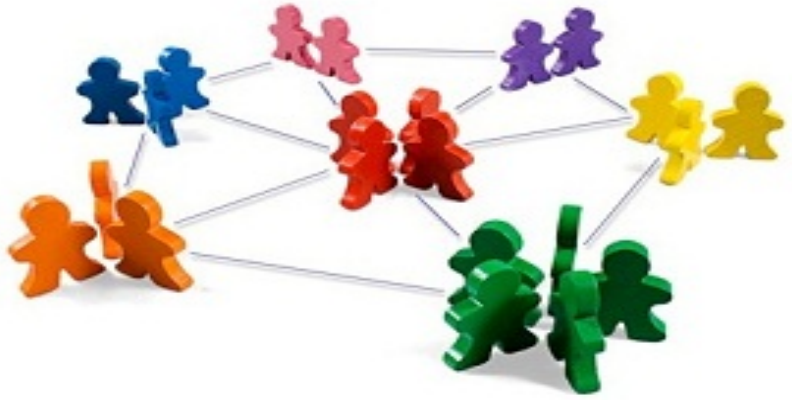
Three Year Cluster Network Action Plan 2017-2020

City Cluster



Welcome to the City Health Network Cluster Plan for 2017 - 20. The City Health Network, based in Swansea, comprises nine general practices working together with partners from Social Services, the voluntary sector and the ABMU Health Board.

The 9 Network Cluster practices cater to a varied population of 52,100.

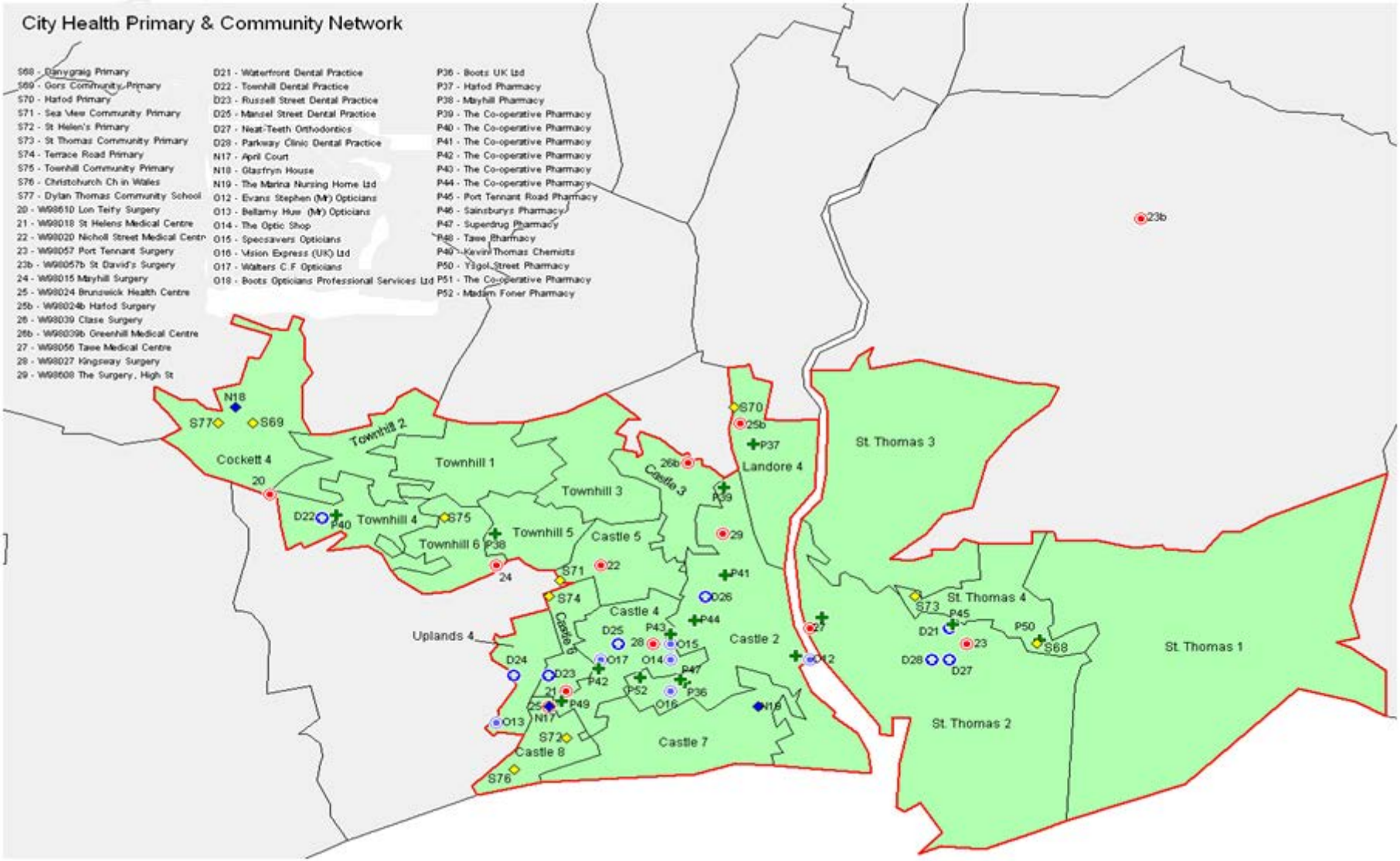
- High deprivation levels; with 24,833 (49%) residents living in the most deprived fifth of areas in Wales
- Large student, asylum seeker and multi-racial/multi-cultural groups
- A large proportion of young parents
- 7,920 patients aged 65+ (16%) and 1,060 aged 85+ (2.2%)

