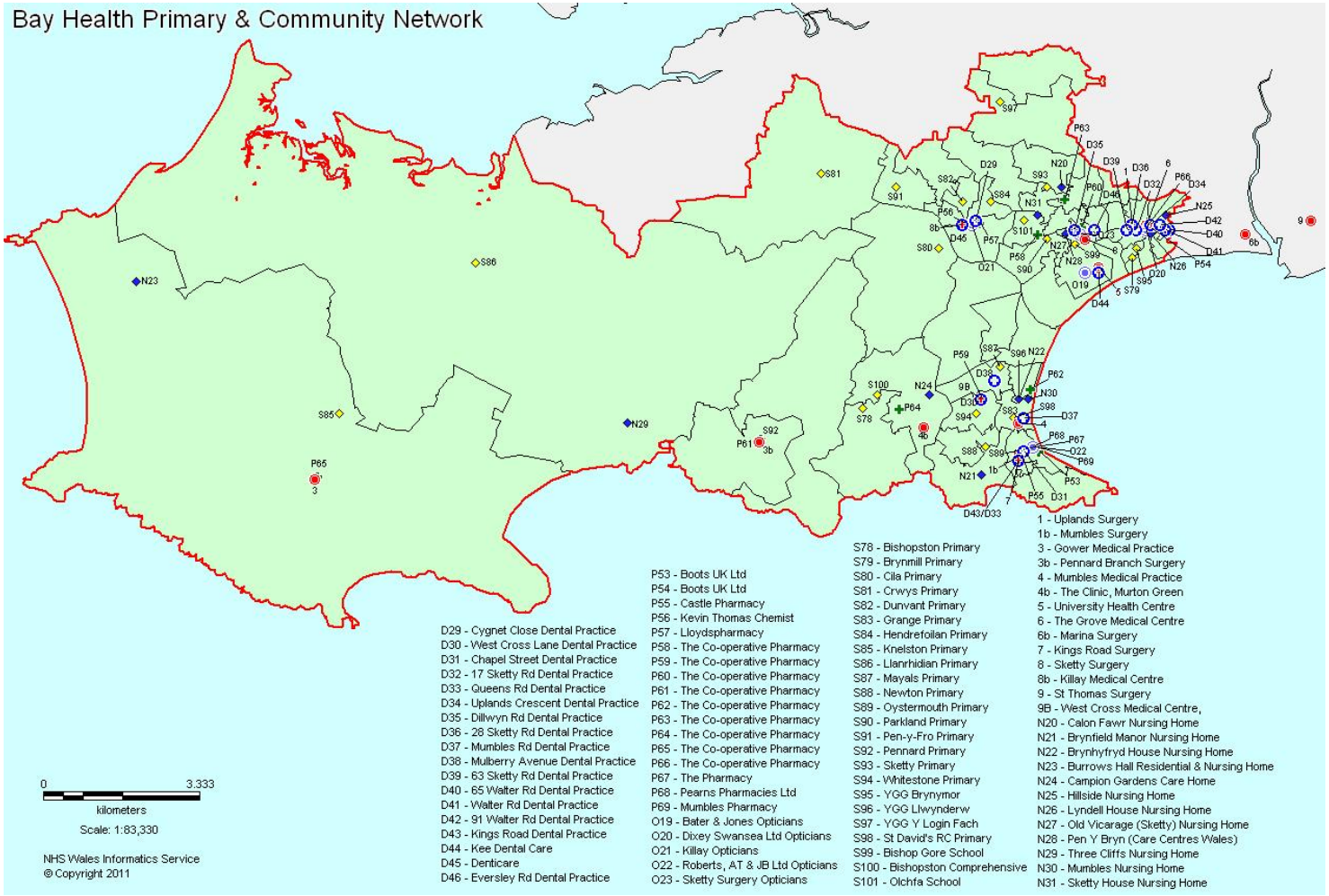
Three-Year Cluster Network Action Plan 2017-2020

Bay Health Cluster

Welcome to the Bay Health Three Year Cluster plan, 2017 - 2020

The Bay Health Network is one of five community network areas in Swansea, geographically covering Uplands, Sketty, West Cross, Mumbles, Killay, and Gower also serving students resident at Swansea University.



Bay Health is made up of eight general practices working together with partners from social services, the voluntary sector, and the ABMU health board, with practice populations ranging from 3,703 to 21,550, amounting to a cluster network total of 75, 198.

Networks aim to work together in order to:

- *Prevent ill health enabling people to keep themselves well and independent for as long as possible.*
- *Develop the range and quality of services that are provided in the community.*
- *Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.*
- *Improve communication and information sharing between different health, social care and voluntary sector professionals.*
- *Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.*

Bay Health Local Health, Social Care and Wellbeing Needs and Priorities

In order to support the development of the network cluster plan, information has been collated on a wide range of health needs within the Bay area. The health needs information has been taken into account when developing the priorities for this plan.

