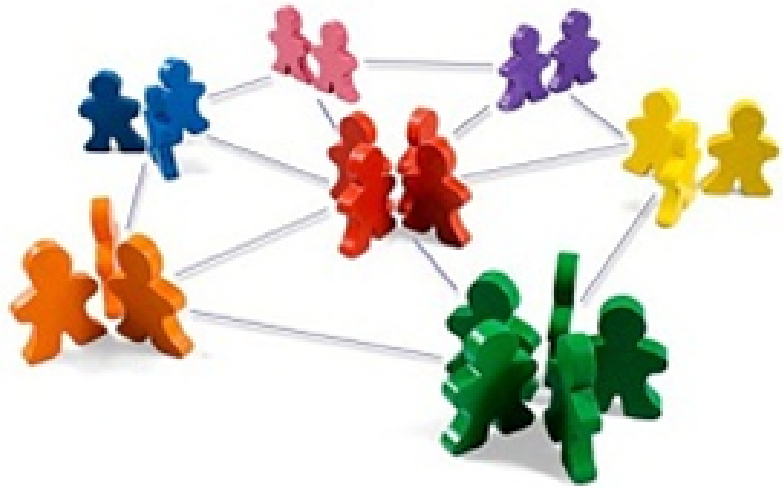
Three Year Cluster Network Action Plan 2017-2020

South Pembrokeshire 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 Action Plan will have a focus on: (a) Winter preparedness and emergency planning.

[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

(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 (CGSAT) and inactive QOF indicator peer review.

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

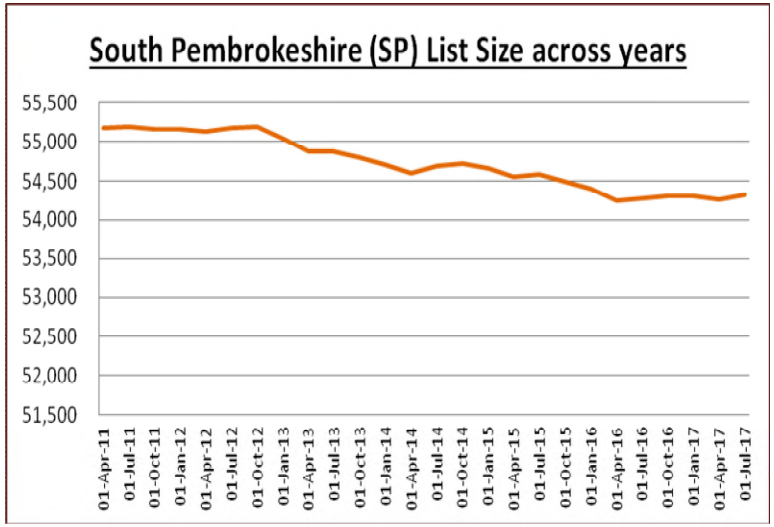
No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
1	To review the needs of the population using available data	Local Public Health Team Public Health Observatory Well being Needs Assessment. Population Needs Assessment	September 2017	To ensure that services are developed according to local need	Our cluster consists of 5 practices ranging from small with list sizes of approximately 3,612 patients to a large practice with a list size of 24,727. We are 5 practices with five main sites and 4 branch site. In July 2016 two practices merged into one practice with a list size of 9,052. 1 practice is actively engaged in training and the other 4 practices are engaged in training of medical students and some offer placements for nursing students. Below the Health Board average for under 25-44 age group, however the cluster is above the HDUHB average for over 65's and over 75's	

	South Pembs	Pembs	HDUHB
Over 65s	**25.4%**	**24.1%**	**23.1%**
Over 75s	**10.81%**	**10.8%**	**10.2%**

South Pembrokeshire is a retirement destination and this accounts for the 2nd highest rates of over 65s the highest rate of 75's within the HDUHB. One practice has the highest rate within the Health Board for over 65,s and 75,s.

The Percentage of the registered practice population living in the most deprived two fifths (40%) of areas in Wales, as determined by the 2014 Welsh Index of Multiple Deprivation (WIMD) stands at 28.5%. South Pembrokeshire is classed as the second highest in the Health Board of patients living in the most deprived fifth.

The county is considered to be rural with 99.1% of the population living in an area classified as rural. Again, this is the second highest locality in Hywel Dda. The list size of the population has steadily decreased over the previous years but has started to increased again



When looking at the 6 most common Chronic Conditions (Asthma, Hypertension, CHD, COPD, Diabetes, Epilepsy, Heart Failure), the locality fares favourably compared to other localities for most. It has the 3rd highest level of COPD rates. However the cluster remains above the Welsh average for Hypertension, CHD and Diabetes and mirroring the Welsh Average for COPD, Epilepsy and Heart Failure.

Crude recorded burden of disease

Indicator	Your Cluster:			Other Clusters in your Health Board:		Health Board	Wales
	Count	Adjusted burden of disease %	Crude burden of disease %	Min %	Max %	%	%
Asthma	2583	7.0	7.0	6.0	7.6	6.8	6.7
Hypertension	6183	14.7	16.8	14.4	18.0	16.2	15.4
CHD	1641	3.8	4.4	3.3	5.1	4.3	3.9
COPD	940	2.2	2.5	1.6	2.6	2.1	2.2
Diabetes	2326	5.6	6.3	4.4	6.5	5.8	5.5
Epilepsy	297	0.8	0.8	0.7	0.9	0.8	0.7
Heart Failure	375	0.9	1.0	0.9	1.3	1.0	0.9

The cluster also has a higher than Health Board average for patients with:

Dementia- 0.7% cluster average, HB-0.6%

Dementia over 75-6.88% HB- 5.96%

Depression- 3.85 % HB- 3.39%

Stroke- 2.5% HB-2.29%

Smoking- smoking prevalence in the cluster is 19.4% which is ranked third in the Health Board. The Health Board average stands at 18.9%.