The Network area is served by:

- 4 General Dental Practices
- 1 Specialist Orthodontic Practice
- 1 Specialist Dental Practice (Sedation and Oral Surgery)

The City Network Practices, in line with other Networks in Swansea, 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.


City Health Primary & Community Network
S68 - Danygraig Primary
S69 - Gors Community Primary
S70 - Hafod Primary
S71 - Sea View Community Primary
S72 - St Helen's Primary
S73 - St Thomas Community Primary
S74 - Terrace Road Primary
S75 - Townhill Community Primary
S76 - Christchurch Ch in Wales
S77 - Dylan Thomas Community School
20 - W98010 Lon Teify Surgery
21 - W98018 St Helens Medical Centre
22 - W98020 Nicholl Street Medical Centr
23 - W98057 Port Tennant Surgery
23b - W98057b St David's Surgery
24 - W98015 Mayhill Surgery
25 - W98024 Brunswick Health Centre
25b - W98024b Hafod Surgery
26 - W98039 Clase Surgery
26b - W98039b Greenhill Medical Centre
27 - W98056 Tawe Medical Centre
28 - W98027 Kingsway Surgery
29 - W98608 The Surgery, High St
D21 - Waterfront Dental Practice
D22 - Townhill Dental Practice
D23 - Russell Street Dental Practice
D25 - Mansel Street Dental Practice
D27 - Neat Teeth Orthodontics
D28 - Parkway Clinic Dental Practice
N17 - April Court
N18 - Glasfryn House
N19 - The Marina Nursing Home Ltd
O12 - Evans Stephen (Mr) Opticians
O13 - Bellamy Huw (Mr) Opticians
O14 - The Optic Shop
O15 - Specsavers Opticians
O16 - Vision Express (UK) Ltd
O17 - Walters C F Opticians
O18 - Boots Opticians Professional Services Ltd
P36 - Boots UK Ltd
P37 - Hafod Pharmacy
P38 - Mayhill Pharmacy
P39 - The Co-operative Pharmacy
P40 - The Co-operative Pharmacy
P41 - The Co-operative Pharmacy
P42 - The Co-operative Pharmacy
P43 - The Co-operative Pharmacy
P44 - The Co-operative Pharmacy
P45 - Port Tennant Road Pharmacy
P46 - Sainsburys Pharmacy
P47 - Superdrug Pharmacy
P48 - Tawe Pharmacy
P49 - Kevin Thomas Chemists
P50 - Ysgol Street Pharmacy
P51 - The Co-operative Pharmacy
P52 - Madam Foner Pharmacy
Cockett 4
Townhill 1
Townhill 2
Townhill 3
Townhill 4
Townhill 5
Townhill 6
Castle 2
Castle 3
Castle 4
Castle 5
Castle 6
Castle 7
Castle 8
Uplands 4
Landore 4
St. Thomas 1
St. Thomas 2
St. Thomas 3
St. Thomas 4