The summary below highlights characteristics of the Bay network:

- Increasing list sizes, approx. 2, 055 (4.3%) patients between 2011 - 2017
- A high elderly population requiring community base care for multiple and complex ailments. One fifth of persons registered in the Bay network cluster are aged 65 + years (21.8%); the fourth highest % of patients 65 + years of all networks within ABMU Health Board area. One tenth of patients registered in the Bay network cluster are aged 75 + years (10.9%).

Bay Health Cluster				% Male/Female Aged 65+ and 75+	
Age Band	**Female**	**Male**	**Persons**	**% Female**	**% Male**
Aged 65+	**9,002**	**8,038**	**17,040**	**53%**	**47%**

Aged 75+	**4,657**	**3887**	**8,544**	**55%**	**45%**

- Large student numbers living in the surrounding areas to the Swansea University Campus meaning practices need to address multi racial/cross cultural needs.
- High numbers of 20 – 24 year old males and females
- A comparatively low % of patients (7%) live within the most deprived areas.
- Uptake on Bowel Screening, 53%, Target 60%.
- Uptake on Cervical Screening, 79.5%, Target 80%
- Uptake on Abdominal Aortic Aneurysm Screening 75.4%, Target (80%)
- Uptake on Breast Screening Uptake 75.8%, Target (70%)
- Estimated 9,900 (15.7%) of known smoking within the cluster population.

Bay Health Disease Registers

Disease Register	Bay Health Register Total 2017	Bay Health Register Changes 2011 – 17 (%)	Swansea Total	ABMU Total
Cancer	2,247	69.2%	6,620	15,040
Dementia	568	47.5%	1,734	3,925
Mental Health	757	21.%	2,704	5,955
Chronic Obstructive Pulmonary Disease	994	3.3%	4,886	12,212
Obesity	4,579	6.1%	21,608	54,284
Diabetes	3,224	4.3%	14,181	33,851
Hypertension	9,170	12.2%	1,425	3,596
Rheumatoid Arthritis	380	0.5%	1,425	3,596

Bay Health Practice Development Plans Consistent Themes Identified 2017

As a result of the analysis of the 6 Practice Development Plans within Bay, the following have been identified by most, if not all of practices. These will be addressed within the Cluster Development Plan:

Access:

- To reduce nurse appointment DNAs
- To review and monitor skill mix within practice
- Increase the use of SMS text reminders
- Promote and encourage use of MHOL for booking appointments online and ordering repeat prescriptions

Planned Care:

- Increase flu immunisation uptake
- Increase electronic referrals via WCCG and monitor rates by specialty
- Increase the use of CO2 monitors, increasing referrals to Stop Smoking Wales. In addition, promote the Help Me Quit Service

Unscheduled Care

- Cluster paramedic and CCN to assist in triaging and monitoring patients to reduce pressures on emergency admissions.
- Undertake the care home enhanced service to avoid admissions to hospital.
- Improve communication of discharges

Prescriptions

- Continue to promote the Big Fight Campaign – reduce antibiotic prescribing
- Utilise pharmacist time for medication reviews effectively to save GP time
- Cluster pharmacists to assist in improving the process of reauthorisation of repeat medication

Practice Developments

- Implement service for initiation and monitoring for patient on warfarin
- Ensure practice is making best use of resources within the cluster i.e. CCN and paramedic
- Engage with cluster regarding collaborative arrangements

Workforce

- Difficulty recruiting GP vacancies and planning for retirements in practice

- Encourage review of skill mix within practice to ensure service delivery of new work e.g. INR service

Developing the Cluster Network Development Plan

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

- To understand local health needs and priorities.
- Linked elements of the individual Practice Development Plans that are common across the cluster.
- Work with partners to improve the coordination of care and 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 cover a three year period and 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.

The three year Cluster Network Action Plan will 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.

[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

This is the fourth cluster plan that has been produced by the network and it is the aim to further develop the plan over the coming years. The network will be regularly monitoring progress against the actions contained within the plan.

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

The Cluster aims to deliver this over 3 years by focusing on easy identification of atrial fibrillation, increasing immunisation uptake, utilising third sector support services and undertaking initiatives to encourage patients to quit smoking.

No	Objective	Key Actions	Key Partners	For Completion by: -	Outcome for patients	Progress to date	RAG Rating
1	To understand the profile of the Bay Community Network and the effect that deprivation has on the practice populations.	To consider the demographics of the community network and the impact on service delivery. To recirculate the Healthy City Directory to Bay practices as a reminder to all services and organisation that can assist and support practice populations.	Public Health / Public Health Observatory / Health Board	Ongoing	Services are developed according to local population need	Demographics have been considered during formulation of this cluster network plan. Bay Health Cluster Network Public Health Profile 2016 - 17 has been cascaded to practices for information and use when drafting PDPs.	

