risk register - recruitment and retention risks are recorded and updated on the HB's risk register.

Training practices - due to the number of reduced GP training practices in Carmarthenshire, it is essential that practices are supported to become training practices. With the support of the County team, refurbishment works at Cross

					Hands HC, 2 additional GMS rooms is available, dedicated for 2 GP trainees. Two further practices in the cluster have successfully been assessed to become training practice. **GMS recruitment campaign** - the pen profiles are part of the advertising. The HB are using social media to advertise vacancies and encouraging practices to use these resources. Practices will be encouraged to use LinkedIn. **Action**: Primary Care Nursing team to complete a Workforce and Education report which is to be shared with the cluster, providing information about their ANP's, PN's and HCSW. Following the findings the Primary Care Nurse team hope to support and offer solutions to practices workforce planning and educational needs within the cluster, working with Swansea University and other local education providers. **Action:** Cluster to look providing alternative ways of working ie Advanced Nurse Practitioner, cluster pharmacist	
4	Resilient General Practice	Practice /HB	Practice/HB	Ensure sustainability of services to meet local need	The primary aim was discussed, 2 overlapping strategies emerged and a consensus agreed: The discussion moved on and a second strategy of development emerged based on putting the networked professionalism of the GP's at the centre of a diversified workforce based on the core foundation of the practice list, with the workforce organised along lines of professional accountability with GPs leading on diagnostics and treatment utilising core medical skills and other clinicians being responsible within teams authorised by the registered GPs of the practice lists, e.g. where staff are attached practices would have a controlling say in their deployment and the preference of the group was to directly employ staff currently attached– this view was strongly endorsed by all, this concept of strengthening and re-iterating an enhanced Primary Healthcare Team (PHCT) approach was supported without any dissenting voices. From this discussion the strategic approach of the cluster to the first priority action of developing Resilient General Practice in Amman Gwendraeth is	

					summarised: Explore the skill sets of the existing medical workforce and develop a programme of clinical networking across the domains of expertise within the group for the benefit of our listed patients (examples already in place – dermatology; follow up dementia. **Action: A'Building Resilient General Practice' workshop took place during a CND meeting**. The outcome of the worshop is a follows: o The cluster has explored the skill set of clinicians in primary care and available services in primary care. Practices have started addressing a more diverse workforce such as the recruitment of Nurse Practitioner/prescribers and Pharmacists rather than advertising of GP posts. Support from Medicines Management team has assisted with the stability of practice workforce o Identify areas to develop clinical networks in the cluster with interests expressed in the following areas: Dermatology; Minor Surgery/Sport injury; Gastroscopy. Example offered for phase 1 development and a commitment to safeguard the dermatology network at a population health group level. Firstly, a simple strategy of strengthening existing models by putting more money into the individual practices enabling them to recruit more doctors and utilising the cluster to develop a network of clinical skills akin to the dermatology network (a proposal to give the practices their own budget at a practice level was NOT AGREED) whilst all agreed with the latter point of creating GPwSI type clinical networks for the Cluster area, there was concerns whether resources existed to achieve the former nor whether this would necessarily demonstrate a prudent approach in our maturity	

					Dermatology  Dermatology SBAR 15.4.2.105.rt... o Support for practices developing these concepts by the health board would energise the cluster and enhance credibility and maturity of the cluster approach amongst this GP group. Deal with issues that undermine the morale of the existing workforce and discourage inward investment. Provide long term support for practices o Explore with the health board innovative ways of supporting practice development and attract new skills and a diversified workforce, recruiting in-house expertise to enable GPs to offer medical activity appropriate to those who need it and confidence to registered patients that services offered in practice are delivered with the authority of the GPs o Explore with secondary care zero waiting time for investigations o Equality of services within primary care o Training in practice manager for all staff or clinicians o Organisational support to reduce variability o Greater contract stability, long term incentives to expand partnerships o Invest in initiatives to support GP returners back to work o No incentive for GP to develop skills o Courses required to enable GP's/practice staff to enhance their skills i.e. Motivational training [held during a PT4L session] **Action :** Cluster to fund additional sessions between August 2016 and March 2017 allowing for further procedures to be underaken	