City Cluster 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 City Network area. The summary below highlights the key points and this information has been used to inform the development of priorities for the plan.

- An 8% obesity rate (ABMU average is 9%)
- 25.3% of smokers across the Cluster population
- An influenza vaccination uptake of 64.8% in those 65 years and older (Welsh Government target is 75%)
- An influenza vaccination uptake of 47.9% in those under 65 years in clinical risk groups (Welsh Government target is 75%)
- Below 80% uptake for scheduled childhood immunisations by age 4 (Welsh Government target is 95%)
- An Incidence rate of 195 per 100,000 population for referrals to drug and alcohol treatment services
- Bowel Screening uptake of 44.5% (Target 60%) – Lowest in Swansea
- Cervical Screening uptake of 69.3% (Target 80%) – Lowest in Swansea
- Breast Screening uptake of 65.7% – The only Cluster in Swansea not achieving minimum standard of 70%
  The highest number of A&E attendances of any network in Swansea
- The second highest rate in Swansea of emergency inpatient admissions
- The highest rate of prescription of anxiolytics and hypnotics, antidepressants, opioid analgesics, Tramadol, NSAIDs in Swansea

Condition	Number of patients	Network %	Swansea %
Asthma	3687	7.2	7.1
CHD	1845	3.7	3.6
COPD	1289	2.5	1.8
Diabetes	2913	5.7	5.4
Heart Failure	380	0.9	1.0
Depression (2013)	2536	8.2	8.0
Mental Health (2013)	677	1.3	1.0
Obesity	4451	8.7	8.6
Palliative Care	140	0.3	0.1
Blood Pressure	6650	13.1	13.6
Hypothyroid	1607	3.2	3.4
Stroke TIA	1001	2.0	2.0

QOF Indicator CND 001W supports the GP contractor to undertake a review of local need and the provision of services by the practice and to create a three year Practice Development Plan with priorities for action. The three year Practice Development Plan will inform discussions at GP Cluster meetings.

City Cluster Practice Development Plans - Consistent Themes Identified 2017

Following analysis of the 9 City Practice Developments Plans, the following have been identified as the issues affecting most if not all of the practices:

- **Sustainability**
- Swansea's Local Development Plan indicates that further housing developments will increase the pressure on an already overburdened service. With a rising student population, those practices nearest the new campus could see a significant increase in patient numbers. Capacity issues are a major concern.

- **Locums**
- Practices continue to have difficulty in finding suitable locums. When locums are accessed the cost is proving difficult to cover on a regular basis. It is a 'sellers market'.

- **GP Recruitment/Retirement**
- This continues to be an issue. A number of practices are faced with the imminent retirement of GPs leading to destabilisation. This is likely to impact on the Network as a whole as patients attempt to register with neighbouring practices.

- **Emergency/Unscheduled Care**
- There is a need to change patient perceptions on the urgency of care via education/information.

- **Winter Preparedness**
- Poor uptake of seasonal vaccinations/immunisations.

