Annex 3

Three Year Cluster Network Action Plan 2017-2020

North Ceredigion Cluster

July 2017

The Cluster Network[1]
Practices to work to collaborate

- Understand local health
- Develop an agreed Cluster
  elements of the individual
- Work with partners to improve
  integration of health and
- Work with local communities
  inequalities.

Development Domain supports GP to:

needs and priorities.
Network Action Plan linked to
Practice Development Plans.
the coordination of care and the
social care.
and networks to reduce health

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.
(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.

North Ceredigion Cluster

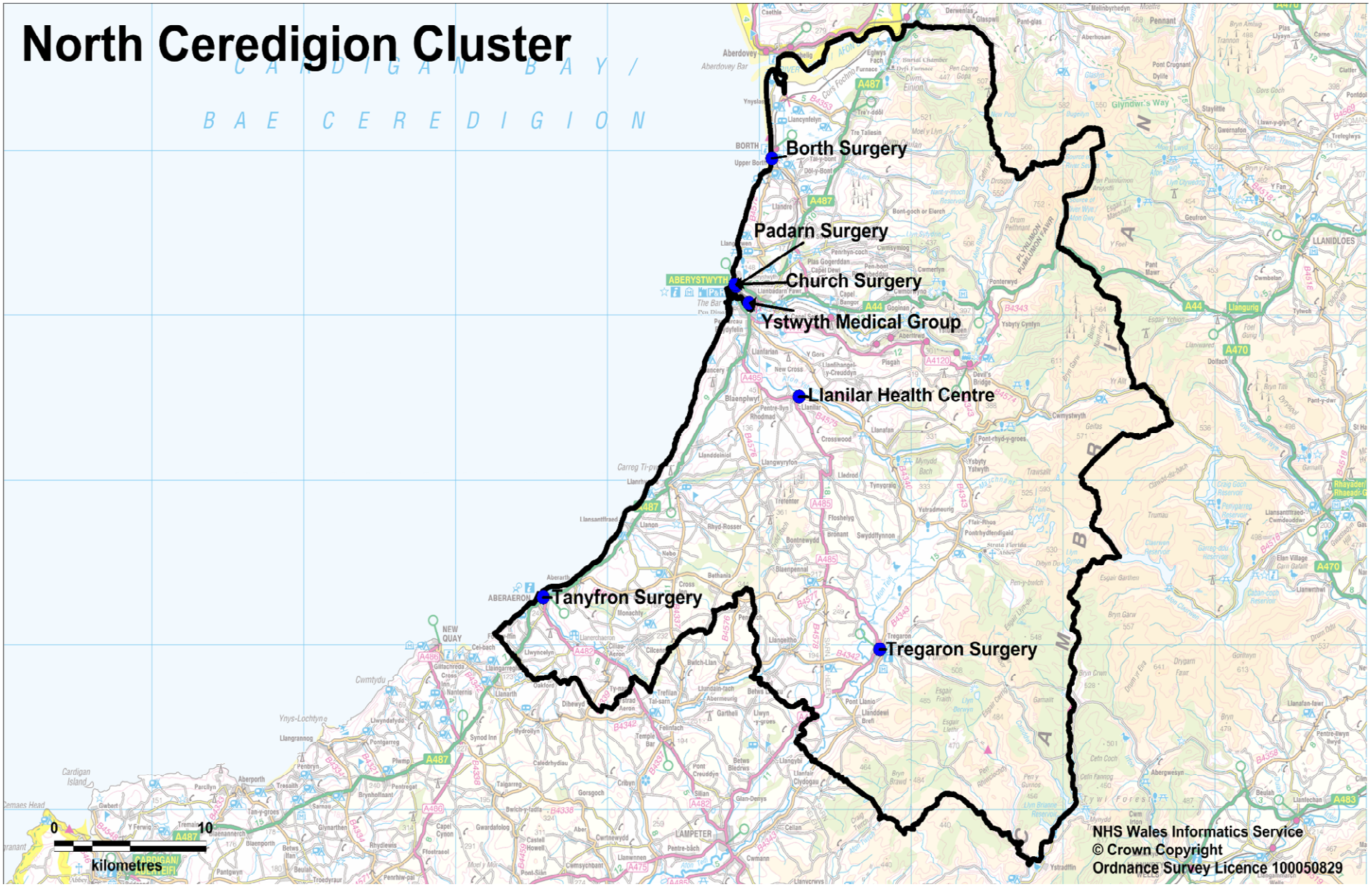
Introduction

The North Ceredigion Cluster Network serves an approximate population of 46,837. The cluster covers the geographical area from Aberaeron up to Borth. This comprises of 7 GP practices,10 Community Pharmacies and 4 dental practices. The cluster also has I general hospital, 15 care homes, 21 primary schools, 4 secondary schools and 1 university.

