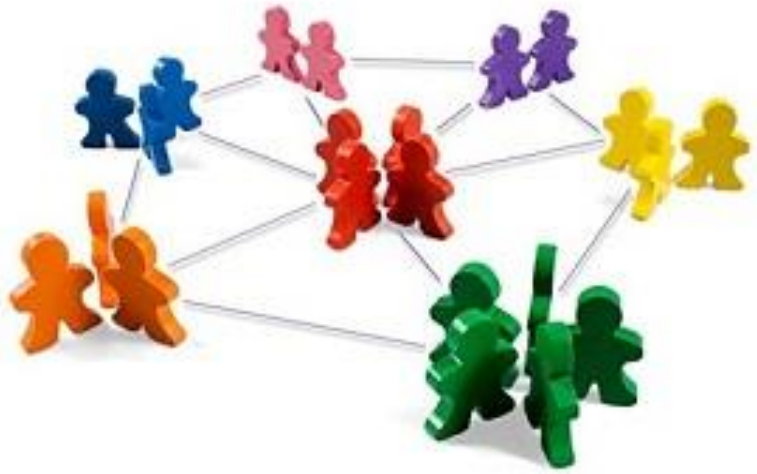
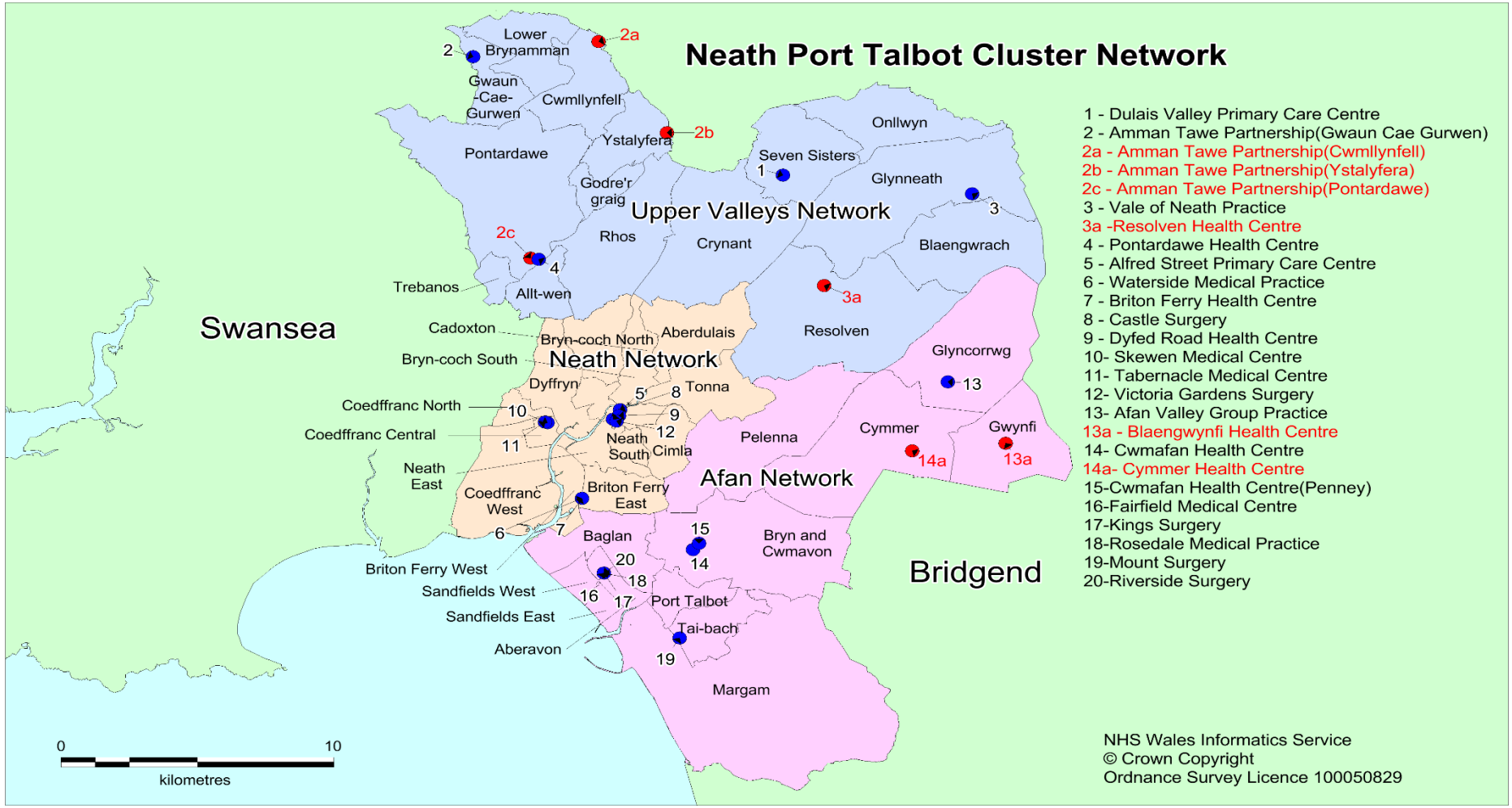
Three-Year Cluster Action Plan 2018 - 2021