2	To promote the identity of the Bay Health Cluster	To purchase ID badges for all practice staff within the cluster that will feature the Bay health logo, persons name, position and surgery to which they are employed	GP Practices / Health Board	September 2017	To increase patient awareness of the cluster branding and improve education within the community	To consider badge options and costs. Business Manager to coordinate.	
3	Easy identification of atrial fibrillation (AF)	GPs and nurses to continue the use of alivecor monitors to allow a 30 second ECG trace of a patient to be recorded. To undertake a feedback and evaluation task on the number of AF patients identified through the use of alivecor monitors in each Bay Health practice.	GP Practices / Community Nurses / Pharmacists GP Practices / Health Board	Ongoing March 2018	To reduce the risk of cardio vascular accidents. Effective use of alivecor monitors will enable early diagnosis and prevention of stroke, providing a prompt and efficient service to patients.	100 alivecor monitors have been distributed between the 8 Bay practices and to the Bay health paramedic, CCN and pharmacists. Cluster to agree a suitable feedback and evaluation process.	
4	To increase flu immunisation uptake beyond figures achieved during 2016 – 17 to strive towards achieving WG targets.	Bay Health Cluster paramedic, CCN and pharmacists to attend a flu immunisation course to refresh knowledge and skills for use during the forthcoming flu campaign.	GP Practices	March 2018	To provide efficient patient care, protecting patients at risk and the wider population by reducing infection.	A suitable course is currently being identified for staff to attend	

		Additional nurse time to be funded to enable housebound patients to receive vaccinations. To share good practice, methods of invitation and any new initiatives within the cluster, with aim of improving uptake during 2017 – 18. To consider public health involvement.	GP Practices / Health Board GP Practices / Health Board / Public Health Wales	August – March 2018 (throughout the campaign) September 2017	Bringing care into the community to ensure patients are protected against flu To reduce the risk of infection by immunising eligible patients	Practice nurses to work through lists of those patients requiring vaccines to be given at home. To be planned earlier this year since a prompt decision has been made by the cluster to fund nurse time. 2016 – 17 Flu Immunisation Uptake Figures have been provided to the cluster on a practice, cluster and Health Board level. Bay Health Cluster uptake has been reported as follows: • **65 yrs and older** – 66.6% Ranked 4th in ABMU. Only one practice within the cluster achieving above the 75% WG target • **65 years at risk** – 44% Ranked 5th in ABMU. No practice reached the 75% WG target • **Children aged 2 & 3** – cluster uptake has increased during the 16 – 17 campaign achieving 44.5% compared to 35.7 % in the previous season. Public Health Wales, has agreed to supply an information pack to the cluster which will contain useful products for the forthcoming flu campaign 2017-18.	

						Practices have been reminded that flu uptake by cluster and practice is updated weekly and can be viewed on IVOR to check progress and achievement, and for comparison with other practices across ABMU. In addition, it has been noted to practices that the target for patients with chronic conditions has been reduced to 55%. Kings Road and Gower Practice have agreed to share methods of invitation and good practice adopted during the flu campaign at the next meeting scheduled 21st September 2017.	
5	To develop third sector support, utilising voluntary sector services	**Year 1** To provide a specialised balanced lives programme with targeted intervention for elderly clients with specific issues addressing mobility movements, mental health issues and cognitive thinking, life style adaption, health promotion, social interaction and peer group stimulation. Nurses to refer appropriate patients to this programme. To develop a range of activities	Health Board / SCVS / Voluntary Sector organisation – Balanced Lives / Action for Elders Health Board / SCVS /	April 2018 Delivery of the course will initially be through 36 weekly 3 hour classes delivered in a social based environment. April 2018 (funding will	Aims to improve clients physical stance, posture and technique coupled with emphasis on breathing and correct mental attitude. Through these exercises, each individual will feel an improvement in their stress levels, energy levels, sleep patterns and overall sense of well-being. Prevention of ill health enabling people to keep	A delivery programme has been developed detailing the content of proposed weekly sessions. James Lewis, Director of the Organisation attended Bay cluster meeting held 13th July to advise that 16 people had attended the last session. Posters have been cascaded to practices for display in practice	

		and groups in the Bay Health Cluster area aimed at older people who are experiencing loneliness and social isolation To develop and routinely update/redesign a range of display boards for update to inform patients of cluster news, Bay priorities and health matters.	Voluntary Sector Organisation – Red café Health Board / SCVS / Public Libraries / GP Practices	cease) September 2017	themselves well and independent for as long as possible. Developing the range and quality of services that are provided in the community. To highlight health matters and Bay priorities to members of the community.	receptions or waiting rooms advertising Red Café groups, the details of when and where groups will be held, including the aims of attending. SCVS have assisted in the display of material on notice boards that have now been placed in public libraries (Oystermouth, Killay, Sketty, Pennard) and Swansea University.	
		<u>Year 2</u> To evaluate the impact and effectiveness of voluntary sector organisations Red Café and Action for Elders on patients within the cluster.					
6	To obtain patient and carer views on network services and priorities programme.	Patient members to receive the cluster action plan for review and consideration of Bay priorities. Comments and feedback to be welcomed as well as any project engagement. Continued development of the patient and carer forum. GP Practices to agree one representative to attend the Patient and Carer Forum on a rotational basis	SCVS / GP Practices / Health Board GP Practices	September 2017 July 2017	Responsive services taking into account service user and carer feedback.	The cluster have agreed to allocate £1,000 to support future patient group meetings during 2017/18. Business Manager to assist in arrangements and matters relating to the Patient and Carer Forum. Next meeting to be scheduled for September 2017. Practices have agreed to identify suitable members to be a representative at the Forum if there are currently no patients attending. Names of patients to	