- **Particular Population Features/Social Factors**
- Mental health / Drug and Alcohol misuse / Deprivation / Unemployment / Housing / Asylum Seekers / Refugees / Speakers of Other Languages / Rising Care Home Population / Increasingly Diverse Network Population

- **Key Health Priorities**
- Mental Health and Counselling / COPD / Cancer / Smoking Cessation / Flu / Obesity / Issues related to social factors

Developing The Plan

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

- Understand local health needs and priorities.
- Develop an agreed Cluster Network Action Plan linked to elements of the individual Practice Development Plans.
- Work with partners to improve the coordination of care and the integration of health and social care.
- Work with local communities and networks to reduce health inequalities.

The Cluster Network Action Plan should be a simple, dynamic document and should cover a three year period

The Cluster Network Action Plan should include: -

- Objectives that can be delivered independently by the network to improve patient care and to ensure the sustainability and modernisation of services.
- Objectives for delivery through partnership working
- Issues for discussion with the Health Board

For each objective there should be specific, measureable actions with a clear timescale for delivery.

Cluster Action Plans should compliment individual Practice Development Plans, tackling issues that cannot be managed at an individual practice level or challenges that can be more effectively and efficiently delivered through collaborative action.
This approach should support greater consistency of service provision and improved quality of care, whilst more effectively managing the impact of increasing demand set against financial and workforce challenges.

The action plan may be grouped according to a number of strategic aims.

The three year Cluster Network Action Plan will have a focus on:

(a) Winter preparedness and emergency planning.

(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 Action Plan produced by the City Cluster Network and we aim to develop it further over the coming years. The Network will also 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:

Three Year Development Plan:

To address specific identified needs for key population groups across the network over 3 years in the following areas: Smokers, Speakers of other languages, Carers, Mental Health, Obesity, Screening Rates.

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1	Meet the needs of the City Network population.	To understand the profile of the City Network and the effect that deprivation has on the practice populations.	Local Public Health Team, Public Health Observatory Health Board	Ongoing	To ensure that services are developed according to local need.	Demographics have been considered during formulation of Cluster Network plan and PDPs. City Network profile has been shared with GP practices for information/comment.	
2	Improve actions to reduce rates of smoking.	**YEAR 1** Signpost smokers to Public Health Level 3 Pharmacy Scheme and support with Public Health materials. Promote "HELP ME QUIT" Campaign. Consider collaboration with ASH smoking cessation charity using CO2 monitors. CO2 levels will be recorded and shared to encourage patients to give up smoking. City Health figures for first three quarters of 2016/17: • An estimated number of **10,800** (25.3%) of smokers • **225** accessed Stop Smoking Wales services • **46** accessed L3 pharmacy service • The cluster has 8 commissioned pharmacies, 4 of which actively delivered • **80** were referred directly from the surgeries to Stop Smoking Wales Services; a 22% drop on	Public Health Wales Community Pharmacy & GP practices ASH NIBD	Ongoing	Reduction of smoking rates within the Network	Pharmacy Steering Group collating source of Level 3 referrals in order to reflect the work that is being undertaken by GP's. 45 pharmacies across ABM have been commissioned to deliver L3 service. City cluster has 8 commissioned pharmacies (the highest number in one cluster), 4 of which actively delivered in 2016/2017**.**	

