Three Year Cluster Network Action Plan 2017-2020

Llwchwr Cluster Network

Welcome to the Llwchwr Cluster Network Three Year Cluster Plan, 2017-2020

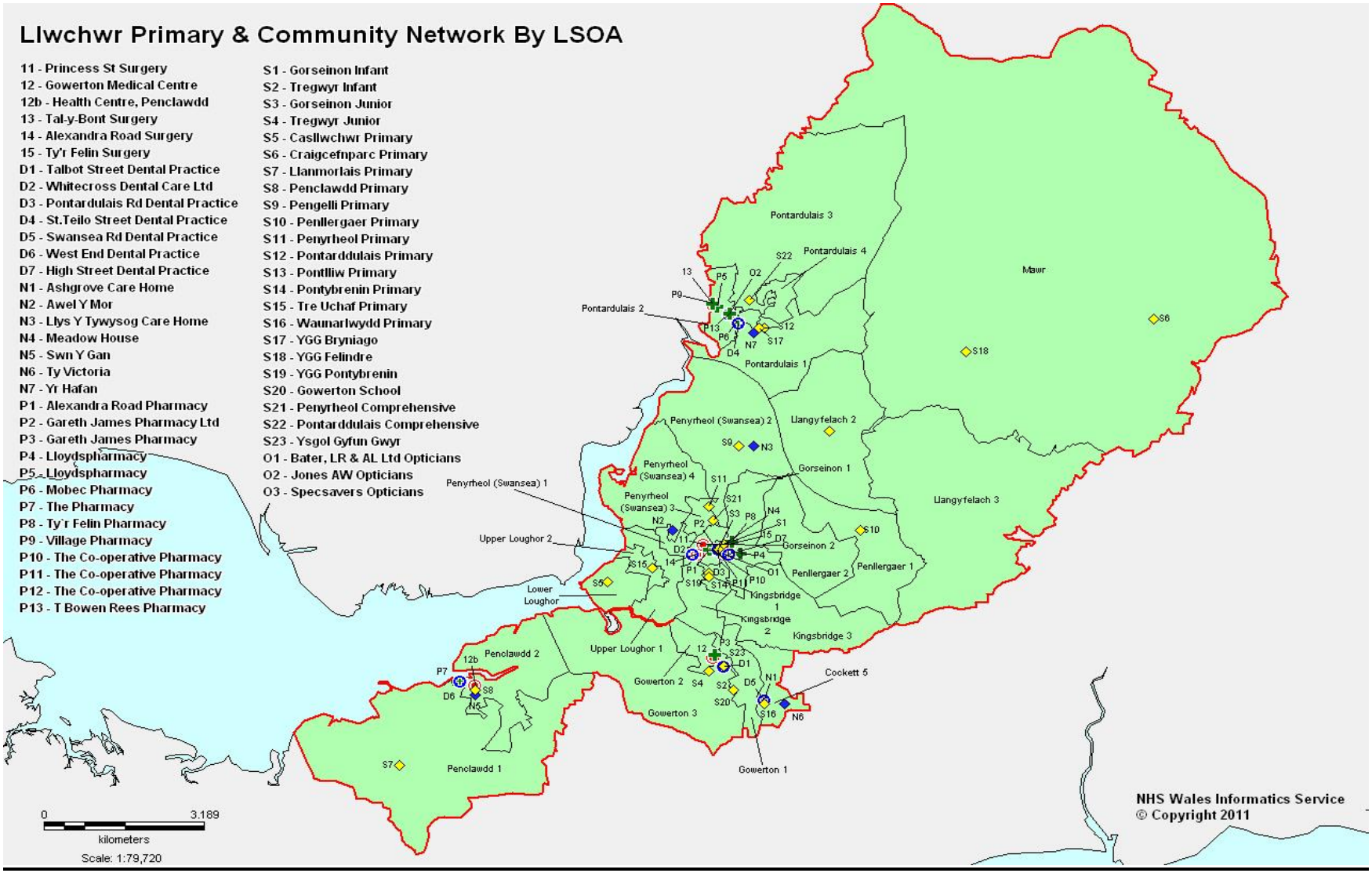
The Llwchwr Cluster Network is one of five community network areas in the City and County of Swansea, covering the Llwchwr geographical area of the of the City incorporating Pontardulais, Gorseinon, Gowerton and Penclawdd areas

The Llwchwr Cluster Network is made up of 5 general practices working in partnership with partners from Social Services, the voluntary sector , Public Health Wales , Pharmacies, Dentists, Optometrists and ABMU Health Board with a Cluster Network population of 47,900.