		Reflections to be communicated and services to be developed where relevant	GP Practices / Health Board / Patient & Carer Forum	March 2018		be provided to the Business Manager for the purpose of circulating Forum material. To be analysed	
7	To reduce the number of patients who smoke within the cluster	To undertake a project in conjunction with the ASH smoking cessation charity using CO2 monitors, recording CO2 levels of patients who are registered as smokers to share recordings and encourage patients to quit smoking. To analyse referral rates to stop smoking Wales, comparing data prior to and after the use of CO2 monitors in practice	GP Practices GP Practices / Health Board / Public Health Wales	Ongoing December 2017	A reduction in the number of patients smoking.	CO2 monitors have been distributed to all patients within the cluster. PHW have agreed to supply data quarterly to the cluster for review and monitoring.	

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

The cluster aims to do this through a review of sustainability of core GP services across practices, sharing difficulties and addressing concerns with peers; developing access arrangements in line with current ABMU Access Standards to meet the needs of local patients; and exploring collaborative working arrangements.

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To review the sustainability of core GP services across practices	**Year 1** All practices within the cluster to complete a	GP Practices / Health Board	June 2017	To provide a more sustainable service for	The Health Board has received completed matrices from all 8	

		sustainability matrix, pre populated by the Health Board.			patients and GP practices	practices within the cluster.	
		To share workforce pressures and the shortage of locums as a cluster and consider potential local workforce plans or resource to assist in sustaining services.	GP Practices / Health Board	September 2017		Practices to bring any vacancies, recruitment of posts and locum arrangements/difficulties for discussion at the September meeting for sharing as a cluster. The nursing team have agreed to share pressures with the cluster also.	
		To discuss increasing peer support within the cluster during time of extreme pressure	GP Practices / Health Board	September 2017		To be explored and discussed as a cluster during the meeting due to be held September 2017	
		To ensure multi-disciplinary professionals employed by the cluster are used appropriately to assist the management of demand and capacity	GP Practices / Health Board	September 2017		Practices have been encouraged and reminded of the available resources within the multidisciplinary team that can be utilised by all. An activity report to be shared at the meeting scheduled September to highlight work undertaken and outcomes for patients. Use of cluster CCN highlighted; to be monitored to ensure workload is appropriate.	
		To address concerns in relation to population increase e.g. housing development, University student registrations.	GP practices / Health Board	September 2017		To discuss any implications to practices within the Bay cluster during the September meeting.	

		To continue to develop the skills and management within GP practices to ensure a sustainability provision of service, e.g. complying with HR, Employment Law and Health & Safety	GP Practices	March 2018	To continue to develop the skills and management within GP practices, complying with HR, Employment Law and Health & Safety	Work is ongoing with practices to develop skills and management of H & S, and employment law within practice.	
		Year 2 To review practice sustainability scores one year on to compare differences To evaluate the impact of the professionals employed as part of the multidisciplinary tea,	GP Practices / Health Board				
		Year 3 To continue cluster development and peer support to help strengthen sustainability within general practice Subject to evaluation of the multidisciplinary team within the cluster, take appropriate action to consider the continuation of employment.	GP Practices / Health Board				
2	To review and develop access	To continue to share good practice and learn from	GP Practices / Health Board	September 2017	To provide more accessible services for patients	To be discussed further, considering actions for any	

	arrangements in line with the ABMU Access Standards to ensure GP Practices meet the reasonable needs of local patients	variations of access arrangements across GP practices, and to ensure levels of access are achieved on a practice/cluster basis in line with the ABMU Access Standards				practices not meeting the reasonable standards. Support Manager to recirculate the Access Standards of 2015 to the cluster for review against provision.	
		To increase the use of text messaging services for health invitations e.g. flu, and appointment reminders from IT systems to improve communication with patients and reduce DNAs	Health Board / GP Practice / NWIS	March 2018	To reduce the number of DNAs/wasted appointments	Practices are keen to utilise text messages to remind patients of appointments to assist in reducing nurse DNAs and assist with the increase of flu vaccination uptake. Some practices have advised of their plans to check mobile telephones contact details recorded to ensure messages can be sent appropriately.	
		To increase the use of My Health OnLine and patient sign up to encourage appointments and repeat prescriptions to be managed online to help reduce the number of calls received by practice.	Health Board / GP Practice / NWIS	March 2018	To allow patients access to an online system of available appointments and repeat prescription management, saving telephone calls and times to practice.	MHOL Uptake/Use as at June 2017: Appointments - 4/8 Practices Prescriptions – 6/8 Practices Cluster Population – 75,198 No. of Patients Signed Up – 6,469 % of Patients Signed Up – 8.9% No. of Apts Booked Online – 341 No of Patients on an Active Repeat – 21,993 No. of Patients who have order online – 1,915 University Practice & Kings Road do not use MHOL as they do not link benefits with their patient population.	