The 7 GP practices have federated (Cambrian Primary Care Ltd) The Practices provide the following enhanced services

North Ceredigion Cluster

	Borth	Church	Llanilar	Padarn	Tanyfron	Tregaron	Ystwyth
Direct Enhanced Services							
Childhood Immunisations							
Influenza for those 65+ and others at risk groups							
Pneumococcal 65+ years							
Warfarin & Anti-coagulation (INR)							
Minor Surgery							
Care Home							
Care of People with Mental Illness							
Care of Adults with Learning Disabilities							
National Enhanced Services							
MenACWY							
MenB							
Children's Influenza programme							
Shingles catch-up programme							
Substance Misuse (Ceredigion)							
Local Enhanced Services							
MMR Immunisation							
HPV Immunisation							
Pertussis Vaccination for Pregnant Women							
Managing Diabetes							
Insulin Initiation							
INR Les (due to be decommissinoed 31-8-2017)							
Near Patient Testing (NPT)							
Denosumab							
Minor Surgery (Supplementary)							
Extended Hours							
Syrian Refugees							
Treatment Room (Minor Injury & Wound Care)							
Gonadorelins & Degarelix							
Long-Active Reversible Contraception (LARC)							
Provision of University Student Health							
Shared Care - drugs monitoring							
Sexual Health							
Additional Services (not Enhanced)							
Childhood Immunisations - PCV/Hib/MenC							
Childhood Immunisations - Rotavirus							
Dispensary							
Shingles (routine cohort)							


North Ceredigion Cluster
CARDIGAN BAY / BAE CEREDIGION
Borth Surgery
Padarn Surgery
Church Surgery
Ystwyth Medical Group
Llanilar Health Centre
Tanyfron Surgery
Tregaron Surgery
0
10
kilometres
NHS Wales Informatics Service
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The North Ceredigion cluster profile:

- An older profile (18%), but also a high student population (20%)
- Whilst the total Cluster Population fluctuates, some Practices have seen a steady decline in their list size

Practice list size change, count, North Ceredigion Cluster, 2005 to 2014

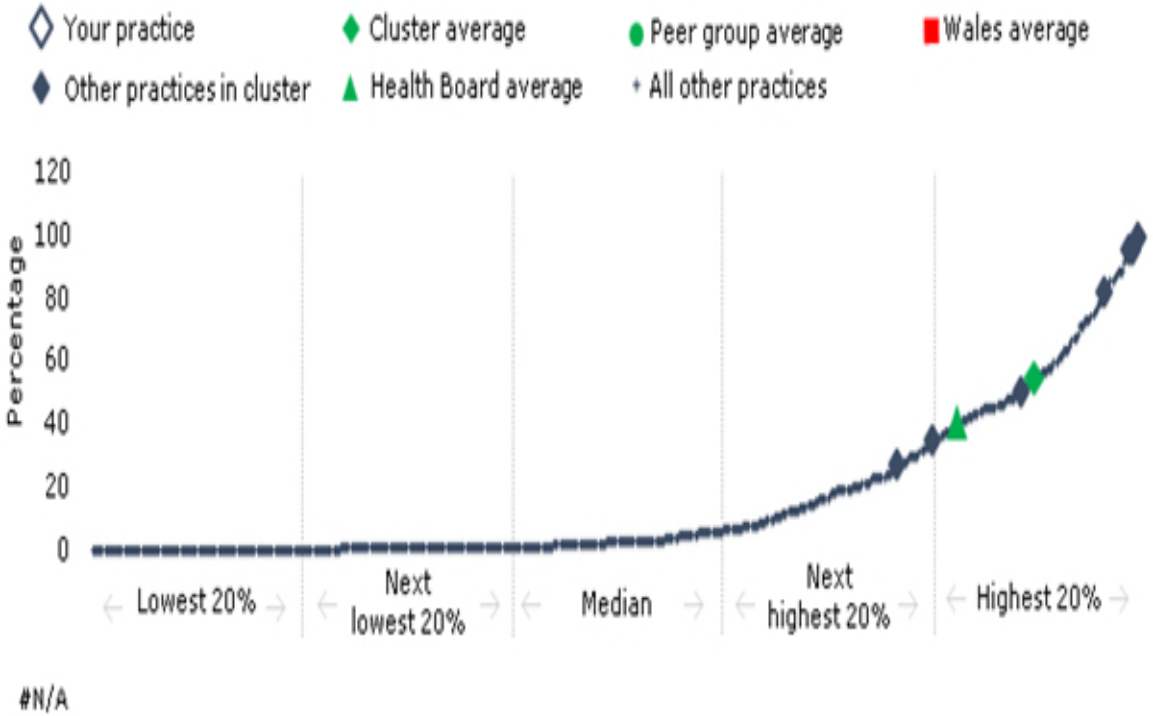
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Total cluster list size	45,120	45,420	45,650	45,740	45,800	46,090	46,020	46,160	46,130	46,190