Afan Cluster



1. ***Welcome to the Afan Three Year Cluster plan, 2018 - 2021***

Afan Cluster is one of the 11 clusters in Abertawe Bro Morgannwg University Health Board, geographically covering the Eastern wards of Neath Port Talbot County Borough Council. The Cluster shares boundaries with both Upper Valleys and Neath Clusters and with Bridgend County Borough Council.



Afan Cluster is made up of 8 GP practices, 4 practices are co-located within the Port Talbot Resource Centre (PTRC), 1 practice is split over two sites and is managed by the Health Board, 2 practices are engaged in GP training, 1 practice is a dispensing practice.

The cluster serves a registered population of 50,845 patients in an urban, semi rural environment, with the split of patients as below:-

GP Practice	Registered population
Afan Valley	2770
Kings	6736
Mount	10663
Cwmavon (Penney)	2245
Rosedale	4379
Riverside	9211
Fairfield	9018
Cymmer / Cwmavon (Health Board managed)	5823

The cluster aims to work together to:

- *Prevent ill health enabling people to keep themselves well and independent for as long as possible.*
- *Develop the range and quality of services that are provided in the community.*
- *Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.*
- *Improve communication and information sharing between different health, social care and voluntary sector professionals.*
- *Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.*

2. ***Our Local Health, Social Care and Wellbeing Needs and Priorities***

Information has been collated on a wide range of health needs within the Afan Cluster area in order to develop the priorities for this plan. 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, QoF data, audit reports and a series of cluster meetings.

The development of the plan has presented an opportunity for GP Practices in Afan to build on the progress made in 2017/18 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.

Between 2018 and 2021, Afan Cluster will continue exploring areas for development and in the first year will focus on the following priorities:-

- Increasing uptake of the flu vaccination
- Tackling Pre-Diabetes to reduce the onset of Diabetes
- Supporting patients to quit smoking
- Supporting patients to manage their weight
- Supporting the development of a multi-disciplinary HUB Model of service delivery
- Supporting the GP Fellowship Scheme
- Signposting patients appropriately to address their needs as quickly as possible

- Engaging in prescribing management schemes
- Implementing robust and sustainable IMT processes
- Meaningful engagement and coproduction with patients to understand their experience of services and to identify their needs
- Exploring areas of collaboration between GP practices, Secondary Care services and with Statutory Sector and Third Sector partners
- Ensuring robust validated clinical governance processes
- Promoting shared learning and good practice

3. ***SWOT analysis***

Key Population Features

- 50,845 patients registered with Afan Cluster GPs
- 50.1% female; 49.9% male
- 20.8% of patients are aged 65+ and 9.4% are aged 75+
- 5.8% live in a Lower Super Output Area (LSOA) that is classified as rural
- 49% of the Afan Cluster is in the category *most deprived area*, 32% is in *next most deprived area*
- 2.7% aged 65+ live in a nursing, non-nursing or other local authority care home
- 33.5% aged 65+ live alone
- 8.5% aged 16-74 are both economically active and unemployed

