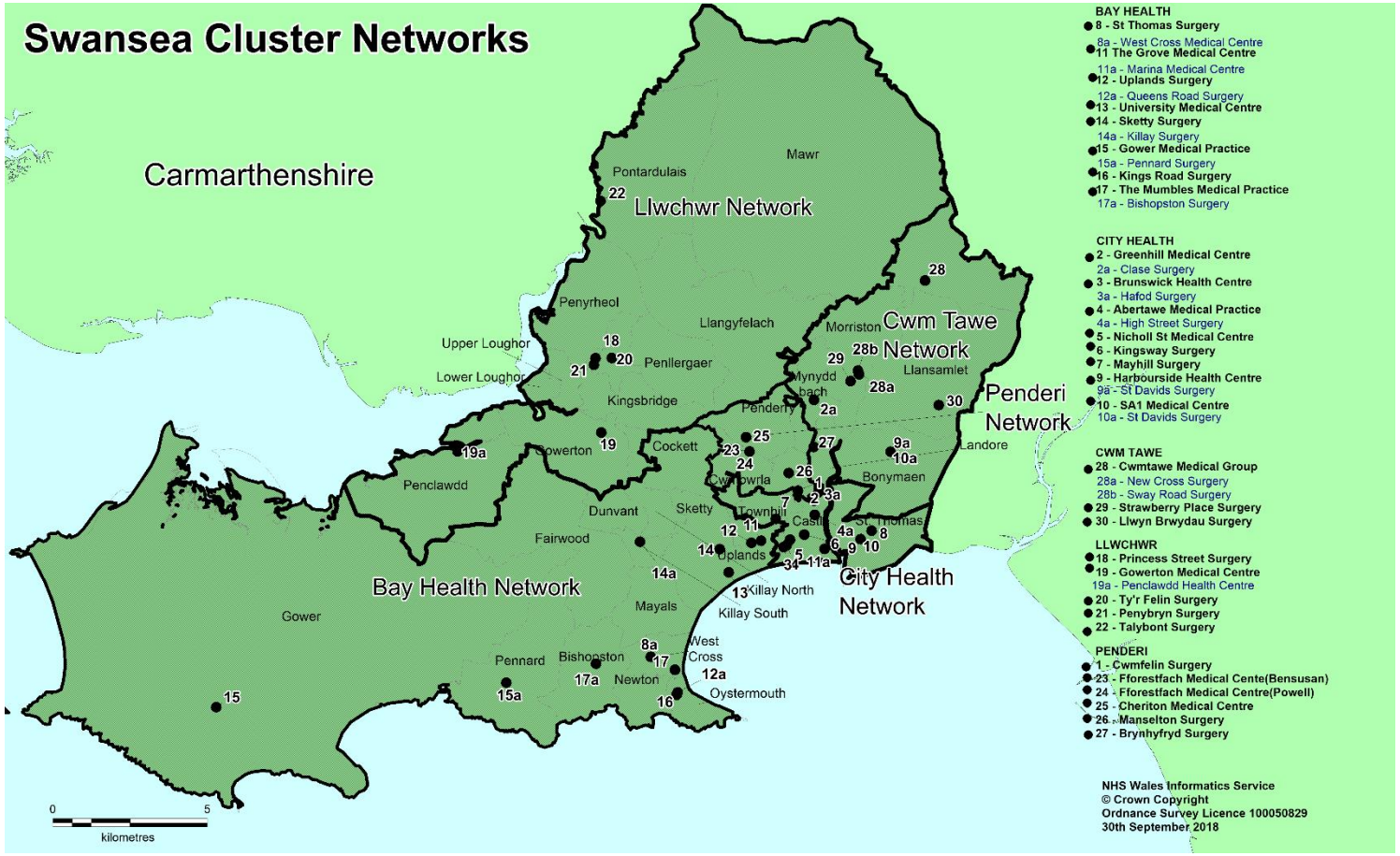
Three Year Cluster Action Plan 2018 - 2021

Bay Health Cluster

Welcome to the Bay Health Three Year Cluster Plan 2018 – 2021

1. Bay Health Cluster Overview

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



Bay Health includes eight general practices, community pharmacies, dentists and optometrists, community and hospital services working together with partners from the local authority and the third sector. Individual practice populations range from 3,707 to 21,325, amounting to a cluster network total registered population of 73,997.