- Discussions are taking place with reference to the Syrian refugee crisis and the possibility that Aberystwyth may have an allocation of refugees (10 per year) moving into the area. Provision for translation needs to be considered.
- Mixed ethnicity
- Welsh speaking is high within cluster, but there is difficulty in recruiting Welsh speaking GPs.
  Tregaron (67%), and Aberaeron (60%) were the wards that returned the highest percentages of Welsh-speakers in 2011 as was also the case in 2001
- The cluster has an above Health Board average for people living within a Rural area (54.2%)
- Deprivation less than Welsh Average (7.1%) and variable across the area
- Older patients having more complex needs
- Big challenges with recruiting GPs and Practice nurses, dentists and other health professionals within the area.
- Challenges with increased demand with tourism and student population

- **Rural area (54.2%)**

Percentage of the registered practice population that live in a Lower Super Output Area (LSOA) that is classified as rural. Rural LSOAs are those defined as "village, hamlet and dispersed area" by the Office for National Statistics.

Please select parameters from above



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North Ceredigion	54.2
Hywel Dda UHB	40.2

#N/A

- **Deprivation**

ercentage 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).

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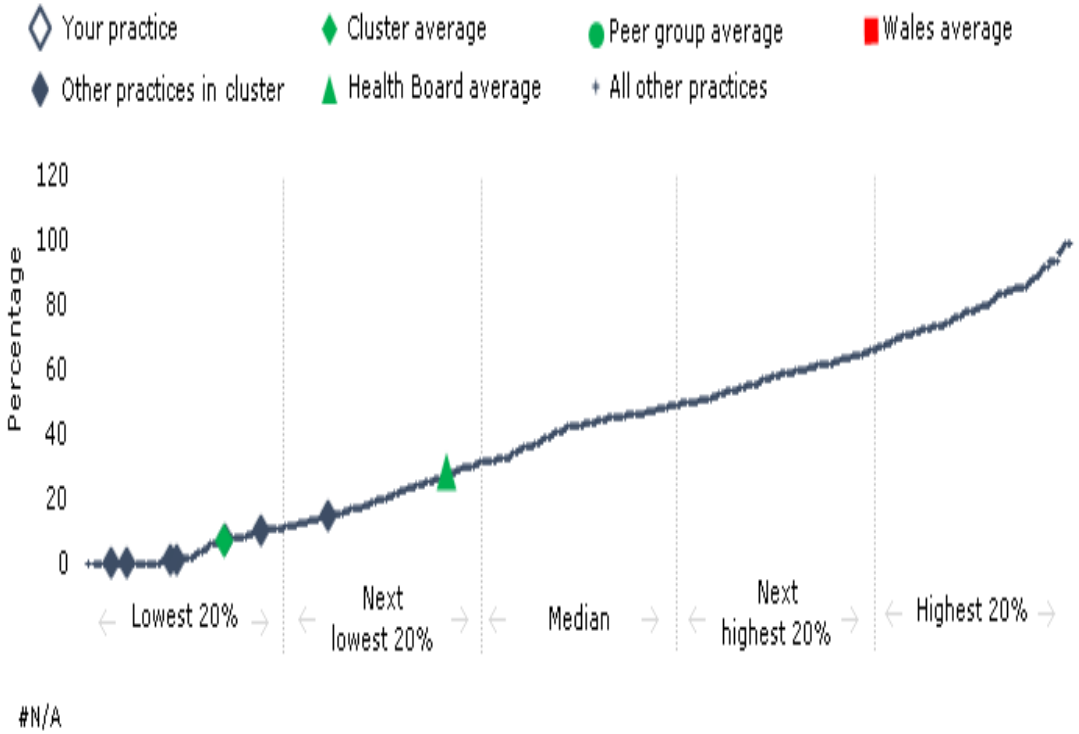

