Three Year Cluster Network Action Plan 2017-2020

Penderi Cluster

:

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

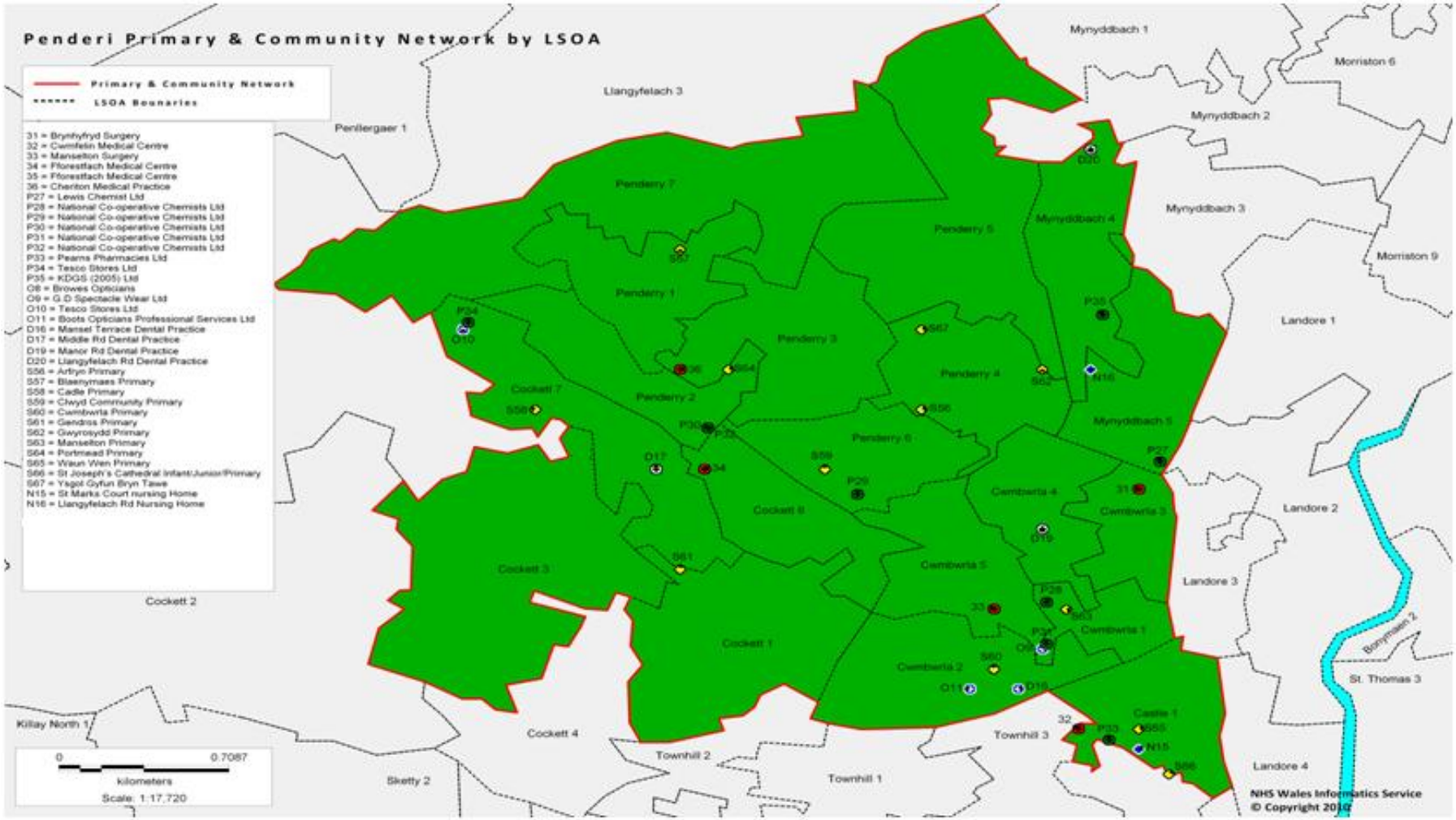
The Penderi Cluster Network is one of five community network areas in the City and County of Swansea, covering the Penderi geographical area on the eastside of the City incorporating Fforestfach, Manselton, Brynhyfryd, Gendros and Cwmbwrla

The Penderi Cluster Network is made up of 6 general practices working in partnership with partners from Social Services, the voluntary sector , Public Health Wales , Pharmacies, Dentists, Optometrists and ABMU Health Board with practice populations ranging from 2,146 to 8,247 amounting to a cluster network total of 37,984.