Clusters across the area have agreed that they 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.*

Through the delivery of our cluster plan we are working to meet the Quadruple Aims set out for Health and Social Care systems in Wales in 'A Healthier Wales Our plan for Health and Social Care' (2018):

- ✓ Improved Population Health and Wellbeing
- ✓ Better Quality and More Accessible Health and Social Care Services
- ✓ Higher Value Health and Social Care
- ✓ A Motivate and Sustainable Health and Social Care Workforce

2.1 Swansea wide 'Headline' Information

Population: 242,4000 residents. High concentrations of population in and immediately around the City Centre, the adjacent wards of Cwmbwrla and uplands (6,800 people per square km, the highest density in the county) and also in Townhill and Penderi

Population has steadily grown between 2001 and 2015. Main driver of population growth in Swansea has been migration. Recorded live births has steadily risen since 2001 and number of deaths have fallen.

Life expectancy in Swansea is increasing: Average life expectancy for males is 78 (Wales 78.5) and 82.4 for females (Wales 82.3). This will impact significantly on the provision of health, social care and other public services in Swansea

Projected population Change: Welsh Government's latest trend based population projections suggest that Swansea's population will grow by 9% (21,600 people) between 2014 and 2039

2011 Census suggests that 14,326 people in Swansea were from a non white ethnic group: 6% of the total population and 20,368 (8.5%) of Swansea's Population were non white British (above the Wales average (6.8%). Census data (2011) suggests the largest non white ethnic groups are: Chinese 2,052 (0.9%), Bangladeshi 1,944 (0.8%), Other Asian 1,739 (0.7%), Black African 1,707 (0.7%), Arab 1,694 (0.7%)

Welsh Language: Proportion of people able to speak Welsh in Swansea decreased from 13.4% (28,938) in 2001 to 11.4% (26,332) in 2011. A fall of 9% despite an increase in population.

2.2 Our Local Health, Social Care and Wellbeing Needs and Priorities

Information has been collated on a wide range of health needs using the most up to date information available, within the Bay Health Cluster area, in order to support the development of the focus areas for this plan.

Health Profiles

Uptake on Bowel screening 53% . Target 60% (PHW Data 2016/17)

Uptake on Cervical Screening 79.5% . Target 80% (PHW Data 2016/17)

Uptake on AAA screening 75.4%. Target 80%. (PHW Data 2016/17)

Uptake on Breast screening 75.8%.Target 70% (PHW Data 2016/17)

Estimated 9,900 (15.7%) known smokers within the cluster.

76.68% of 16+ yr olds with a record of alcohol intake (ABMU average 76.58)

Comparatively higher rates on GP Disease Registers (2018) for :

Cancer
Atrial Fibrillation

The lowest number of Emergency Department attendances (rate: 100.43/1000, number:15,006) in the Swansea Clusters 01/09/17 - 31/08/18.

Lowest rate in ABMU of GP OOH attendances (rate:48.24/1000, number: 7,208) 01/09/17 - 31/08/18.

Flu Immunisation Uptake (PHW Data 2017/18):

Patients 65y and over: 69.3% (ABM 68.2%, Swansea 67.4%)

Patients under 65y at risk 48.5% (ABM 46.7%, Swansea 46.5%)

Children aged 2&3 Years 48.5% (ABM 49.1%, Swansea 47.4%)

Other Key Influencing Features

Some areas are very rural with poor transport links to the city centre

A high elderly population requiring community based care for multiple and complex ailments

Public Service Board, Local Wellbeing Plan Focus:

Early years: Making sure children have the best start in life.

Live Well. Age Well – making Swansea a place to live and age well.