Teenage pregnancy

Teenage conceptions, rate per 1,000 females†, 2011

	Under 16		Under 18	
	Number conceptions	Rate per 1,000	Number conceptions	Rate per 1,000
Hywel Dda*	-	-	235	34.6
Ceredigion*	-	-	38	33.6
Pembrokeshire	17	7.9	91	39.7
Carmarthenshire	15	4.6	106	31.5
Wales	**330**	**6.1**	**1,885**	**34.2**

Produced by Public Health Wales Observatory, using conceptions data (ONS)

†Rates for females under 16 are per 1,000 females aged 13-15; rates for females under 18 are per 1,000 females aged 15-17

*Rates based on counts of less than 5 have been suppressed; secondary suppression has been applied where necessary

The children and young people data profile published in 2013 illustrates that across the locality there is a range between 16.8 and 39.8 per 1,000 people who have a teenage pregnancy.

The cluster has continue with the joint working across practices such as LARC r with three practices providing all 3 levels.

Flu

To improve the flu uptake through more publicity driven by the cluster, patient engagement and flu mop up clinics in community settings.

As a cluster we are working hard at practice level looking at different approaches to target the patient

					population. To look at road show events for each practice. As the proof of concept has been proved in different formats as a health event and also an open day for a Surgery.. To utilise the cluster pharmacist and the Healthy Lifestyle Advisor also to look at training the Occupational Therapists when they are visiting the patients in home setting working with PHW. **Vaccinations:** To look at Men ACWY uptake. To improve the update in the South Pembrokeshire cluster area. To work with PHW and schools/college	
2	To identify additional information requirements to support service development	Local Public Health Team Practices NWIS Health Board		Improved support for service development	To continue to work to develop risk stratification templates with Audit + team to identify at risk patients using practice data. To support the OT, Pharmacist and the Healthy Lifestyle Advisors and all new staff supporting the practices. To work with the EEP team to support various course to support patients. To aim to integrate this with the Healthy Lifestyle Advisors Supporting the Fragility ANP and the CNS Heart Failure Nurse within the Cluster area by supporting them with IT equipment a laptop also a printer and a	

					scanner so when visiting patients within their homes they are able to access patient information and support the patient with information. Equipment was purchased a Bladder Scanner and two ECG machines which would enable the equipment to be used within the patients homes and they are portable Working with PHW to provide a evaluation of CRP testing in the Cluster we purchased 7 machines. Training has also been given through the company who supplied the machines. Audit + team visiting all cluster practices to give one to one training. Templates to be discuss with the cluster Pharmacist, Occupational Therapists, Healthy Lifestyle Advisor, Chronic disease CNS and Fragility ANP. The cluster continues to work with Pocket Medic. This is a prescription of information service for health care providers which are a valuable additional resource which should encourage patients to self manage. New Housing developments have been highlighted to the cluster in Narberth, Kilgetty, Tenby and Saundersfoot which will have an impact on the services at practice level this is a growing concern. Syrian refuges have been placed within the cluster	

					area. So some of the practices will be supporting this process within health. Public Health Wales have a standing agenda item on each cluster agenda.	
3	To consider learning from previous analyses to identify any outstanding service development needs	Practices Local Public Health NWIS Health Board		To develop services which are based on population needs assessment..	Scope Project this is a Joint project with PCC and the South Cluster to fund a delivery of evidence based exercise into Day and Residential Care Homes in Pembrokeshire addressing the Frailer Older Adult agenda. The project will use qualified members of NERS to deliver an eight week evidence based exercise that will evaluate levels of exercise and emotional response. This project has been completed. Full evaluation to cluster in April 2017 has been given. To look at a service needs of the OT's within practice • Using the Anticipatory Care Planning approach, identify patients who are regular users to the service and increasingly frail and isolated. • Provide proactive Occupational Therapy intervention for the identified group; frail elderly with complex presentation and multiple co-morbidities Working with Chronic Disease Nurses and the County Team to look at the service a new model and to	

					develop new ways of working as a service to support patients. Discussions with the CMAT team and the service.	
4	Investors In Care	Practices/HB	ongoing		All Practices are at Bronze Level at Investors in Care. Ongoing. 1 Practice would like to be at silver level.	
5	PHW Advocates	Practices PHW Lifestyle Advisors Community Connectors Third section	ongoing		2 Practices out of 5 for 2017/2018 will be still part of the Advocates programme. Each of the 5 practices currently link in with the Community Connectors Project. They visit the practice monthly. One practice has a community connector involved in the PPG meeting.	

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	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To review current demand and capacity	GP Practices Patient Participation Groups CHC Social Services DNs County Team Cluster Staff Third Sector	ongoing	Services to be developed to reflect local need.	Downgrading of USCs – all practices routinely receive weekly USC reports for all referrals which outline any down grading. Practices have implemented processes to ensure that the relevant GP within a practice receives the information and any queries with regard to downgrading can be raised in a timely fashion To look at CRT and MDT working. Narberth Surgery currently testing this concept. Evaluation March 2018. 3 Practices in the South Cluster area hold MDT meetings to discuss vulnerable patients.	
2	My Health Online	Practices	Ongoing	Additional way to access appointments /prescriptions	4 out of the 5 practices are currently sign up to use MHOL. 3 practices are using the service for prescribing and 2 practices are using it for the appointments. 1 practice is using both services and 1 practice is not using the MHOL service but this will be completed by July 2018.	
3	Sustainability	Practices/ HB	Ongoing	Service to be supported and	The South Pembrokeshire cluster had a workshop event in May 2017 looking at the sustainability of all 5 practices the 7 Pillars and the RAG rate for all practices.	

