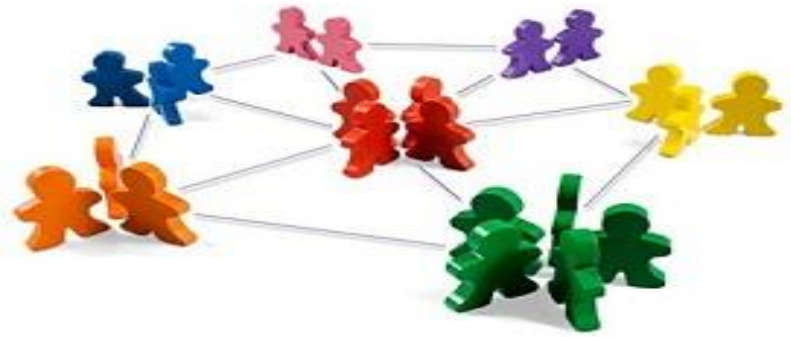
Three Year Cluster Network Action Plan 2017-2020

Upper Valleys Cluster



VERSION CONTROL: Version 3 (25th July 2017)

Introduction

The Upper Valleys Cluster includes four practices delivering services from across eight sites. The cluster serves a population of 31,365 patients.

GP Practice	Practice Registered population
Amman Tawe Partnership	3416
Dulais Valley Primary Care Centre	6012
Pontardawe Health Centre	12404
Vale of Neath Practice	9533

In line with the requirements of the Quality & Outcomes Framework (QoF) Cluster Network Domain 2017/18 the Upper Valleys Cluster has developed a 3 year action plan clearly outlining its objectives for the period 2017 – 2020.

Agreement on the objectives and actions within the plan has been reached through a combination of analysis of individual Practice Development Plans, a review of Public Health Priorities and a series of cluster meetings.

The development of the plan has presented an opportunity for GP Practices in Upper Valleys to build on the progress made in 2016/17 and has involved partners from Public Health Wales, other Health Board teams and directorates namely medicines management, physiotherapy and Nutrition and Dietetics; and the 3rd Sector and Social Services. More work will be done in the coming months and years to ensure that a wider range of partners, including other primary care providers are involved in cluster planning.

In 2016/17, the cluster made significant progress in the following areas:

Prevention

All practice identified health champions for a range of areas, including: smoking cessation, vaccinations, and dementia. The practices ran publicity campaigns for a range of public health initiatives, including smoking and flu. Practice staff participated in a range of training sessions including – flu myth busting, dementia friends, active signposting, Nutrition Skills for Life, Vision 360, CRP and spirometry. There has been a slight improvement in the uptake of flu vaccinations. Also as part of the proactive approach to preventing the onset of disease, the cluster participated in the pre-diabetes project, identifying pre diabetic patients and offering them lifestyle advice.

Cluster MSK project

The cluster employed 2 part time physiotherapists who are offering local services to patients, utilising V360 shared appointment booking system. All relevant staff and physiotherapists were trained on how to use the system.

Development of Local Community Services leaflet

Working with the 3rd sector, the cluster developed a leaflet which aims to raise awareness of available services and groups within the upper valley areas to help improve patient's health and wellbeing. This leaflet will also be used as part of the pre diabetes lifestyle coaching. The leaflet has its own QR code which will take patients to an electronic version of the leaflets that they can read on their mobile phone or other smart device. The cluster is keen to develop the use of QR codes across all services to help patients to access information in an easy and cost effective way.

Counselling Service

The cluster commissioned Ystradgynlais Mind to provide mental health support services for people experiencing early symptoms of depression, stress and anxiety in the Upper Valley GP cluster. Funding was provided for structured, time limited therapeutic counselling interventions to patients who have low to medium support needs. Following are review, the cluster agreed to terminate the SLA from January 2017.

CRP testing

In order to support the reduction in antibiotic prescribing and re-educate patients regarding the use of antibiotics, the Upper Valley Cluster agreed to purchase CRP machines for each practice.

