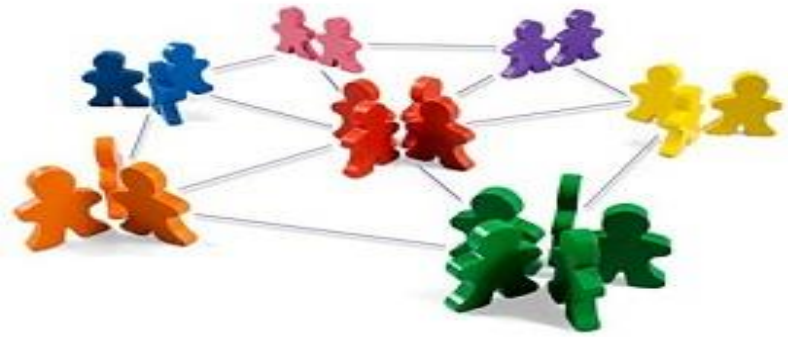
Three Year Cluster Network Action Plan 2017-2020

Afan Cluster



VERSION CONTROL: V1 July 2017

Introduction

The Afan Cluster Network comprises of 8 GP practices, two practices are engaged in GP training and one practice is managed by the Health Board, this practice has recently been merged with another practice following the resignation of the single handed GP. The cluster network estate includes nine main practices, four of which are located within in Primary Care Resource Centre (PTRC), one branch/split site surgery and one dispensing practice. The Afan Cluster Network area contains 9 Nursing/Residential Homes. There are 12 community pharmacies and 6 dental practices.

The cluster serves a population of 50,566 patients in an urban, semi rural environment. The population size has remained fairly static within the cluster (0.3% increase) and the Afan cluster is a low social economic area resulting in high demand on health workers including high rate of social housing and unemployment. 49% of the Afan Cluster is in a most deprived area, with a further 32% being in the next most deprived area.

Significant changes since last cluster plan

A main area of development within the cluster is dedicated IT support, exploring a cluster website and workflow optimisation. Going forward there will be a greater focus on measurable public health improvements. Ensuring robust Information Governance systems are in place is a major priority for the cluster. Patient engagement will be strengthened.

Key achievements from 2016/17

The cluster network achieved a number of priorities during 2016/17 including:

- Development of a programme of up-skilling for the HCSW in the cluster.
- Development of a Pre-Diabetic Service that provides, monitoring, screening and lifestyle advice, to those at risk of developing diabetes. Bespoke training for practice staff was delivered to enable proactive lifestyle advice to be offered and the development of a pre- diabetes information leaflet.
- Rolling out of lifestyle skills and dietary advice developed for pre-diabetics to all diabetics.
- A cluster flu champion identified who encouraged and supported the cluster working through peer review and sharing of good practice which increased uptake of flu vaccine in eligible groups.

- Anticipatory care model rolled out to all 9 practices, to proactively manage vulnerable patients who have complex care needs, who are at risk of losing their independence, avoiding unnecessary admission to hospital or Long Term Care Homes.

How are we spending our Cluster Budget?

