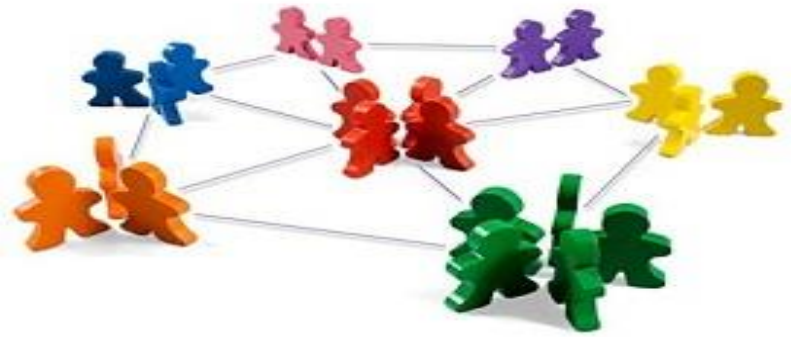
Three Year Cluster Network Action Plan 2017-2020

Neath Cluster



VERSION CONTROL: Version 3 (25th July 2017)

Introduction

ABMU is comprised of GP 11 Clusters. Neath Cluster consists of the following GP practices:

GP Practice	Practice Registered population January 2017
Alfred Street PCC	2413
Waterside Med Centre	5611
Briton Ferry Health Centre	5966
Castle Surgery	11240
Dyfed Road Health Centre	9778
Skewen Medical Centre	8344
Tabernacle Medical Centre	4977
Victoria Gardens Surgery	8206
Total Registered Population	**56,535**

In line with the requirements of the Quality & Outcomes Framework (QoF) Cluster Network Domain 2017/18 the Neath 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 Neath to build on the progress made in 2016/17 and has involved partners from Public Health Wales, the 3rd Sector, and other Health Board teams and directorates namely medicines management, physiotherapy, mental health, audiology and district nursing. More work will be done in the coming months and years to ensure that a wider range of partners, including other primary care providers and social and other local authority services, are involved in cluster planning.

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

Prevention

Each GP practice identified a wellbeing champion, and worked towards improving uptake of flu vaccines. The practices also participated in a project aimed at identifying and offering lifestyle advice to pre-diabetic patients and patients at risk of developing prediabetes pre-diabetes project

Demand Management and sustainability

The cluster developed and implemented a pacesetter primary care hub made up of a pool of shared professionals (pharmacist, physiotherapist and mental health support worker) and this service has supported them in managing patient demand.

Upgrading telephone systems to support demand management and telephone consultation

Practices reviewed their telephone systems and upgraded their systems to suitable specification.

Med Management

38 prescribing clerks across the cluster 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 funded the post of a pharmacy technician who supported practices with a focus on repeat prescribing, prescription queries and clinical audit, liaising with various health and social care professionals, visiting care homes and directly supporting patients to help them take and understand their medicines and identify any potential issues. All practices also participated in the prescribing management schemes and improved prescribing in key areas including antibiotics, pain medication and inhaler prescribing.

Anticipatory Care

Patients registered in the cluster practices benefited from the anticipatory care project which identifies vulnerable patients who require an anticipatory care plan

Bowel Screening Pilot

The cluster participated in a PHW bowel screening pilot project and results show an increase in uptake.