				developed	Currently we have practices within our cluster that are experiencing difficulties with recruitment and retention.	
4	To develop local workforce development plans	Practices/HB	Ongoing	To develop and plan for the future. To test and try.	To discuss at a cluster level after the Sustainability Workshop. To discuss plans for projects at the scoping meetings held bi monthly.	
5	Training	Practices/HB/ Colleges	Ongoing	To develop and to become a more robust workforce and share the learning	Look at training needs within all practices. PT4L – time will commence in October for all GP's to have protected learning time for the first time in a number of years. The first event takes place on 11th October 2017 and will look at 'managing chronic pain – a whole system approach' and primary care mental health. 1 Practice is providing training at the practice for all staff with Carmarthen College. This is under development with the practice. - ongoing North and South Clusters are joint working and have provided a bid which has been successfully with pacesetter funding with Wrexham University signposting and communication the course will run over 3 months Jan to March 2018. It has positive feedback so far. We were struggling to gain interest from Pembrokeshire due to work pressures within practice so we offer this project out to all cluster areas and Pharmacy, Dental and	

					Optom. The Wrexham Glyndwr University has for 2 years been running a diploma course for Primary Care Practices in mid and North Wales. The course, which was planned in conjunction with their local GP practices and Clusters in the area, runs for 4 weeks and seeks to develop staff core skills and knowledge in regards to the patient experience, the integration of Health and Social Care and social prescribing/signposting. There will be no cost to practices and while the course is directed towards reception staff, we anticipate that is may appeal to reception and admin staff or assistant managers, in fact anyone involved in administration within Primary Care Primary Care Training for Coaching. Ongoing. Business Development Planning. Work Force/New Models of Working. British Heart Foundation Education Programme Cardiovascular – DN's Nurses, Cluster Pharmacist, Reception Staff. Evaluation March 2018 – Cluster Pharmacist attended. Oral Anti- Coagulation with Warfarin – DES – Service Improvement Team.	

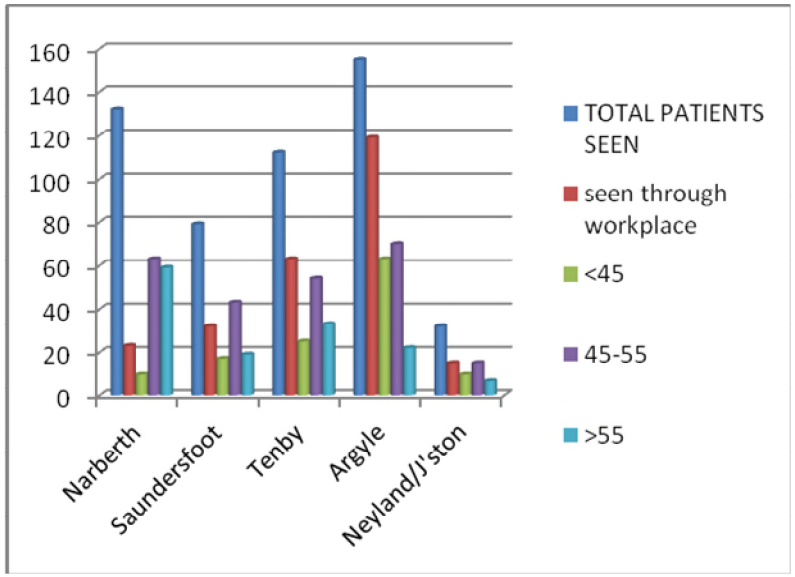
6	Patient Engagement	Practices / HB/ Schools/Third Sector/HLA	Ongoing	Enable better engagement with patients	QR Info Pods are a new and innovative way of communicating information to patients through a fast, measurable digital interface and can save practices thousands of pounds each year in printing costs. QR codes are already extensively used in health services worldwide and are now being introduced in the UK. The QR pods include codes linking patients directly to all of their online services such as their website and registration pages for online appointments and repeat medication. The pods also have dedicated sections linking to their social media sites and a wealth of self help guides, educational videos such as antibiotic awareness and carers services, national and localised health promotional campaigns as well as localised services. Crucially there are codes linking patients to seasonal information sources such a flu vaccination campaign videos and materials which the practice found to be invaluable during the busy winter months. This will be a Health Board wide initiative but will start with the South Pembrokeshire Cluster to link in with the HLA work. Two Practices within the cluster currently have Patient Participation Groups (PPG's) to enable them to engage with the local population. The Cluster plan for the next two years is for all practices within the cluster to have a PPG started with in their practice. The cluster continues to work with Pocket Medic. This is	

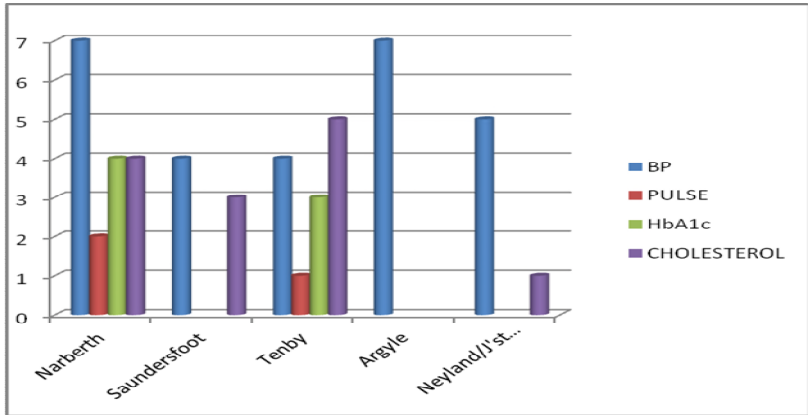
					a prescription of information service for health care providers which are a valuable additional resource which should encourage patients to self manage. **Schools Project Argyle Medical Group**: Working with a local Community School The aim of the project: • High demand for GP appointments for "minor illness." • High school absence rate due to "minor illness." • Collaborative approach between GP surgery and local primary school to develop a package of work with the aims of: - Increasing knowledge relating to the causes of minor illness eg. What is a virus? - Increasing awareness of the local healthcare options available and the role of different healthcare professionals. - Increasing knowledge relating to the management of minor illness eg. Antibiotic awareness and absence from school guidelines. **What did you do?** • **In School** - Generate a questionnaire and letter explaining the projects for parents - Generate pupil questionnaire	