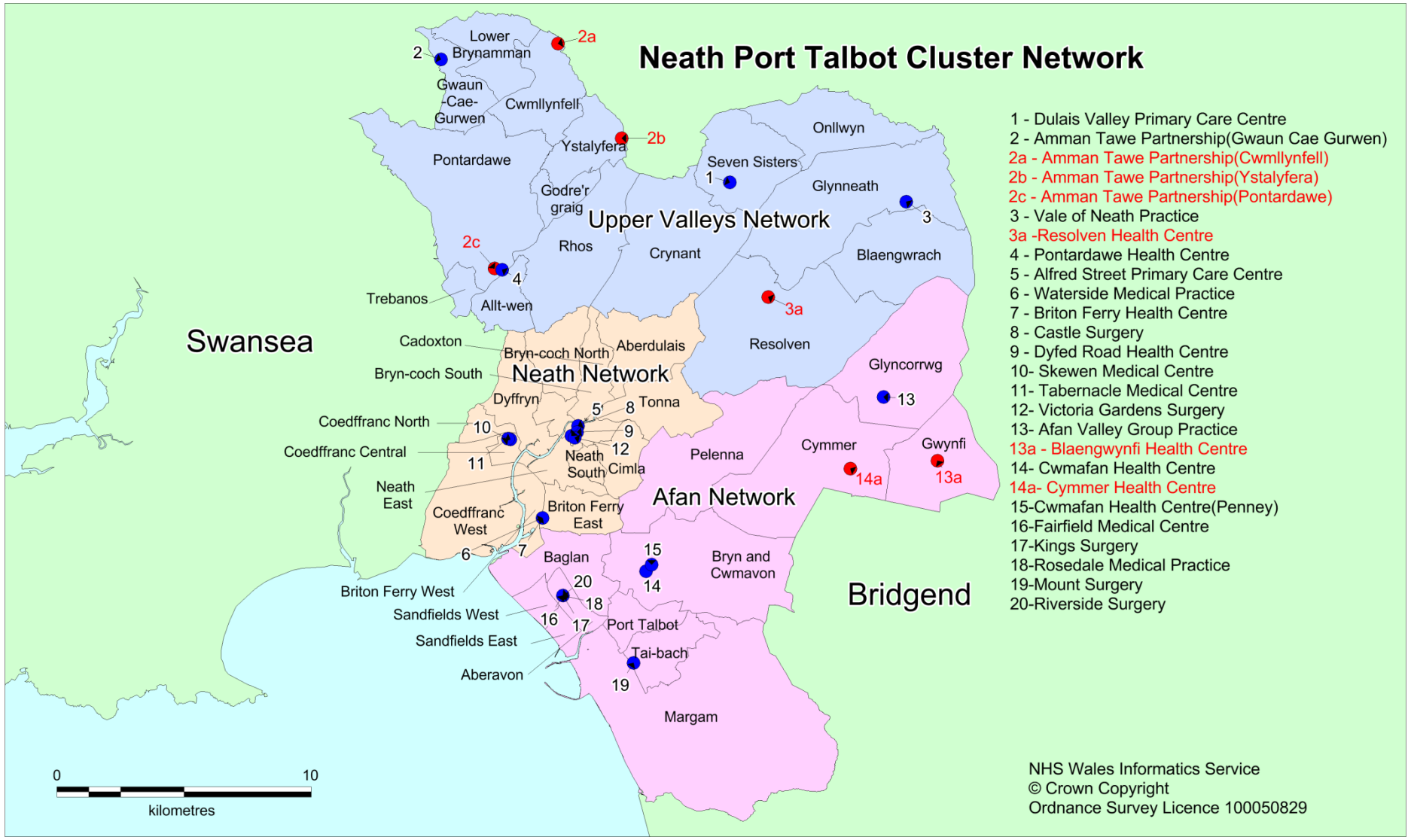
The Afan Cluster has a budget allocation of £ 179,299. The majority of the budget has been allocated to our preventative pre-diabetes initiative and the diversification of the skill mix within the cluster to effectively manage demand a final priority is the up skilling of staff to ensure quality and prudent healthcare principles are maintained.

Sustainability / Workforce challenges

There is a strong focus on sustainability of all practices within the Afan Cluster going forward. This will be improved by the training programme for HCSWs and other practice staff throughout 2017/18 and also by the development of other clinical roles to support the cluster as a whole, e.g. paramedic and pharmacist roles.

What does our cluster look like by 2020?

Geographically Afan is diverse with a mix of rural, semi rural and urban communities with limited employment opportunities. Local Development Plans are in place to increase new and social housing as well as a proposal to build a new prison in the cluster which will propose future demand challenges.


Neath Port Talbot Cluster Network
Upper Valleys Network
Neath Network
Afan Network
Swansea
Bridgend
Lower Brynamman
Gwaun -Cae- Gurwen
Cwmllynfell
Ystalyfera
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
Pelenna
Coedffranc West
Briton Ferry East
Briton Ferry West
Sandfields West
Sandfields East
Aberavon
Baglan
Bryn and Cwmavon
Port Talbot
Tai-bach
Margam
Glyncorrwg
Cymmer
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
kilometres
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KEY THEMES & PRIORITIES IDENTIFIED FROM PRACTICE DEVELOPMENT PLANS

Demography - Areas of high deprivation, unemployment and social issues are identified.

Needs Profile - High rates of chronic disease and long term conditions are identified.

Access Arrangements

- My Health Online and text messaging can bring efficiencies, help to facilitate better patient choice and self management and impact on DNA rates.
- Use of laptops to assist with remote access is being pursued.
- The numbers of and needs of the frail elderly and care home patients is increasing and puts pressure on GPs with an increased demand for house calls. This impacts on the number of surgery appointments that can be offered. Telephone First Triage can assist in demand management.
- Allocating specific timeslots for those who work or have caring responsibilities can improve patient experience.
- Sustainability issues may force some practices to consider reducing list sizes and some may apply to close their lists.

Education & Training

- Practice Placements will continue to be provided for medical students.
- GP Training collaboration, joint training sessions for GP registrars.
- Programme of Upskilling for HCSWs and other practice staff will take place during 2017 – all practices are signed up to

Service Provision

- Due to sustainability issues the focus will be on core GMS work.
- Increasing the skills mix in order for GP time to be better used is being pursued. The development of a “Hub Model” could provide Pharmacist, Paramedic and Mental Health support workers which would assist with closer working for all practices across the Afan Cluster.
- PTRC practices are considering how to work closer together to share current resources, e.g. sharing of identified clinics.
- Winter preparedness - Afan Cluster is working towards mechanisms for providing influenza vaccinations for patients from whom District Nursing have withdrawn provision.