Working with nature- improving health, supporting biodiversity and reducing our carbon footprint

Strong communities- supporting communities to promote pride and belonging.

PSB aims to make all services work together by sharing resources, assets and knowledge

Population & Community Assets

Swansea University

Libraries

Extensive countryside

Uplands Wellbeing Centre

Volunteer capacity

Leisure Centres

Major employers in the cluster are: CCS schools, ABMU Health Board (Singleton Hospital), Swansea University, University of Wales Trinity St Davids, Gower College Swansea, Welsh Ambulance Service NHS, Swansea West Industrial Estate (part of), Parc Fforestfach retail park, tourism and agriculture.

Cluster Features

73,997 patients registered

8 Pharmacies
10 Dentist Practices
5 Opticians
24 Schools
5 Libraries

15 Electoral Wards

Swansea Council South Delivery Area includes Sketty Park with particular features arising from deprivation

Service demands

The number of registered patients aged 20-24

Some areas are very rural with poor transport links to the city centre

An average of 13.2 patients per month contact the Help Me Quit Service between January 2018 and June 2018, with 29 patient achieving a 4 week quit rate status.

Key Population Features

Resident population; 70,800 (Community Area Profile: Source Mid 2016 rounded estimated ONS)

A comparatively low % of patients (7%) live within most deprived areas

Over 17,000 (21%) of patients aged 65+ (15.6% for Swansea)

Over 8,500 (10.9%) of patients aged 75+ (9.2% for Swansea)

Over 2,500 (3%) of patients aged 85+ (2.7% for Swansea)

Large proportion of students, including those with multi-racial/cross cultural needs

High numbers of 20-24 year olds; 22,521 (31.8%)

Sketty 4 (the second most deprived LSOA in this area) is in the 10% most deprived LSOAs in

Wales in both the employment and income domains, but much less deprived in terms of

physical environment, housing and access to services

A comparativlely low % of patients in both Bay West (3.5%) and Bay East (4.1%) live with a long-term sickness or disability (Swansea 6.9%)