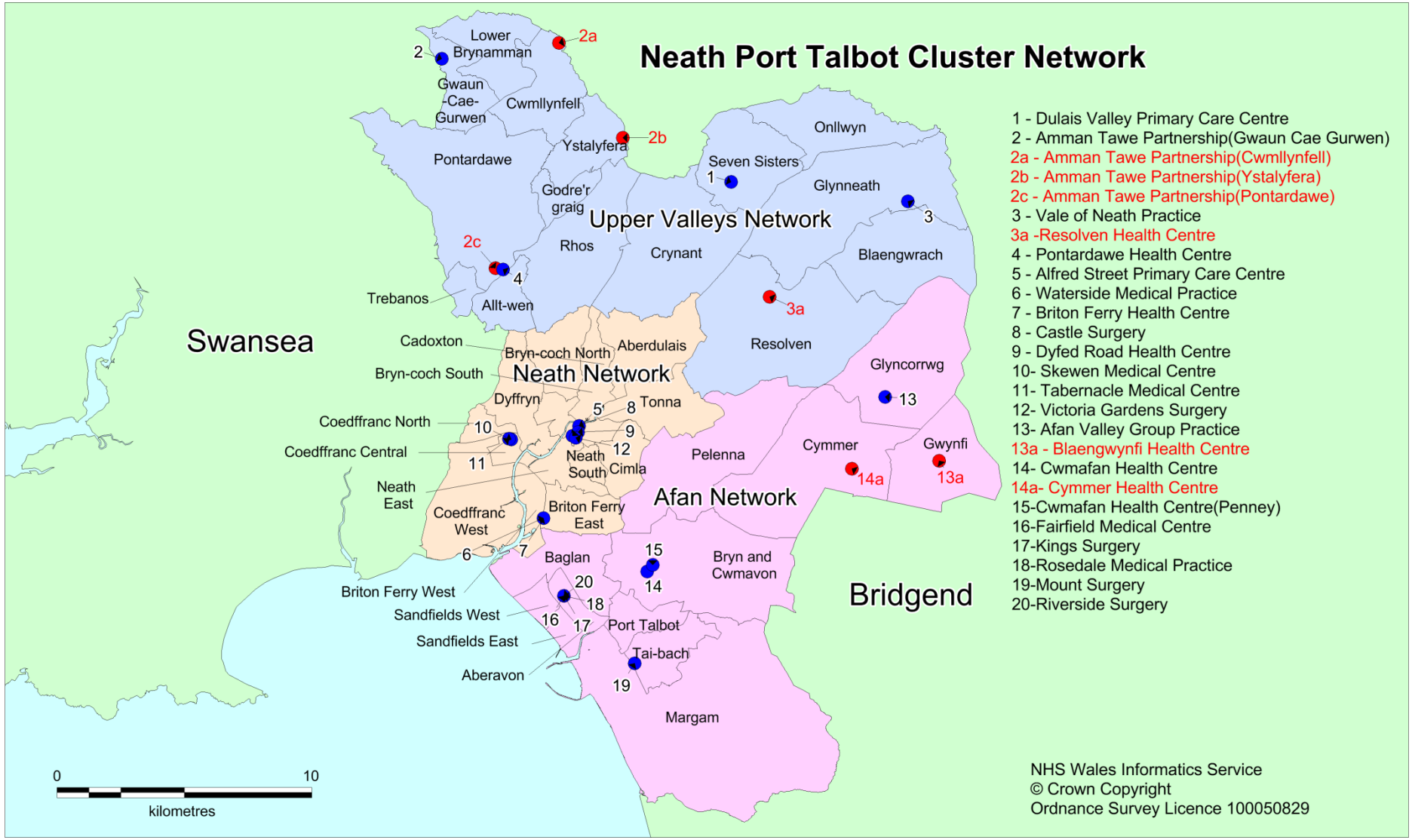
Practice Staff training

Each practice assessed its training needs and organised training for its staff thereby improving their knowledge and skills.

The cluster received a recurrent allocation of £183,705 from Welsh Government in 2016/17. This sum was spent on implementing the objectives and initiatives in the cluster plan including the employment of a pharmacy technician, the pre-diabetes project, telephone system upgrades and the upskilling of practice staff. Plans are in place to utilise the allocation in 2017/18.

Practices in the cluster are as are other clusters in Wales, facing 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. The cluster plan seeks to implement initiatives which will not only help to address sustainability issues but also benefit the local population.

The 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
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
Coedffranc West
Briton Ferry East
Briton Ferry West
Sandfields West
Sandfields East
Aberavon
Baglan
Bryn and Cwmavon
Pelenna
Cymmer
Glyncorrwg
Gwynfi
Port Talbot
Tai-bach
Margam
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

- Between 2016 & 2017 the overall cluster list size has decreased by .1%. However, a recent temporary list closure by a practice which between 2011 – 2017, has seen an increase of 7% in its list size and a reduction in its GP workforce is resulting in increasing list sizes in some of the other cluster practices.
- A few practice have also seen an increased patient base due to new local housing developments
- The cluster has an increasing elderly population with 22.2% of the registered population 65+ and 10.1% over 75 (both demographic are over the ABMU average of 19.7% and 8.9% respectively)
- There are high levels of deprivation, with high levels of low income and unemployment, some of which is perceived to be linked to the redundancies at TATA Steel.