The Cluster Network has 4 dental practices, 8 pharmacies, 5 Opticians, 1 nursing home and 20 schools

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.


Penderi Primary & Community Network by LSOA
Primary & Community Network
LSOA Boundaries
31 = Brynhyfryd Surgery
32 = Cwmfelin Medical Centre
33 = Manselton Surgery
34 = Fforestfach Medical Centre
35 = Fforestfach Medical Centre
36 = Cheriton Medical Practice
P27 = Lewis Chemist Ltd
P28 = National Co-operative Chemists Ltd
P29 = National Co-operative Chemists Ltd
P30 = National Co-operative Chemists Ltd
P31 = National Co-operative Chemists Ltd
P32 = National Co-operative Chemists Ltd
P33 = Pearns Pharmacies Ltd
P34 = Tesco Stores Ltd
P35 = KDGS (2005) Ltd
O8 = Browes Opticians
O9 = G.D Spectacle Wear Ltd
O10 = Tesco Stores Ltd
O11 = Boots Opticians Professional Services Ltd
D16 = Mansel Terrace Dental Practice
D17 = Middle Rd Dental Practice
D19 = Manor Rd Dental Practice
D20 = Llangyfelach Rd Dental Practice
S56 = Arfryn Primary
S57 = Blaenymaes Primary
S58 = Cadle Primary
S59 = Clwyd Community Primary
S60 = Cwmbwrla Primary
S61 = Gendros Primary
S62 = Gwyrosydd Primary
S63 = Manselton Primary
S64 = Portmead Primary
S65 = Waun Wen Primary
S66 = St Joseph's Cathedral Infant/Junior/Primary
S67 = Ysgol Gyfun Bryn Tawe
N15 = St Marks Court nursing Home
N16 = Llangyfelach Rd Nursing Home
Mynyddbach 1
Morriston 6
Llangyfelach 3
Mynyddbach 2
Penllergaer 1
Penderry 7
Penderry 5
Mynyddbach 4
Mynyddbach 3
Morriston 9
Penderry 1
Penderry 3
Penderry 4
Landore 1
Cockett 7
Penderry 2
Penderry 6
Mynyddbach 5
Cockett 6
Cwmbwrla 4
Cwmbwrla 3
Landore 2
Cockett 3
Cwmbwrla 5
Landore 3
Cockett 5
Cwmbwrla 1
Cockett 1
Cwmbwrla 2
St. Thomas 3
Killay North 1
Castle 1
Cockett 4
Townhill 2
Townhill 3
Landore 4
Sketty 2
Townhill 1
0
0.7087
kilometers
Scale: 1:17,720
NHS Wales Informatics Service
© Copyright 2010

Penderi Local Health, Social Care and Wellbeing Needs and Priorities

In order to support the development of the cluster network plan, information has been collated on a wide range of health needs within the Penderi area.

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

The summary below highlights the key characteristics of the Penderi Cluster Network:-

- There are 37,984 individuals registered to practices belonging to the Penderi Cluster Network
- Overall the network shows increasing list sizes with an overall increase of 194 patients across the network compared to last year. (Manselton and Cheriton practices have shown a reduction in list sizes)
- Nearly 50% of patients registered to practices in the Penderi Network are living in the 20% most deprived areas (according to the Welsh Index of Multiple Deprivation (2014 revised) as at 15th January 2017.
- There is a large population of children and Young people. High proportion of families with children of Primary School age
- With regard to the ageing population 17.5% of patients are aged 65+ and 8.0% of patients are 75+. (The average life expectancy in Swansea is 77.8 for males and 81.7 for females)

Penderi Cluster				**% Male/Female Aged 65+ and 75+**	
Age Band	**Female**	**Male**	**Persons**	**% Female**	**% Male**
Aged 65+	**3,471**	**3,303**	**6,774**	**51%**	**49%**
Aged 75+	***1,651***	**1,450**	**3,101**	**53%**	**47%**

- A large number of patients are unemployed and/or single parents/patients on benefits
- Increasingly diverse population. Large numbers of ‘speakers of other languages’ in the network catchment area necessitating an increase in the use of language line. (Includes Asylum Seekers and Syrian Refugees)
- High levels of substance misuse
- High numbers of patients with mental health issues