2.3 Disease Register Information

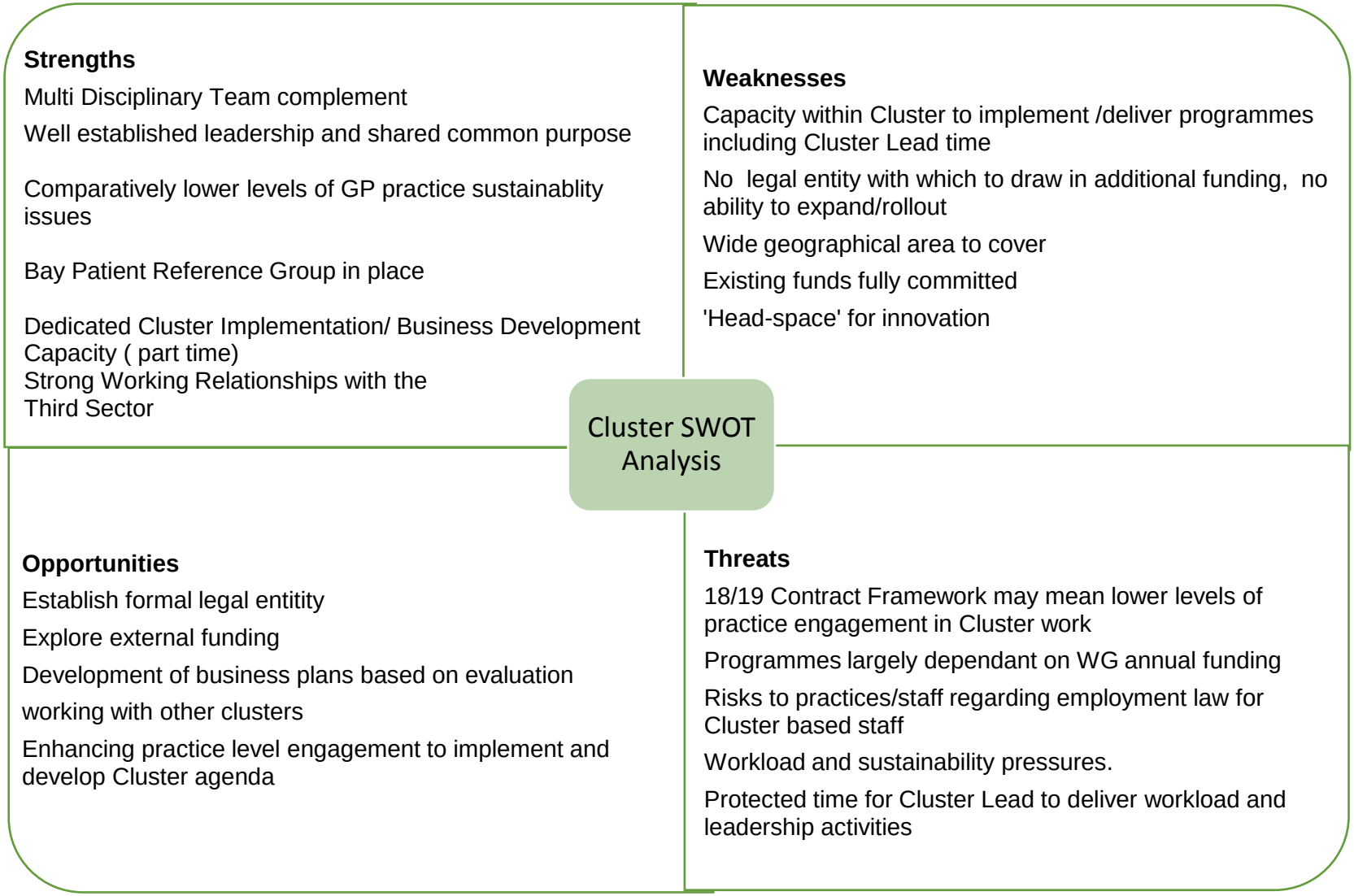
Disease Register	Bay Health Register Total 2018 (%)	Swansea rate %	ABMU rate %	Cluster Trend/Highlights
Atrial Fibrillation	1825 (2.4%)	2.2%	2.3%	2nd highest rate and highest numbers in Swansea Clusters
Cancer	2634 (3.2%)	2.7%	2.9%	Highest rate and numbers in Swansea Clusters
Dementia	559 (0.7%)	0.7%	0.7%	Joint highest percentage in Swansea
Mental Health	766 (1.0%)	1.1%	1.1%	3rd highest percentage rate in Swansea Clusters
Obesity	4583 (6.1%)	9.0%	10 %	*Lowest rates* in Swansea, second highest numbers.
Palliative Care	107 (0.1%)	0.2%	0.2%	

2.3 Antibiotic Prescribing

Items Apr 17 - Mar 18	**Items April 16 - Mar 17**	**Items % Variation**	**Items Difference**
41,894	42,125	-0.55%	-231

(With regard to antibiotic prescribing levels nationally there was a 2.2% reduction for the period noted in the table above

3. ***Strengths Opportunities Weaknesses Threats (SWOT) Analysis: Bay Health Cluster***



4. ***Cluster Vision and Aims***

In June 2018, Bay Health Cluster jointly agreed a Cluster Vision for the next three years. The Vision sets out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Bay area and its practices.

Bay Health Cluster Network

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Our Vision

"All Bay Health Cluster primary care services working together in partnership with patients, hospitals and the third sector to provide high quality services to meet patient's needs. We envisage a whole systems approach to transform services to meet the local needs of our patients."

Our aims

Bay Health aims to promote healthy lifestyles ensuring engagement of patients and communities in supporting their own care and participating in shared decision making. We wish to expand our multi-professional team to improve access to those housebound and improve education for patients with chronic illness. Information technology is essential to improve access to health online and we wish to seek out programmes for our patients to utilise, working in conjunction with the local authority.