		To consider the use of an IPad and administrative assistance in practice to encourage patient sign up to MHOL and to support initial log in.	Health Board / GP Practice / NWIS	December 2017		Digital Inclusion has been identified as an organisation who might be able to assist – contact name to be made available. For further discussion during September meeting and consideration of any associated costs.	
3	To further explore the benefits of collaborative working	To gather ideas and feedback from other clusters on experiences and presentations received regarding federations and collaborations. To seek clarification and advice regarding next steps from PCC and legal advisors to compare and contrast contracts.	GP Practices / Health Board Health Board / GP Practices	December 2017	Enables groups of practices to come together, collaborating to provide a greater range of services to patients, sharing responsibility for developing and delivering high quality, patient focussed services in their local communities.	An initial workshop conducted by PCC was held 25th Jan 2017 to allow practices to start thinking about collaboration. KT has discussed experiences with other cluster leads allowing feedback to be shared. Correspondence has been exchanged between the HB, PPC and Blake Morgan. A meeting is to be arranged to work through finer detail of the collaboration process. To obtain and provide a presentation to the cluster written by Paul Thomas for review and further understanding.	
4	To further establish a successful cluster multidisciplinary team of healthcare professionals, providing the Bay community with quick and efficient access to services.	Cluster paramedic to respond to and triage house calls across the cluster.	GP Practices / Cluster Paramedic	Feb 2018	Quick access to health care in urgent situations. Assist in reducing pressures on emergency services and free up GPs to manage other demands as required.	Bay Health Cluster Paramedic commenced 23rd January 2017, hosted by West Cross St Thomas Surgery. Work has been undertaken across the 8 Bay practices with positive feedback being received to date. Dr Matt Giles has been appointed as mentor.	

						Initial feedback has been provided by the paramedic during a cluster meeting and PLTS. A minor illness clinic has been proposed, starting in The Grove Medical Centre; this is currently being explored the dedicated mentor.	
		Cluster Chronic Conditions Nurse to educate patients and improve chronic conditions management.	GP Practices / Chronic Conditions Nurse	Feb 2018	Providing a domiciliary and practiced based care in the Bay Health area for the coordination, management and monitoring of the care of housebound patients with long- term chronic illness.	Bay Health CCN commenced February 2017, hosted by Mumbles Medical Practice. Induction is now complete with work being undertaken across the cluster. The CCN is due to report feedback on work undertaken to date at the cluster meeting during September 2017.	
		To consider the employment of a cluster physiotherapist to incorporate services into the community	Health Board / GP Practices / Paramedic / CCN	March 2018	Better access and prompt triage for patients with MSK problems	The cluster have received a presentation providing information on a physiotherapy service model currently being used in Neath. A meeting is due to be held with the Senior Manager at MCAS, 25th July 2017 to discuss this proposal.	
		Regular activity reports to be shared detailing emergency admissions and A & E attendances for comparison prior to and since the employment	GP Practices / Health Board	September 2017 and ongoing	Efficient care and service delivery to patients	Activity has been requested from the Information Department – to be shared with the cluster once available. Handsets and costings have been	

		Non-contract mobile telephones to be identified for distribution to the multidisciplinary team.	GP Practices/ Health Board	September 2017	Quicker access to service delivery	retrieved by the Practice Manager at Kings Road. Non -contract phoned to be ordered for CCN and paramedic use to enable direct contact between patient and MDT team, including a message facility for patients.	
5	To establish the role and responsibilities of the cluster business and implementation manager	**Year 1** To identify, develop and implement opportunities to align services between practices, share resources, and meet the day-to-day needs of the network population by working more closely together. A further programme of work is to be developed in line with agreed cluster action plan.	Business Manager / GP Practices / Health Board	March 2018	To guide and implement plans set by the cluster to improve the quality and efficiency of services for patients	Business Manager has commenced in this role, 3rd July 2017. Initial discussions have taken place to progress work initiatives for the cluster.	
		Year 2 Consider extension of employment, if extended, develop a year 2 cluster work programme	Business Manager / GP Practices / Health Board	May 2018	To guide and implement plans set by the cluster to improve the quality and efficiency of services for patients		
		Year 3 Dependant on outcome of year 2	Business Manager / GP Practices / Health Board		To guide and implement plans set by the cluster to improve the quality and efficiency of services for patients		

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

The cluster will, over a 3 year period, engage effectively and make improvements between the primary and secondary care interface; aim to reduce wastage of medicines and achieve better health outcomes through prudent prescribing; ensure patients have access to newly designed enhanced services, namely care homes and oral anticoagulation with warfarin; and prolong independence of elderly patients through the development of anticipatory care plans.