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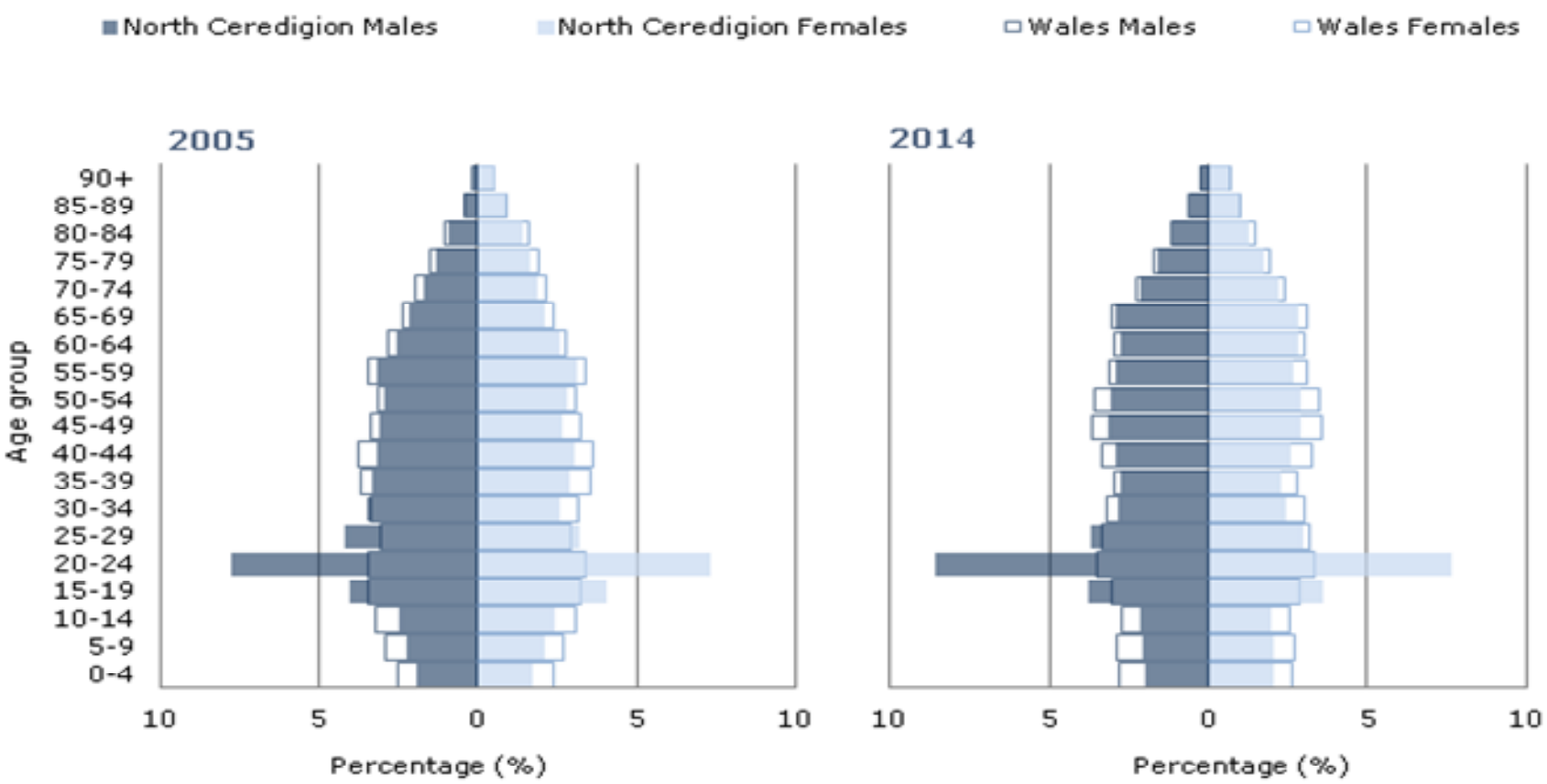
North Ceredigion	7.1
Hywel Dda UHB	28.3