Medicine Management

11 prescribing clerks across the cluster have completed the Health Board Repeat Prescribing Training Pack to support their role in the repeat prescribing process and so improve quality and safety. The cluster also engaged in a pacesetter targeting support to patients with known problems managing medicines in their own home without a package of care, through a collaborative approach with the medicines management domiciliary care team. All practices participated in prescribing management schemes and improved prescribing in key areas including antibiotics, pain medication and inhaler prescribing. The cluster has focussed on antimicrobial Stewardship has been a focus during the year and have undertaken an acute cough audit, developing and submitting improvement plans.

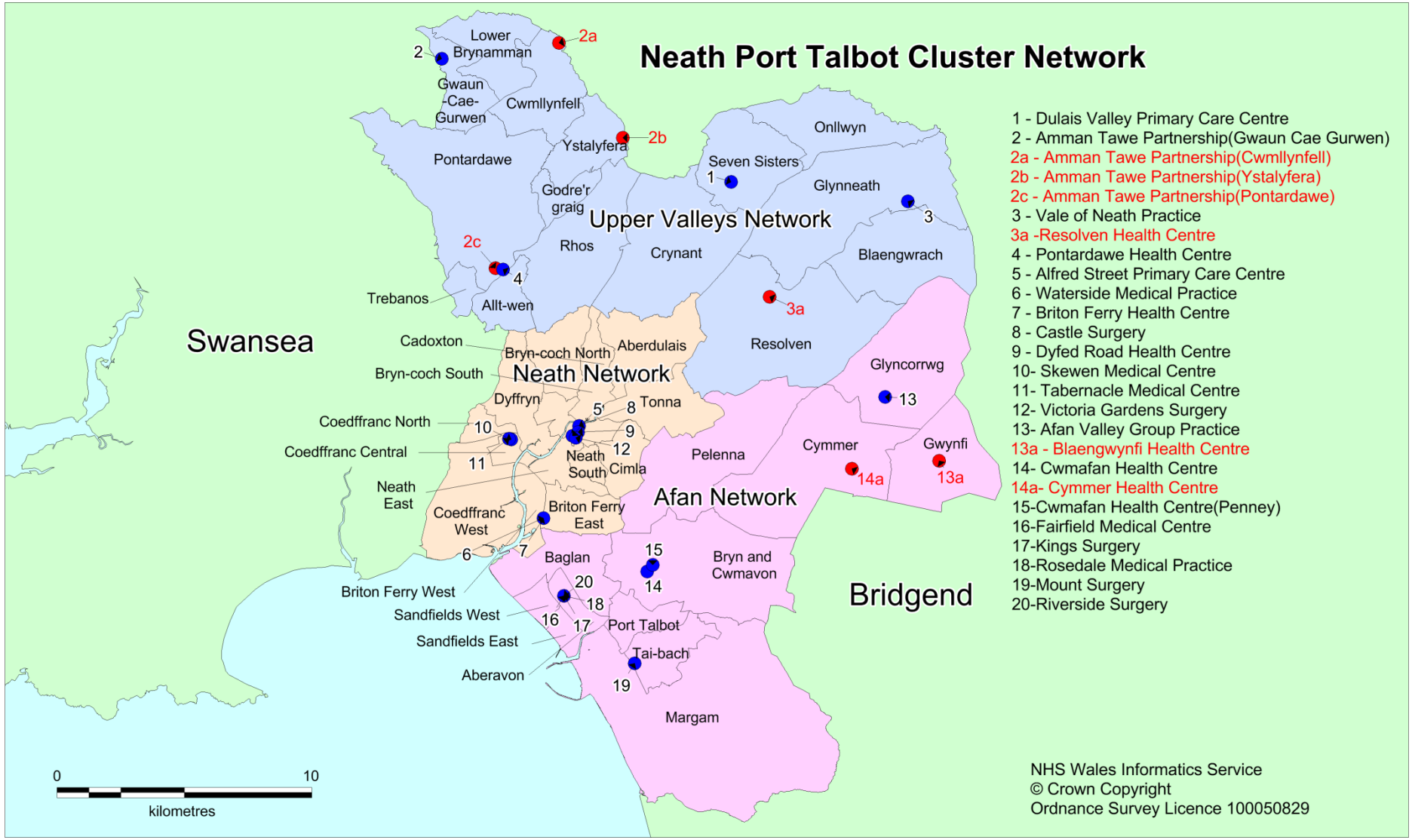
The cluster practices are situated in predominantly rural areas and for this reason have significant problems with the recruitment and retention of GPs and are having to rely on locums. This is not a sustainable solution to the problem as availability and expense are an issue. The cluster is supporting an incentive scheme linked to the NPT-wide GP fellowship scheme and have to date benefitted from the appointment of 2 Fellowship GPs.