The Cluster Network has 7 dental practices, 11 pharmacies, and 6 nursing homes

Cluster Networks 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 ordinate 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.


Llwchwr Primary & Community Network By LSOA
11 - Princess St Surgery
12 - Gowerton Medical Centre
12b - Health Centre, Penclawdd
13 - Tal-y-Bont Surgery
14 - Alexandra Road Surgery
15 - Ty'r Felin Surgery
D1 - Talbot Street Dental Practice
D2 - Whitecross Dental Care Ltd
D3 - Pontardulais Rd Dental Practice
D4 - St.Teilo Street Dental Practice
D5 - Swansea Rd Dental Practice
D6 - West End Dental Practice
D7 - High Street Dental Practice
N1 - Ashgrove Care Home
N2 - Awel Y Mor
N3 - Llys Y Tywysog Care Home
N4 - Meadow House
N5 - Swn Y Gan
N6 - Ty Victoria
N7 - Yr Hafan
P1 - Alexandra Road Pharmacy
P2 - Gareth James Pharmacy Ltd
P3 - Gareth James Pharmacy
P4 - Lloydspharmacy
P5 - Lloydspharmacy
P6 - Mobec Pharmacy
P7 - The Pharmacy
P8 - Ty'r Felin Pharmacy
P9 - Village Pharmacy
P10 - The Co-operative Pharmacy
P11 - The Co-operative Pharmacy
P12 - The Co-operative Pharmacy
P13 - T Bowen Rees Pharmacy
S1 - Gorseinon Infant
S2 - Tregwyr Infant
S3 - Gorseinon Junior
S4 - Tregwyr Junior
S5 - Casllwchwr Primary
S6 - Craigcefnparc Primary
S7 - Llanmorlais Primary
S8 - Penclawdd Primary
S9 - Pengelli Primary
S10 - Penllergaer Primary
S11 - Penyrheol Primary
S12 - Pontarddulais Primary
S13 - Pontlliw Primary
S14 - Pontybrenin Primary
S15 - Tre Uchaf Primary
S16 - Waunarlwydd Primary
S17 - YGG Bryniago
S18 - YGG Felindre
S19 - YGG Pontybrenin
S20 - Gowerton School
S21 - Penyrheol Comprehensive
S22 - Pontarddulais Comprehensive
S23 - Ysgol Gyfun Gwyr
O1 - Bater, LR & AL Ltd Opticians
O2 - Jones AW Opticians
O3 - Specsavers Opticians
Pontardulais 3
Pontardulais 4
Mawr
Pontardulais 2
Pontardulais 1
Penyrheol (Swansea) 2
Llangyfelach 2
Penyrheol (Swansea) 4
Penyrheol (Swansea) 1
Gorseinon 1
Penyrheol (Swansea) 3
Llangyfelach 3
Upper Loughor 2
Gorseinon 2
Penllergaer 2
Penllergaer 1
Lower Loughor
Kingsbridge 1
Kingsbridge 2
Kingsbridge 3
Upper Loughor 1
Penclawdd 2
Gowerton 2
Cockett 5
Gowerton 3
Penclawdd 1
Gowerton 1
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kilometers
Scale: 1:79,720
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Llwchwr 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 Llwchwr area.

The health needs information has been taken into account when developing priorities for this plan

The summary below highlights the key points. The health needs information has been taken into account when developing the priorities for this plan.

Llwchwr Network has:

- 7 Dental Practices
- 11 Pharmacies
- 6 Nursing Homes
- High numbers of Elderly population
- High numbers of Asthma patients
- High numbers of Care Home patients
- Low student population
- Low ethnic minority patient numbers
- Low asylum seekers numbers
- The smallest percentage of patients in the ‘most deprived’ category of all Swansea networks
- The highest percentage of patients living in areas classified as rural

- The second highest percentage of patients on GP Practice CHD or CHD related chronic conditions register amongst Swansea networks.
- The second lowest rate of people who smoke in Swansea networks and is significantly lower than the health board average.