#N/A

This population pyramid, highlights that in North Ceredigion we are higher than the National average for an ageing population

Proportion of population by age and sex, practice North Ceredigion and Wales, 2005 and 2014
Produced by Public Health Wales Observatory, using WDS (NWIS)



The North Ceredigion Cluster Network comprises of representatives from

- 7 GP practices (Primary Care)

- Community dental
- Community pharmacy
- County management team (Secondary care)
- Medicines management team (secondary care)
- Public health Wales
- Voluntary sector
- Local Authority

This year, the cluster will meet 5 times, to update on the progress of the actions for the cluster plan.

The Cluster have agreed to focus on the following 9 priorities

1. Develop a shred BP protocol
2. Continue with and evaluate the pre-diabetes project
3. Avoiding inappropriate admissions and improving discharge
4. Frail and Elderly – Pharmacist enhanced service
5. Developing a new service model for diabetes
6. Developing the Federation
7. Develop Sustainability plans and skill mix
8. Improve dental access in North Ceredigion
9. Continue to progress the work with the University around Student health and wellbeing.

Agreed priorities and achievements for 2016 -2017

We looked at the needs of our community : -	**Our agreed priorities for 2016/17 were:-**
• Immunization uptake in over 65s and at high risk groups • Diabetes (4.1%) • Heart failure (1.1%) • Antibiotic prescribing • Frailty • Sustainability of GMS workforce	• Workforce/service sustainability • Pre-diabetes • Frail and Elderly • Chronic conditions management • Vision Anywhere / 360 • Antibiotic prescribing (CRP) • Physiotherapy pilot
What we have achieved in 2016/17: -	**Our plans for2017/18 :-**
• We have tested new models of working within individual Practices e.g. employing a paramedic, pharmacists, pharmacy technicians, advanced nurse practitioners. • We have employed an advanced nurse practitioner and Frailty nurse to work within the cluster as part of a frailty hub • We have continued with the pre-diabetes project and demonstrated very positive outcomes for patients in reducing their risk of becoming type 2 diabetic • We have completed a pilot project around smoking cessation with PHW • We have worked with secondary care in developing a project to deliver pulmonary rehab via video-conferencing to a community hall in our locality. Plans to implement it next financial year (17-18) • We have shared good practice to promote flu vaccination uptake • We have linked with the 3rd sector to undertake screening within the community • We have completed 2 audits re: the CRP testing in Practice. This has demonstrated that using this test in Practice, has supported appropriate antibiotic prescribing • We have purchased Vision 360 to connect all 7 Practices to allow for flexible working and cover.	• Develop the frailty hub with the County team • Develop physiotherapy in Primary Care working with secondary care • Implement and evaluate the Pulmonary rehabilitation project • Develop a sustainable diabetic service in North Ceredigion • Continue with the pre-diabetes for the 3rd year (final year of project) evaluate and share the learning • Continue with CRP testing in Practice. • Support the roll out of the smoking cessation service delivery via Video-conferencing • Develop the model for physiotherapy within Primary and community settings

Key Themes and Priorities Identified from Practice Development Plans 2017-18

The following themes were identified 2016-17 and nothing new has been identified. The cluster decided to

The cluster have agreed to focus on the following 9 priorities this year:

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2. Continue with and evaluate the pre-diabetes project
3. Avoiding inappropriate admissions and improving discharge
4. Frail and Elderly – Pharmacist enhanced service
5. Developing a new service model for diabetes
6. Developing the Federation
7. Develop Sustainability plans and skill mix
8. Improve dental access in North Ceredigion
9. Continue to progress the work with the University around Student health and wellbeing.

focus time and energy to progress the 9 listed. Although some of this work does overlap and interlink.