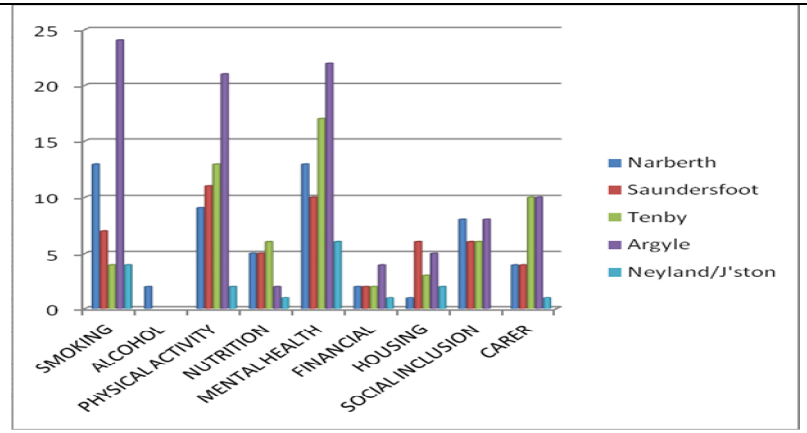
					- Create a learning log task for the pupils to complete over the Easter holidays – assess logs on their return - Research the role of health professionals (doctor, nurse, social worker, paramedic, pharmacist, dietician, healthcare assistant, optometrist and GP) – possibly turn information produced by pupils in QR codes to go home to parents - Watch video about bacteria and viruses – carry out research about minor illnesses and allergies – children are to complete a chart about minor illness, symptoms and treatments work produced to be sent home to parents - Children to produce a poster about reducing the spread of bacteria/ viruses - Generate a questionnaire at the end of the term to be sent home to parents to see if they will change their ways with understanding the symptoms and treating minor illnesses. **GP practice visit:** - Small groups of pupils were invited to the practice where the work done in class was reinforced by a series of activities and Q&A sessions led by a GP and allied health professionals. **What were the results and impact of our project/research:** - The project appears to have been well received by all those involved. - Given short time frame since delivery and small cohort we can't evidence whether there	

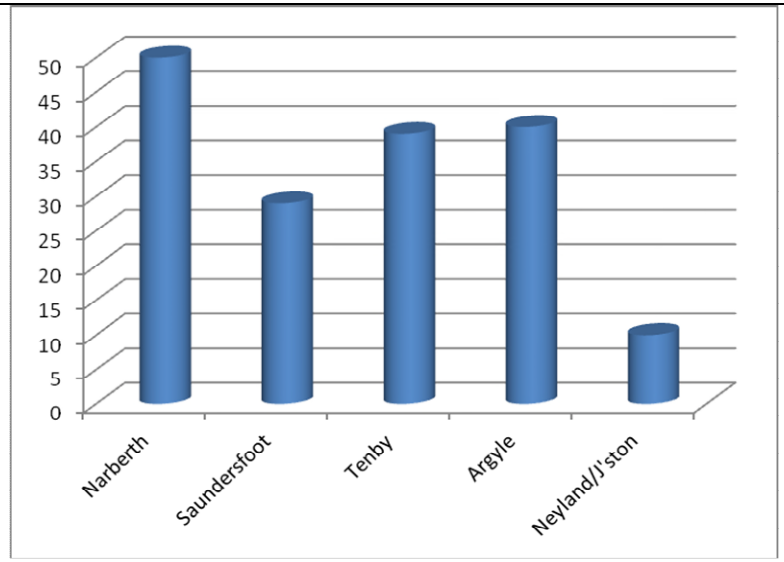
					has been any behavioural change amongst pupils and their families in regards to how they perceive and act in regards to minor illness. **What did we learn:** - The project was a pilot to see how local health and education services could work together to address pressures on local GP services and improve school attendance. - Any longer term behaviour change within the community in regards to the use of local health services would be difficult to measure on this small trial. - Feedback from participants suggests that targeting the school curriculum with support from clinical staff is an appreciated mechanism of delivery for health education. - We would like to investigate ways to develop and scale up what we have attempted to date.	
7	Working across all primary care contractors	HDUHB Practices Community Pharmacy	Ongoing	Increased access and integrated working	Minor Aliments scheme across the South Pembrokeshire Cluster area all are up and running. Choose Well.	
8	Networking arrangements .	Practices	Ongoing	Increased collaborative working	Scoping meetings have commenced in the cluster with all the practice Managers meeting every other month to look at different ways of working to increase collaborative working and to develop business plans for further projects.	

					Primary Care Events Community Connectors/Third Sector/Education/Schools PT4L sessions. North and South Clusters Cluster Meetings Pacesetter Projects – Bids submitted 2018/2019 - ongoing	
9	Cluster Funded Projects	Practices HDUHB HLA Pharmacist Medicines Management OT Community Connectors Third Sectors Physio CMAT County Team Patients PPG's	Ongoing 31st March 2018 end of year feedback.	Increased collaborative working Patient Care Support for practices services	**Healthy Lifestyle Advisor – An** Holistic Approach to Health. Employment of 1 x 37.5 post – Nov 2016 Employment of 1 x 30hrs until 31st March 2017 from 1st April 15hrs a week Started in post Nov 2016 they both had 8 weeks to embed into the project and started seeing patients in Jan 2017. The South Pembrokeshire Cluster identified high prevalence around Cardiac/Heart Failure and they decided to think outside the box and look at an holistic, behaviour change intervention to improve health. The vision was supported by the Public Health Team and an opportunity was created for an individual to deliver prudent, preventative, healthcare for a cluster of GP practices in the South Pembrokeshire locality.	