  There is a significant overlap of registered patients who live in adjacent geographical areas of Carmarthen

Disease Register:

2017 Disease Register Totals					
	Area	**Cancer**	**COPD**	**Dementia**	**Mental Health**
Health Board	**ABMU**	15,040	12,212	3,925	5,955
Local Authority Area	**Swansea**	6,620	4,886	1,734	2,704
Cluster Network	**Llwchwr**	1,404	844	352	429

- The estimated number of smokers is **9,940 = 18.1%** of the cluster population
- Influenza vaccination uptake in those 65 years and older, is 61%, against the Welsh Government target of 75%. And has dropped from 63% in the previous season

- Influenza vaccination uptake in those under 65 years in clinical risk groups is 39.6% a decrease from 43% in 2015/16 against the Welsh Government target of 75%

- Llwchwr is **the 2nd highest** cluster for influenza vaccine uptake in children aged 2 and 3 years increasing from 45.9% in 2015/16 to 50.9% this season

- Llwchwr is **ranked 1st** for scheduled childhood immunisations by 4 years at 92.2% against the Welsh Government target of 95%

- Uptake of MMR 1 by 2 years of age is **96.7% exceeding the Welsh Government target** of 95%

- Uptake for 2 doses of MMR by 4 years of age is 94.1% against the Welsh Government target of 95% **and ranked 3rd.** Penybryn Surgery and Talybont have uptake above 95%

Developing the Cluster Network Development 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 (CGPSAT) and inactive QOF indicator peer review.

This is the fourth cluster network development plan that has been produced by the network and it is the aim to further develop it 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

The Cluster aims to deliver this over 3 years by focusing on obesity levels, working with physiotherapists; smoking levels and to address the lack of counselling services for children and young people

No	Objective	Action	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
1	To improve access to mental health support services, for the patients of Llwchwr cluster	To provide Counselling sessions for those patients identified as having low level Mental Health issues To use questionnaires to ascertain the views of the patients accessing the service	GPs Practice Managers Health Board SCVS Third Sector Organisations	April 17 – March 18	Will improve access to CBT for Llwchwr population as current waiting list is >1 year Will improve the quality of management of depression in primary care	Further funding agreed by the Network to support the provision. Awaiting outcome of Health Board Options exercise to agree the way forward. Patients are limited to 6 sessions per 12 month period	
2	To improve access to mental health support services, specifically counselling through CBT, for the patients of Llwchwr cluster aged up to 18	**Year 1** To fund a Third sector organisation to provide counselling sessions for Children under the age of 18 **Year 2** To evaluate the scheme and the outcomes of those patients that have accessed the service with a view to further fund the project **Year 3** Continue to fund the project	GPs SCVS Third Sector	Commenced March 2017. Funding currently until Dec 2018	Better access for counselling for young people. Evaluation to be undertaken by the Organisation	Organisations identified and sessions underway. Quarterly monitoring to be received by SCVS. To date 25 Children have been seen by the counsellor	

3	To address rates of overweight and obese patients in the network	**Year 1** To embed the Weight Watchers/Positive Steps 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 **Year 2** To continue to evaluate the patients receiving the vouchers and highlight the benefits and link in with other agencies to promote healthy eating and exercise **Year 3** To further evaluate the patients that have already accessed the scheme and o fund further vouchers and continue to encourage patients to lose weight	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	Practices are referring patients to Weight Watchers and patients showing weight loss. Project progressing well. Further vouchers bought Continued funding from the Network. Large numbers of patients have been referred. To date 120 referrals made by the Cluster to WW.	
4	Improve Multi disciplinary Team working across the Cluster Network	Employ Pharmacist, to work across all practices. Advertise for a Network Pharmacist	GP Practices / Health Board / Secondary Care	August 17 and ongoing	Efficient care and service delivery to patients	Health Board approval for a permanent Pharmacist received. Advert agreed and published	