					Frailty Service – The cluster have developed a frailty model which also incorporates cluster priority, namely resilient general practice. Our cluster development plan not only addresses the needs of our frail and elderly population but also serves to support general practitioners at a time of increasing workload and a diminishing share of resources. The team consists of a named GP Lead, Advanced Nurse Practitioner and a Pharmacist who undertake scheduled visits in the specified care homes within the cluster. The team work in integration with community, mental health , acute and social care staff and play a vital role helping to improve services for the frail elderly patients, those who are housebound and living in care homes. **Action:** To review the service in October 2016 to include the number of sessions undertaken, number of patients seen, patient and family feedback and outcomes	
5	Develop nursing skills to support delivery of chronic disease management.	Practice /HB	Practice/HB	To support practices to develop clinical skills	**Training for Nurse Practitioners to sign off radiology referrals**: Cerinwen Jones has fed back the following information: this has been discussed at length within the Non Medical Prescribers forum. Chris Hayes gained clarity on this and stated that Radiology forms can be signed by qualified ANP's but a GP signature is also required for training ANP's. **Action**: Chris Hayes is working on a HB policy to cover Radiology referrals **Independent Prescribing Training course**: practice staff members have booked on this course. Swansea University run this course every year (October start) There is usually some limited funding available from WG via the Health Board and each application is considered on an individual basis. Link to the course below included: http://www.swansea.ac.uk/humanandhealthsciences/continuing-professional-development/stand-alonemodules/masterslevelmodulesallsubjects/	
6	What capacity could be reduced by minimising	Practice /HB	Practice/HB	Improved patient care.	**Chasing appointments, discharge letters and specialist advice.** If that is a significant issue ensure that data is captured to highlight the scale of the problem and include this as an issue to be taken forward by the HB.	

	waste				**Action:** Practices to undertake an audit between 1st October 2016 and 31st December 2016 on Discharge Letters documenting: o Diagnosis o Change of medication o What stopped and started o Any follow up o Name of Consultant o Date of admission and date of discharge o Legibility Reporting the findings at January 2017 Cluster meeting and feedback to the Medical Director at the Health Board on any issues established **Stoma Service** A 2 year stoma service has been established in the cluster to work with the Medicines Management team to review all patients in primary care receiving stoma products on prescription. The key features of the project include the nurse reviewing existing prescribing and follow up as needed with patients via clinics, telephone calls, home visits as needed, as per the original pilot. Actions taken to improve GP control of mail order supplies direct to patients: In contrast to the supply of prescription medication, where the GP practice decides on treatment and issues a prescription, in many cases stoma products are supplied direct to the patient by an appliance contractor who then retrospectively requests a prescription from the GP practice. The Nurse provides informal education and training	

					opportunities to GPs, Practice Nurses on the use of stoma products and also provides advice to District Nurses and Care Home/ Nursing/ Residential Home staff in regards to the care of patients who use stoma products. **Outcome and cost savings to date**: In year 1, 234 patients seen in 8 practices across Amman Gwendraeth and Llanelli with a cost savings of **£73,094.02.** **Primary Care Phlebotomy Service** Cluster funding has enabled this service to continue. The service is available in the practice for non-housebound patients and delivered by phlebotomists or Healthcare Support workers across the cluster. The funding has allowed for receptionists to train as phlebotomists. Where required. The aim of the phlebotomy service provides a service closer to the patients home; supports GP practices to improve patient care; alleviates pressures on PN's to see the more complex cases and relieves the pressure on the secondary care service, thereby enabling them to concentrate on an acute site service including wards and out-patient service. The Primary Care Phlebotomy Service is held from Monday to Friday. **Action:** Continue to fund the Phlebotomy service in 2017/18	
7	Collaborative working with local partners	Practice /HB	Practice/HB		**MDT meetings** - Continue with the ongoing work developed from the QP process, with effective established monthly Multidisciplinary Team meetings to discuss and review the needs of the relevant patients identified at risk. The group will discuss the active management plans to identify any learning needs and related changes in patient management to help improve patient care so as to reduce unscheduled admissions or unscheduled care. **Action**: Cluster representatives to meet up with Locality Manager once in post to address the lack of social services representation at MDT meetings in a number of practices	