- High service need for patients living in a care home that specialises in patients with mental health problems and previous drug abuse issues
- Two Women's Aid refuges within the network (safe houses for victims of domestic abuse)- Vulnerable individuals with complex health and mental health needs
- Penderi has high rates of Emergency Department attendance. In 2016, 11,724 patients attended A&E. (Crude referral rate: 310 per 1,000)
- Penderi is the second highest network for COPD emergency admissions in Swansea. In 2016, 114 patients were admitted. (Crude referral rate: 3 per 1,000)

The population of Penderi exhibits a wide range of health and well being issues:

- The network has high levels of patients who smoke. The estimated number of smokers in the network is 7,420 (24.7% of the cluster population)
- The average number of lung cancer cases per annum is 32 (Crude rate per 100,000 population is 86.6%). This is the highest rate out of the five clusters in Swansea. '*Lung cancer incidence is higher in the most deprived areas of all ABM's clusters with varying deprivation gaps'* (CGP Cluster Lung Cancer Profile ABMU HB September 2015)
- Influenza vaccination uptake in those 65 years and older is 61.5% against the Welsh Government target of 55%
- Influenza vaccination uptake in those under 65 years in clinical risk groups is 43% against the Welsh Government target of 75%
- Influenza vaccine uptake in children aged 2 and 3 is 30.3%
- Uptake for scheduled childhood immunisations by 4 years is 84.5% against the Welsh Government target of 95%
- Uptake on bowel screening 47.4%. (Target 60%)
- Uptake on cervical screening 75.3%. (Target 80%)
- Uptake on AAA screening 75.9%. (Target 80%)
- Uptake on Breast Screening 71.3%. (Target 70%)

Penderi Cluster Network Disease Registers 2017

	Penderi Total	Penderi %	Swansea Total	Swansea %	ABMU Total	ABMU %
Hypertension	5264	13.9%	34593	13.5%	84010	15.3%
Cancer	871	2.3%	6620	2.6%	15040	2.7%
Chronic Obstructive Pulmonary Disease	921	2.4%	4886	1.9%	12212	2.2%
Dementia	202	0.5%	1734	0.7%	3925	0.7%
Diabetes	2373	6.2%	14181	5.6%	33851	6.1%
Mental Health	405	1.1%	2704	1.1%	5955	1.1%
Obesity	3790	10.0%	21608	8.5%	54284	9.9%
Rheumatoid Arthritis	221	0.6%	1425	0.6%	3596	0.7%

Penderi Practice Development Plans- Consistent Themes identified 2017

As a result of the analysis of the 6 Practice Development Plans within Penderi. The following have been identified as issues affecting most if not all of the practices. These issues will be addressed within the Cluster Development Plan:

- **Sustainability**-Swansea's Local Development Plan indicates that further housing developments will increase the pressure on an already overburdened service. Some areas in Penderi 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
- **Access/Appointment Systems**- Appointment demand frequently outstrips supply in some practices. List sizes are increasing in the majority of 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
- **Particular Population Features/Social Factors**- The Practice Development Plans identified the following as issues for the network: Mental health/Drug and Alcohol misuse/Deprivation/Unemployment/Housing/High levels of Single Parents/Requests for letters of support for Personal Independence Payment resulting in increasing workloads/ Asylum Seekers/Refugees/Speakers of Other Languages/High Care Home Population/High Rates of Domestic Violence/Increasingly Diverse Network Population
- **Disease Prevalence**: High Rates of Smoking. All practices are participating in the Pre Diabetes Scheme
- **Key Health Priorities**: The following issues were identified as key issues by network Practice Development Plans: Mental health and Counselling/COPD/Cancer/Smoking Cessation/INR/Flu/Obesity/Social Prescribing/Issues related to social factors
- **Practice Population Needs Assessment**: Key issues-Most practices have expressed concern over the future of Protected Learning Time Sessions.

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: -

[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

- 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 and sustainability of 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 Information Governance Toolkit.

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:

Three Year Development Plan: To address specific identified needs for key population groups across the network: Including those with non medical/social needs affecting outcomes for: Whole families, victims of domestic abuse, smokers, speakers of other languages and carers.