2 practices have practices premises which require upgrading/renovation and this causes significant problems with the delivery of services. Health Board support is necessary to address these difficulties.

The cluster practices have each reviewed their skills mix and processes and implemented systems such as telephone triage in some practices to meet their rising demand and a range of allied health care professionals to support the clinical staff.. The cluster plan seeks to implement initiatives which will not only help to address sustainability issues but also benefit the local population.

The cluster received a recurrent allocation of £112,393 from Welsh Government in 2016/17. This sum was spent on implementing the objectives and initiatives in the cluster plan including funding the Mind Counselling service, the Pre Diabetes project, the CRP Testing project, Fluenz parties for childhood immunisation, the MSK service, and staff training. Plans are in place to utilise the allocation in 2017/18.

The Cluster plan is a living and evolving document and will be monitored regularly at cluster meetings. Further actions and initiatives will be developed based on population need.


Neath Port Talbot Cluster Network
Upper Valleys Network
Neath Network
Afan Network
Swansea
Bridgend
Lower Brynamman
Gwaun -Cae- Gurwen
Cwmllynfell
Ysta lyfera
Pontardawe
Godre'r graig
Rhos
Crynant
Onllwyn
Seven Sisters
Glynneath
Blaengwrach
Resolven
Trebanos
Allt-wen
Cadoxton
Bryn-coch North
Aberdulais
Bryn-coch South
Dyffryn
Tonna
Coedffranc North
Coedffranc Central
Neath East
Neath South
Cimla
Coedffranc West
Briton Ferry East
Briton Ferry West
Sandfields West
Sandfields East
Aberavon
Baglan
Bryn and Cwmavon
Port Talbot
Tai-bach
Margam
Pelenna
Cymmer
Glyncorrwg
Gwynfi
1 - Dulais Valley Primary Care Centre
2 - Amman Tawe Partnership(Gwaun Cae Gurwen)
2a - Amman Tawe Partnership(Cwmllynfell)
2b - Amman Tawe Partnership(Ystalyfera)
2c - Amman Tawe Partnership(Pontardawe)
3 - Vale of Neath Practice
3a -Resolven Health Centre
4 - Pontardawe Health Centre
5 - Alfred Street Primary Care Centre
6 - Waterside Medical Practice
7 - Briton Ferry Health Centre
8 - Castle Surgery
9 - Dyfed Road Health Centre
10- Skewen Medical Centre
11- Tabernacle Medical Centre
12- Victoria Gardens Surgery
13- Afan Valley Group Practice
13a - Blaengwynfi Health Centre
14- Cwmafan Health Centre
14a- Cymmer Health Centre
15-Cwmafan Health Centre(Penney)
16-Fairfield Medical Centre
17-Kings Surgery
18-Rosedale Medical Practice
19-Mount Surgery
20-Riverside Surgery
0
10
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KEY THEMES & PRIORITIES IDENTIFIED FROM PRACTICE DEVELOPMENT PLANS

Demography

- Available data shows an overall cluster year on year increase in registered patients from 2014. However, whereas most of the practices have, between 2011 & 2017, had a fairly static list size, one practice has seen an increase of 7%.
- The Local Development plan includes new housing development sites in the area which could have an implication for practice list sizes
- The cluster has an increasing elderly population with 22.8% of the registered population 65+ and 10.0% 75+ (over the ABMU average of 19.7% and 8.9% respectively)