					Dementia Review clinic - The Amman Gwendraeth GP Locality priorities have included dementia over the past number of years. In the first year a Memory Clinic pathway was developed in the Locality. This was positive in that it increased GP expertise in responding to patients reporting symptoms of dementia and eliminated inappropriate referrals to the Memory Clinic. In the following year, as a preliminary to GP commissioning, a pathfinder group was set up. Representatives of the practices within the Locality met to increase their knowledge of dementia in order to both improve practice and also to identify commissioning opportunities. The Community Memory Clinic in Llandybie Hall, Llandybie developed from this initiative. Links with Memory Clinic., Psychiatric Services, Alzheimer's Society and Community Resource Team. Patient satisfaction surveys - all patients are ritually asked for feedback on the service provided. This feedback is overwhelmingly positive with service users claiming, for example that the service is: "Thank goodness we came""First introduction to service was a good one and welcoming experience""Excellent service". **Action:** Obtain feedback from the Service Provider establishing outcomes of the service including feedback from the Alzheimer's Society **Third Sector Broker Volunteering recruitment project -** Third sector broker attended a CND meeting with an update on the project currently in place in two practices in the cluster. **Action**: Awaiting an evaluation report from the Third Sector Broker	
8	Develop MHOL for repeat				Further work has been carried out to encourage practices to use My Health on Line, giving the patient the opportunity to book appointments, order repeat prescriptions, update their general details. This system is in collaboration with	

	prescriptions and routine appointments				practices and NHS Wales. Repeat prescriptions only – 6 practices. 1 practice is undergoing training in October 2016 and the other practice will introduce this service. Routine appointments – 1 practice **Action**: No further action as all 8 practices to use MHOL	

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	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Increased waiting lists for secondary care -reduce waiting times to see a consultant	HB /Secondary Care and Partners		Reduced patient waiting times	**Action:** Continued encouragement for practices to use the e-mail advice service in secondary care with the aim of reducing the number of referrals for the following services - haematology; rheumatology; paediatrics; respiratory Continued pressure on policy makers to improve access to secondary care and reduce waiting times	
2	Dementia network developed. GP review community memory clinic established. Support Dementia Friendly Community at Pontyberem	GP/HB/Social Care/Third Sector		Care provided closer to home. Holistic service provided to patients and their carers MDT approach should	The Dementia Network – Memory Clinic are operational from Llandybie Hall on the 1st and 3rd Friday of each month with a GP from a pool of three GP's from the cluster providing the sessions. Established collaborative working, consisting of Memory Clinic Nurse, GP, Third Sector and	

				improve on communication and have a positive impact on patient care. Social Worker waiting time reduction. Community dementia support service. Avoidance of hospital admission and facilitate early discharge. Increased prevalence rates	Social Worker. Dementia Friendly Community established in Pontyberem. Continued monitoring of the dementia prevalence rates in the Pontyberem Ward area for patient and carer. Engagement with the Dementia Support Worker at MDT meetings extending the invitation to the Alzheimer's Society. **Action:** Capacity issues for the GP to undertake training in order to commence the service in the Gwendraeth area therefore, a delay in establishing the service	
3	Maintain good pathways developed in previous QP work for frailty/dementia/EOL	Practices/ CDM		Improved patient care.	Action: Practices to continue to monitor progress of read coding. Aid practice to read code certain disease areas. To continue noting inappropriate referrals. To review those urgent 10 days referrals.	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Social admissions still problematic despite MDT's. Third sector input i.e. night sitters.	CRT		Timely hospital discharges	New funding has enabled the Rapid Response service to continue.	