No	Objective	Key Actions	Key partners	For completion by:	Outcome for patients	Progress to date	RAG Rating
1	To continue to understand the profile of the Penderi Community Network and the effect that deprivation has on the practice populations	To use the demographics considered during the formulation of the Cluster Network Plan and Practice Development Plans to inform activity and service delivery.. To cascade the statistical data provided by the Health Board, Public Health Wales and Welsh Government to practices for information. To continue to monitor changing demographics affecting the profile of the network in Years 2 and 3	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 the formulation of the Cluster Network Plan and Practice Development Plans. Statistical data provided by the Health Board, Public Health Wales and Welsh Government has been cascaded to practices for information/comment	
2	To continue to understand and support the needs of an increasingly diverse network population	Offer further/ongoing Cultural awareness training for front line staff as appropriate Increase awareness of Language Line Services by providing information in appropriate languages via links with the HHAVGAP Steering Group.	SCVS HHAVGAP Steering Group	March 2018	Improved communication and awareness of services offered to patients who are speakers of other languages	Asylum Seeker Training delivered by Dynamix took place in September 2016 and was offered to front line staff across the Network. Feedback related to this training was excellent. Further information/training packs /Aide Memoires are being developed by HHAVGAP	

		To develop links with the City Network's Asylum Seeker Support Worker and learn from work undertaken with asylum seekers in Primary Care as a result of the pilot.				Group related to Asylum Seekers and Working with Gypsy Travellers-There are to be shared with front line staff.	
3	To continue to improve access to mental health services:	- promote the LMPHSS information clinic - Refer patients to Cluster CBT scheme - Refer patients to relevant Third Sector Programmes eg: Down to Earth In Year 2 to inform an assessment of mental health service assessment in Primary Care based on identified strengths and weaknesses	SCVS Health Board GP Practices Third Sector Organisations eg: Down to Earth	Ongoing	Improved, timely access to mental health services. Improved access to counselling services for patients who need support	Information has been circulated to all practices. Generic stands have been updated LHMPSS information stand is in Fforestfach practices on a weekly basis Mental health guides developed and shared with practices Working links made with third sector organisations including Down to Earth. A stop has currently been put on the funds allocated for Counselling owing to procurement issues. Awaiting outcome.	
4	To focus on improving child and adolescent mental health across the Network	Link with SCVS to investigate undertaking a survey with local schools and College related to accessing services to inform developments locally	GP Practices SCVS Local Schools Gower College Swansea	March 2018	Improved understanding of services available for Children and Young People. Timely and relevant information available at GP Practices and schools/college	Discussion taken place with SCVS regarding progressing this work. Helen Foster developing proposal for discussion at the meeting on September 27th	
5.	To improve provision of information and support for Carers across the Penderi area and to	Continue to monitor progress and referrals and evaluate service in partnership with SCVS and Swansea Carers	Swansea Carers Centre SCVS GP Practices	March 2017 and ongoing	A direct accessible service for carers is received within Primary Care. Carers are identified across the network	Update delivered at Cluster Network meeting on May 24th. Swansea Carers Centre have	

	address sustainability of the service moving forward	Centre. End of Project Report to be provided Jan/Feb 2018. Exit strategy to be developed and implemented in Year 2/3			providing them with the support they need when they need it, helping to prevent carers reaching a crisis point.	worked with 10 carers at the help desk sessions to date. New carers have been identified and some who have returned for further support. The network were encouraged to make further referrals to the service.	
6	To support patients with easy to access non medical support services to help with low level mental health issues and to address sustainability of the service moving forward	Continue to monitor and evaluate the service in partnership with SCVS and Citizen's Advice Bureau. End of Project report to be provided-Jan/Feb 2018. Exit Strategy to be developed and implemented in Year 2/3	CAB SCVS GP Practices	March 2017 and ongoing	To receive advice and support on a wide variety of issues (including debt, benefits and money matters) to patients in a Primary Care setting.	Update delivered at Cluster Network meeting on May 24th . Schedule of appointment bookings circulated service currently operating at Fforestfach, Cheriton and Cwmfelin. 12 appointment slots have taken place and support has been taken on for 8 patients (5 with benefit issues and 3 debt related)	
7	To continue to provide an appropriate targeted level of service for vulnerable patients who have experienced domestic abuse.	To build on training delivered to network by Women's Aid. Continue to raise awareness among staff of issues and support available for victims of domestic violence. Continue to review and evaluate Refuge Service and consider any further recommendations. Report to be provided to the network in December 2017. Practice recommendations to be implemented in Year 2/3	Brynhyfryd Surgery Health Board Women's Aid	March 2017 and ongoing	To ensure that holistic , patient centred service is provided for women who have suffered domestic violence. Ensuring ease of access to Primary Care services and timely health checks. Patient given the opportunity to discuss health issues with a trained, experienced health professional	Successful Pilot was completed in 2016/17. 45 refuge patients have been registered by the practice. 16 patients have attended to see the nurse and full service offered. 15 patients have been seen 1 or more times usually related to emergency meds, sick papers, psychiatric referrals. Patients have complex needs. Important to invest the time in patients to ensure effective support given. .	
8	To invest in the Early Years and improve outcomes for families in	-Ensure that Best Start parenting messages/ interventions are provided	Local Authority Early Years Team	March 2018	Issues related to child behaviour, routines, mental health etc are addressed in a	Early Years worker has received 106 referrals.100% of families	