Needs Profile

The Cluster:

- Has a high proportion of smokers (21.2%) and needs to increase referrals to smoking cessation services
- Is not yet meeting the WG targets for immunisations and vaccinations, particularly influenza vaccination uptake for the 65+, under 65 in clinical risk groups, children aged 2 & 3 and MMR vaccines.
- Has a high prevalence of obesity (62% of adults and 26.8% of under 5s in NPT), coupled with low levels of physical activity and poor rates of referrals, and patient uptake of NERS.
- Has more patients with mental health issues (including young people) with depression or anxiety than the ABMU average.
- Has poor uptake of cervical screening, though a good uptake of AAA and breast screening

Access Arrangements

- 6 out of the 8 Cluster practices are offering a full telephone first model, with same day appointments for all patients who need to see a GP. 2 practices offer a mixture of telephone first and pre-bookable appointments
- The Cluster will continue to develop the Neath Primary Care Hub of shared services and professionals including Physiotherapists, Mental Health Support Worker, Pharmacist and Audiologists to support the management of patient demand.

Service Provision

- Cluster practices continue to provide enhanced services to patients and continue to participate in the pre-diabetes screening project. The cluster will develop clear protocols and pathways for referrals
- Practices also have identified the need to work more closely with the 3rd Sector to signpost patients appropriately.
- The cluster will engage more closely with patients as well as other primary care, social services another providers to meet the needs of the community

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 and online courses available to improve skill set, and utilise Pt4L sessions as required.

Workforce

- Sustainability: Recruitment of GP's, retirement, locums remains an issue. The cluster is committed to assessing 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

Neath Cluster Network	Waterside Briton Ferry	Dyfed Road	Castle Surgery	Skewen Medical Centre	Victoria Gardens	Dr Wilkes & Partners	Tabernacle Street	Alfred Street
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	**N**	✓	✓	✓	✓	✓	✓	**N**
Care of People with Learning Disabilities	✓	✓	✓	✓	✓	✓	✓	✓
Care of People with Mental Illness	**N**	**N**	**N**	✓	**N**	**N**	**N**	**N**
National Enhanced Services								
Anti Coagulation (INR) Monitoring	✓	✓	✓	✓	✓	✓	✓	✓

Services Delivered

Neath Cluster Network	Waterside Briton Ferry	Dyfed Road	Castle Surgery	Skewen Medical Centre	Victoria Gardens	Dr Wilkes & Partners	Tabernacle Street	Alfred Street
Shingles Catch- Up Programme	✓	✓	✓	✓	✓	✓	✓	✓
Services to patients who are drug/alcohol misusers	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Local Enhanced Services								
Shared Care	**N**	✓	✓	✓	**N**	✓	✓	**N**
Gonadorelins / Zoladex	✓	✓	✓	✓	✓	✓	✓	✓
Immunisations during outbreaks (MMR)	✓	✓	✓	✓	✓	✓	✓	✓
Care Homes	✓	**N**	**N**	✓	**N**	✓	✓	✓
Care of Homeless Patients	**N**	**N**	**N**	**N**	**N**	**N**	✓	**N**
Hep B Vaccination of at risk groups	✓	**N**	✓	✓	**N**	✓	✓	✓
Wound Management A	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Wound Management Part B	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Wound Care SLA Feb 17 to Jun 17	✓	✓	✓	✓	✓	**N**	✓	✓
Men C Catch-up for University	✓	✓	✓	✓	✓	✓	✓	✓
Cross Border Patients	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Anti-coagulation level 4 – ** Practices awaiting equipment and training.	**	**	**	**	**	**	✓	**

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.	**To develop a network of GP practice Wellbeing Champions**	Patients receive timely, targeted and appropriate health and lifestyle advise	March 2018	Local Public Health Team Wellbeing and 3rd sector sub group GP practice Wellbeing Champions	**Action:** • Identify practice Wellbeing Champions • Scope project and role of Wellbeing Champion • Deliver targeted training to champions • Monitor activity of champions • Evaluate Wellbeing Champions project (6 monthly initially)	**A**
1.2.	**To identify pre-diabetics & tackle problem of increasing levels of diabetes in Cluster population**	The onset of diabetes is delayed or prevented. [Community network project initiated by Dr Mark Goodwin (Afan Valley Cluster)]	March 2018	GP practices Practice Managers Practice Wellbeing Champions	**Action:** • Continue to engage with Pre-diabetes scheme (Afan Valley model) to identify patients at risk of pre-diabetes • Train appropriate staff to deliver intervention • Identify pre-diabetics (run searches) • Invite to come into surgery • Perform tests etc. to identify status (HbA1c) • Deliver "healthy lifestyle" intervention • Monitor outcomes at regular intervals • Review project at the end of 2018	**G**
1.3.	**To tackle obesity amongst patients in Cluster**	Patients engage in exercise programmes	March 2018 (thereafter ongoing each year)	Local Public Health Team Dieticians 3rd sector NERS	**Action:** • Link to pre-diabetes screening project • Follow-up patients 6 monthly to check weight etc. • Improve NERS referral rates across the cluster	**A**