					Despite MDT working and risk profiling when a frail elderly patient needs extra care there are simply no resources therefore, no other option than a medical admission. The Cluster frailty service will help support GP's to avoid such admissions. **Action:** Social Services to participate in MDT meetings	
2	To improve the utilisation of monthly MDT meetings and to encourage more appropriate attendance. Review of patients to be recorded.	Practices/ other parties		Waiting times reduced. Improved communication will promote the care of the patient. Reduced patient waiting times into CRT services.	Continued scheduled monthly MDT meetings. MDT Workshop held with CRT leads to evaluate how the MDT meetings are working. Contact list has been distributed to ensure that all parties in practice and CRT are aware of contact names for distribution of patient list in preparation of the meetings. Allocated Social Worker monthly MDT meetings. The MDT lists are increasing in size. PM to review how this is manageable. I.e. review dates for stable patients. This will release time during the discussion to work with the high risk patients. **Action**: Cluster representatives to meet up with Locality Manager once in post to address the lack of social services representation at MDT meetings in a number of practices	
3	Hospitals to ensure that discharge letters are completed and legible to follow.	HB			Peter Skitt, Director of Acute Services is addressing the issue of timely and accurate Discharge Summaries. **Action:** Practices to undertake an audit	

					between 1st October 2016 and 31st December 2016 on Discharge Letters documenting: o Diagnosis o Change of medication o What stopped and started o Any follow up o Name of Consultant o Date of admission and date of discharge o Legibility Reporting the findings at January 2017 Cluster meeting and feedback to the Medical Director at the Health Board on any issues established	
4	Choose Well Campaign	Practice		Patient access appropriate services Avoid patients attending A&E with long waiting times.	**Action:** Practices to continue to promote literature - choose well. Information stored on Practice website. Practice to educate patients with regards to the choose well campaign.	
5	X ray hot reporting – GPs to have access to the immediate report of significant x-ray findings – elsewhere in Wales this a&e/GP link has already demonstrated results	Practice/HB		Reduced waiting times for acute episodes of care.	Ongoing work **Action:** Practices to undertake GPTR training	

Strategic Aim 5: Improving the delivery of end of life care

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To support general practitioners to review the experience of patients at End of Life	HB/Practice	Practice	Improve patient care.	Regular palliative care meetings with emphasis on reviewing deaths to assess how to improve documentation of end of life decisions in practice records. Increase awareness of Advance care plan and DNCPR – training needed on new end of life pathway and new drug and syringe driver charts. Include HF and COPD patients on the palliative care register. Cluster frailty service will support GP's with end of life pathway and advance care planning in care homes. **DNRCPR** – due to the lack of information regarding DNACPR forms noted on the patients information, this will be reviewed within the surgeries to ensure all appropriate read codes are used and to ensure all clinicians note when these discussions take place, especially when patients are on ICP. It was felt that DNR forms were sometimes inappropriately requested by residential homes. **ICP** – Often recorded in free text, not on guidelines. In most cases GP's had visited patients before noting on pathway. **JIC boxes** – due the lack of recording on patients notes, this will be reviewed in within the surgeries. A safe system of JIC boxes for residential homes is needed. **GP Lead** recorded– due to the lack of recording on patients notes; this will be reviewed within surgeries.	