		Agree a programme of work for the Pharmacist	Cluster Pharmacist			soon	
5	Encourage self care in the community in relation to specific health needs, and for those experiencing social isolation	ABMU to work with LACs to provide clear eligibility criteria for referring patients Practices to actively refer patients where suitable: To improve the numbers of referrals to LACs Currently 2 LACs appointed to cover areas within the Network with another expected to be appointed in the coming months Local Area Co-ordinator continues to attend cluster meetings and Patient Carer Forums	Local Area Coordinators Practices Health Board	Ongoing	Improved support and signposting for residents within parts of the Network	Local Area Co-ordinator is attending Network meetings and has made links with all the practices in the Network and identified and helped patients. Further LAC appointed for the Pontardulais area with another appointment planned for later in the year. Working with LACs to agree Community projects that could be funded by the Network in future In 24 months in Gorseinon/Loughor 48 introductions from surgeries, out of a total of 198, so 24%. Over this past 12 months 28 introductions out of a total of 89 so 31% (which is higher than any other sector). In Pontardulais in this past 12 months 25% of introductions have come from surgeries.	
6	Improve access to muskulo-skeletal/physio provision across the network	**Year 1** Evaluate the outcomes of the current Physiotherapy provision and look to roll out to other practices	GP Practices Physios	Commence July 2017	Improved and quicker access for patients requiring physiotherapy	Each practice has a funding allocation to proceed with the Physiotherapy service	

		Year 2 Collect data and prepare a business case for the future if appropriate **Year 3** If successful continue to build on the provision					
7	To further develop the third sector support project increasing the use of voluntary sector services by the Llwchwr Network population	Provide opportunities for third sector organisations to attend Protected Learning Time Sessions with GPs and non clinical staff Develop and circulate a training guide, outlining what provision is available within the third sector that GP Practice staff can access. 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. 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 Led by Network practices supported by SCVS Led by Network practices supported by SCVS Led by Network practices supported by SCVS Led by Network	Ongoing Ongoing Ongoing Ongoing Ongoing	Improved support and access to services for the Llwchwr Network population	SCVS are supporting the implementation of the Grant scheme for the provision of counselling services for Children, Young People	

			practices supported by SCVS				
8	To further improve actions to reduce reported rates of smoking uptake in the network	Improve recording /updating of patient smoking status To promote access to level 3 prescribing service offered by local pharmacies and Stop Smoking Wales or establish an in house stop smoking service.	GP Practices PH Wales GP Practices PH Wales	Ongoing Ongoing	A reduction in the number of patients smoking.	Further work with Public Health colleagues to identify gaps and improve the service. Work with PHW in producing advertising and promotional material	
9	Increase flu immunisation uptake specifically targeting the immunisation of children	To continue to raise awareness of the flu immunisation programme and build on previous success. To evaluate rates of figures To link in with Public Health screening officers	PHW Network Practices Community Pharmacies	Mar 2018	Protect patients at risk and the wider population.	Good practice discussed and key areas for progression identified. Public Health colleagues attended Network meeting to promote flu jabs.	
10	To increase cervical screening uptake	To continue to raise awareness of cervical screening programme and build on previous success. To evaluate figures Advertising via posters & leaflets provided by cervical screening including GP practices, community pharmacists and local authority buildings To link in with Public Health screening officers	GP practices Community Pharmacists Local Authority Cervical Screening Wales	March 2018	Early detection of health risks	Uptake figures to be analysed when end of year numbers become available	

11	To improve access to mental health services	To increase mental health nursing input To provide in house counselling services To further develop the SCVS Mental Health clinic within the Llwchwr Network and explore new ways of working e.g. Development of Mental Health focussed Notice boards/Information Provision within the GP Practices To review and be aware of referral mechanisms to CAMHS	SCVS Health Board GP practices LAC	Ongoing	Improved, timely access to mental health services Improved access to counselling services for patients who need Tier 0 support either via practice or network level	Link in to Mental Health officer in SCVS Signposting patients to Tier 0 services Further discussion to be undertaking at Networks to progress further CAHMS presentation given at Patient Carer Forum	

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 over a 3 year period by ensuring practices are aware of the scale of increase in future demand for their services; utilising PLTS sessions: identifying an appropriate MDT by employing a Cluster Pharmacist and ensure that they are fully utilised; develop protocols for practices to see patients from other practices. Ensure the workforce is trained and receives upskilling. To work closely with Patient Care Forum.