					The vision was to support the patient (and their family where appropriate) to make positive and sustained changes towards healthier lifestyle choices. Additional support being provided, to patients, around improving their physical health, activity levels and mental well being in order to support healthy ageing. **The story so far:**  **Initial Assessment – protocol in place** ▸ Height, Weight, BMI, BP, Pulse ▸ HbA1c, Cholesterol	

					▸ Smoker – current, total time, how many ▸ Alcohol, U/week ▸ Nutrition ▸ Family History – CHD, Stroke, Diabetes, Asthma ▸ GPPAQ ▸ WEMWBS ▸ Financial, Housing, Social Inclusion ▸ Carer **Referral to clinicians**:  **Signposted/referred to other services**	

					 **3 month Behaviour change intervention**	

					 Jan to Jun 2017 this shows patients that have been seen. Total Patients seen – **472** Total Patients seen in the workplace – **227** Total patients on further support and intervention – **156** Total Patients needing GP and Nurse intervention – **48** Total Patients signposted on to use other services - **265** We are looking into funding to continue the project from 31st March 2018. This was discussed at the cluster meeting on the 18th May 2017. We are also looking at different funding streams with Planned/Leader and a	

					meeting is set to discuss further via the LDM. As part of the Healthy Lifestyle Advisor project, Living Well Living Longer (inverse Care Law – Cardiovascular) bid was successfully for a total 100k with already being successfully with additional 50k the South Pembrokeshire cluster will be working with the HDUHB with this project alongside all 5 practices. A work steam has already been set up to deliver this service successfully with the involvement of the Healthy Lifestyle Advisor as part of the intervention support being offer after the Health Check. We shall monitor the impact the Living Well Living Longer project has on the cluster Healthy Lifestyle Advisors roles. As a cluster we are keen to see this project work and we would like to continue with both Healthy Lifestyle Advisors the positive impact so far has been greatly received by patients and clinical professionals Cardiff University are keen to conduct a research and design and conduct service on the project so we are in early conversation with the university. Evaluation Letters have been sent to all patients and the outcomes will be feedback to the cluster at the end of year meeting 20th March 2018	

					Occupational Therapists. Number of Referrals being sent to the OT's and the outcomes of the cohort of patients – This project has already been piloted Nov 2015 – Jun 2016 in a cluster practice with 25,213 patients using 1 x OT. An evaluation took place on this pilot. The cluster agreed to fund across all five practices from the pilot with two Occupational Therapists. The cluster continues to work with the Occupational Therapist in all 5 practices who started in post on 14th Nov 2016 1.88 WTE. In total since the Occupational Therapists have started in post they have seen 516 new patients, across the South Pembrokeshire Locality area. This financial year they have seen 149. The occupational therapists have felt very well received by each practice. In Hywel Dda University Health Board, core Occupational Therapy (OT) services are accessed as part of secondary care, community resource teams and via social care & housing. Referrals, however, are frequently received at point of crisis and people often have to wait a number of weeks for a routine assessment. Intervention and impact is commonly remote from GP's who hold the responsibility for the ongoing primary support. Importantly the South Pembrokeshire GP Cluster Occupational Therapists utilize aspects of the Anticipatory Care Plans (ACP) approach. This is a	

					Process designed to support individuals living with a chronic long-term condition to help plan for an expected change at some time in the future, and a voluntary progressive process of discussion with the individual at a time when they have capacity to make healthcare decisions. Referrals are triaged and the Occupational Therapists' work with GPs to identify patients who are regular users of the General Practice Surgery/Medical Centre and are increasingly frail and isolated. **Demonstrable benefits include**: Reducing demand on general practitioners by addressing and resolving underlying issues that are the root cause of multiple and regular contacts. Releasing GP's, practice and community nursing staff time to focus on doing what only they can do. Proactively resolving health and social issues at an early stage, minimizing crisis situations that result in presentation/admission to the acute hospital. Sustaining people at home following discharge from hospital. Reducing falls, improving safety and confidence enabling people to engage in daily life.	

					Releasing professional capacity by enabling people to maximize their own potential, promoting self management, preventing ill health and dependency**.** **Interventions provided consist of:** Holistic assessment in order to address underlying functional difficulty and reduce demand on General Practice. Signposting and transfer i.e. with individuals where ongoing / further community rehabilitation required • Timely response to avoid inappropriate admission or referral • Advice and Support • Liaison between professionals • A Service information leaflet is in progress. All 5 practices have met with the OT's to discuss the next steps/future vision. Report will be given at the end of cluster meeting 20th March 2018 **Cluster Pharmacist** – Cluster Pharmacist started in April 2016 fulltime working with practices and nursing homes. Review the care home patients for each surgery. The value of the intervention. Polypharmacy reviews.	

					She has visited the majority of nursing homes within the practices boundaries who are pleased to have support with their patients from a medicine/pharmacy perspective. These homes will be reviewed at least once a year. The pharmacist is carrying out medication reviews The cluster is also looking at polypharmacy in all practices and the pharmacist has commenced reviews with patients. Supporting practices with clinical audits and also supporting the practice pharmacists in two of the practices. Liaised with the medicines management team with the Health Board. Setting up COBWEB in all 5 practices. Audited Spironolactone monitoring. Conducted Polypharmacy clinic with over 100 polypharmacy reviews in one practice. See 307 patients to date in a medication review clinic. Supporting staff in level 3 prescribing clerk. Set up search in the process of auditing patients on long term antibiotics for UTI prophylaxis. Pharmacist has passed her prescribing course which	

					was fully supported by the cluster and was fully supported /mentor by Dr Jenny Boyce GP from Argyle Medical Group Practice. The cluster pharmacist interest for her prescribing is cardiovascular and she has enrolled on the British Heart Foundation Cardiovascular Disease Education Program covering: • **Increase knowledge of the causes and consequences of Cardiovascular Disease** • **Develop an understanding of signs, symptoms and importance of effective management** • **Raise awareness of local cardiovascular services, patient pathways and how to respond to 'red flags'** This course is for one year for 2 hrs a month. The pharmacist is now providing flu clinics and joint working with the cluster OT's. **Update provided by 20th March 2018.** **Screening Project:** The cluster has invested in a project focusing on increasing screening uptake with CAVO and Public Health to increase the uptake of bowel screening, breast, AAA and Cervical Screening	

Advance Care Planning. Working with Paul Sartori

This project originally focussed on work in care homes. At a previous meeting we outlined the limitations of working solely in this way. The Cluster agreed to a broadening of the remit to include work in GP practices.