					However, it is felt unnecessary in smaller GP practices to record name of GP lead as all patients are seen by all GP's and are discussed regularly. **Preferred place of death & Actual Place of Death** – although there was improved recording of actual place of death, it is unknown in many cases of the preferred place of death due to the lack of recording on patient records. Due to the lack of information regarding DNACPR forms, Just in Case boxes, ACP discussions, Named GP Lead and OOH information noted on the patients information. A note is entered onto the reminder box within patients notes, to flag up all who are seen by PHCT. Family members of the deceased to be offered bereavement support after death. No information from Secondary Care to advise how and when the patients were admitted. This information may prove beneficial in order to audit if the patient accessed secondary care during primary care opening hours. Although anticipatory care planning is often discussed with the patient and relatives, it is rarely recorded. In cases where ICP had not been documented it was not felt that this had any negative impact on patients care in their last days. **Action:** Discuss findings at a cluster meeting	
2	To support general practitioners to identify and	HB/Practice	Practice		Cluster based care home service now provides proactive management of terminally ill patients. All deaths should be discussed routinely at weekly meetings with monthly MDT meetings used for	

	address issues in relation to delivering high quality end of life care.				reflective discussion. To consider adding patients with chronic diseases i.e. dementia lung disease and HF onto the palliative care register – not only cancer patients. Use of guidelines and consistent documentation is vital to increase palliative care register. ICP should be documented in guidelines, rather than free text. The ability of health professionals to communicate effectively with families and involve them in decision making consistently emerges as an important contributor to their satisfaction with care at end of life. DS1500 – low in numbers. This suggests patients are not receiving funding even though they are eligible. Not forgetting the self funding patients in home may benefit from this. JIC and DN's often didn't have the capacity to increase JIC and PRN medications in syringe driver if needed and this often meant returning to GP and delay in relieving symptoms. Encourage early notification of JIC. Often discrepancies in what is recorded in GP notes and those entered by district nursing. There is a clear need to have one unified clinical system. Pain and symptom control with palliative patients – further work is require to train all professionals in assessing, monitoring and treating pain and distressing symptoms in all settings. Teaching session on suicide by a local psychiatrist is valuable. DNR - A Significant Event was raised when all DNACPR forms at a local nursing home were void as they had not been completed correctly by the GPs. Following this finding all the GPs are now confident in completing these forms correctly. It was felt that completing these forms has now become an integral part of everyday work. This is in contrast to the situation several years	

					ago where these forms were hardly ever completed in the community. This is beneficial to patients as it ensures a dignified and peaceful death. Also, it is felt that this had been a positive change which will benefit patients and their families at a difficult time. It was also agreed that there was huge waste of medicines when multiple JIC boxes were prescribed for different patients, and many of which were not used at all. It was felt that the District Nurses could keep a JIC box in their office and use the appropriate drugs for individuals as required. It was also felt that one JIC box for every nursing or residential home would be adequate. This would reduce the wastage of medicines and save on costs. **Action:** Discuss findings at a cluster meeting	
3	To support general practitioners to share information with members of their network, and, through networks, to support Health Boards/ NHS Wales to progress the End of Life Delivery Plan.	HB/Practice	Practice		**Monthly MDT palliative care meetings** are pivotal to patient care for those patients on the palliative care register. All MDT members to be aware of the importance of identifying end of life care needs and the triggers which can prompt patient identification. The District Nursing attendance is necessary to provide an up to date assessment for the last days of life. Communication has improved between all service providers such as Macmillan nurses, Social Workers to ensure that most effective and efficient care is given. McMillan nurses – difficult in referring patients to them – some uncertainty of role with little feedback. Introduction at an early stage of a Marie Curie nurse. Nurses are prepared to visit non cancer patients with less than 6 months to live. Marie Curie nurses can give short respite periods that also allow time to get to know the patient. Bereavement team – visits/contact would be helpful to	

					pick up feedback for discussion at subsequent review meetings. Suggestions were also made about practices sending sympathy cards and make contact with family after each death and offer support. **Action:** Discuss findings at a cluster meeting	
3	To encourage general practitioners to monitor progress (or maintenance of high quality) in the delivery of End of Life Care through further reviews	HB/Practice	Practice		Review practice data to ensure recording of EOL practice data improves. Review JIC process. Continued work with the Bereavement team. Continued monthly MDT meetings in line with GSF. Improved communication with DN's. To follow recommended guidelines and further improve the recording of end of life pathway data. Continue audits of JIC and advanced planning tools and documentation to ensure a robust system GP's and clinical staff encouraged to place non-cancer patients on register **Action:** Discuss findings at a cluster meeting	