Population and Community Assets

- 2 Swimming Pools
- Several Community Centres
- An extensive range of Third Sector Organisations serves the Afan Cluster area providing services for example to Carers, those with mental health needs, citizens advice, care and repair, domestic abuse and a range of condition specific services e.g. Substance Misuse

Cluster Features

- Serves an urban, semi-rural geographical area
- Fairly static practice list sizes (0.3% increase between 2011 – 2017)
- 8 GP practices
- 13 Community Pharmacies, 7 Dental Practices and 3 Optometry Services
- 9 Nursing/Residential Homes within the cluster boundary, 7 out of 8 practices have signed up to deliver the Care Homes LES

Health Profile (comparative to all 11 clusters)

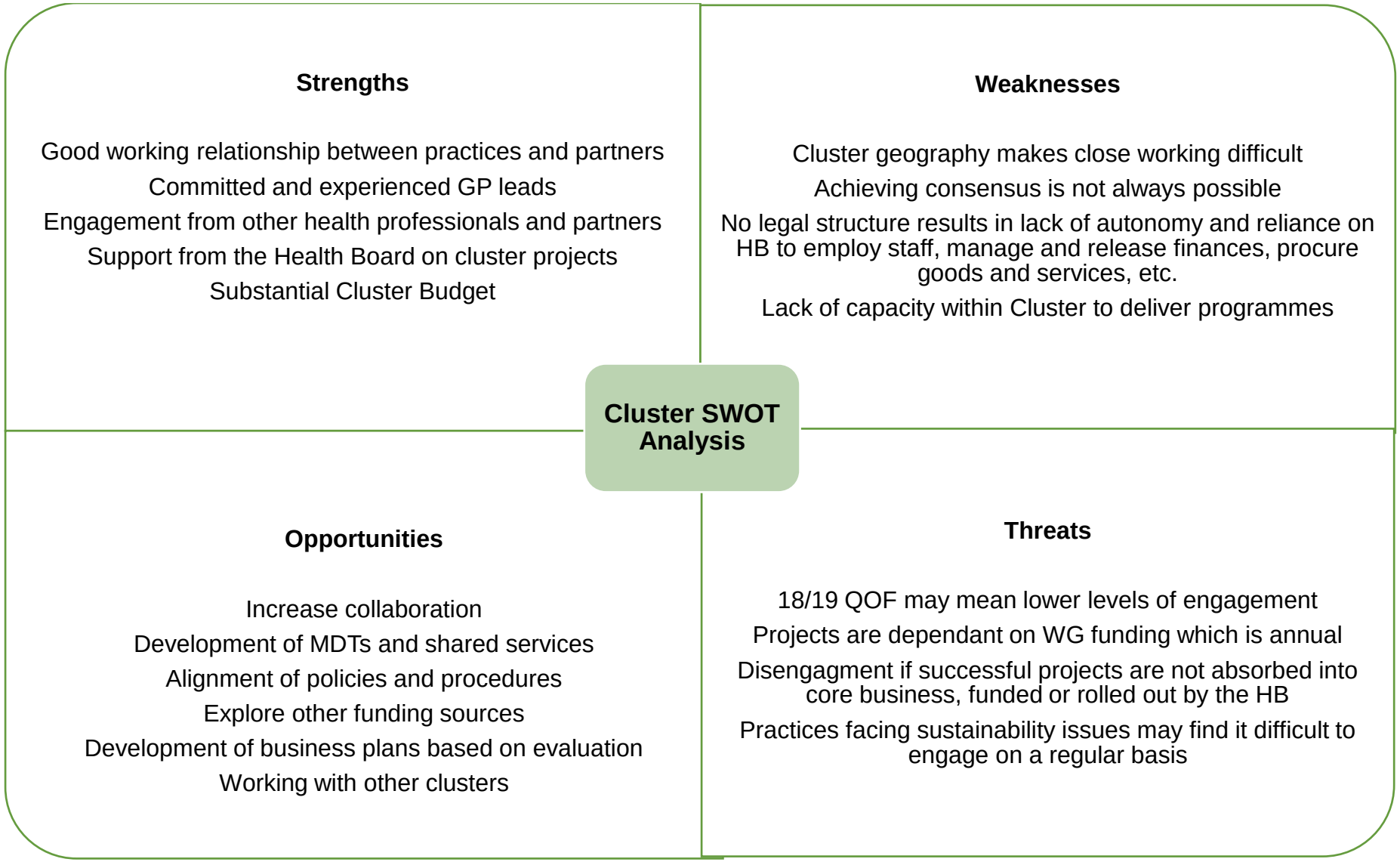
- **Chronic health conditions** - prevalence in Afan:-
  - COPD - 2.8% (2nd highest)
  - Diabetes - 7.5% (highest)
  - Cancer - 2.8% (joint 6th)
  - CVD - 3.15% (4th highest)
- **Flu Immunisation** - uptake at April 2018:-
  - 70% in patients 65+ (2nd highest)
  - 51% in patients <65 at risk (highest)
  - 57.5% in 2-3 year olds (highest)
- **A&E Attendances** - between April 2017 and March 2018 were at a rate of 390 per 1,000 (highest)
- **Smoking** - prevalence is 29.23% (3rd highest)
- **Alcohol** - aged 16+ with a record of alcohol intake is 82.85% (highest)
- **Cervical Screening** - uptake is 26.03% (4th highest)
- **Exercise** - 28.2% aged 16+ reported undertaking at least 30 minutes moderate exercise on five or more days in the previous week
- **Healthy Diet** - 30.4% aged 16+ reported consuming five or more portions of fruit or vegetables on the previous day. Obesity rates are 13.3% (2nd highest)