	Penderi.	within a Primary Care Setting. Post is aimed at supporting families outside the current government funded 'flying start' programme. -Service to be reviewed at Cluster Meeting July 26th Service highlighted at Innovation Conference held on June 9th. -Local Authority is currently working on a revised 'sustainable' model to adopt going forward -Network agreed to fund Early Years Work next year at meeting on 27/09/17	GP Practices Health Board Public Health Wales 1,000 Lives Team		timely way by the Early Years Worker who visits families in their own home to provide the necessary interventions to support the family	receiving intervention have reported positive improvements following intervention. Data currently being collected to evidence distance travelled. Feedback from patients accessing the service has been excellent.	
9	To increase the take up of screening services across the Penderi Network	To continue to promote screening and preventative services to patients . To make links with Screening Services to access up to date promotional material and data. Actively advertising Screening services and opportunities	GPs Practices Public Health	December 2017	Early identification of areas of concern. Adopting a preventative approach to health issues	Penderi participated in Bowel Screening Pilot in 2016. Training on Screening Services was organised for the Cluster in 2016	
10	To obtain patient and Carer views on network services and priority programme	To commission an involvement project to gather views related to access to Child and adolescent mental health services In Year 2 to use the findings to further develop the service. Depending on outcomes and success of model. Plan further patient participation models in Year 3	GP Practices Patients SCVS	December 2017	Improved understanding of what matters to patients will result in better service delivery and improved communication	Network have agreed to focus on gathering views and data related to accessing child and adolescent mental health services by engaging with young people in the network area. Proposal to discussed and agreed at meeting on Sept 27th	
11	To continue to reduce smoking rates across	-Practices to promote access to Level 3 Pharmacy Service	Public Health GP Practices	December 2017	Improvement in Smoking cessation rates resulting in	The estimated number of smokers accessing Stop	

	the network	to increase numbers of patients accessing the service -All practices to investigate hosting Smoking Cessation Clinic on a regular basis. -To liaise with ASH regarding the potential of using CO2 monitors into Penderi practices.	Third Sector Organisations eg: Ash		better long term health outcomes for the Penderi population. A reduction in smoking rates from 24.7 % to 22%	Smoking Wales in 2016/17 was 256. The number of smokers accessing the L3 Pharmacy service was 31. Penderi has 4 pharmacies commissioned to deliver the Level 3 service(Boots-Morfa/Tesco-Fforestfach/Well-24Conway Road/Well 118 Ravenhill Road), 3 of which actively delivered in 2016/17. There is a need to increase referrals to these services. Fforestfach Practices and Cwmfelin host a weekly smoking cessation clinic. Need to investigate if this clinic can be extended to all practices.	
12	To tackle rates of obesity and pre diabetes within the cluster network focussing on patients over the age of 45.	To continue to invest in the pre diabetes work with a view to promoting healthy lifestyle advice and guidance to over 45's in the network area. -Practices to undertake lifestyle advice and guidance to individual patients Outcomes to be monitored and evaluated	Dr Mark Goodwin Practices	March 2018	Improved wellbeing and reduced risk of developing Type 2 Diabetes. - Patients with pre diabetes are 12 times more likely to increase the risk of developing Type 2 Diabetes. In the absence of intervention most patients will develop pre diabetes within 5-10 years. Intervention will improve risk levels significantly	Practices began the Pre diabetes scheme in September 2016. Training has now taken place to enable practices to deliver the Lifestyle Advice and Guidance element of the scheme. Fforestfach practices are holding XPERT Diabetic Classes at the practice on a monthly basis As at the end of June 2017 The network is seeing steadily rising hba1c screening testing suggesting these patients are being identified and called in lifestyle coding is also rising but progress is	

						slow at 8%	

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, educating and informing patients in relation to appropriate use of services and considering workable solutions related to sustainability across the cluster network.