Needs Profile

The cluster has:

- A high proportion of smokers (21%) and needs to increase referrals to smoking cessation services
- The **lowest uptake in NPT** for influenza vaccination in those 65 years and older at 60.5% against the Welsh Government target of 75%
- The **lowest uptake** in NPT **for influenza vaccination in those under 65 years in clinical risk groups at 36.3%** against the Welsh Government target of 75%
- Greatly increased uptake of the influenza vaccine in children aged 2 and 3 years from 14.5% last season to 32.6% this year and at **96.6% has exceeded** the Welsh Government target of 95% for administering MMR 1 by 2 years of age
- A high prevalence of obesity (62% of adults and 26.8% of under 5s in NPT), low levels of physical activity and low levels of referrals to NERS in 3 out of the 4 practices
- An increased prevalence of diabetes
- A high number of patients with mental health problems and very limited availability of services.

Access Arrangements

- 2 of the 4 cluster practices are offering a full telephone triage model with patients directed to the most appropriate professional or managed with advice. These practices see all patients who need to be seen on the day.
- 2 practices offer a hybrid model, offering telephone consultations, appointments on the day. Where needed, all 4 practices offer pre-bookable appointments.
- The Cluster has developed a locally accessible shared triage and treat MSK service which has improved access for patients.
- 2 practices are accommodated in premises which are no longer fit for purpose and this has an impact on their services

Service Provision

- Cluster practices continue to provide enhanced services to patients and continue to participate in the pre-diabetes screening project.
- Practices have identified the need to work more closely with the 3rd Sector and other health and social care professionals

Education & Training

- A cluster skills and needs analysis of the cluster HCSW has been led by Afan cluster and training courses sourced to upskill identified staff.
- The cluster will also identify local courses and online courses available to improve skill set, and utilise Pt4L sessions as required.

Workforce

- Recruitment of GP's, retirement, locums remains an issue. Need to assess the workforce skill mix and the development of a wider clinical team.
- The cluster will explore the recruitment of advanced practitioners, pharmacists, minor illness specialist to support practices.

Services Delivered

Upper Valleys Cluster Network	Amman Tawe	Pontardawe Health Centre	Dulais Valley, Seven Sisters	Vale of Neath
Additional Clinical Services				
Cervical Screening	✓	✓	✓	✓
Contraceptive Services	✓	✓	✓	✓
Vaccinations & Immunisations (Non Childhood)	✓	✓	✓	✓
Childhood Vaccinations & Immunisations	✓	✓	✓	✓
Child Health Surveillance	✓	✓	✓	✓
Maternity Services	✓	✓	✓	✓
Minor Surgery	✓	✓	✓	✓
Directed Enhanced Services				
Childhood Immunisations	✓	✓	✓	✓
Influenza for those 65 and over and others at risk groups (2-3 year olds)	✓	✓	✓	✓
Extended Minor Surgery	✓	✓	✓	✓
Care of People with Learning Disabilities	✓	✓	✓	✓
Care of People with Mental Illness	**N**	**N**	✓	**N**
National Enhanced Services				
Anti-Coagulation (INR) Monitoring	✓	✓	✓	✓

Services Delivered

Upper Valleys Cluster Network	Amman Tawe	Pontardawe Health Centre	Dulais Valley, Seven Sisters	Vale of Neath
Shingles Catch- Up Programme	✓	✓	✓	✓
Services to patients who are drug/alcohol misusers	**N**	**N**	**N**	**N**
Local Enhanced Services				
Shared Care	✓	✓	✓	✓
Gonadorelins / Zoladex	✓	✓	✓	✓
Immunisations during outbreaks (MMR)	✓	✓	✓	✓
Care Homes	**N**	✓	✓	✓
Care of Homeless Patients	**N**	**N**	✓	**N**
Hep B Vaccination of at risk groups	**N**	✓	✓	✓
Wound Management A	**N**	**N**	✓	✓
Wound Management Part B	**N**	**N**	**N**	**N**
Wound Care SLA feb 17 to Jun 17	✓	**N**	✓	**N**
Men C Catch-up for University	✓	✓	✓	✓
Cross Border Patients	**N/A**	**N/A**	**N/A**	**N/A**
Anti-coagulation level 4				