Workforce

- Sustainability within Practices is a major cause for concern. The number of GPs is reducing and there is a general impact of staff retirements and recruitment issues in all staff groups.
- Cost of Locum GPs remains a significant issue.
- Reduced access to District Nursing input continues to have an impact on patient care.
- Continuity of Health Visiting support is highlighted as a concern.
- Health Board and Cluster to continue to recruit GP’s for the fellowship scheme.

Services Delivered

Afan Cluster Network								
	Rosedale	Afan Valley	ABMU (Cymmer / Cwmavon)	New Mount	Fairfield M C	Riverside	Kings Surgery	Cwmavon (Dr Penney)
Additional Clinical Services								
Cervical Screening	Y	Y	Y	Y	Y	Y	Y	Y
Contraceptive Services	Y	Y	Y	Y	Y	Y	Y	Y
Vaccinations & Immunisations (Non Childhood)	Y	Y	Y	Y	Y	Y	Y	Y
Childhood Vaccinations & Immunisations	Y	Y	Y	Y	Y	Y	Y	Y
Child Health Surveillance	Y	Y	Y	Y	Y	Y	Y	Y
Maternity Services	Y	Y	Y	Y	Y	Y	Y	Y
Minor Surgery	Y	Y	Y	Y	Y	Y	Y	Y
Directed Enhanced Services								
Childhood Immunisations	Y	Y	Y	Y	Y	Y	Y	Y
Influenza for those 65 and over and others at risk groups (2-3 year olds)	Y	Y	N	Y	Y	Y	Y	Y
Extended Minor Surgery	N	Y	Y	Y	Y	Y	Y	Y
Care of People with Learning Disabilities	Y	Y	Y	Y	Y	Y	Y	N
Care of People with Mental Illness	N	N	Y	N	Y	N	N	N
National Enhanced Services								
Anti-Coagulation (INR) Monitoring	Y	Y	Y	Y	Y	Y	Y	Y

Shingles Catch- Up Programme	Y	Y	Y	Y	Y	Y	Y	Y
Services to patients who are drug/alcohol misusers	N	N	Y	N	N	N	N	N
Local Enhanced Services								
Shared Care	N	N	Y	N	Y	Y	Y	N
Gonadorelins / Zoladex	Y	Y	Y	Y	Y	Y	Y	Y
Immunisations during outbreaks (MMR)	Y	Y	Y	Y	Y	Y	Y	Y
Care Homes	Y	Y	Y	Y	N	N	N	Y
Care of Homeless Patients	N	N	Y	Y	N	N	N	N
Hep B Vaccination of at risk groups	Y	N	Y	N	Y	N	Y	Y
Wound Management A	Y	Y	Y	Y	N	N	Y	Y
Wound Management Part B	N	N	Y	N	N	N	N	N
Wound Care SLA Feb 17 to Jun 17	Y	Y	Y	Y	N	N	Y	N
Men C Catch-up for University	Y	Y	Y	Y	Y	Y	Y	Y
Cross Border Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anti-coagulation level 4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	To identify pre-diabetics and tackle the problem of increasing levels in the cluster population	Te onset of diabetes is delayed or prevented	March 2018	GP Practices		GREEN
2.	To provide standardised training for HCSW to ensure they have appropriate skill levels to fulfil and develop their roles	Standardise cluster HCSW skills ensuring they are able to work at the top of their skill set.	March 2018	Practice Managers / Cluster Support Manager	Schedule of Training in place	GREEN
4.	To engage with patients to understand their experience of services and identify their needs.	Targeted health care to meet identified needs	March 2018	All Practices Supported by PC	A survey for use with the platform My Health Online is being developed (July 2017)	AMBER
5.	To ensure a consistent approach to the implementation of the public health agenda to support achievement of the NHS Tier 1 smoking cessation target	Increased referrals to "Help Me Quit" Support to the smoking population to make a quit attempt	March 2018	All Practices Help Me Quit Community Pharmacy PHW		AMBER

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
6.	To increase uptake of influenza vaccine in target groups	Reduced morbidity / patient demand / hospital admissions due to influenza	March 2018	PHW All Practice staff		AMBER
7.	To tackle obesity through interventions such as the local weight management programmes	Improved population health including the reduction in obesity and the likelihood of diabetes, heart disease and stroke	Ongoing	All Practices NERS		AMBER