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To continue to review demand and capacity	-Consider impact of Local Development Plans related to housing developments. -To assess the strategic priorities of the cluster against available and current MDT's, focussing on workforce, sustainability matrix, triage models and evaluation, demand and capacity on counselling services and the Early Years Development Worker. This will be adjusted in Year 2 and reassessed in year 3. -Work with HB to consider impact of retirement of GPs in other practices across the cluster network and work together to stabilise the cluster network. -Consider Cluster approach to concerns expressed re increase in MDU fees -Consider cluster approach	Practices GPs HB Cluster Lead GP	December 2017 and Ongoing December 2017 December 2017 December 2017 December 2017 December 2017	Ensuring appropriate access to services for all Penderi Patients	Concerns flagged to HB and Local Authority over Local Development Plan	

		regarding living wage for front line staff having impact on sustainability of front line staff. To be flagged with Senior Health Board Staff					
2	To further develop and improve Third Sector Support and pressure on practices/outcomes for patients in the network	Cluster network to decide how to progress Social Prescribing Champions role within practices. Proposal for SCVS to train Cluster Pharmacist put forward. Scheme to be evaluated in Year 2.	SCVS Practices Nominated Social Prescribing Champions	October 2017	Improved access to social prescribing opportunities offered across network resulting in increased opportunities for improved mental health and wellbeing	Social Prescribing Champions Training delivered to practices on July 4th by SCVS. Capacity within practices has been identified as an issue. Alternative Social Prescribing Project related to Cluster Pharmacist has been agreed. .	
3..	To continue to educate patients with regard to appropriate access to services.	-Revised access leaflet to be issued across all practices Information to be shared with patients via electronic notice boards/posters etc -Promote services offered by local pharmacies	Practices	September 2017	Awareness of appropriate Access Channels and alternative services Improved patient care and sustainability	Access leaflet has been revised and distributed annually in 2015 and 2016. New access leaflet shared with practices Sept 2017	
4..	To ensure that access information is available in other languages relating to Primary Care	Info to be made available in alternative format/languages. Link to be developed with work being undertaken by HHAVGAP Steering Group and City Network Asylum Seeker Support	Practices HHAVGAP Steering Group SCVS City Network-Asylum Seeker Support	March 2018	Awareness of appropriate access channels and improved communication with patients who are speakers of other languages	Issues flagged with HHAVGHAP Group and City Network Asylum Seeker Support Worker for production of materials to be shared across networks as appropriate	

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 and identify strengths, gaps, weaknesses and possible training opportunities. Consider effectiveness of advice lines and sharing good practice/links with colleagues.

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1.	To continue to improve quality of dermatology services offered in Practices and reduce number of referrals to secondary Care	-Determine impact of investment in equipment and training attended by GPs across the network -Secondary care dermatology referrals to be requested for evaluation and review during 2017/18 and into 18/19	GPs Health Board	March 2018	Appropriate and timely 'joined up' services offered within the community	Dermatology Training sessions have been attended by 4 GPs across Penderi Practices. Dermatoscopes and cameras have been purchased for all practices	
2.	To continue to improve communication and strengthen working relationships with secondary care colleagues	-To continue to develop valuable links with Secondary Care Colleagues through PLTS sessions and 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 query strengthening secondary links with paediatrics-concerning what services/advice could	Secondary Care Consultants GPs Cwmtawe/ Llwchwr Cluster Networks	March 2018 and ongoing into Years 2 and 3.	Improved communication leading to production of timely discharge summaries and greater comprehension of individual patient needs/requirements.	Secondary Care Colleagues have attended and presented at Network PLTS sessions. Improving understanding of key pathways related to Lung Cancer/Sepsis/COPD/CAHMS. There are issues with regard to the future of PLTS. Practices are currently making their own arrangements for cover and training. Link made with Dr Chris Bidder Paediatrics. Dr Bidder has outlined that discussions are currently taking place with Primary Care Managers-	