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

1	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.1	Review the needs of the population using available data To understand the profile of the cluster and the effect that deprivation has on the practice populations	To ensure services are developed according to local need Local Public Health Team	Ongoing	Cluster Local Public Health Team	**Action:** • Cluster planning to be informed by PDPs and public health profiles. • Proactively utilise the Primary Care Portal to identify areas for improvement. • To consider the demographics of the community network and the impact on service delivery	**G**
1.2	Increase the number of smokers accessing specialist smoking cessation support to quit through Smoking Cessation Services (Level 3 Community Pharmacy service; 'Time to Quit') in line with the Welsh Government Tier 1 Targets Ensure patient smoking status is recorded and regularly updated	Smokers being supported through their quit attempt via evidence based services Improved opportunities to improve health through quitting smoking.	March 2018	Local Public Health Team ABMU HB Primary care team Stop Smoking Wales 'Help me Quit' Community Pharmacies	**Action:** • Practices identify a smoking champion • All patients have updated smoking status on records • Proactive identification of smokers from lists with invitation to 'Help me Quit' services • Scrutinise referrals to cessation services on cluster basis	**G**
1.3	Increase the uptake of flu vaccinations in target groups in line with the Welsh	Increased protection from flu through	March 2018	ABM Public Health Team PHW Vaccine	**Action:** • Ensure all practice flu plans are completed and submitted to Health Board	**A**

1	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	Government Tier 1 Targets; in line with best practice and evidenced based activities : Towards 75% Over 65s 6 month-64 years at risk Children aged 2-3 Pregnant women Towards 50% Practice Staff	increased uptake of flu vaccination. Reduce morbidity & mortality over winter period (particularly in vulnerable)	August (annually)	Preventable Disease Programme ABMU Immunisation Co-ordinator ABMU Primary care team Third Sector	• 1:1 support from ABM PHT on development of flu vaccination campaign around good practice • Each practice identify vaccination champion • Training for non-clinical practice staff on flu myth busting • Scrutinise IVOR flu vaccination uptake data on cluster basis • Contribute article and advert to the August Community Magazine annually	
1.4	Increase the uptake of childhood immunisations in line with the Welsh Government Tier 1 Targets to 95% of all scheduled vaccinations by age 4	Improve health and wellbeing of children. Reduce morbidity & mortality	March 2018	Health Visitors ABM Public Health Team PHW Vaccine Preventable Disease Programme ABMU Primary care team	**Action:** • Scrutinise uptake data on cluster basis • Consider Fluenz parties (ATP to support/share good practice)	**A**
1.5	Support patients to manage their weight	Improve health and wellbeing Reduce obesity	March 2018	ABM Public Health team ABM Nutrition and Dietetics Department	**Actions: (Linked to 2.5 & 3.1)** • Increase referrals to NERS • Increase referrals to the Nutrition and Dietetics department 4 week weight management programme • Participate in the pre-diabetes project	**A**

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

2	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
2.1	Improve recruitment and retention of GPs through support for the GP Fellowship Scheme.	Improved access to GP services and increased sustainability of core GMS.	March 2018	ABMU Health Board	**Action:** • Participation in recruitment, training and mentorship	**A**
2.2	Optimise GP practice back office work flow	Engaged and empowered medical administrators Better stewardship of the patient journey Accurate and consistent information entered on medical records Clinician time saved	March 2018	GP Practices HERE Parnership	**Action:** • Participation in the HERE workflow optimisation project	**A**
2.3	Streamline and signpost patients to the most appropriate healthcare professional	Reduce burden of appointments and targeted care provided	March 2018	All practices INPS	**Action:** • Monitor uptake of the shared cluster MSK service • Evaluate MSK service	**A**