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To pilot electronic radiology request forms	**Year 1**			Benefits patient referrals		

		To work with NWIS to pilot a newly designed All Wales electronic request forms within the Bay cluster for radiology referrals	NWIS / GP Practices / Health Board	March 2018	and care outcomes	The cluster has agreed to pilot electronic forms. NWIS are due to attend the cluster meeting during September 2017 to provide more detail of the forms and the outcomes to be achieved.	
		Year 2 To evaluate the pilot; effectiveness and outcomes for primary and secondary care. To continue use of electronic referrals if deemed appropriate.	NWIS / GP Practices / Health Board	July 2018	Benefits patient referrals and care outcomes.		
		Year 3 Encourage routine use of electronic referrals	NWIS / GP Practices / Health Board	July 2018	Benefits patient referrals and care outcomes.		
2	To increase electronic referrals via WCCG	**Year 1** To increase the use of electronic WCCG referrals, communicating more effectively between primary and secondary care.	GP Practices / Health Board / Secondary Care	March 2018	Improved and faster referral route for patients	The cluster to encourage use of WCCG referrals within practice. To be discussed further during the cluster meeting scheduled September 2017. Electronic referral rates to be requested by specialty.	
		Year 2			Improved and faster		

		To monitor referrals via WCCG by specialty	GP Practices / Health Board / Secondary Care	March 2018	referral route for patients		
		<u>Year 3</u> To continue use of electronic referrals via WCCG	GP Practices / Health Board / Secondary Care	March 2018	Improved and faster referral route for patients		
3	To deliver services effectively and efficiently using modes of technology	To consider the cost implications and sign up to Vision 360 to allow healthcare professionals mobile access	GP Practices / Health Board / NWIS	Ongoing	Quicker access to patient information. More sustainable services.	The business manager has met with colleagues to discuss the system and potential costs to the cluster. Original quote in 2016 £22,500, a £1,800 reduction has now been offered to the cluster.	
		To use technology to increase IT/skype consultations to improve communication and provide a more efficient service to particular cohorts of patients, or patients in certain settings, e.g. care homes.	GP Practices / Health Board / NWIS	January 2018	Prompt service to patients	Methods of good practice to be discussed between practices to encourage increased use of technology to enable skype/IT consultations.	
		To maintain, update and improve the use of the Bay Health Cluster Website	GP Practices / Health Board / NWIS	Ongoing	Enable patients to access Bay health news and priorities within the	Practice Manager at Gower Medical Practice has agreed to update and maintain the Bay health website going forward.	

		To increase promotion of the Bay health cluster, good news stories and experiences to local patient through the use of social media i.e. Bay health Facebook page.	GP Practices / Health Board / NWIS	Ongoing	community.	Bay health have started to upload information and news using this method to educate patients and the local community on various matters. Increased use and planned headlines to be considered for the months ahead.	
4	To engage effectively and highlight improvements between the primary and secondary care interface to plan patient care.	To invite key secondary care colleagues by specialty to future meetings to discuss methods of engagement and to assist the strategic aim, ensuring patients needs are met through planned care.	GP Practices / Health Board / Secondary Care	March 2018	To ensure patients needs are met through prudent care pathways, facilitating rapid accurate diagnosis and management, and minimising waste and harms.	Specialty colleagues to be considered for invitation to future cluster meetings. To discuss further September 2017.	
5	To reduce the wastage of medicines in care homes	Cluster pharmacists to undertaken care home medication reviews and administration records for individual patients to highlight any issues with prescribing and to minimise waste resulting from patient refusal or non-adherence. Cluster pharmacists to discuss medicines wastage with carers to retain (Pro Re Nata) PRN medicines.	Cluster Pharmacists / Care Homes / GP Practices	March 2018	Improved care	Cluster pharmacists are in the process of undertaking medication reviews for patients within the cluster who are registered at care homes to determine whether medication is still effective/appropriate for the patient and discuss further with the appropriate GP. To be undertaken and findings fed back to the cluster routinely. To be undertaken and	

		Prescribed nutrition drinks to be reviewed for need and effectiveness.				findings fed back to the cluster routinely.	
6	To address the complex medical needs and to provide an enhanced provision of care for residents in Care Homes. Delivering best-evidenced treatment and services to ensure a decrease in unplanned transitions of care and poly pharmacy.	To consider the provision of the care home enhanced service via the cluster to those practices not participating in the DES Assessments and regular reviews of the mental and physical health of the residents	Health Board / GP Practices / Cluster Pharmacist / GP OOHs	Ongoing	Collaborative working with other local health services throughout the primary care clusters to provide overarching leadership of multi-professional teams. Wraparound services provided for the patient, i.e OT, Podiatrist, Dental, Optometry, Audiologists, Dieticians, Mental health care. A decrease in Unscheduled admissions A decrease in Polypharmacy	Cluster Uptake : 7/8 Practices	
7	To ensure, with the Health Board, that all network patients have access to the new Service for Oral Anticoagulation with Warfarin	To consider the provision of the enhanced service for oral anticoagulation with warfarin via the cluster to those practices not participating in the DES	Health Board, GP Practices, secondary care, medicines management team	May 2017	Safer services through not separating roles of monitoring and prescribing – in line with MHRA	A GP has attended the Bay cluster to present and discuss the proposed model to GP practices, for information/consideration. Cluster Uptake: 6/8 Practices	
8	To prolong independence of older people through identifying those people most at risk of losing	To continue with active involvement in the anticipatory care programme	GP Practices, Health Board,	March 2016 and ongoing	Early identification of those patients most vulnerable of losing their independence. Care	Bay cluster has acted as an early adopter. . Practices have continued their involvement in the	