		be developed. To implement services where appropriate into network in year 2. Evaluate implementation in year 3 in conjunction with other clusters and secondary care partners.				Support offered by Paediatrics to Primary Care shared with Network	
3.	PMS Plus To continue to undertake a range of prescribing initiatives as required to improve respiratory prescribing	Monitoring to continue with support from Meds Management Team	GP Practices Meds Management Team Pharmacist	March 2018	Improvement in patient symptom control	Practices have agreed to participate in PMS+ Scheme extended until March 2018.	
4.	To increase uptake of the mental health directed enhanced service	Participate in Mental Health DES as a cluster network-	GPs Health Board	March 2018	Informed practice staff offering adequate support and direction to patients	Awaiting outcome of Network PLTS discussion. Advice required re way forward from Health Board A revised mental health directed enhanced service specification has been circulated to the cluster. Plans for a PLTS session in Nov 2017 to be discussed and topic of study to be agreed. If this can be organised as part of PLTS Network will progress.	
5	To focus on effective delivery of MMR Vaccine to children under 5 across the network. Target to vaccinate 95% of under 5 year olds for MMR vaccine (See Strategic Aim 6)	Network agreed to adopt MMR Vaccine as the third Cluster priority. Investigating Public Health info needed to support campaign	Cluster Lead Primary Care Manager GP Practices, Health Board, Public Health	February 2018	All children in Network are protected by having MMR Vaccine	Discussion taken place at Extraordinary Network meeting on July 12th. MMR agreed as Network Priority. Cluster Network to adopt the recent release of a specification guide for implementation by Primary Care Manager	
6	To achieve better health outcomes and safer care through prudent prescribing	-Identify and designate antibiotic champions. -Cluster Pharmacist trained in Independent Prescribing-	GP Practices. Health Board,	March 2018 and ongoing	To provide efficient and effective healthcare to patients resulting in reduced medicines wastage and costs	Antibiotic Champions have been appointed in Fforestfach Practices Medication and polypharmacy reviews, medication queries new	

		-Polypharmacy reviews ongoing by Cluster Pharmacist	Cluster Pharmacist			patient medication reviews, plus any medication related queries from all staff in Primary care have been undertaken by cluster pharmacists and remain ongoing. Cluster Pharmacist has been trained in independent prescribing. The cluster pharmacist has given a presentation to the network on work undertaken and good practice regarding presecribing	
7.	To understand the new DES for oral anticoagulation with warfarin and consider participation as a practice/cluster	Practices to indicate to HB if they are interested in participating in scheme to transfer INR monitoring from secondary care colleagues	GP Practices HB	July 2017	Services provided locally within Penderi Community. Numbers of Patients affected across the network: 549 (Fforestfach Practices x2: 197 Cwmfelin: 151 Brynhyfryd: 100 Manselton: 83 Cheriton: 18)	Fforestfach Practices and Cwmfelin Medical Centre have indicated that they would like to participate in the scheme	

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 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

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1.	To reduce the inappropriate use of A&E and GP OoHs	A need has been identified to query how appropriate the referrals to A&E are. Invite ED Colleagues to Cluster Meeting to query situation	GP OoHs A&E HB	March 2018	Greater awareness on how to access services appropriately to meet patient needs across the Network and all Primary Care Services	Generic Information to be provided to all surgeries as is visible in all hospital settings. Choosewellwales.org.uk Access leaflets developed and distributed across Penderi Practices- September 2017	
2.	To take appropriate actions to ensure that practices are prepared for winter season. (Winter preparedness)	-To develop winter preparedness checklist for the network by Oct 2017 -To increase flu vaccinations in the over 65 age group and in 2-3 year olds. -Ensure housebound	GPs Community Pharmacies Community Pharmacy Wales Front of House Practice Teams Public Health	Sept/Oct 2017 until February 2018	At risk group effectively targeted resulting in greater uptake of flu immunisation rates thus reducing the number of people at risk of getting flu. 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.	Flu Myth buster session has been organised for front of house staff September 2017. Clinical Pharmacist has undertaken training to deliver flu immunisations. Primary Care Manager investigating parity of HVs service with Senior Staff	

		patients also receive Pneumonia and Shingles vaccinations -To make enquiries with HV's regarding delivering vaccinations to 2-3 age group and possible delivery at Nursery schools.	Primary Care Manager Cluster Development Manager (5 Clusters)			Agreed to book agency nurse to deliver Flu vaccinations/Pneumonia Vacs and Shingles Vacs to housebound patients in October 2017	
3.	To address the complex medical needs and to provide an enhanced provision of care for residents in Care Homes. Delivering the 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 disciplinary teams -Wraparound services provided for the patient ie: OT, Podiatrist, Dental, Optometry, Audiologists, Dieticians, Mental health care -A decrease in unscheduled admissions -A decrease in polypharmacy	100% update from all practices within Penderi	
5	To continue to improve access to Phlebotomy services to help streamline service for patients	Seek regular updates from DNs and GPs regarding effectiveness of service and any issues/recommendations moving forward. Review	GPs DNs Health Board	May 2016 and ongoing	Providing a swifter, efficient and more effective service operating at a local level	Phlebotomist resigned in March 2017.New phlebotomist began her post on July 17th. Phlebotomist post currently runs up until March 2018	

		of effectiveness of service to be provided before March 2018 to inform possible funding of the post moving forward into year 2.					