Strategic Aim 6: Targeting the prevention and early detection of cancers

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Review the care of all patients newly diagnosed between 1st January 2016 and 31st December 2016 with lung (including mesothelioma), digestive system cancer and ovarian cancerusing a Significant Event Analysis tool.	Primary Care/HB	Practice/ HB	Improve patient care	Ongoing **Action:** Discuss findings at a cluster meeting	
2	Summarise learning and actions to be shared with the network and the wider LHB.		Practice/ HB		All USC referrals are followed up with a telephone call to the patient to confirm that they have been seen or have had an appointment. Weekly cancer referral data reports from secondary care allow the practice to monitor the downgrading of USC referrals. Practice development of a "Well Man" clinic with a view to picking up early prostatic symptoms and ED. Follow set pathways and audit compliance with national guidelines 2015 NICE Guidance on cancer referrals may lead to changes in practice – all GP's to be aware of new guidelines and amend practice accordingly Continue to develop and monitor use of pathway to improve cancer care.	

					Practices have had limited feedback on the national screening programme. Referrals were downgraded although there was no clear information supplied to the practice from Secondary Care. As a result expedited letters were sent from practices. X-rays and MRI, CAT and USS were recorded on patients who had been referred from Primary care but there was no record of any investigations from patients already under Secondary Care. Bowel screening has proved worthwhile with earlier diagnosis identified. In all cases for bowel cancer, patients were either smokers or ex-smokers. Occasionally, patients do not return to see GP when symptoms continue even when prompted to return. GP delay in diagnosis – particularly relevant with patients suspected of having COPD that subsequently turn out to be lung cancers as symptoms overlap. If a patient moves to the UK and has an EU card, the patient could still be refused care from the hospital if the original diagnosis was made outside the uk. This means that patients would have to pay to be seen privately. **Cancer Care Nurse** - The appointment of a cancer care nurse [in one practice] and discussion of new cancers at MDT meetings has enabled the practice to respond more quickly to the needs of patients. The cancer care nurse makes contact immedicately cancer is confirmed and provies help. Support and information to patients and acts as a point of contact	

					through treatment and beyond to recovery or end of life. **Carmarthenshire GP PT4L session held in November 2014** – topics presented: Bowel Screening Wales, Upper GI Cancers; Mc Millan Support for patients and GP's; Ms Singh, Colorectal Surgeon. **Action:** Discuss findings at a cluster meeting	
3	Identify and include any relevant actions to be addressed in the Practice Development Plan.		Practice/ HB		Delay in faxing safe haven referral due to poor communication between GP and typing pool. Difficulty in managing patients with chronic symptoms and identifying a new diagnosis was discussed. To be more aware of lower GI malignancy developing in age> 55 if ongoing GORD symptoms. Early urgent ultrasounds should be considered for patients with abnormal liver tests. Downgrades from secondary care to be forwarded to the referring doctor. **Action:** Discuss findings at a cluster meeting	
4	Summarise themes and actions for review with the GP cluster network and share information with the LHB as required.		Practice H/B		Patients with suspicion of cancer who have investigations should have appropriate follow up with the same Dr to support patient continuity. Admin staff track USC referrals and chase further information. System implemented to ensure downgrades are shared with the referring Doctor. Following on from Q & P 2013/14 practices have already started to	

					follow-up all USC referrals with a telephone call to the patient to see if they had been seen or had had an appointment. The weekly receipt of USC referral data has improved on this by informing us of downgrading. Poor communication regarding downgrades from secondary care colleagues to be highlighted to the Health Board. **Communication** - Need to clarify with hospital at early state patient's eligibility for NHS care. **Training** – Introductory Behavioural Motivational Interview training held during GP cluster PT4L session. Renewed effort to educate and encourage patients to stop smoking. Consider training COPD nursing staff on cancer awareness and identifying COPD nurse as a key role in lung cancer detection and follow up. Record history of smoking status, weight loss and other GI symptoms more explicitly in notes. Consider chest x-ray for patients with unexplained hyponatremia. Ensure that all Safe Haven referrals are completed with clear instructions. **Action:** Discuss findings at a cluster meeting	