1. Develop a shared BP protocol – develop pathway for the management of BP. Arrange staff training
2. Develop shared asthma protocol – capacity, backfill, specialist nurse, other professionals, to release specialist nurse time.
3. Pre-diabetes – continue project
4. Depression – particularly in the Young
5. Sexual health
6. Antibiotic Prescribing
7. Phlebotomy – funding, All Wales policy
8. Admissions and discharges
9. Frail & Elderly – pharmacists, enhanced service
10. Increase demand
11. Joint care beds – ICB
12. Hospice
13. MDT working
14. Lack of consultants
15. Dental
16. Sustainability and skill mix
17. D/N capacity

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

1.0	To review the needs of the population using available data	Local Public Health Team Public Health Observatory Cluster	September 2017	To ensure that services are developed according to local need	A review of the population health needs was under taken via a needs assessment workshop on 28th March 2017 North Ceredigion Cluster Needs Assess Public Health Wales Observatory General Practice population profiles 2015 http://howis.wales.nhs.uk/sitesplus/922/page/63747 Public Health Wales Observatory NCC Po Practice development plans from the 7 GP practices identified key themes. The cluster have agreed 7 priority areas for 2017-18. (as above) Each Practice is taking a lead for 1 of the identified priorities.	1.0 completed

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

2.0	To develop local workforce development plans	**Practice Lead** **Ystwyth** **Working with** Federation LHB Welsh tourist board & Aberystwyth University	March 2018	Service modernisation to meet changing needs Ensure sustainability of local services	Within our Cluster we have a high % of GPs and PN retiring in the next 3 years. 16.3% of GPs and 68.4% of PN. There are few new trainees coming through. Recruitment remains to be a challenge nationally. But is particularly problematic within our rural area. 1. Cluster: consider recruitment campaign, working in partnership Welsh Tourist Board and Aberystwyth University 2. Explore opportunity for pharmacist to be assigned to Practice. 3. Develop cluster sustainability plan to include up-skilling and training	
2.1	To review current demand and capacity	**Practice lead** Borth Surgery	Practices	Services developed to reflect local need	Cluster felt that they provided adequate access for their patients. Consultation rates varied between the smaller and larger Practices. 1. develop new models of working	

		Federation **Working with** GP Practices, LHB, CHC			2. increased GP triage within Practices 3. Improve patient information to the changes to service delivery 4. Cluster: to exploit use of IT to signpost and empower patients to gain information and signpost e.g. My Health on Line, GP to GP transfer of data within the cluster 5. Practices to develop Patient Participation Groups to help educate patients on health & service issues	

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
3.1	Continue with Pre-diabetes project (3rd year)	**Practice lead Church** Practices HB dietetics EPP University	September 2018	Reduce risk of developing type 2 diabetes through brief intervention and signposting to support services.	Share initial learning at Research and Innovations conference on 13th July 2017. University liaising with some Practices to progress project into research. Produce Final evaluation report (September 2018)	
3.2	Develop services for management of Chronic conditions	**Practice lead** **Tanyfron Surgery** **Working with** Cluster County team LHB	March 2018	Improved service provision	• Set up meetings to discuss developing plan / proposals for funding streams that may become available with Claire Hurlin. • Explore use of cluster funds to pay for specialist nurse time in Primary care. • Nurse Advisor to look into secondary care nurses having a “taster” in primary care. • Develop training plan for primary care nurses. • Develop BP protocol • Develop asthma shared care protocol	

					• Develop an innovative model of care in Diabetes to include management across boundaries of care throughout primary and secondary care & the wider community (i.e. local authority, PPGs, voluntary sector) • To ensure sustainability of Diabetic care for our population • Implement and evaluate the Pulmonary Rehabilitation via Video-conferencing programmes	
	Physiotherapy Pilot	**Practice lead** **Padarn Surgery** **Working with**	March 2018	Reduce workload in Practice. More streamlined service for patients	• Develop job plan • Develop job description • Advertise job vacancy • Pilot physiotherapist role working in practice	

		Cluster LHB				

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
4.0	Practices to address winter preparedness and emergency	Practices	June 30th	Consistent care for patients	PDPs submitted	

	planning in PDPs					
4.1	Practices to discuss their plans with each other to agree cluster / federation support in adverse weather condition/ emergencies	Practices LHB 3rd sector	December 31st 2017	No loss of service during extreme situations		

Strategic Aim 5: Improving the delivery of dementia; liver disease, and COPD,

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
5.1	To improve delivery of dementia care		March 2018	Every person with dementia in Wales has: • The right to a timely diagnosis.	Cluster has agreed to use Toolkit 1 dementia toolkit.docx	