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
12	Understand network status for current demand for appointments and clinical capacity	Continue review of current appointment demand and clinical capacity Identify any potential streamlining systems and processes including the use of any toolkits/software available Follow up on work carried out with the Primary Care Foundation to assess access and demand	Practice Primary and Community Unit	Ongoing	Services developed to reflect local need in line with capacity to deliver safe and effective services	Number of practices transitioned to telephone triage in whole or part to help deal with patient demand. Generally this has been positively received by patients, but the practices continue to review. Practices exploring alternative employment options to support GPs, eg Nurse Practitioners, Pharmacists, and/or Paramedics	

	Ensure succession planning of practice and community staff	Review workforce demographics within practices and within community – particular emphasis on GPs and PNs Practices not currently implementing "Telephone consultation systems" will visit those that are to learn and to train staff Review the communication processes between GP practices and community nursing team				Improved communication set up for community hub and patients now redirected to contact hub direct. Currently working towards a single point of contact	
13	Ensure that access arrangements are in place that meets the reasonable needs of local patients.	Continue to review access arrangements.		Quarterly	Services developed to reflect local need Release more capacity for patient care.	Discuss at future meetings.	
14	Ensure appropriate use of cluster pharmacist where available	**Year 1** Appoint Cluster Pharmacist and work with them to identify the issues within Llwchwr	Practice teams Medicines Management team	Ongoing (dependant on funding)	Improved medicines management and access	Currently no Pharmacist in place but agreement made and advert to go out imminently	

		Year 2 Agree work plan and priorities of the pharmacist **Year 3** Continue to build on successful areas and focus on current priorities					
15	To address difficulties in recruiting partners and the shortage of locums	Address the pressure facing general practice:	GP practices ABMU HB	Ongoing	More sustainable services	Government/central interventions needed to incentivise interest in general practice	
16	To consider the potential for the network and its practices to deliver INR provision	To understand the new Directed Enhanced Service for Oral Anticoagulation with Warfarin and to consider participation as a practice or cluster. Consider INR enhanced service and whether to provide on a cluster basis.	Health Board GP Practices Secondary Care Medicines Management	July 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.	
17	To obtain patient and carer views on network services and priorities	**Year 1** To continue to work with the patient/carer group developed through Community Voices	SCVS	Ongoing 17/18	Responsive services taking into account service user and carer feedback.	Regular meetings taking place between representatives of the Network and patients. Good attendance at these meetings. Network	

		To consider areas of work that the Community Voices group can support practices in sharing appropriate messages e.g. waste management **Year 2** To support and fund the independent Patient Carer Group and obtain views from members that will feed into Network plans and projects **Year 3** To build on the success of the group				agreed to fund the Patient Carer Forum for 17/18	

18	To review workforce pressures and develop local workforce development plans	To consider succession planning arrangements at practices to be better prepared for leavers Increase peer support Consider use of network monies to develop a GP resource for practices to access. Consider developing skill mix across the network to deal with patient demand and GP pressures	Practice ABMU HB	Ongoing	Seamless service provision for patients	As above – and exploration of alternative methods of working with other key professionals, eg Nurse Practitioners, Pharmacists, Paramedics, etc.	
19	Take appropriate actions to address concerns in relation to population increase specifically resulting from housing developments in the area	Assess potential list size increase with growth of further housing developments	Primary and community services delivery unit Local Authority Planning Department	Ongoing	Avoid difficulties in accessing GP appointments due to higher demand	Discussions are still ongoing between relevant partners	

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 achieve this over 3 years by identifying and taking account of patients wishes; focusing on increasing services in the community such as dietetics; medication reviews and increasing access to nursing services.

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
20	To ensure that the needs of patients and carers are reflected in the work of the networks	To continue implementation of the patient and carer participation group as part of the Community Voice Programme To undertake Carers training through PLTS	GP Practices Community Nursing Social Services Third sector Patient and Carer Participation Groups	Established and ongoing	Patients better informed of priories within the Network	Patient Carer Forum is well attended and a varied agenda takes place	
21	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 . To continue to develop valuable links with Secondary Care Colleagues through PLTS sessions and	GP Practices / Health Board / Secondary Care	March 2018	To ensure patient's 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 October 2017.	

		usage of GP Portal. To investigate pilot models being adopted by other Clusters related to advice lines for gastroenterology and to implement in year 2. To implement services where appropriate into network in year 2. Evaluate implementation in year 3 in conjunction with other clusters and secondary care partners					
22	To engage in the Prescribing Management Scheme (PMS) and PMS+ respiratory schemes (which contain polypharmacy elements)	Undertake a range of prescribing initiatives to improve: respiratory, antibiotic, pain management prescribing and yellow card reporting	GPs Practice Nurses Medicines Management team	PMS 17/18 by Jan 18 PMS+respiratory –	Improved medicines management including polypharmacy Investment in other service areas for patient benefit	Discussed at all annual practice prescribing visits Practices engaged and making progress Medicines management team supporting where possible	
23	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.	