Strategic Aim 5: Improving the delivery of Cancer and COPD (National Pathway Priorities)

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	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To focus on COPD as a Network Clinical Priority	To follow COPD QP pathway to improve COPD Care within the context of the framework embedded within QOF as per timeline specified	GP Practices	March 2018	To help patients understand why spirometry test consistent with COPD To help patients record quality of life assessments/ability to use inhalers and their understanding of how to help themselves through access to self care.	Agreed that COPD is a network priority at the Cluster meeting held on May 24th Baseline COPD data to be shared with practices on July 26th.	
2.	To focus on prompt recognition and early referral of Cancer as a Network Clinical Priority	To complete Module 2 of the Macmillan Cancer Toolkit for General Practice in Wales as set out in GMS Contract 2017/18 as per timeline specified	GP Practices	March 2018	'*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)	Agreed that early diagnosis of cancer will be a network priority at the Cluster Meeting held on May 24th.	

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority: Improving MMR Vaccination Rates across the network

Three Year Development Plan: 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	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1.	To increase number of children vaccinated across the network to above 95%	-Targeting Parents with info Push on MMR across network involving HV/Early Years Worker/Local Nursery Schools. -Spec to be produced that Network can adopt for this work. -To make use of baseline data provided by the Health Board and PHW. -To continue to review actions to improve vaccination take	GP Practices Public Health Nursery schools	March 2018	100% vaccination rate resulting in no outbreaks of Measles, Mumps and Rubella across the Network	Network agreed to adopt MMR as a local pathway at the Extraordinary meeting held on July 12th Network has discussed and agreed spec and details of local MMR pathway Welsh target for scheduled Childhood Imms by 4 years is 95%. Penderi currently achieves 84.5%.	

		up rates in years 2 and 3.					

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

Three Year Development Plan: The Cluster will actively demonstrate effective governance procedures, review significant events, undertake peer reviews and discuss and monitor inactive QOF to ensure that quality systems and procedures result in improved outcomes for all patients.

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Demonstrating Governance procedures within practices resulting in better outcomes for patients.	To effectively demonstrate governance procedures within practices Completion of CGPSAT	GP Practices	Ongoing	Assurance that practices have clinical governance procedures in place	CGPSAT is now open and live to all practices for further completion and progression following the last submission March 2017	
2	To continue to review significant events highlighting themes and trends	Discuss sharing Significant Events/incidents at Network Board Level among practices. Network PLTS sessions to include SEA -Ensure Risk register amended as necessary following each Cluster meeting	GP Practices HB	Ongoing	Potential changes to services based on significant events in cases where there are positive/negative actions	SEA's reviewed by individual practices on ongoing basis with learning to be shared through network meetings via PLTS sessions. Incidents with direct correlation to secondary care being notified to Health Board	

		to as					
3	Monitoring and Discussion of Inactive QOF	-Mid Year Peer Review of Inactive QOF to be discussed at meeting on Sept 27th. -HB to provide template in advance of the meeting for inactive QOF discussion and areas for review within CGPSAT. -Agree areas for review within CGPSAT and IG Toolkit at Sept 27th meeting	GP Practices	December 6th	Quality systems maintained. Service delivery of high quality and meeting QOF and safety standards	Template produced by Primary Care Manager outlining requirements at each cluster meeting. Template shared with Network at Extraordinary Meeting on July 12th	
4	End of Year Peer Review to be undertaken on Dec 6th	End of Year Peer Review of inactive QOF to take place. End of Year Peer Review of: Clinical Governance Information Governance	GP Practices	December 6th	Quality systems maintained. Service delivery of high standard and meeting QOF and safety standards	Review factored into meetings calendar requirements to be discussed/flagged with network as appropriate.	

Strategic Aim 8: Other Locality Issues

Three Year Development Plan:

The Cluster will seek opportunities to work together to share knowledge, best practice and improve services offered within the community resulting in improved outcomes for patients

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To develop a shared education agenda through community network PLTS	Areas of interest regarding training to be identified and appropriate network training sought	GP Practices Health Board Third Sector Organisations	Ongoing	Improved training will result in improved impact on patients/front line service users	Comprehensive PLTS programme organised making valuable links with secondary care and Third Sector Organisations. Resulting in improved awareness of patient pathways into secondary care and improving interface between primary and secondary services. Issues with OOH cover have halted Network wide organisation of PLTS. Alternative solutions to be discussed regarding cover arrangements.	