2	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
		to patients. Increased access to allied health professionals				
2.4	Increase access and signposting to community services that support self-care and independence in order to help patients' self-help and improve their wellbeing independently.	Increased awareness of available services/groups within the local community to support their health and wellbeing	March 2018	NPTCVS ABM	**Action:** • Scope opportunities for local Health Advocacy	A
2.5	Improve utilisation of National Exercise Referral Scheme to support patients to increase patients physical activity levels in line with national physical activity guidelines (linked with pre diabetes screening objective)	Reduced health risks through increased participation of physical activity	March 2018	GP practices NERS co - coordinators	**Action:** • Review attrition compliance and completion of NERS programme in conjunction with NERS co-coordinators	A
2.6	Increase collaboration between GP practices and other primary care providers, social services and other	GP practices are better able to manage demand	2018 and ongoing	GP practices Other primary care providers	**Action:** • Social Services to participate in GP practice MDT as requested • Engage with Local Area Co-ordinators	**A**

2	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	cluster partners				Explore opportunities for collaboration • Between practices .e.g. DES delivered across the cluster, back office functions which could be shared; • With other primary care providers e.g. common ailments scheme with community pharmacies etc. • With social services and other partners • Implement agreed decisions	
2.7	Provide standardised training for HCSW & receptionists to ensure that they have the skills to perform their roles HCSW training	Standardise Cluster HCSW skills ensuring they are able to work at the top of their skills set.	March 2018	Practice managers HCSW and receptionists	**Action:** • Cluster to fund courses aimed at upskilling HCSW and receptionists • Practices to identify learning needs of HCSW and put them forward for relevant course	G

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.

3	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
3.1	Proactively identify patients who are pre diabetic or at risk of pre diabetes in order to help reduce the onset of diabetes in later life. Support those patients	Early diagnosis and proactive intervention to prevent or delay the onset of diabetes	Ongoing	All Practices	**Action:** • Implementation of the pre diabetes service specification • Brief interventions • Referral to NERS	**G**

3	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	in undertaking lifestyle changes which will benefit their health and wellbeing					
3.2	Provide proactive, timely care to those who are most vulnerable and complex to manage	Vulnerable patients who have complex care needs, who are at risk of losing their independence will be proactively supported to help, avoid unnecessary admission to hospital or Long Term Care Homes	Ongoing	NPTCBC ABMU HB Practices	**Action:** • Actively refer appropriate patients to the local anticipatory care team for development of an anticipatory care plan	**A**
3.3	Improve prescribing and medicines management including engagement in Prescribing Management Schemes and improving performance against National Prescribing indicators	Improved outcomes from medicines	Ongoing	Medicines Management team	**Action:** • Engage in prescribing management schemes	G

3	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
3.4	Provide support to patients with known problems managing medicines through a collaborative approach with the medicines management domiciliary care team (MMDCT)	Advice and practical support to help individuals manage medicines in their own homes. Improved patient outcome form the management of chronic disease and reduce unscheduled admissions.	Ongoing	Medicines management domiciliary care team	**Action:** • Practices to work closely with MMDCT to support patients in managing their medicines	A
3.5	Improve EOL for patients and patient's family	High quality care delivered to patients at the end of their lives and to their families		Practice staff and DNs GP practices Anticipatory Care Team	**Action:** Practices to • Continue to review significant event analysis with regards EOL • Review their MDT/ Palliative Care processes • Encourage uptake of referrals to Anticipatory Care Team where appropriate	A

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

4	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
4.1	Further improve antimicrobial stewardship	Improved outcomes and reduced resistance and side effects	Ongoing	Medicines management	**Actions:** • Undertake antibiotic audit linked to PMS • Follow up to date health board antimicrobial guidelines • Monitor prescribing data	A
4.2	Utilise CRP testing in order to reduce the use of antibiotics for adult patients with upper respiratory tract infections.	Reduction in antibiotic prescribing rates for upper respiratory tract infections. Re-education of patients regarding the use of antibiotics	Ongoing	GP Practice teams	**Actions:** • Continue funding of the CRP Project • Evaluate project	**A**
4.3	Promptly identify and proactively manage respiratory patients. Improve reporting and interpretation of spirometry results	Early diagnosis of COPD, access to education and pulmonary rehab. Access to	31st March 2018	General Practice ABM Swansea University	**Action: (Link to strategic Aim 5)** • All appropriate practice staff will engage with the national ARTP spirometry training which is being delivered locally to improve reporting and interpretation of spirometry results • Smoking status of all patients to be captured • Flu vaccination to be promoted	A