The remit of the posts will be to assist practices in identifying people for whom ACP might be most urgent and relevant, and working with those patients to complete ACPs

Awareness Raising in Practice Reception Areas

	1:1 Conversations	Booklets handed out
Argyle	53	55
Narberth	19	20
Neyland	21	21
Pembroke	15	16
Saundersfoot	37	37
Total	145	149

The cluster is now looking at other ways of utilising the ACP work across the cluster. Holding events to look at a cohort of patients that are over 75+ and have 2 x admissions in to secondary care as a admission.

					Ongoing. **CRP machines** 7 x CRP machines purchased in 2015/2016 for all practices**.** To look at the benefit of the equipment in practice. Ongoing monitoring - PHW The cluster is still working towards Vision 360 or EMIS Anywhere this has problematic for the cluster in regard to the connectivity within the area. One practice is currently trailing EMIS Mobile within one practice with one GP. The cluster is also in talks with NWIS with regard to IT systems. Currently the project is on hold due to connectivity problems within the south locality this hopefully will be resolved in 2017/2018. To joint work with the Living Well Living Longer Team HCSW's. To look at a service model with the CMAT/Physiotherapy Team to start those conversations. The cluster aspirations for future planning and funding chronic disease to share between the 5 practices. Also Physiological well being – counselling for patients. To have conversations with medicines management team, pharmacy technicians who attend practices for audits to look at the skills that they have e.g. inhaler technique clinics. The cluster would really like to have a physiotherapist to join the cluster team and also look at	

					having Chronic Disease Nurses to cover all 5 practices to see patients instead of going into to secondary care. The cluster has matured during the year and is continuing to develop with projects and staff employed 30 AF APPS where purchase to be utilise in practice by the GP's, ANP and NP – 6mth evaluation on the use of the APP – May 2018.	

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	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Minimising waste and harm	GP Practices/ HB	Ongoing		Practices using the Text Message system. My Health Text on line and also using MHOL service.	
2	MDT Working	GP Practices / County Teams /	Ongoing	Improved integrated care	To look at CRT/MDT working. Narberth Surgery currently testing this concept.	

		Social Services				
3	Referral forms	HB / Practices	Ongoing	Improved efficiency of electronic referral system	To improve the information sent to the practices and duplication. To become more streamline from all departments. E- referrals - Electronic referrals can best be used to support improvements in health care processes and outcomes, and designed to identify and expedite urgent cases. The secure system is used for submitting electronic referral requests to specialty clinics. Rather than submitting referral requests by fax or telephone, the referring provider completes a form with the patient's relevant history and the provider's referral to a consultant/specialty. All relevant patient and provider information for each referral is automatically extracted from the electronic health record and is linked to the electronic referral request for subsequent review. Currently there are four specialties with a primary reviewer who triages each referral request and can communicate with the referring provider via the electronic application. Initial implementation of this system for four specialty clinics at HDUHB has shown promising early results, for improving specialty access and the timely delivery of critical services. Supported through Primary Care Service Improvement Team.	
4	Flu	GP Practices / Health	ongoing	Increased uptake in	To improve the flu uptake through more publicity driven by the cluster, patient engagement and flu mop	

		Board/ Public Health		immunity	up clinics in community settings. The cluster is still not hitting the targets for flu. As a cluster we are working hard at practice level looking at different approaches to target the patient population. To look at road show events for each practice. As the proof of concept has been proved in different formats as a health event and also an open day for a Surgery. To utilise the cluster pharmacist and the Healthy Lifestyle Advisor also to look at training the Occupational Therapists when they are visiting the patients in home setting working with PHW. Cluster Pharmacist providing flu clinics and nursing home patients.	
5	Cross cover between GP Practices	GP Practices	Ongoing	Sustainability of Services	To look at sharing resources – An aim from the sustainability workshop. Discussion at cluster meetings and scoping meetings. Practices have submitted bids to work together through pacesetter funds - ongoing	
6	Community based education programmes	HB/Practices	Ongoing	Care for patients	To look at providing more courses to patients through the EPP programme. To look at third sectors courses for patients through the HLA. Pembrokeshire College have course for patients with memory problems- dementia patients and families. T	

7	Community Optometry	Practices / local Optometrists	Ongoing	Integrated service with seamless provision for patients	To Engage with the cluster. We have an interest in this role hopefully will be able to join the role 2018/2019	
8	Community Dental	Practice/Local Dentists	Ongoing	Integrated service with seamless provision for patients	Will be joining the cluster in the end of year March 2018. The North and South Clusters will be share the Dentist.	
9	Community Pharmacy	Practice / local pharmacy	Ongoing	Integrated service with seamless provision for patients	To Engage with the cluster and share the learning. The minor Aliment scheme has enabled the Community Pharmacies to work with the practices and the patients.	
10	Voluntary Sector	HB/Practice		Better availability of information to enable patients to be aware of and access additional services.	To continue to work with the third sector • Community Connectors • PAVS • Paul Sartori • Macmillan	
11	Prostate Cancer Pilot	Primary Care/HB Practice Service Improvement	Early Stages	Better Care for patient.	To offer nurse led follow up clinics for stable prostate cancer patients in the community. The current plan is to recruit two nurses, one for each county. The nurse post is a Band 6 and the clinics will initially run once a fortnight in each cluster. Clinics will be required in a	