5. ***Bay Health Cluster Practice Priority Issues***

Practices have expressed a range of areas which are a priority for them in delivering a sustainable and effective primary care service. These issues have also been taken into account in developing the Bay Health Cluster Plan.

Our Cluster Plan

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

Our three year focus:

- Alcohol Consumption – working to ensure levels of alcohol consumption and its side effects are reduced/managed
- Overweight and Obese Population – working to reduce/manage overweight and obese patients

No #	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
Overweight and Obese						
1.1	Implement Improving Health with Technology. A 5-week course providing patients with a Fitbit and support.	Voluntary Sector	March 2019	Referrals into a 5 week course to run 6 times over a 12 month period rotating round the surgeries as a venue to hold the events. Each patient referred will be provided with a fitbit. Reduction in obesity levels for participating patients	First course will commence 6th November.	
1.2	Commissioning of administrative and clinical time to measure patient BMIs	GP Lead	March 2019	Accuracy of recording BMI's will be improved		
1.3	Provision of communications tool for professionals to enable productive conversations about physical activity, diet, and weight/BMI	All	March 2019	All Health Care Professionals enable to have productive discussions with patients	Health Care Professionals feel uncertain of best way to initiate discussions	

1.4	Undertake MECC (Making Every Contact Count Training) for professionals to provide additional support for patients	All	Ongoing	Complete mandatory training for Making Every Contact Count (MECC)		
1.5	Increase the Health Literacy levels amongst Bay Health Cluster patients and citizens	All	Ongoing	Staff to use Health Literacy Tool routinely. Improved Health Literacy among patient population.	Public Health Wales to provide training sessions.	
1.6	Increase use of CO monitors during consultations	GP Practices	Ongoing	Increase smoking cessation working with ASH charity to promote smoking cessation	All practices have received CO monitor, including branch practice. Event held by PHW and ASH Wales.	
Alcohol Consumption						
1.7	All new patients register will complete a screening questionnaire	GP Practices	Ongoing	Practices will understand alcohol consumption levels amongst their patients, to inform service delivery.	Procedures to be reviewed by Practices.	
1.8	Appropriate lifestyle advice and appropriate referral to be undertaken on patients with increased alcoholic consumption	GP Practices	Ongoing	Alongside the patient questionnaire and MECC training, practices will be able to have open discussions with patients and refer appropriately.	Undertaken during new patient checks by Practice nurse	

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

Our three year focus:

- Fully implement a sustainable, evidence led, robust Multi-Disciplinary Healthcare Team within the Cluster which meets the workforce requirements overall of all Cluster practices and their populations by 2021

- Deliver a comprehensive Cluster training programme which supports staff and clinicians to work in the most effective way possible
- Significantly increasing the use of My Health Online for Bay Health practices.

No #	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
2.1	Scope preferred option for training provider to enhance workflow in practices, commission.	Cluster Business and Implementation Manager	March 2019	All frontline staff able to work in the most effective way possible Reduction in unnecessary GP workload appropriate to practice requirements	Some practices benefiting from workflow good practice implementation	
2.2	Increase use of My Health Online – Work in partnership with Digital Communities Wales to improve update.	All	March 2019	Reduce impact on practices Better access for patients More patients in Bay Health using MHOL	In collaboration with Digital Communities and SVCS an event will take place to raise awareness of My Health Online to encourage and increase uptake.	
2.3	Develop a business case for the permanent employment of Cluster MDT staff by the Health Board	Cluster Business and Implementation Manager and Health Board	March 2019	To allow Bay Health to employ Cluster staff without individual practices being at risk	Links have been made with Red Kite to build on previous expert input.	
2.4	Specialist Nurse in Chronic Disease to complete minor illness course and training to become an ANP in full.	CCN	March 2019	Once up skilled, CCN will be able to enhance the current role.	CCN has commenced Minor Illness course	

2.3	To employ additional Specialist Nurse in Chronic Disease.	Cluster Business and Implementation Manager and Health Board	March 2019	Cluster chronic conditions nurse supporting practices and current chronic conditions nurse and develop services within Bay health	Awaiting new financial year and awaiting discussions with the HB on employment	

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.