Service Demands

- **Complexity** - increasing number of patients presenting with comorbidities requiring long term care
- **Sustainability** - aging workforce, with inadequate succession plans in place
- **Recruitment** - difficulties in employing GPs and other Health Care Professionals
- **Economics** - low social economic area with pockets of deprivation resulting in high demand on health professionals

Other Influencing Factors

- **Transport** - Public transport is poor at the top geographical area of the cluster
- **Estates** - Primary care infrastructure is of variable quality across the cluster
- **Housing/Employment** - High levels of social housing and unemployment across the cluster
- **Environment** - Local Industry impacts on air quality in the lower geographical area of the cluster


Strengths
Good working relationship between practices and partners
Committed and experienced GP leads
Engagement from other health professionals and partners
Support from the Health Board on cluster projects
Substantial Cluster Budget
Weaknesses
Cluster geography makes close working difficult
Achieving consensus is not always possible
No legal structure results in lack of autonomy and reliance on HB to employ staff, manage and release finances, procure goods and services, etc.
Lack of capacity within Cluster to deliver programmes
Cluster SWOT Analysis
Opportunities
Increase collaboration
Development of MDTs and shared services
Alignment of policies and procedures
Explore other funding sources
Development of business plans based on evaluation
Working with other clusters
Threats
18/19 QOF may mean lower levels of engagement
Projects are dependant on WG funding which is annual
Disengagment if successful projects are not absorbed into core business, funded or rolled out by the HB
Practices facing sustainability issues may find it difficult to engage on a regular basis

4. ***Cluster Vision***

The Afan Cluster Vision sets out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Afan Cluster area and its practices.