	independence and developing anticipatory care plans.	To participate in a full evaluation when the programme rolls out to all clusters	Community Hubs, Mental Health		coordinator and care plan systems will assist those patients most at risk.	anticipatory care programme establishing systems to: • Assist in making it core business • Identifying those most vulnerable of losing their independence • Identify care coordinator and care plan systems	
9	To review the effectiveness of dermatology services offered within the community	To consider an appropriate evaluation process following the purchase of dermatoscopes across the cluster	GP Practices / Health Board	March 2018	Better service to patients. Fewer secondary care referrals.	Secondary care dermatology referrals have been requested for review and evaluation during 2017/18.	
10	PMS Plus: respiratory prescribing	To continue to undertake a range of prescribing initiatives as required to improve respiratory prescribing	GP Practices / Medicines Management Team / Pharmacists	Ongoing	Improvement in patient symptom control	Notification of cluster award during 2016 / 17 £26,006	
11	To achieve better health outcomes and safer care through prudent prescribing	To continue to promote the wastage of medicines campaign Cluster pharmacists to assist and support practices in day to day work to alleviate pressures focusing on the following areas as part of their role.	GP Practices / Health Board / Pharmacists	March 2018 and ongoing	Reduced wastage of medicines and costs. To provide efficient and effective healthcare and lead a cost effective and educational role.	To discuss what is being done during 17 / 18 to help promote the campaign Work plan to be discussed for inclusion within plan	

		To share results, evaluations and outcomes of work undertaken by cluster pharmacists To improve antimicrobial stewardship	Medicines management team		Reduced resistance. Reduced c.diff. Increased knowledge and empowerment to self care	Methods to be discussed Discussed at annual practice prescribing visits. Cluster level data shared at meeting.	

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

The cluster will achieve this over 3 years utilising the time of multidisciplinary professionals, and educating patients in how to manage self-care and identifying the most appropriate place to receive treatment.

No	Objective	Actions	Key Partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To effectively utilise the cluster paramedic time to respond to patients presenting with urgent care needs.	**Year 1** Cluster paramedic to support general practices within Bay health, providing high quality and consistent care for those patients with urgent care needs. To share capacity between	GP Practices / Bay Health Paramedic	March 2018	High quality care, improved patient experience.	Practices are beginning to increase patient referrals to the paramedic for triage and response. Evaluation to be undertaken and further work planning to be mapped.	

		practices within the cluster to support the development of services, improving patient experience, coordination of care and effective risk management, and in addition, as a mechanism to winter preparedness and emergency planning.					
		Year 2 To continue to evaluate findings and outcomes of employing a multidisciplinary team					
		Year 3 Consider extension of employment, if extended, continue to build on good work					
2	To effectively utilise the cluster chronic conditions nurse to respond to patients with urgent care needs.	**Year 1** Cluster chronic conditions nurse to support general practices within Bay health, providing high quality and consistent care for those patients with urgent care needs. To share capacity between practices within the cluster to support the development of services, improving patient experience, coordination of care and effective risk	GP Practices / Chronic Conditions Nurse	March 2018	High quality care, improved patient experience	Practices are beginning to increase patient referrals to the cluster nurse for chronic disease management. Evaluation to be undertaken and further work planning to be mapped.	

		management, and in addition, as a mechanism to winter preparedness and emergency planning.					
		Year 2 To continue to evaluate findings and outcomes of employing a multidisciplinary team					
		Year 3 Consider extension of employment, if extended, continue to build on good work					
3	To coordinate care and the effectiveness of risk management through the anticipatory care project.	To ensure anticipatory care plans are written, shared and available at patients homes to assist urgent care needs and emergency planning when necessary.	GP Practices / Health Board / Local Authority / WAST	March 2018	Improved patient experience, coordination and quality of care. Smooth transition of care.	Practices are continuing to participate in the anticipatory care project. Since the referral age now has no limit, practices and the community hub will look to identify any further patients.	
4	To educate patients in identifying the most appropriate place to receive treatment and how to manage self care.	To promote self care education through use of resources such as the choose well campaign, newsletters, notice boards, social media and Bay website.	GP Practices	Ongoing	Better educated to understand how to self care and identify the most appropriate place to access services and receive treatment.	Resources have previously been cascaded to practices and patients, however, a refresh is now required.	