Strategic Aim 7: Minimising the risk of poly-pharmacy

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Identify and record number the % of patients aged 85 years or more receiving 6 or more medications	Practice/MM	Practice/HB	Identify frail vulnerable patients at risk.	Ongoing - annual report will be presented for data analysis. **Action:** Discuss findings at a cluster meeting	
2	Undertake face to face medication reviews, using the "No Tears" approach or similar tool as agreed within the cluster, for at least 60% of the cohort defined in 1 above (for a minimum number equivalent to 5/1000 registered patients. If the minimum number of reviews cannot be undertaken	Practice/MM			Pharmacist in post at one practice has proved to be helpful link in optimising concordance. Face to face review with at least 60% our practice patients aged over 85 years on 6 or more medications will be done at the practice with the support of the prescribing team at the HB It was felt that some patients were found to have stopped taking some medication but items still being ordered by pharmacy. Some patients on diuretics had not had annual U&Es. Few items were removed from repeat therapy following review as most were considered necessary. Not all patients understood why they were taking their medication and could not recall the possible side effects. Sleeping tablets were reduced or stopped in a small number of patients as patients felt they did not need them. Patients had a record of medication not ordered for some time	

	because of the small size of the cohort defined in 1 above, consider reducing the age limit until the minimum is reached)				that was subsequently removed. A proportion of patients that received 'testing and monitoring' had regular clinics, e.g. diabetic, cardiovascular and therefore the monitoring was already done. This could be included in the clinic review with the nurse as is appropriate. Side effects discussed and in some cases resulting in laxatives being added to script to counter effect of cocodomal pain relief. Medications removed – where switches had been done or medication removed, particularly from nursing homes there was a number of occasions where the patients required this medication once more. Documentation of why it was stopped was often difficult to come across. Also, communication was poor with the nursing home which resulted in increased prescription requests. A large number of patients were prescribed items i.e. catheter bags, colostomy bags that were required, but not classed as medication and appeared in the Vision search. These needed to be excluded from polypharmacy review. Patients prescribed emollients, many of which were no longer being used but had not been removed from repeat prescribing list. **Action:** Discuss findings at a cluster meeting	
3	Identify actions addressed in the Practice Development Plan.	Practice/MM			To continue the face to face review of all patients aged over 85 years on six or more medications. To continue to monitor "at risk" patients through MDT meeting. The introduction of a Frailty Service within the cluster should	

					enhance the service provided for the practice's increasing housebound population. Continue engagement with CRT, MDT regarding falls and those at risk. To support the practice in-house pharmacist in developing a poly pharmacy register. Educate health professionals on drug interactions and adverse effects. Promote regular structured medication reviews with the elderly and frail by the practices in-house pharmacist. Continue NO TEAR medication reviews. GP's to improve coding of "poly pharmacy" Housebound medication reviews, new protocol needed for the practice Continue to develop and monitor use of pathways to improve care of the frail and use guidelines [templates] for accurate recording. Identify 085 practice population being prescribed with six or more medications and institute systematic face to face review process, supported by the resident pharmacist. Continue to prioritise elderly patients [over 75 years] on 6 or more repeat medications. Patients will have face to face reviews with carers where appropriate with the emphasis being on ensuring appropriateness of medication, adverse effects, risk reduction and compliance. Easy access to No Tears Protocol for all GP's and encouraged to be done as best practice for all poly pharmacy.	