		Team			number of locations in order to cover the geography of the counties. The urology team are currently looking at job descriptions. This is a great opportunity for perhaps nurses who have done the Macmillan cancer nurse training and want to advance their learning or perhaps a nurse who wants a new challenge doing something different. The urology team will be providing the training in house. They have set up a urology email advice line towards this so that any problems/clinical concerns that arise can be dealt with ASAP by the urology team. This will hopefully not cause any extra workload for Primary Care colleagues	
12	Dermatology	Primary Care/HB Practice Service Improvement Team	Early stages Ongoing	Better care for patients	Tele Dermatology acts as an aid in the diagnosis of skin lesions. It must not be used in isolation but instead combined with a good history and naked eye examination. In the right hands Tele Dermatology can reduce referrals and also unnecessary skin surgery. The majority of practices should now be in receipt of a digital camera and 2 optical attachments to enable the practice to photograph skin lesions are then send the images securely as an attachment to a Consultant Dermatologist to diagnose whether further treatment is necessary or not. This in most cases saves	

					patients a journey to hospital to see a Consultant Dermatologist. Many dermatological conditions can be triaged and/or diagnosed by qualified specialists from good photographic images, and many cases triaged or diagnosed in this way can be managed in the community by GPs, minor surgery, especially if they have specialist support. A Referral model is in place**.** This project will fulfil the aims and objectives of establishing and implementing a simple but effective teledermatology solution/service for patients. The benefits will include: • Efficient and prioritised pigmented skin lesion dermatology service • Improved process for referral of pigmented skin lesions • Improved local access to quality healthcare for patients from remote areas • Reduce waiting times for specialist opinion • Reduced time for informing general practitioners of their patient's diagnosis • Better use of scarce resources, e.g. Expert GPs and Consultant's time and availability • Improved process for second opinion • Move towards standardisation of referral	

					processes within region • Patient/carer - Images could be used as evidence for effectiveness of treatment improvement/deterioration of lesions • Imaginative service improvement/use of professional services.	
12	Vasectomy Service	Primary Care/HB Practice Service Improvement Team	Awaiting	Better prompt care for patients.	In line with the wider ambition of the health board to deliver care closer to home and taking into account factors such as accessibility for patients, quality standards and development opportunities, it was agreed that a proposal to reshape the delivery of vasectomy services would be developed. The increasing demand on urological services means that patients are waiting longer than 26 weeks, some more than 36 weeks. Therefore, it was proposed that, as the majority of men are suitable for a local anaesthetic technique, which can be performed safely and conveniently in the community, a vasectomy service delivered in primary care would improve access and deliver UHB standards. As a result we are currently planning to offer a Primary Care Vasectomy Service that will be provided by General Practitioners with Special Interests (GPwSI) which will demonstrate a successful pathway re-design from a hospital delivered model to one that is based in and delivered by primary care.	

					It is hoped that the new pathway will commence during Autumn 2017 and delivered by four providers from GP premises in Pembrokeshire and Carmarthenshire. for HDUHB registered patients via referrals into a single access point (WCCG). Patients will be referred and accepted into either of the service locations and it is expected that the total patient pathway does not exceed 15 weeks in total from the initial receipt of referral. It is hoped that the service will undertake 350 procedures with patients able to access an efficient service that has shorter waiting times and provided in convenient modern community premises which will help to improve patient experiences. The service will release capacity both in outpatient and day theatre as a result of the safe, effective transfer and has will provide positive working relationships between primary and secondary care colleagues. The service will be commissioned outside of the GMS Contract and the pathway redesign will require funding from UHB and will support a maximum of 350 cases per annum.	

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
1	Improve co-ordination of care	Practices/ HB	Ongoing	Integrated service without delays in treatment	To look at different ways of joint and collaborative working in the scoping meetings. Development projects. Sharing the learning	
2	Chronic Conditions Management in the Community	Practices/ Community Teams	Ongoing	Improved integrated care	To support a very demanding support look at different ways in supporting the teams. New work in progress in putting a business plan together with the county team.	
3	MDT working	Practices/ HB/LA	Ongoing	Improved integrated care	Pilot has started for 3 months looking at CRT/MDT working. Narberth surgery has been the pilot site	
4	Lack of mental health services within the Locality	Practices/ HB	Ongoing	Improved integrated care/patient care	CRT working in all practices. To also look at Mental Health engagement at the Cluster Meetings.	
5	Business Continuity	Practices	Ongoing	Care	To look at and support as a cluster and also sustainability for all practices. To look at the winter preparedness and emergency planning.	
6	Paramedic/ WAST services	Practices/ WAST	Ongoing	Support and management of Patients	To look at building better relationships with WAST. LDM attends the Frequent Callers meeting monthly to look at top ten callers to WAST services. To look at a template to interlink a management plan for the	

					frequent callers to link in with the Chronic Disease Nurse Team this is work in progress. WAST attending the Cluster Meetings and providing an update at the meeting.	

Strategic Aim 5: Improving the delivery of dementia;; cancer.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Cancer	GP Practices / Health Board	March 2018	Better Care	Improve referrals/care/outcome. All five practices fed back to the meeting Improved recording of and coding of USC referrals made rather than the diagnosis only, continue to review data from referrals and where referrals are downgraded review these with referring clinician. WCCG referrals do not READ code into the clinical system which means that practices have to keep a register. Increase awareness of pancreatic cancer and lung cancer. Cancer picked up on screening for other matters.	