Our three year focus:

- Diabetes: transforming care for patients with Type 2 Diabetes, ensuring care in place as a cluster, focusing on delivering the early implementation of the National Enhanced Service for the ABMU Health Board
- Mental Health: To continue to improve multi agency mental health services for adults children and young people with a quality improvement approach

No #	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
3.1	Continued participation in the National Diabetes Audit Providing diabetes care closer to home Uptake of the DES – Gateway module	GP practices/MDT	March 2019	Reduction in ED attendances for Hypoglycaemia Reduction in Amputations Reduction in hospital length of stay/bed days Reduced duplication across primary & secondary care Improved self-management by patients	Business case submitted for approval to Investment Benefit Group	

3.2	Improve Adolescent Mental health: working with REACH to provide counselling to patients aged 14-25	Voluntary Sector/ SCVS	March 2019	Direct referral from practices to support Adolescent Mental Health Reduce waiting times Reduce inappropriate referrals to practices	Sessions commencing Oct/Nov 2018	
3.3	To reduce social isolation improve mental health and wellbeing by working in collaboration with Action for Elders providing the Balanced Lives scheme	Voluntary Sector/ SCVS	March 2019	Addressing mobility movements, mental health issues and cognitive thinking, life style adaption, health promotion, social interaction and peer group stimulation.	Additional sessions available. Encourage referrals	
3.4	Increase social prescribing utilising community activators in collaboration with Action for Elders	Voluntary Sector/ SCVS	March 2019	GP to be able to refer to alternative services routinely and effortlessly	Encourage signposting to Activators	
3.5	Social prescription pads to be created in collaboration with SCVS and Bay Health.	Voluntary Sector/ SCVS	March 2019	GP to be able to refer to alternative services routinely and effortlessly	Currently in draft form	
3.6	Continue implementing Wellbeing Grant Scheme	Voluntary Sector/ SCVS	March 2019 and ongoing		Bids have been submitted via VEAT	

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

Our three year focus:

- To improve Flu vaccination
- Build on current Chronic Condition Specialist Nurse role capacity to meet needs of the population

No #	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
4.1	Flu immunisations to be given to housebound by practice nurses or Bay specialist nurse	GP practices/MDT	March 2019	CCN and practice nurses increase flu uptake with housebound patients for over 65.	2017 – 18 Flu Immunisation Uptake Figures have been provided to the cluster on a practice, cluster and Health Board level.	
4.2	To effectively utilise the cluster chronic conditions nurse to respond to patients with urgent care needs	GP Practices / Chronic Conditions Nurse	March 2019 and ongoing	Cluster chronic conditions nurse supporting practices within Bay health.	Providing high quality and consistent care for those patients with urgent care needs. Sharing capacity between 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.	

Strategic Aim 5: To develop the Cluster as a structure for delivery of identified priorities.

Our three year focus:

- Ensure appropriate Cluster Governance in place and develop Cluster to maximum appropriate level of maturity
- Maximise use of additional funding sources for Cluster programmes