4	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
		high quality spirometry testing			• Referral to Pulmonary Rehab for all COPD patients	
4.4	Follow guidance Respiratory PMS+, and maximise cost effectiveness of prescribing	Improved medicines management for patients with COPD	PMS+ to January 2018	Medicines Management Team	**Action:** • Continue with respiratory PMS+ until January 2018	G
4.5	Engage with patients to understand their experience of services and to identify their needs and facilitate their participation in the development and evaluation of services	Practice objectives are in line with patient needs Ensure good lines of communication between practices and patients.	Ongoing	Practice Patients NPTCVS Wellbeing and 3rd sector sub group	**Action:** • Engage with patients in the further development of actions as part of the Cluster plan, including review and evaluation of Cluster projects • Practices to explore best method of patient engagement including questionnaires, Patient Participation Groups	**R**

Strategic Aim 5: Improving the delivery of Cancer and COPD services (Agreed National Clinical Pathways)

5	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
5.1	Engage in the COPD national priority area for the management of patients with COPD	Higher percentage of accurate coding and recording of COPD consultations	March 2018 and ongoing	Cluster practices	**Action:** Using a PDSA cycle • Engage with the clinical priority work at a practice and cluster level • Discuss any data provided to the practice or cluster • Agree small steps of change to test out any new	A

5	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
		More appropriate prescribing and referrals Improvements being measured by the practice and shared with the cluster			ways of working in the practice or cluster • Share the results of small tests of change with peers in the cluster (whether positive or negative)	
5.2	Engage in the Cancer national priority area for the management of patients with Cancer	Prompt recognition and early referral of patients with Cancer	March 2018 and ongoing	Cluster practices	**Action:** Using a PDSA cycle • Engage with the clinical priority work at a practice and cluster level • Discuss any data provided to the practice or cluster • Agree small steps of change to test out any new ways of working in the practice or cluster • Share the results of small tests of change with peers in the cluster (whether positive or negative)	**A**

Strategic Aim 6: Improving the delivery of the MMR vaccine to children by the age of 5 years (Locally agreed clinical pathway priority)

6	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
6.1	Engage in the locally agreed priority area for increasing the percentage of individuals born since 1970 who have received 2 doses of MMR vaccinations	Increase uptake of the MMR Vaccine Prevent outbreaks of measles	2018 - ongoing	Public Health	**Action:** Practices are to • Conduct searches to identify patients / validate lists • Invite patients who have not had 2nd MMR (up to three invites via mixed methods) • Share practice performance data within cluster and discuss performance so far, share lessons and learning. • At 3 months, share performance data within cluster and discuss performance so far, share lessons and learning. State what practices did differently to improve uptake • At 6 months, share performance data within cluster and discuss performance so far, share lessons and learning. State what practices did differently to improve uptake. • Target parents at Baby Clinics • Immunise opportunistically (unless patient has infection – then book appointment)	A

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

7	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
7.1	Engage with a robust validated clinical governance process	Improved safety and quality	31st March 2018	All GP practices	**Action:** • Update the Clinical Governance Practice Self-Assessment Toolkit, complete the Information Governance Self-Assessment Toolkit and utilise	**A**

7	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
					learning / outcomes from same in peer review at cluster meeting • Peer review the designate inactive QOF indicators within the practice at a designated cluster meeting. • Include appropriate actions resulting from this analysis within the Practice Development Plan and consider whether any issues need to be discussed at cluster network meetings. .	
7.2	Promote shared learning and good practice through increased incident reporting	Improved quality and safety of services	ongoing	General Practice	**Action:** • Encourage use of DATIX for incident reporting	**A**
7.3	Produce and maintain a cluster risk register	Improved quality and safety of services	Ongoing	Cluster	**Action:** • Regularly update the risk register	**A**