1.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
		Improved education on healthy eating Reduction of obesity			• Work with ABMU nutrition and dietetics department to target obesity • Work with 3rd sector to develop signposting materials of local services related to healthy lifestyles	
1.4.	**To develop a consistent approach within Cluster to reduce smoking** **Practices to assist with branding and promotion of the new "Help Me Quit" smoking cessation service**	Increased referrals to "Help Me Quit" Reduced local prevalence of smoking – reduced morbidity / mortality	March 2018 (thereafter ongoing each year)	Local Public Health Team GP practice Wellbeing Champions Community pharmacies	**Action:** • Work with Local Public Health team to develop and implement sustainable processes/initiatives that lead to increased referrals to the Help Me Quit local smoking cessation services" • Increase engagement with the local Pharmacies Level 3 service • "Wellbeing Champions" to support staff to 'Make every contact count' and to signpost smokers to appropriate services. • Practices to take part in a cluster wide No Smoking day campaign	**A**
1.5.	**To increase uptake of influenza vaccine in target groups**	Reduce morbidity / mortality / hospital admissions due to influenza	March 2018 and ongoing	Local Public Health Team GP practice Wellbeing Champions Involve ALL practice staff	**Action:** • Regularly review IVOR data for flu vaccination • Work with Local Public Health Team to develop and implement sustainable processes/initiatives that lead to increased uptake of flu vaccination and childhood immunisation. • Review processes to enable the increase of uptake of the flu vaccination in the 'aged under 65 years and at risk' group. • Practices to share "best practice"	**A**

1.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.6.	**To engage with patients to understand their experience of services and to identify their needs**	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 • Organise "Patient Engagement Event" on a Cluster-wide basis at a central location	**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.	**To manage demand in GP practices by utilising the services available at the Neath Primary Care Hub**	Improved access to appropriate services and healthcare professional Reduction of GP workload that is not appropriate	March 2018 (thereafter ongoing each year)	Hub Operational Manager GPs, clinical and admin staff Staff employed in Hub	**Action:** • Evaluate the Neath Primary Care Hub • Develop a business case for sustainability and continued development of the Primary Care Hub • Expand the Hub to include a wider range of services / professionals	**A**

2.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
2.2.	**To provide standardised training for HCSW & Receptionists to ensure that they have the skills to perform their roles**	Standardise Cluster HCSW skills ensuring they are able to work at the top of their skills set.	March 2018	Practice Managers HCSW and Receptionists "Health Train" organisation	**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 • Evaluate skills development programme	**A**
2.3.	**To ensure appropriate use of Cluster Technician and Pharmacist where available**	Improved Medicines management Remove burden of Meds Mgt from GPs	Ongoing dependant on funding	GP practices Medicines Management Technician Cluster Pharmacist	**Action:** • Recruit to vacant post of Medicines Management Technician • Continue to develop role to meet the needs of the Cluster and to review service provided by technician. • Needs assessment for Pharmacist underway	A
2.4.	**To improve recruitment and retention of GPs through support of the GP Fellowship Scheme.**	Practices which have sustainability issues and are able to access GPs employed under the Scheme	2018 and ongoing	Clinical Director (sustainability) GP practices	**Action:** • Cluster to continue funding agreed proportion of the Fellowship incentive scheme	A
2.5.	**To increase collaboration between GP practices and other primary care providers, social services, Community**	GP practices are better able to manage demand & improve patient care / experience	2018 and ongoing	GP practices Other primary care providers	**Action:** Explore opportunities for collaboration • Between practices .e.g. DES delivered across the cluster, back office functions which could be shared;	A