		the previous year from **102.** These figures highlight the need for urgent action and additional support in these areas to ensure that the 64% of smokers that want to give up are given as much support and advice as possible to achieve this. **YEAR 2** Continue to monitor smoking rates, assess action to date and implement changes. **YEAR 3** Continue to monitor smoking rates, assess action to date and implement changes.					
3	To improve access to mental health support services.	**YEAR 1** To continue to provide CBT/counselling services; agreeing the most cost-effective model. To develop local Mental Health primary care services and information clinics within the City Network and explore new ways of working e.g. Development of Mental Health focussed Noticeboards/Information Provision within the GP Practices. **YEAR 2** Measure effectiveness of services using questionnaires. **YEAR 3** Further develop Mental Health services within the cluster.	SCVS Health Board GP practices	April 17 – March 18	Timely access to mental health services; improving management of depression/anxiety in primary care. Improved access to counselling services for patients who need Tier 0 support either via practice or network level	Agreed to cap referrals to 6 sessions per patient. Exercise underway to look at different model options for future counselling service. Looking to commission from Third Sector provider. SA1 agreed to host. Signposting patients to Tier 0 services Develop service for all practices to receive LMPHS All practices to use counselling guides developed by SCVS as a resource.	
4	Increase uptake of bowel, breast and	**YEAR 1** Continue to raise awareness of bowel and	GP practices Community		Increased cancer detection and	Current screening uptakes of: Bowel Screening 44.5% (Target 60%)	

	cervical screening	cervical screening programme. Advertise via posters and leaflets provided by cervical screening; including GP practices, community pharmacists and local authority buildings. Compare actions of best-performing City practices. Consider funding for administration time to pull notes for cancer screening. **YEAR 2** Review data and impact of changes; agree new actions. **YEAR 3** Review data and impact of changes; agree new actions.	Pharmacies Local Authority NIBD		earlier diagnosis; reduce avoidable deaths.	Cervical Screening 69.3% (Target 80%) Breast Screening 65.7% (Target 70%) Screening resources have been displayed and promoted to encourage patient uptake. SA1 Diabetes Nurse giving a talk at mosque. Can highlight need for screening.	
5	To address rates of overweight and obese patients in the Network	**YEAR 1** To embed the Weight Watchers programme across the Cluster Network To fund further vouchers and continue to encourage patients to lose weight To evaluate the patients that have already accessed the scheme To increase numbers of referrals by reviewing/reducing referral criteria to make service available to other patients who would benefit	GPs Weight Watchers PHW Health Board	Ongoing	Better health for those patients with chronic diseases Improved lifestyle choices leading to a less medicalised model of care	Very few practices are referring patients to Weight Watchers. Need to increase uptake.	

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

Three Year Development Plan

To continue to develop models for self care including working in multi disciplinary teams, over 3 years, through educating and informing patients in relation to appropriate use of services and considering workable solutions related to sustainability across the cluster network.

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1	Ensure that access arrangements are in place that meet the reasonable needs of local patients.	**YEAR 1** To continue to share good practice and learn from 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	Network practices Cluster Lead	Quarterly	Services developed to reflect local need Release more capacity for patient care.	Discuss at future meetings.	
2	To continue to review demand and capacity	**YEAR 1** Consider impact of Local Development Plans related to housing developments. Work with HB to consider impact of retiring GPs and work together to stabilise Network. **YEAR 2** Continue to monitor developments and likely build dates. **YEAR 3** Continue to monitor developments and likely build dates.	Practices GPs HB	Ongoing	Ensuring appropriate access to services.	Concerns flagged to HB via PDPs.	
3	Address Homelessness Service continuation and improvement.	**YEAR 1** Ensure that access to services is suitable. **YEAR 2** **YEAR 3**	Network practices Health Board	Quarterly		Service operating from High St, Central Clinic and Access Points. HHAVGAP supporting.	

4	Accelerate the development of the Network and maximise the potential of working together, through ensuring implementation of Network driven projects and schemes, and developing business of the Network to meet its potential.	**YEAR 1** Work with Network Implementation and Business Development Manager: Revise workplan Agree clear measures Develop catalogue of projects for Spending Plan Identify new funding streams **YEAR 2** Evaluate impact of role **YEAR 3** Take action to continue post, or successful elements thereof, subject to evaluation.	GP practices NIBDM	Ongoing	Cluster schemes to meet strategic priorities delivered in a timely manner. Clear aims and objectives evaluated.	Work plan developed.	
5	Address difficulties in recruiting GPs and shortage of locums.	**YEAR 1** Develop GP Fellowship scheme: • Agree scheme with Cluster • Advertise and recruit Consider ways to educate and upskill members of MDT. **YEAR 2** Review impact of GP Fellowship Scheme in addressing sustainability.	GP practices Cluster Lead Health Board	Aug 17	Sustainable services.	Practices asked to consider recruitment difficulties and shortage of locums; completing Sustainability Matrix. Proposal for GP Fellowship scheme considered at May Board.	
6	Supplement existing nursing provision.	**YEAR 1** Employ dedicated Dressings Nurse. Ensure training and development of role. **YEAR 2** Evaluate effectiveness of role.	GP practices	Apr 17	Enhanced sustainable services.	3 months into post. Training completed.	