Strategic Aim 5: Improving the delivery of Mental Health and Wellbeing; and Chronic Obstructive Pulmonary Disease (COPD)

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To participate in a clinical priority pathway focusing on Improved Mental Health & Wellbeing	To engage with the priority work at a cluster and practice level To discuss any data provided to the practice/cluster To agree small steps of change to test out any new ways of working To share the results of small tests of change within peers in the cluster	GP Practices / Health Board	31 March 2018	To deliver quality improvement to enhance care	Priority area to be further discussed during next meeting scheduled September 2017	
2	To participate in a clinical priority pathway focusing on Chronic Obstructive Pulmonary Disease (COPD)	To engage with the priority work at a cluster and practice level To discuss any data provided	GP Practices / Health Board	31 March 2018	To deliver quality improvement to enhance care	Priority area to be further discussed during next meeting scheduled September 2017	

		to the practice/cluster To agree small steps of change to test out any new ways of working To share the results of small tests of change within peers in the cluster					

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority; Atrial Fibrillation and Anticoagulation

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To participate in a local priority pathway focusing on Atrial Fibrillation & Anticoagulation	To engage with the priority work at a cluster and practice level To discuss any data provided to the practice/cluster To agree small steps of change to test out any new ways of working To share the results of small tests of change within peers in the cluster	GP Practices / Health Board	31 March 2018	To deliver quality improvement to enhance care	Priority area to be further discussed during next meeting scheduled September 2017	

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

The cluster will demonstrate governance using the CGPSAT and Information Governance toolkits; undertaking peer review work to gain assurance on standards.

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To demonstrate governance within the practice through completion of the CGPSAT and Information Governance Self Assessment Toolkit	All practices within the cluster to update and submit the CGPSAT and IG Toolkit by 31st March 2018.	GP Practices	March 2018 and ongoing	Assurance that practices have clinical governance procedures in place	The Health Board has agreed to share cluster results following CGPSAT submission dated March 2017	
		To participate in training facilitated by the Health Board on each of the toolkits.	Health Board	September 2017	To ensure systems of clinical governance are adhered to.	The Health Board will arrange appropriate training for practice managers on the toolkits.	
		To utilise the toolkits to share learning and outcomes at cluster	GP Practices /		To improve systems of clinical governance	To be discussed at	

		meetings	Health Board			future meetings	
2	To undertake a peer review exercise	To peer review designated inactive clinical QOF indicators in order to gain assurance on standards, providing feedback to the Health Board	GP Practices / Health Board	September 2017 & March 2018	To improve systems of clinical governance and enable identification of any specific cause for concern.	To be discussed further	

Strategic Aim 8: Other Locality issues

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To work closely with Local Area Coordinators to ensure relationships are strengthened within the community	To support older people, people with mental health problems, the disabled, carers and other family members to remain strong and connected, feel safer and more confident. To assist in the promotion of Local Area Coordinator projects in practice areas	Health Board / GP Practices / Local Area Coordinators	March 2018 and ongoing	Better sign posting to services that can meet patients social needs	LACs have attended network meetings to introduce themselves. Evaluation is conducted through promotion of patient stories. Jon Franklin has agreed to share service evaluation for review within the cluster.	
2	To educate practice staff in line within cluster plans and Health Board and cluster priorities	To develop a shared education programme for future cluster training sessions that will focus and assist priorities set out within the cluster plan.	Cluster Lead / GP Practices / Health Board / Community Teams / Voluntary	Ongoing Throughout 17/18	Staff will receive up to date information that can be filtered down to patients	An excellent programme has been run by the cluster over the past 12 months. Topics of education have included INR,	

			Organisations			Child and Adolescent Mental Health, Collaborative Working and Prudent Prescribing	
		To participate in the Mental Health Directed Enhanced Service, securing a speaker who will focus training on selected training topic. on Eating Disorders in Adolescence and Early Adulthood	Cluster Lead / GP Practices / Health Board / Community Teams / Voluntary Organisations	January 2018	Educated practice staff will be in a position to offer adequate support and direction to patients	A revised mental health directed enhanced service specification has been circulated to the cluster. Links are now being made with B-eat organisation to source a speaker who will facilitate a training session on Eating Disorders in Adolescence and Early Adulthood. If unavailable, an alternative topic will be agreed within the cluster. Learning time for Mental Health training has been protected during January 2018.	
		To consider potential training programmes suitable for non-clinical staff. Business Manager and Practice Manager at Mumbles Medical Practice to consider options for consideration within the cluster.	GP Practices / Health Board / Training Providers	March 2018	Enhanced skill of practice staff	To be discussed further	
		To agree GP on call arrangements within the cluster	GP Practices	September		To be discussed	

		should the Out of Hours Service be unable to provide adequate cover for the purpose of PLTS		2017	Ensuring medical cover is in place for patients, creating little disruption to care during times of practice education.		