2.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	Resource Team and other Cluster partners				• With other primary care providers e.g. common ailments scheme with community pharmacies etc. • With the Dementia Support Team (Jo Blanco-Martin) • With the Anticipatory Care Team (Rachel Meyer)With social services and other partners • Implement agreed decisions	

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.	**To continue improving prescribing and medicines management including engagement in Prescribing Management Schemes and improving performance against National Prescribing indicators**	Improved Medicines Management Prudent use of finite resources Improved patient care	2018 and Ongoing	GP practices Medicines Management Team Cluster Pharmacist	**Action:** • Practices to continue engaging in the prescribing management schemes (PMS) and sustain improvements against most indicators	G

3.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
3.2.	**To better manage patients by directing them to the most appropriate professional**	Improved rapid access to appropriate diagnostic / treatment services	March 2018 (then ongoing)	GP Practices Hub operational manager Hub Staff	**Action:** • Continue patient referrals to Primary Care Hub Physiotherapists, Wellbeing (Mental Health) Support, Pharmacy Staff (if the hub decides to recruit to the vacant post) and Audiologists • Regularly review Primary Care Hub activity.	**A**
3.3.	**To increase GP participation in the ABMU anticipatory Care planning for those most vulnerable in the community who are at risk of losing their independence**	Vulnerable patients are identified and personalised care plans developed to enable a quicker response in care pathways	March 2018 and ongoing	GP practices Anticipatory Care Team Dementia Support Team	**Action:** • GP practices engage with the Anticipatory Care Project • Regular reports on activity are received by the cluster • Practices to engage with Dementia Support Team (Jo Blanco-Martin & Team)	**A**
3.4.	**To 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**
3.5.	**To increase and improve signposting**	To provide more specialist and appropriate	March 2017 (then ongoing)	GP Practices 3rd Sector	**Action:** • Work with the 3rd sector to map available 3rd sector services	**A**

3.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
	to Third Sector services	support for patients		Wellbeing (Mental Health Support Worker Wellbeing champions	• Widen engagement with 3rd sector linked to identified cluster themes	

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.	**To increase uptake of the Flu vaccination**	Reduce morbidity / mortality / hospital admissions due to influenza	March 2018 and ongoing	Local Public Health Team GP practice Wellbeing Champions	**Action:** (See strategic aim 1 above)	**A**
4.2.	**To better manage patients with COPD**	Unscheduled admissions of patients with COPD are prevented	March 2018 and ongoing	GP practices Medicines Management Team 3rd sector	**Action:** • Link with the COPD national priority are (See Strategic Aim 5 below) • In addition follow guidance under the respiratory PMS, and maximise cost effectiveness of prescribing • Use effective antibiotics first line in exacerbations	**A**

4.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
					• Educate patients to complete course of antibiotics every time • Engage with 3rd sector organisations which support patients with COPD • Maximise Flu / Pneumovax immunisation • Refer to "Help Me Quit" • "Wellbeing Champions" to deliver brief intervention re smoking / lifestyle	
4.3.	**To manage patients with common ailments in the community rather than in GP Practice. Improve patient education**	GP practices see fewer patients with common ailments	March 2017 and ongoing	LHB Community Pharmacies GP practices	**Action:** • Work with community pharmacies as they implement the new common ailments scheme • Refresh and deliver "Choose Well" campaign through Practices	**A**
4.4.	**To promote self-care through patient education**	Generally improve health of patient population Reduce burden on GP Practices	March 2017 and ongoing	Wellbeing Champions All Practice staff Public Health resources	**Action:** • Engage with Patient Participation Groups at practices to support "Choose Well" and patient education. • Explore avenues such as ABMU social media platform to disseminate patient information and messages.	**A**
4.5.	**To further improve antimicrobial stewardship**	Improved outcomes and reduced resistance and side effects	March 2017 and Ongoing	GP practices Medicines Management team Practice Antibiotic Lead	**Action:** • Undertake antibiotic audit linked to PMS • Follow up to date health board antimicrobial guidelines • Educate patients regarding antimicrobial stewardship	G

4.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
				Wellbeing Champions	• Monitor prescribing data and discuss at Cluster Meetings	

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.	**To engage in the COPD national priority area for the management of patients with COPD**	Higher percentage of accurate coding and recording of COPD consultations More appropriate prescribing and referrals Improvements being measured by the practice and shared with the cluster	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**