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/secondary care interface

Three Year Development Plan

To review progress made on strengthening links with Secondary Care Colleagues over 3 years and identify strengths, gaps, weaknesses and possible training opportunities. Consider effectiveness of advice lines and sharing good practice/links with colleagues. Evaluate dermatology, INR, education programmes and communication mechanisms.

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1	Deliver services effectively and efficiently.	**YEAR 1** Continued use of Pocket Medic. **YEAR 2** Evaluate usage and effectiveness. **YEAR 3**	GP practices	Ongoing	Faster appropriate referrals.	Pocket Medic being used by all practices.	
2	To improve access to dermatology services within the community, therefore reducing the number of patient referrals to hospital.	**YEAR 1** GPs to be up-skilled and receive appropriate training in the use of dermoscopy and its technique. BSM to ensure set up of cameras for each practice. **YEAR 2** Evaluate usage and effectiveness. **YEAR 3**	GP Practices Health Board	Jun 17	Less secondary care referrals. Better service for patients.	Dermoscopy training session arranged for 7th June. NWIS trialling Webcam software for EMIS and Vision.	
3	To ensure that all Network patients have access to new Care Home enhanced service.	**YEAR 1** Network practices are asked to consider and confirm sign up to the service by 31st May 2017. **YEAR 2** **YEAR 3**	Health Board GP Practices	Sep 17	Improved quality of care through pre-emptive medical care, thorough medical assessment, regular medication reviews,	The revised Care Home Directed Enhanced Service now published. 5 practices signed up. 3 practices declined. 1 practice still considering.	

					anticipatory care planning and improved care at end of life planning.		
4	Achieve better health outcomes and safer care through prudent prescribing.	**YEAR 1** PMS Plus - continue to undertake a range of prescribing initiatives to improve respiratory prescribing. **YEAR 2** **YEAR 3**	GP Practices Medicines Management Team Pharmacists	Mar 18 Ongoing	Improvement in patient symptom control.	Network Clinical Pharmacist in place for third year. Medication reviews, polypharmacy reviews, medication queries, new patient medication reviews plus any medication related queries from all staff in primary care have been undertaken by cluster pharmacists and remain ongoing. Pharmacists have given presentations to the Network on areas of work undertaken. Further updates to be provided to the network at future meetings to share evaluation and potential outcomes.	
5	To understand the new Directed Enhanced Service for Oral Anticoagulation with Warfarin and to consider participation as a practice or cluster.	**YEAR 1** Consider INR enhanced service and whether to provide on a cluster basis. **YEAR 2** **YEAR 3**	Health Board GP Practices Secondary Care Medicines Management	May 17	Safer services through not separating roles of monitoring and prescribing – in line with MHRA.	Practices signing up individually. Will then consider provision as a cluster. Clinical Pharmacist to deliver a presentation looking at advantages of cluster based provision.	
6	To develop a shared education agenda through Network PLTS.	**YEAR 1** Subject to discussions on future delivery of PLTS, Network leads continue to secure a range of speakers and form detailed programmes for Practices within the cluster linked to City Health and Health Board priorities.	GP practices Health Board	Ongoing	Staff receive up to date information that can be filtered down to patients.	PLTS discussed at July Board Meeting. Agreed to continue as much as possible with practices arranging cover for colleagues.	