				• The right to access quality post diagnostic support. • The right to person centred, co-ordinated, quality care throughout their illness. • The right to equitable access to treatments and therapeutic interventions. • The right to be respected as an individual in their community	For the toolkit chosen, each practice in the cluster will: 1. Use the toolkit to assess their performance in the chosen area of dementia care 2. Have a dedicated meeting within the practice to discuss the findings 3. Develop a practice Quality Improvement Plan for that area of dementia care Each cluster will then: 1. Discuss the shared practice Quality Improvement Plans for dementia care with the other practices in a cluster meeting 2. Develop a Cluster Quality Improvement Plan for dementia care 3. Include this plan in the Cluster Report 4. Review the actions within the plan regularly to ensure progress is made to achieving them The Cluster QI plans for dementia care will then be reviewed HB level, and	

					support given to address identified actions.	
5.2	To facilitate appropriate management of abnormal ALT tests and, thereby, more timely diagnosis of patients with liver disease.		March 2018	1. To reduce the number of repeat liver function tests following an abnormal ALT 2. To increase appropriate testing following an abnormal ALT 3. To increase appropriate referrals to hepatology for patients with abnormal ALT indicative of hepatic fibrosis	The contractor will undertake a baseline audit of the management of patients with raised ALT levels in the previous two months. 2. The practice will follow the clinical pathway illustrated by the algorithm in Appendix A in the management of the results of patients with abnormal function tests. 3. After a period of two months the practice will audit the outcomes of the management of those patients with raised ALT levels. 4. The practice will participate in a facilitated discussion of the collated data from the baseline and first cycle intervention audits. This will include consideration of how the Cluster Network can support its constituent practices and other stakeholders in management of patients	

					with risk factors for liver disease including excess alcohol consumption 5. The practice will continue to follow the pathway and repeat the audit after a further two months. The collated results of the practice audits will be discussed by the Cluster Network and included in the Cluster Network Annual Report.	
5.3	To improve coding and recording of COPD consultations, prescribing and referrals			There will be higher percentage of accurate coding and recording of COPD consultations, and more appropriate prescribing and referrals, with the improvements being measured by the practice and shared with the cluster.	**Step One: Reflection on National Clinical Audit:** The contractor will review their individual National COPD Audit outcomes and consider any action points arising from this review either for • action within the practice or • discussion with the cluster or • for feeding back to HB (e.g. where gaps in service provision identified or resources needed to address problems identified).	

					Step Two: Review Spirometry Results: o The contractor will review the spirometry results of patients on their COPD register to ensure accurate diagnostic coding (using a national COPD template if available) **Step Three: Collate Outcomes of review and share learning** The practice to collate outcomes of this review: i.e. % correct diagnoses, incorrect diagnoses (and brief outlines of subsequent actions taken) and themes from their review of their individual COPD audit data. o This data to then be discussed at cluster level together with review of QOF data extraction and other allied issues relating to the whole COPD pathway to identify further actions required across whole pathway	

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority. – as strategic Aim 5

The cluster have agreed to all do the same pathways for peer review.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating

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
	To review quality assurance of Clinical Governance Practice Self Assessment	Practices	March 2018		The contractor updates the Clinical Governance Practice Self-Assessment Toolkit, completes the Information Governance Self Assessment Toolkit	

	Toolkit (CGSAT) and inactive QOF indicator peer review.				and utilises learning / outcomes from same in peer review at cluster meeting The contractor agrees to peer review the designated inactive QOF indicators within the practice at a designated cluster meeting mid way through year and at the end of the year. The outcome of the inactive QOF peer review to be completed and shared with the Local Health Board by 31 March 2018. The contractor will include appropriate actions resulting from this analysis within the Practice Development Plan and will consider whether any issues need to be discussed at cluster network meetings.	

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
8.0	To continue work with Aberystwyth	**Lead: LDM** Practices	March 2018	Health needs are met in a timely	Attend Fresher's fairs	

	university around Student health and wellbeing	Community Pharmacy LHB 3rd sector		manner by the most appropriate person	Liaise with Student Union re: choose well Meet with HR of the university to develop health screening opportunities Work with Dr 'Knut Schroeder' to progress student app evaluation Work with Community pharmacy to trial common aliments scheme and student evidence	
8.1	To explore stronger collaborative / federated ways of working	**Lead Federation** **Working with** Practices LHB NWIS INPS	March 2018	Sustainability and continuity of service provision	• Explore cluster use of time banking e.g. SPICE • Work with IT department / NWIS to links Practices systems to see patients records when needed • Develop federated model	
8.2	Develop self referral into dermatology	LEAD – Borth LDM Aberystwyth University IT company	August 2017		• Bid to be written for ETT funds	