No #	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating

5.1	Agree operational model for Cluster that best meets needs of Cluster	All	March 2019	Cluster members able to deliver and provide clarity regarding roles and responsibilities.	First meeting to take place in Oct 2018 to build on previous discussions	
5.2	Allocate protected time and headspace for innovation for cluster leadership roles	All	March 2019	To create a forum to collaboratively work on funding bid, additional funding streams and developing services for the Bay Health population	First meeting to take place in Oct 2018. Cluster Lead allocated ½ day per week to deliver all cluster work as per SLA.	
5.3	Establish clear cluster accountability mechanisms for agreed work programmes	All	March 2019	Cluster programmes delivered more rapidly, with engagement.	Lack of clear resource/capacity for implementation.	
5.4	Establish business planning cycle for cluster to prioritise cluster projects and planning spend	Cluster Business and Implementation Manager and Health Board	March 2019	More vigorous approach to delivering cluster strategic direction and minimising likelihood of slippage, ensuring most effective use of funding.	In place on an ad hoc basis in relation to cross cluster issues.	
5.5	Establish Cluster communications strategy, identifying key internal and external stakeholders to influence to maximise impact, including sharing best practice delivered in Bay Health	Cluster Business and Implementation Manager and Health Board	March 2019	Strategic stakeholders aware of key Bay Health programmes. Cluster members better aware of outcome from use of time and resources.	Comms made on opportunistic basis eg via WG comms scheme through Health Board. Cluster has relatively well developed comms activity but strategic approach required.	
5.6	Ensure Cluster compliant with GDPR for Cluster based/delivered activity	All	March 2019	All staff with receive GDPR training via online training provider Bluestream	Training to be undertaken during protected learning sessions	
5.7	Review of cross cluster IT, Estates infrastructure to meet aims	Cluster Business and Implementation Manager	March 2019	Understanding of infrastructure, resources, cluster money to be invested	Clear understanding of resources to be considered in planning of services.	
5.8	Implement mobile technology to support Cluster working	Cluster Business and Implementation	March 2019	To deliver services effectively and efficiently	Vison anywhere has been supplied to all clinical staff – other opportunities to be identified	

		Manager and NWIS		using modes of technology		
5.9	Enable practice and team time to collate and set out data for external evaluation	All	March 2019	Demonstration of effectiveness of Cluster programme. More prudent commissioning of services.	Practices identifying time within current constraints.	
5.10	Develop potential for planning Cluster spend across 3 year period	All	Ongoing	To have clear aims, objectives and vision of areas in which Bay Health wish to implement change and develop existing services	Cluster vision set, priority areas of focus. 18-24 month spend plans in place.	
5.11	Identify and secure additional funding streams	Cluster Business and Implementation Manager	March 2019	External funding for the cluster accessed to deliver the aims of the cluster	Some leverage of additional funding and resources to be reviewed.	

Strategic Aim 6: Other Cluster and area specific issues

Our three year focus:

- To undertake quality improvements to services in identified Cluster Priority Areas: Urinary Tract Infections (Antibiotic Prescribing)
- Further the role of the Bay Health Cluster Development Group to deliver Cluster Aims

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
6.1	UTIS: Recurrent UTI prescribing will be reviewed and where appropriate prophylactic antibiotics stopped as per National guidance	GP Practices	March 2019	Review all patients on prophylatic antibiotics and stop if appropriate in	Document currently under production to disseminate to practices.	

				keeping with recent national guidance.		
6.2	AF: Aspirin monotherapy to be reviewed and all patients with a CHADSVASc2 score or more to be counselled regarding anticoagulation	GP Practices	March 2019	All Bay Health practices will ensure that all patients with lone AF should no longer be anticoagulated with Aspirin. All Bay Health practices will ensure that all patients with CHADSVASc Score greater than 2 will be anticoagulated appropriately with Warfarin or a DOAC if not contraindicated	Practices to commence work once document disseminated	
6.3	**Support the mainstreaming of services via the business case application process** through 'Balancing the System – shifting resources from secondary to primary care' for: **Mental Health Services for Tier 0** **Pharmacist Provision** **Physiotherapy** on a Cluster basis	Cluster Development Managers, Cluster Lead	Oct/Nov 2018	Services mainstreamed and Cluster funds released where relevant	Pharmacy outline case summarised for consideration by ABMU Strategy and Finance Depts. Physiotherapist preferred option model being costed. Pharmacist case in draft. MH counselling preferred options to be presented in Nov.	

6. Cluster Finance Statement

Bay Health Cluster has a financial allocation from the Welsh Government of just over 217k. In addition Clusters have access to other funding streams such as through the Health Board delivered PMS+ scheme. In 18-19 that has amounted to £26,488.