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and top support the continuous development of services to improve patient experience, coordination of care and effectiveness of risk management. To address winter preparedness and emergency planning.

Three Year Development Plan:

The Cluster will address improvements over a three year period. The impact on the numbers of patients vaccinated will be considered. Improved operational links with colleagues in secondary care will be developed. The cluster will continue to develop access to services within community settings as opposed to hospitals.

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1	To reduce the inappropriate use of A&E and GP Out of Ours	**YEAR 1** To improve patient education e.g. display "Choose Well" posters Link in with alternative services e.g. AGPU and ACO. **YEAR 2** **YEAR 3**	GP OOH A&E MIU Health Board Community Voices	Ongoing	Better education on how to access services appropriately to meet their needs	ABMU Communication Team has become involved with surgeries and assist in providing correct information. "Choose Well" campaign progressing in all practices.	
2	Reduce hospital admissions	**YEAR 1** Use of discharge summaries Explore potential for use of e-mail / telephone advice lines with ENT, oncology, etc. Signpost to other community-based options (more amenable to patient). Ensure referrals made, whenever appropriate, to ACO/ACR Take up of the anticipatory care pilot. **YEAR 2** Assess rates of A&E attendance and trends in Cluster. **YEAR 3** Assess rates of A&E attendance and trends in Cluster.	Secondary Care Primary Care Community Care	Ongoing	More appropriate streamlined care	Practices auditing summaries to forward to Network Chair. Medical Director advised that Health Care Inspectorate Wales are launching their national review of discharge summaries, on behalf of the Welsh Audit Office's discharge planning review. They are planning to interview our colleagues in ABMU, as well as other Health Boards. These interviews will involve giving examples of when patients have been or put at risk of harm.	

3	As part of winter preparedness measures: To increase flu vaccinations in the over 65 age group and in 2-3 year olds	**YEAR 1** Lower performing practices to work with PHW Discuss schemes in place/share good practice across practices that increase high uptake and how they manage defaulters. Consider further use of Clinical Pharmacist (or book agency nurse) to deliver Flu vaccinations/Pneumonia Vacs and Shingles Vacs to housebound patients in October 2017. Approach Health Visitor's re delivering vaccinations to 2-3 age group and possible delivery at Nursery schools. **YEAR 2** **YEAR 3**	PHW GP practices Community Pharmacies	Feb 2018	Protect patients at risk and the wider population. Research indicates that if 50% of 2-3 year olds can be vaccinated against flu, this will impact positively on the rest of the population.	PHW assisting practices to improve uptake. Good practice discussed. Key success factors identified as : • GP Immunising • Flexible clinic times • Personal contact to patients PHW sharing data with practices. Best performers sharing approach with colleagues.	
4	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 polypharmacy.	Assessments and regular reviews of the mental and physical health of the residents.	GP Practices Health Board 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.		

Strategic Aim 5: Improving the delivery of: cancer; MMR; and COPD

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1a	Undertake National Pathway work: Cancer	**YEAR 1** 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	March 18	Quality improvements for enhanced care	Area agreed at 23rd May Board Meeting. Baseline data being retrieved for discussion.	
1b	Undertake National Pathway work: COPD	**YEAR 1** 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	March 18	Quality improvements for enhanced care	Area agreed at 25th July Board Meeting. Baseline data being retrieved for discussion. Cluster considering use of HB provided framework.	

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

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1	Undertake Local Pathway work: MMR	**YEAR 1** 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	March 18	Quality improvements for enhanced care	Area agreed at 23rd May Board Meeting. Baseline data being retrieved for discussion.	

Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and Information Governance over 3 years. To include actions arising out of peer review Quality and Outcomes Framework (when undertaken)

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1	To continue to review Significant Event Analysis highlighting themes and trends	SEAs to continue to be reviewed by individual practices on an ongoing basis Incidents where there is a direct correlation to secondary care are being notified to the Health Board Practices to share SEAs at Network meeting to share learning Share Practice Datix analysis	GP Practices GPs Practice Nurses Practice Managers	March 2018	Potential for changes to services based on outcomes of significant events where there has been positive/negative action	All practices have presented SEAs and identified lessons learnt at cluster meetings.	
2	Demonstrating governance within the practice: Completion of the CGPSAT Completion of Information Governance Toolkit QOF Peer Review	Each practice to complete the CGPSAT Each practice to complete Information Governance toolkit and share learning. Undertake peer review of designated inactive QOF – Meeting 3 and Meeting 4 or 5	Practices	March 2017 and ongoing	Assurance that practices have clinical governance procedures in place	All practices have completed CGPSAT	
3	To highlight the downgrading of cancer referrals	Practices to review all cancer referrals that have been downgraded that were subsequently found to be cancer	GP Practices	Ongoing	Improvement to systems to benefit future detection	Ongoing discussions. Issues need to raised with Health Board. New ABMU Cancer Commissioning Board established	
4	Improve Discharge Summaries	To continue to raise awareness of the problems with practices receiving complete, timely discharge summaries	GPs Locality CD Medical Director	Ongoing	Primary Care staff will be better informed of patients condition and treatment e.g. Medication	Issues raised with Health Board colleagues. Further discussions continuing. Some discussions ongoing regarding the roll out of Electronic Discharge summaries.	

Strategic Aim 8: Other Locality issues / Third Sector / Partnership working / Asylum Seekers

No	Objective	Action	Key partners	Completion by:	Outcome for patients	Progress to Date / Current Position	RAG
1	To further develop the Third Sector support project, increasing the use of voluntary sector services by the City Network population	**YEAR 1** Ensure that links are made with voluntary sector organisations supporting the agreed Network priority areas where possible. SCVS to map Third Sector provision against network priorities. SCVS to develop and circulate a training guide, outlining training available within the sector for GP practice staff. Maintain consideration of funding Third Sector support via Network slippage monies. Monitor and evaluate EYST Asylum Seeker Support Worker. Provide opportunities for third sector organisations to attend Protected Learning Time Sessions with GPs and non clinical staff. Ensure that up to date information on voluntary sector services is displayed in GP practices, e.g. information stands, notice boards.	Led by Network practices supported by SCVS NIBD	Ongoing	Improved support and access to services.	Third Sector Grant Scheme piloted. A total of £10,000 has been allocated to the scheme and it was agreed to allocate to Ethnic Youth Support Team, which will fund an Asylum Seeker Support Worker (0.4WTE), working within the Network GP Practices. Cluster exploring further opportunities to access Third Sector provision to deliver on priority areas e.g. Substance Misuse	
2	To obtain patient and carer views on network services and priorities	**YEAR 1** Access a patient/ carer participation group within the network area in line with the Community Voices programme.	SCVS NIBD	Ongoing	Responsive services taking into account service user and	Fourteen individuals registered with the City Patient & Carer Participation group, but attendance has been low. Consideration being given to	

	programme.	Support patient engagement activities as considered appropriate by the Cluster, e.g. patient questionnaire. **YEAR 2** Continue to develop Cluster services based on patient and carer reports.			carer feedback.	combining with another group.	
3	Address issues of social isolation and seek opportunities for non-medicalised intervention and support in the community.	ABMU to develop and work with Local Area Coordinator's (LACs) to provide clear eligibility criteria for referring patients. Practices to actively refer patients where suitable. ABMU to assist in promotion of LAC project to practices. Evaluate success of LACs	Health Board LAC Network practices	Ongoing	Improved support	LACs now working in City practices and making links. LAC's have post codes of each area to pass on to GP's/Practice managers in area. Provides guide of '*can person seen be referred to LAC and if so which one*'.	