24	Reduce unnecessary use of antibiotics within primary care	Undertake CRP testing in cluster practices	GPs Practice nurses NMPs Medicine Management team Big Fight team WEQAS	Ongoing	Fast test result Help to optimise treatment Convenient for the patient Improved patient experience Potential reduction in antimicrobial prescribing Potential reduction in re-attendance of patients Greater patient involvement in their own care	Analysis of first 3 months of CRP data to be undertaken Review of first three months (Jan-Mar 2017) complete, ready to discuss with individual practices 4 out 5 practices providing service	
25	To prolong independence of older people through identifying those people most at risk of losing independence and developing anticipatory care plans.	To continue with active involvement in the anticipatory care programme To participate in a full evaluation when the programme rolls out to all clusters Assist in making it core business Identifying those most vulnerable of losing their independence Identify care coordinator and care	GP Practices, Health Board, Community Hubs, Mental Health	March 2016 and ongoing	Early identification of those patients most vulnerable of losing their independence. Care coordinator and care plan systems will assist those patients most at risk.	Llwchwr cluster has acted as an early adopter. . Practices have continued their involvement in the anticipatory care programme establishing systems to:	

		plan systems					
26	Deliver services effectively and efficiently, promoting self care and improving	To purchase medic within the practices and arrange training for staff.	GP practices	Ongoing	Faster appropriate referrals.	Pocket Medic being used by all practices. #s of prescriptions recorded and increasing	
27	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.	Assessments and regular reviews of the mental and physical health of the residents	GP Practices Health Board Cluster Pharmacist GP OOHs	Sep 17 and 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	The revised Care Home Directed Enhanced Service has now been published. Practices within the cluster have been asked to consider and confirm sign up	

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 by reducing waste in the ordering of drugs; improve the uptake of vaccinations and immunisations for those at risk; to reduce inappropriate visits and reduce prescribing or antibiotics and promoting public health campaigns.

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
28	To reduce the inappropriate use of A&E and GP Out of Ours	To improve patient education e.g. display posters Link in with alternative services e.g. Acute Clinical Response Team Decrease the number of unscheduled care attendances Signpost patients to ensure attendances are appropriate including e.g. ”choose well’’ posters in practices To improve	GP OOH A&E MIU HB Community Voices	Ongoing	Better education on how to access services appropriately to meet their needs	Anticipatory Care Project rolled out in Llwchwr. Newly appointed Anticipatory Care manager to visit GP practices to discuss the project moving forward Potential funding agreed for the production of new posters advising patients where and when to attend health premises. This will be done in conjunction with the Llwchwr Patient and Participation Group	

		patient knowledge of 'over the counter drugs' To look into the possibility of running campaigns on the radio e.g Flu					
29	Better facilities for patients being discharged from hospital	To investigate the potential of obtaining Step down beds at Gorseinon hospital to enable patients can be discharged from hospital whilst their homes are being adapted	Secondary Care GP Practices Health Board Community Staff	July 2017 and ongoing	Allow patients medically fit to be discharged from hospital	To be discussed at October Network Meeting	
30	To continue to improve antimicrobial stewardship	To improve antimicrobial stewardship To utilise CRP testing during the winter months	Medicines management team	Ongoing Quarterly Monitoring of trends	Reduced resistance Reduced C.Diff Increased knowledge and empowerment to self care	Discussed at all annual practice prescribing visits. Cluster level data to has been shared at Network meeting	
31	Provide support for carers of patients diagnosed with Dementia	**Year 1** Work with newly appointed Admiral Nurses in providing support to carers of complex needs dementia patients Continue to link	GP Practices Admiral Nurses	Commenced July 17		2 new Admiral nurses appointed and attended July Cluster Network meeting	

		with Dementia Champions in the Cluster **Year 2** Link in with Carers Centre and build on the links created with the Nurses **Year 3** Continue to build on the work and provide support for carers of complex needs patients					
32	To educate patients in identifying the most appropriate place to receive treatment and how to manage self care.	To improve antimicrobial stewardship To promote self care education through use of resources such as the Choose Well campaign, newsletters, notice boards, social media and create a Llwchwr Facebook page	GP Practices	Ongoing	Better educated to understand how to self care and identify the most appropriate place to access services and receive treatment.	Further advertising of the Choose Well Campaign Launch of the 111 project	
33	To support the Big Fight campaign and	CRP equipment purchased and testing is being	GP Practices Pharmacists	Sept 2016 and ongoing	Improve patient experience	CRP equipment purchased, training undertaken and Med	

	improve patient experience	undertaken within the practices			and faster test results	Mgt team undertaking a review and evaluation of the project	