Through the delivery of our plans we will work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales in 'a Healthier Wales' (2018):

- ✓ improved population health and wellbeing
- ✓ better quality and more accessible health and social care services
- ✓ higher value health and social care
- ✓ a motivated and sustainable health and social care workforce

The Cluster will work collaboratively with Public Health to achieve the outcomes noted in the 'Burden of Disease' Action Plan by adopting the five ways of working as outlined in the Wellbeing of Future Generations Act. (Long term, integrated, involving, collaborative, prevention)

Our Vision is:

To enable communication between the right people at the right time leading to cohesive working for the betterment of the population with provision of equitable services across the Network that are safe, timely and accessible.

5. ***Afan Cluster Practice Priority Areas***

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

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
1.1	Identify Pre-Diabetics and tackle the problem of increasing levels of diabetes in the cluster population	All Practices	Ongoing	Pre-Diabetics will be identified, given lifestyle advice, monitored and long term the prevalence in the cluster population will decrease and the onset of diabetes is prevented or slowed down.	• All practices continue with Pre-Diabetes project, consistently achieving high levels of engagement. • Programme of Level 2 Food and Nutrition Training and Annual Refresher Training is being implemented and will be delivered by ABMU Dietetics.	Amber
1.2	Engage with patients to understand their experience of services and identify their needs	All Practices (supported by Palexra)	Ongoing	Targeted health care will be delivered and will meet identified needs	• Online version of GPAQ survey developed which can be completed on mobile phones. • Taken forward by 2 other practices along with Mount Surgery. • All Afan Cluster practices to be re-engaged again with the aim of full sign up for 2018/19.	Amber

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
1.3	Ensure a consistent approach to the implementation of the public health agenda to support achievement of the NHS Tier 1 smoking cessation target	All Practices Help Me Quit Community Pharmacy PHW	Ongoing	An increase in referrals to “Help Me Quit” Better support to the smoking population to make an attempt to quit		Amber
1.4	Increase uptake of influenza vaccine in target groups	PHW All Practice Staff	Ongoing	A reduction in morbidity/patient demand/hospital admissions due to influenza		Amber
1.5	Tackle obesity through interventions such as the local weight management programmes	All Practices NERS	Ongoing	Improved population health including reduction in obesity and the likelihood of diabetes, heart disease and stroke		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	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
2.1	Recruit additional clinical roles within Primary Care to support and strengthen the skill mix, e.g. Physicians Associates, Pharmacy and Physiotherapist roles and support the development of a multidisciplinary HUB Model of service delivery including the redesign of how services are delivered in the Port Talbot Resource Centre to meet individuals needs	All Practices ABMU HB	Ongoing	Improved patient experience, more sustainable primary care services	• Three newly qualified Physicians Associates appointed in the cluster with ongoing training and liaison with University and intention to develop further opportunities in subsequent years. • Further Cluster discussions needed in relation to Pharmacy and other roles that would assist in widening skill mix and assist in sustainability. • HUB Steering Group established to scope the elements required by Afan Cluster for a HUB Model.	Amber
2.2	Improve recruitment and retention of GPs through support of the GP Fellowship Scheme	Cluster Lead (supported by Unit Clinical Director)	Ongoing	Improved patient experience, more sustainable primary care services	• Cluster has continued to support and remains committed to GP Fellowship Scheme	Amber

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
2.3	Ensure effective use of IT software, development of appropriate data collation frameworks / templates and provide identified support to all practices	Palexra (Paul Carmichael)	March 2019	All Practices able to fully utilise their IT systems in a consistent and timely manner	• All practices engaged. • Paul has undertaken training with Vision for the development of logic based Vision+ templates which will enable Afan cluster to develop and future proof data collection requirements for upcoming projects.	Green
2.4	Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of: • Infoengine • Dewis • Social Prescribing • Local Area Coordination	All	Ongoing	Patients are more informed and empowered to manage their own health and prevention of ill health		Amber