					All GPs have ACCESS to NICE guidelines such as Summary of NICE Suspected Cancer Guidelines 2015 and NG12 Recognition and Referral All practices engage with their Patient population with regards risk and importance of vague symptoms throughout information screens and leaflets and health promotion and screening. Signposting patients to the Healthy Lifestyle Advisors. MDT meetings held to discuss cases and Clinical Governance meeting for any lessons identified and completion of an additional significant event report to compliment the CND report. Macmillan Cancer Decision tool utilised to support clinical judgment of Clinician Performance and General Medical Service provider met all objectives and Referral guidelines but in essence evidence stands up to report very good. Meeting with McMillan Cancer Lead on how cancer referral to treatment time, coordination, data control, reporting, expediting, any trends and lessons identified can be improved. Use of websites, notice boards, Face book and	

					display initiatives, including the recent patient awareness regarding persistent coughs and the need to see a doctor.	
2	Dementia	GP Practices / Health Board	March 2018	Better Care	Improve dementia care/outcome All five practices fed back to the meeting. New Care Home DES providing resource to facilitate dementia review in care homes. Increased read coding for all carers especially for all those in a nursing home environment. Referral into Paul Sartori Foundation for Advance Care Planning. One practice has appointed a lead GP as the Dementia and Care Home lead and have key members of the PHCT who have become Dementia Advocates/Champions and link in with our Carer Advocates/Champions. We have ensured that all available support information is assessable and navigate the patients within the cohort to respected support services: Care and Repair, Community Connectors, Carers,	

					Dementia Friends, Alzheimer's Society, Marie Curie EOLC Dementia., CAB., PIVOT following admission., Palliative Care for end stage Dementia Each year on their anniversary of their confirmed diagnosis, a GP led assessment is undertaken in collaboration with other service providers as per attached document and consideration to onward referral for specialist input i.e. memory clinic. Being proactive with coding of patients presenting with memory problems and dementia diagnosis. Linking in Dementia CNS , Secondary Care and third sector organisations Flu uptake for at risk patients.	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Liver Disease	Practices/HB/	31st March 2018		Improve Liver Disease Care through Learning and reporting to the group. Practices are more engage with protocols Improved communication with bio chemistry. Raised awareness of low level LVT More understanding of Liver disease. Some patient's signpost for Lifestyle Advice through the Healthy Lifestyle Advisor cluster project. Reduced repeat liver function tests following an abnormal ALT To increase appropriate testing following an abnormal ALT Re audits in 6 to 12 months with expected improvement. .	

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	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Downgrading of USC referrals	HB / Practices	Ongoing	Care of patients Efficient service to the patient	Lack of communication. More streamline service. Reason why the downgrading of a USC. Practices now receive weekly USC referral reports electronically confirming whether USC referrals have been downgraded, upgraded or upheld. In early 2017 reports had not been issued regularly, this issue has been highlighted and reports have recommenced on a weekly basis.	
2	Improve communication	HB / Practices	ongoing	More streamlined service	HB to improve communication with Practices to ensure they are consulted upon and are aware of service changes.	
3	Datix	HB / Practices	Ongoing/training	Effective clinical care.	Continue to report incidents on Datix	
4	To review quality assurance of the Clinical Governance	Practices	March 2018	Quality of clinical care	All practices will update the Clinical Governance Practice Self Assessment Toolkit. Practices will peer review inactive QOF	

	Practice Self Assessment Toolkit (CGSAT) and the inactive indicators in the QOF Peer Review.				indicators for discussion at cluster meetings mid way through the year and at year end. The review will be shared with the Health Board and any appropriate actions will be included in Practice Development Plans in 2019.	
5	Notification of death in hospital	HB / Practices	Ongoing		Practices reported that they continue to experience delays in receiving notification of deaths from the hospitals. When they are received they often have not details for the reason of death included. Dr Burrell to feedback and liaise with secondary care colleagues.	

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Leg Ulcers	HB/Practices	ongoing	Care for the patients	4 out of 5 practices handed back the Leg Ulcers to the Health Board and one practice continues to provide a leg ulcer service to its patients but they are finding this more and more difficult to manage in-house due to time constraints for our Practice Nurse. But they feel they will continue with this service as they feel it is more convenient for the patients but this will be monitor closely.	
2	DNAR Forms	HB/Practice Paul Sartori	ongoing	Care for the patients	To increase the number of patients who have DNAR forms completed. To improve upon the number of patients who have a discussion about the patient preferred place of death. ACP planning work.	
3	Chronic Diseases Nurses	HB	Ongoing	Care for the patients. Support for the Practices with the patients	The increase in the population with Chronic disease with work with the Health Board to look at different ways of working and to look at a business case to support a different model of team working.	
4	Home visits	Practices	Ongoing	Care for the patients	All practices within the cluster is showing a marked increase in Home Visits to patients causing a demand on practices for this service to patients.	

5	Tenby Cottage Nurse Led Service	Practices/ HDUHB	ongoing	To support practices/HB/ Patients and Holiday makers.	2 practices within the south cluster have been joint working with the HDUHB regarding the implementation of “nurse led” walk in centre at Tenby Cottage Hospital – The service is run by ENP and HCSW commenced on 10th July 2017 in the first 2 months of operation a total of 986 patients were seen at the walk in service. The report shows 984 patients were local. 175 were Temporary residents and 8 were other unknown.	
6	Model of Health Care Changing within Practice	Practices HDUHB	Ongoing	Care for patients Patients	To look at patients acceptance of different models of care – education surrounding new models of health care within general practice. Some practice are looking at different models of care within their practice to support the demand and capacity.	
7	Secondary Care	Practices HDUHB	ongoing	Care for patients	Secondary care is under strain patients having early discharges. No packages of care for patients. Lack of appointments impact on the GP’s patients repeat visiting the practice whilst awaiting an appointment.	
8	CAMHS	Practice Patients HDUHB		Care for patients	The Access to CAMHS	
9	Awareness of Sepsis	Practices	ongoing	Care of patients	Awareness/implementation of Protocols. Education with in practices	
10	Frailty/Falls	HB Practices	ongoing	Care of patients	To look at the new model of care being offer by the Older Adult team model at WGH – Angela Puffett Consultant. CRT/MDT working and linking with the cluster Occupational Therapists.	

11	Storage and Space.	HB Practices	ongoing		Primary Care funding for notes to be scanned and stored. Primary Care grants for new improvements within practices.	