5.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
5.2.	**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 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.	**To engage in the locally agreed priority area for increasing the percentage of children who have received 2 doses of MMR vaccination by age of 5 years to over 95%**	Increase uptake of the MMR Vaccine Prevent outbreaks of measles	2018 - ongoing	**Public Health**	**Action:** Using a PDSA cycle: • 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	**A**

6.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
					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)	

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.	**To improve systems of clinical governance in GP practices**	Improve education of clinicians and hence improve patient care.	March 2018 (then ongoing	GP Practices LHB (Datix)	**Action:** Practices to: • Update the Clinical Governance Practice Self-Assessment Toolkit • Complete the Information Governance Self-Assessment Toolkit • Utilise learning / outcomes from same in peer review at cluster meeting	**A**

7.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
					• Participate in the peer reviews of the designated inactive QOF indicators (2017/18) • 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 • Continue reporting significant events on the Datix system • Participate in ABMU Clinical Governance forum	

Strategic Aim 8: Other Locality issues

8.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
8.1.	**To support practices which are facing issues of sustainability**	Continuation of primary care services to all patients in Cluster	March 2017 and ongoing	**LHB** Practices in Cluster Welsh Government	**Actions:** • All practices to complete "Sustainability template" & monitor changes regularly • Evaluate / quantify any "spare capacity" that practices may have to take on more patients from struggling practices. • Continue to participate in the GP Fellowship scheme incentive scheme (2 GPs now recruited and allocated to Practices in the Cluster) • Evaluate Federation model as an option to help sustainability • Explore alternative models of loan finance to encourage new Partners to join practices	**A**

8.	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
					• Explore possibility of expanding “Fellowship” model to include ANPs / Physios / Pharmacy Techs • Where sustainability not possible, consider merger opportunities	
8.2.	**To facilitate and support the upgrading of practice premises where needed**	Ensure “safety / suitability” of premises Continuation of primary care services to all patients in Cluster		**LHB** Welsh Government	**Actions:** • Appropriate section of “sustainability template” to be completed • Evaluate alternative models of financing premises, e.g.: Practice vs Individual GP loans / mortgages • Consider “Partnership” working with private sector e.g. Pharmacies	**A**

RISK REGISTER 2017/18

ID Number	Date	Description of Risk and Impact	Mitigation	RAG	Lead
1.0	**1/8/2017**	**Practice sustainability** Recruitment and Retention issues Failure to recruit additional GPs Expense and availability of Locums to provide cover. Reflection of national recruitment and retention problems. GP practice sustainability issues.	Consider national sustainability framework application Practices to consider workforce skill-mix Opportunities for cluster initiatives to support practices. Re-routing of patient demand through Primary Care Hub	**A**	**Cluster Lead**
2.0	**1/8/2017**	**Sustainability of Neath Primary Care Hub** Welsh Government Funding for the hub ends 2018 Internally, funding reduced by 50% in 2017/18 Unless agreement for funding is reached, services may be unstainable	Evaluate Primary Care Hub impact Develop business case for sustainability Consider alternative funding options	**A**	**Cluster Lead**
3.0	**1/8/2017**	**Fully utilising Welsh Government allocation** The cluster has received recurrent funding from Welsh Government Cluster must utilise funds on projects which add value and improve services for patients and address sustainability of practices Projects take time to develop.	Cluster to work with partners to develop and agree projects for spend within financial year	**A**	**Cluster Lead**
4.0	**1/8/2017**	**Downgrading of Urgent Suspected Cancers** Could result in delayed cancer diagnosis especially if not communicated effectively to referring clinician	Proactively challenge USC downgrades	**A**	**Cluster Lead**

		Delayed cancer diagnosis leading to poorer prognosis	Maintain DATIX submissions for inappropriate USC downgrades Utilise WCCG gateway audit tool to filter and check downgrades Empowering patients to manage their own referral		
5.0	**1/8/2017**	**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 re-admission to hospital	Continue to raise at Health Board Senior Level through the NPT Medical Advisory Group, CG lead meetings, DATIX submission and Health Improvement Wales regular meetings.	**A**	**Cluster Lead**
6.0	**1/8/2017**	**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 to work. Continue to raise at Health Board Senior Level through the NPT Medical Advisory Group, CG lead meetings and through Datix	**A**	**Cluster Lead**
7.0	**1/8/2017**	**Premises Issues** Will impact on practice abilities to provide fit for purpose sites 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 Estate Strategy	**A**	**Cluster Lead**