Strategic Aim 5: Improving the delivery of Dementia and COPD,

Three Year Development Plan:

The Cluster will address improving the delivery of National Pathway Priorities. The Cluster will reflect on lessons learnt and test changes for improved systems through quality improvement methodology

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
34	To participate in a clinical priority pathway focusing on COPD	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 and agreed	
34(a)	To participate in a clinical	To engage with the priority work	GP Practices / Health	31 March 2018	To deliver quality improvement to	Priority area to be further	

	priority pathway focusing on Dementia	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	Board		enhance care	discussed and agreed	

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

<u>Three Year Plan</u>:

The Cluster will address improving the delivery of locally agreed Pathway Priorities. The Cluster will reflect on lessons learnt and test changes for improved systems through quality improvement methodology.

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
35	To participate in a clinical priority pathway focusing on Cancer	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 '*Earlier diagnosis will lead to improved survival rates in many cancers. Treatment options and chances of a full recovery are greater'* (GMS Contract 2017/18)	Priority area to be further discussed and agreed	

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

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
36	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 will have presented SEAs and identified lessons learnt at cluster meetings.	
37	To demonstrate governance within the practice through completion of the CGPSAT and Information Governance Self Assessment	All practices within the cluster to update and submit the CGPSAT and IG Toolkit by 31st March 2018.	GP Practices Health Board	March 2018 and ongoing September 2017	Assurance that practices have clinical governance procedures in place To ensure systems of clinical	Health Board has agreed to share cluster results following CGPSAT submission dated March 2017 To be discussed at	

	Toolkit	To participate in training facilitated by the Health Board on each of the toolkits. To utilise the toolkits to share learning and outcomes at cluster meetings	GP Practices / Health Board		governance are adhered to. To improve systems of clinical governance	future meetings	
38	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 be raised with Health Board. New ABMU Cancer Commissioning Board established	
39	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

No	Objective	Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
40	Improve links with non-medicalised services to improve patient outcomes and reduce demand on services	Access to Citizens Advice Bureau within General Practice CAB to provide an advice service resource in the GP practices within Llwchwr The pilot will also be fully evaluated following the end of the pilot	CAB GP Practices SCVS	Funding until July 2017 Full evaluation will then be undertaken	Better support for patients with welfare /social problems that need dedicated support and guidance.	Funding has been given to C.A.B to start a pilot and they will be present in a Llwchwr surgery for 1 ½ day each week to provide information and support to patients. This to be evaluated	
41	Assess potential list size increase with growth of further housing developments	**Year 1** To engage with the Local Authority over the impact new houses being built in Llwchwr will have on Primary Care services. **Year 2** Monitor the impact on the new developments on the practices **Year 3** To further monitor the impact on GP practices	Health Board PMs Local Authority	Ongoing		LA LDP currently out for consultation. Meetings have taken place. Practices affected by the developments have written to the LA outlining their concerns.	
42	Improving patient	Ensure cohesive	Social Services	Ongoing	Integrated	All key partners	

	care within Llwchwr by working with key partner agencies	working relationships with the Locality, ED colleagues, secondary care, Local Authority, Pharmacy, third sector and to improve patient care within Llwchwr	Community Nursing Third sector Primary Care Domiciliary care Independent care providers		service provision providing seamless care for patients	attending Network meetings	
43	Ensure that the working arrangements of central hubs for community nursing do not have a detrimental effect on working relationships	Participate in discussions to ensure that a safe and effective service model is developed and communication with GP Practices is transparent. Encourage the development of a phlebotomy service for domiciliary patients	GPs Health Board Local Authority	Ongoing	Improved access to services for patients with chronic conditions	Hubs established and two way communication being facilitated through community network meetings, and further links in place. Problems have been identified and fed back to Hubs and Health Board District nursing function to be coordinated via the Intake Team. This has ensured better two way communication going forward.	