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

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Recruit additional clinical roles within Primary Care to support and strengthen	Improved patient experience, more	Agree Job Descriptions	All Practices	Dr Mehta to liaise with WAST and feedback by late August	RED

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	the skill mix, i.e. Pharmacy and Paramedic roles	sustainable primary care services	Advertise and recruit			
2.	To provide standardised training for HCSW to ensure they have appropriate skill levels to fulfil and develop their roles	Standardise cluster HCSW skills ensuring they are able to work at the top of their skill set.	March 2018	Practice Managers / Cluster Support Manager	Schedule of Training in place	GREEN
3.	Explore the possibility of a Physician Associate role attached to the PTRC practices	Improved patient experience, more sustainable primary care services	Consider examples in other areas Advertised and recruit	PTRC practices		RED
4.	To improve recruitment and retention of GP's through support of the GP Fellowship Scheme	Improved patient experience, more sustainable primary care services	Map need across Cluster Advertise and recruit	MG Supported by AM		AMBER
5.	To ensure effective use IT software, development of appropriate of data collation frameworks /		March 2018	PC VIPC		GREEN

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	templates and provide identified support to all practices					

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.

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	To improve prescribing and medicines management including engagement in Prescribing Management Schemes and improving performance against National Prescribing Indicators	Improved outcomes from medicines	Ongoing	All Practices Supported by Medicines Management	All Practices are engaged in prescribing management schemes	GREEN
2.	Development of a prescribing dashboard for primary care	To improve safety and prescribing	March 2018	Medicines Management Cluster Representative		RED

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
3.	Engage with Secondary Care colleagues to facilitate better clinical referral pathways and appropriately commissioned services	Appropriate and timely treatment for patients	March 2018	All Practices Secondary Care departments ABMU Commissioning Boards		RED
4.	To increase and improve signposting to Third Sector Services	To provide more specialist and appropriate support for patients	March 2018	GP Practices Third Sector Cluster Representative		RED

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.

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Further improve antimicrobial stewardship	Improved outcomes and reduced resistance	Ongoing	All Practices		GREEN

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
		and side effects		Supported by Medicines Management		
2.	Flu vaccinations at home for elderly frail and housebound patients	Vulnerable, at risk groups are appropriately immunised	Audit and mapping of skills Delivery of immunisations	All Practices	Audit of GP databases undertaken to identify possible numbers, suitably qualified staff and capacity identified amongst current practice staff compliment	AMBER

Strategic Aim 5: Improving the delivery of cancer and COPD.

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	COPD – Follow guidance and maximise cost effectiveness of prescribing	Improved outcomes	March 2018 as per QoF guidance	All Practices Supported by Medicines Management	Cluster signed up for respiratory PMS+ until January 2018	AMBER
2.	To engage in the COPD national priority area for the management of patients with COPD	Higher percentage of accurate recording of COPD consultations	March 2018 as per QoF guidance	All practices		RED

No	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				
3.	To 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 as per QoF guidance	All practices		RED

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority – MMR vaccination rates

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	To engage in the locally agreed priority area for increasing the percentage	Higher rates of target population are	Contact target population Deliver immunisations	All Practices Supported by information from PHW		RED

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
		appropriately vaccinated				

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).

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Explore the development of a Cluster Website	Better Information Governance, consistent patient information, ease of access to information	Map providers Obtain initial practice information Engage provider to build website Ensure that information is kept up to date	All Practices Supported by PC		RED
2.	Cluster Lead to engage in Clinical Governance Meetings and Cluster Lead Meetings facilitated by Health Board in order to share good practice	Robust Clinical Governance is improved and monitored	Ongoing	MG Supported by AR / SP		GREEN

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	and ensure high quality and evidence based services are provided in Primary Care					
3.	Ensure that Information Sharing Protocols are in place to facilitate information exchange within the Cluster	Assurance of robust information sharing	Draw up ISP Obtain agreement from all Practices to content Submit to WASPI	All Practices Supported by PC		RED

Strategic Aim 8: Other Locality issues

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Improve practice premises to enable access and capacity to deliver new pathways	Improved facilities and sustainable services				RED

RISK REGISTER

ID Number	Date	Description of Risk and Impact	Mitigation	RAG	Lead
1.	01/08/2017	Recruitment and retention of staff, particularly GP's remains an issue. This is reflected on a national level. The expense and availability remains a specific concern.	Practices to consider diversification of workforce	RED	Cluster Lead
2.	01/08/2017	Limitations of service development due to need to identify and implement appropriate data sharing mechanisms		RED	Cluster Lead
3.	01/08/2017	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 them be re-referred to the most appropriate professional	Make use of GPC template to send back. Continue to raise at Health Board Senior Level through the NPT Medical Advisory Group, CG lead meetings and through Datix	RED	Cluster Lead