					The No Tears template to be incorporated into PDP. Monthly search set up to recall patients on diuretics for blood test PPI – many on maximum dose. Will look at reducing to maintenance dose then stop. Use of medication reviews in over 85's as starting points to discuss DNACPR status. Opportunity to use reviews to complete QoF actions that otherwise may not have been done. Need for patients to be reminded at review of side effects. Need for all medications to be synchronises to ensure review completed on all meds. Look at using nurses for medication reviews when doing the cardiovascular and diabetic clinics as appropriate. Think about constipation at first prescription of Cocodamol. Need to address a system wide approach to remove unordered medication. More detail in notes why medication has been stopped. More practice based meetings to get some common guidelines for prescribing.	

					SCRAMS has had a positive impact. **Action:** Discuss findings at a cluster meeting	

Strategic Aim 8: Deliver consistent, effective systems of Clinical Governance

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Contractor completes the CGPSAT and confirms completion to the HB	Practice	31st March 2016	Improved patient care	**Action:** Practice completes Clinical Governance Practice Self Assessment Toolkit and to confirm completion and submission to the HB by 31.3.2017. Practice participates in a review of the appropriate healthcare standards as noted	
2	Contractor will include appropriate actions resulting from this analysis within the PDP and annual report and will consider whether any issues need to be discussed at GP Cluster level.	Practice/HB		Improved patient care	**Action:** All actions included in CND domain after consideration at cluster network meetings.	
3	Datix recording	Practice/HB		Improved patient care	**Action:** Practices to record all significant event analysis via Datix. Datix reports are shared with practices. Practices to use practice meetings and PT4L sessions to share the lessons learnt.	

Strategic Aim 9: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Carers Aware Training	Practice		Improved awareness which will enable carer support.	All practices have received the bronze carer aware training. 1 practice has commenced with the silver training. **Action**: Practices to review 2 year bronze carer training and update if required	
2	Literature on local services	Practice		Improved patient knowledge on local services	**Action**: Practices to educate patients and staff on the local services available. Encourage practices to update web-sites; information displayed in practice waiting areas/corridors. Third Sector organisation developing a database on local services available which will be shared with clusters once completed.	
3	IT Myrddin training E-Test Request	LDM/Practice		Increased awareness of patient activity in secondary care and community therapy.	**Action**: Continue with Myrddin training. Practices to inform HB of further training requirements. GP- ETest Request is a new system introduced to allow practices to electronically request and view test results from hospitals. E-Test Request pilot commenced at Coalbrook practice. This work is still ongoing.	
4	Difficulties with patients attending GP services concerning dental problems				**Action**: GP's to continue to exclude serious illness and recommend dentist opinion if appropriate. Dental helpline number given to patients if dental services access is a problem.	
5	Structure of the Cluster				Structure of the cluster group has been agreed – core GP group with sub-committee and agreed	

					Terms of Reference. Transparent decision making processes **Action**: Discuss at Cluster meeting	
6	Promote smoking cessation services	Practices/HB/PHW	ongoing		Smoking remains the biggest cause of premature death in Wales, killing 6,000 people in Wales every year • 68,000 in Hywel Dda smoke, around 20% of the population • One in two long –term smokers will die of a smoking related disease There are two national public health campaigns where the cluster can plan an important part and help change the affect of smoking has on the population. Smoke Free Cars as of October 1st 2015 Stoptober **Action**: Practices to promote smoking cessation services	

7	Cluster Frailty Model				Frailty project – review of project to assess specific outcome measures to decide if the project has been a success so far. Expansion of successful aspects of the project using cluster money. Cluster to be actively involved in nurse practitioner training. Cluster to discuss implications of the new care home enhanced service on the frailty model. Care home service and MDT meetings identify patients at risks of falls. Proactive management of care home patients to reduce multiple visits for acute work. **Action:** To review the service in October 2016 to include the number of sessions undertaken, number of patients seen, patient and family feedback and outcomes