Strategic Aim 8: Other Locality issues

8	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
8.1	Ensure that inequities and inconsistencies of referral mechanisms are minimised for practices and patients affected by cross border problems	Appropriate channels of referrals through improved cross border working arrangements	Ongoing	Multi Health Board areas	**Action:** • Continued development work by the LHB's to ensure that referral pathways are identified and implementation does not impact upon delivery of patient care	**A**

8	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
8.2	Improve practice premises to enable capacity to deliver new pathways and increase capacity	Improved facilities and sustainable services	March 2018 and ongoing	ABM VON/ATP	**Action** • Appropriate section of "sustainability template" to be completed • Health Board to be approached to support renovation/upgrade/relocation to alternative premises • Practices to evaluate alternative models of financing premises	**A**
8.3	Manage public expectations and understanding of advanced, specialist and new roles, promoting alternative models of care through patient engagement	Improved access and prudent care	March 2018 and ongoing	ABM CHC	**Action:** • Explore opportunities for patient engagement/awareness raising.	**A**
8.4	Introduce new models of effective and efficient delivery of service supported and facilitated by technology	More sustainable services	March 2018 and ongoing	GP Practices Health Board NWIS	**Action:** • Introduce use of purchased technology such as hand-held devices, and enable Skype facilities to improve communication and provide a more efficient service to particular cohorts of patients, or patients in certain settings, e.g. care homes	**A**

RISK REGISTER 2017/1

ID Number	Date	Description of Risk and Impact	Mitigation	RAG	Lead
1.		**Sustainability - Recruitment and Retention issues** Being in a predominantly rural area, recruitment and retention of GP continues to be problematic -causing GP practice sustainability issues This is also reflected on a national level though more acute in rural areas. Expense and availability of Locums to provide cover is an isuue..	Practices to consider workforce skill-mix. Opportunities for cluster initiatives to support practices. Consider national sustainability framework application. Develop an agenda for Primary and community care engagement, social service engagement and third sector engagement - seek funding structures to assure partnership with these groups. Ensure that General Practice services are being utilised appropriately	**A**	**Cluster Lead**
2.		**Downgrading of Urgent Suspected Cancers** Could result in delayed cancer diagnosis especially if not communicated effectively to referring clinician. Delayed cancer diagnosis leading to poorer prognosis	Proactively challenge USC downgrades. Maintain DATIX submission for inappropriate USC downgrades. Utilise WCCG gateway audit tool to filter and check downgrades. Empowering patients to manage their own referral	**A**	**Cluster Lead**

3.		**Discharge Summaries** Poor communication and/ or delayed discharge summaries can lead to significant incidents and potential for harm. Can lead to delayed primary care follow-up and lack of safety of transfer of care back to the community. May lead to readmission to hospital	Continue to raise at Health Board Senior Level through the NPT Medical Advisory Group, CG lead meetings and though DATIX submission.	**A**	**Cluster Lead**
4.		**Excessive and inappropriate transfer of work to primary care** Growing demands on GP practices which are either inappropriate, not resourced or are outside a practice's capability or competence Inappropriate workload impacts on core GMS and can result in inappropriate appointments. Delays in patients care if they have to then be re-referred to the most appropriate professional.	Make use of GPC template to send back work. Continue to raise at Health Board Senior Level through the NPT Medical Advisory Group, CG lead meetings and though DATIX submission	**A**	**Cluster Lead**
5.		**Premises Issues** Will impact on practices abilities to provide fit for purpose sites. Practices particularly affected VON Practice/Amman Tawe Partnership. Possible restriction of services and sustainability issues	Ongoing engagement with Health Board and where appropriate to prioritise /flag as part of the development of ABMs Estates Strategy	**A**	**Cluster Lead**