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	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
3.1	Improve prescribing and medicines management including engagement in Prescribing Management Schemes and improving performance against National Prescribing Indicators.	All Practices (supported by ABMU HB Medicines Management)	Ongoing	Improved outcomes from Medicines	• Engagement continuing • Outcomes being achieved	Amber
3.2	Development of a prescribing dashboard for Primary Care	ABMU HB Medicines Management Cluster Representative	March 2019	Improved safety and prescribing	• Prescribing data shared at annual visits and prescribing leads. • Cluster savings opportunities dashboard produced for 2018/19 PMS+. • Ad Hoc prescribing data to be shared as required. • Limited demand and capacity to produce anything further at this time	Amber
3.3	Engage with Secondary Care colleagues to facilitate better clinical referral pathways and	All Practices	March 2019	Appropriate and timely treatment for patients		Amber

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
	appropriately commissioned services	Secondary Care Departments ABMU Commissioning Boards				
3.4	To increase and improve sign posting to Third Sector partner organisations	All Practices Third Sector Cluster Representative	March 2019	Patients receive specialist and appropriate support from Third Sector partners	• Attendance of NPTCVS Health and Wellbeing Facilitator at Cluster meetings provides a link to Third Sector partner organisations in NPT. • Services provided by Citizens Advice via ABMU SLA have been remodelled to provide most appropriate and responsive services for patients within Afan Cluster.	Amber
3.5	Maximise the use of digital solutions to support the delivery of primary care services e.g. My Health Online and QR Information Boards	All	Ongoing	Patients are more readily able to access information in a timely manner		Amber

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

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
4.1	Further improve antimicrobial stewardship	All Practices (supported by ABMU HB Medicines Management)	Ongoing	Improved outcomes and reduced resistance and side effects	• Afan Cluster is an outlier with the highest rates of prescribing compared to all other clusters. • Increases in prescribing of co-amoxiclav, quinolones and cephalosporins were also noted in the Afan Cluster.	Amber
4.2	Flu vaccinations at home for elderly frail and housebound patients	All Practices	January 2019	Vulnerable, at risk groups are appropriately immunised	• Audit of GP databases undertaken to identify possible numbers, suitably qualified staff and capacity identified amongst current practice staff compliment. • Programme of flu vaccinations planned and delivered within patients homes.	Green
4.3	Active Promotion of Choose Well and Winter health initiatives such as My Winter	All	Ongoing	Individuals access appropriate services at the right time		Amber

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
	Health Plan to reduce demand on unscheduled care services					

Strategic Aim 5: To develop the Cluster as a structure for delivery of identified priorities

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
5.1	Development of a common patient information tools (i.e. QR Pods, Cluster Website)	All Practices (supported by Palexra)	Ongoing	Better information governance, consistent patient information, ease of access to information	• Concept explored and agreed in the Cluster Development Session	Green
5.2	Cluster Lead to engage in Clinical Governance Meetings and Cluster Lead Meetings facilitated by Health Board in order to share good practice and ensure high quality and evidence based services are provided in Primary Care	Cluster Lead (supported by Unit Medical Director and Head of Primary Care)	Ongoing	Robust Clinical Governance is improved and monitored	• Cluster Lead is engaged in relevant fora and attends meetings	Green

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
5.3	Ensure GDPR compliance	All Practices	March 2019	Appropriate Clinical information flows		Green

Strategic Aim 6: Other Cluster and area specific issues

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
6.1	Improve GP premises to enable access and capacity to deliver new pathways	All Practices (supported by ABMU Primary Care Estates Manager)	Ongoing	Improved facilities and sustainable services	• ABMU Primary Care Estates Manager has undertaken an audit of current premises • Maximum utilisation of HB owned premises	Amber
6.2	Support the Delivery of three Business Cases for IMTP inclusion based on key service delivery schemes which support Primary Care: a) Cluster Physiotherapy b) Cluster Pharmacists,	All	Dec 2018	These three area have been piloted by Clusters over recent years and have been seen to provide benefits to access and patient experience alike. The principle that Cluster monies were provided to facilitate innovation now means	• The three cases are to be included for consideration in this year's IMTP process in both ABMU & Cwm Taf.	Amber

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
	c) Cluster Tier 0 Mental Health and wellbeing support			there is a need to identify alternative funding for such projects where benefits have been demonstrated		