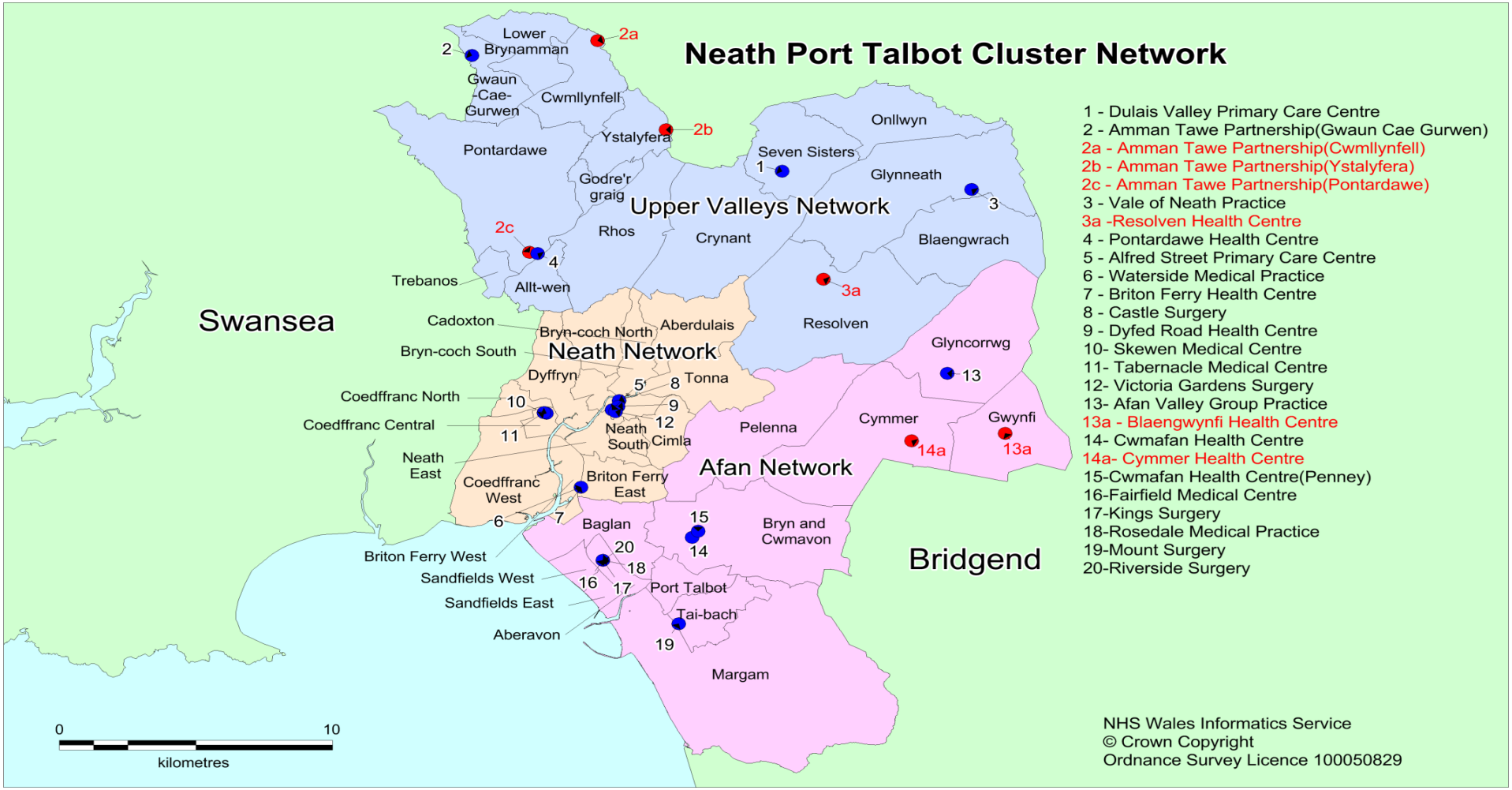
Three-Year Cluster Action Plan 2018 - 2021

Neath Cluster

1. ***Welcome to the Neath three Year Cluster plan, 2018 - 2021***

Neath Cluster is one of 11 Clusters in Abertawe Bro Morgannwg University Health Board covering the geographical areas shown in the map below:



Neath Cluster is made up of eight general practices working together with partners from social services, the voluntary sector, and the ABMU health board. The Cluster serves about 56,500 patients registered with the GP practice

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

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 Neath Cluster area in order to develop the priorities for this plan. Agreement on the objectives and actions with 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 the Neath Cluster 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 third Sector and Social Services.

Between 2018 and 2021, Neath Cluster will continue to explore areas for development and in the first year will focus on the following priority areas:

- Reducing or delaying the onset of diabetes
- Tackling obesity
- Developing a consistent approach to reducing smoking
- Increasing the uptake of influenza vaccine in target groups
- Engaging with patients to understand their experience of services and to identify their needs
- Managing demand in GP practices by utilising the services available at the Neath Primary Care Hub
- Providing standardised training for HCSW & Receptionists
- Improving recruitment and retention of GPs through support of the GP Fellowship Scheme

- Ensuring appropriate use of Cluster Technician
- Improving prescribing and medicines management
- Increasing and improving signposting to Third Sector services
- Better management of patients with COPD
- Supporting the community pharmacies common ailments scheme
- Promoting self-care through patient education
- Increasing collaboration between GP practices and other primary care providers and partner
- Improving systems of clinical governance in GP practices

Key Population Features

- 56,500 GP registered Patients
- 50% female; 50% male
- Increasing elderly population (22.2% aged 65+ and 10.1% 75+)
- 0.3% live in a Lower Super Output Area (LSOA) that is classified as rural.
- 46.2% live in the most deprived two fifths (40%) of areas in Wales
- 4.5% aged 65+ live in a nursing, non-nursing or other local authority care home
- 32.7% aged 65+ live alone
- 6.6% aged 16-74 are both economically active and unemployed
- 82.07% of People Aged 16 and over have a GP a record of alcohol intake (3rd highest)

Population and Community Assets

- 2 Leisure Centres
- Several Community centre

  4 Libraries
- Voluntary Sector organisations including mental health, physical activity and other charities aimed at supporting health and wellbeing

Cluster Features

- Mainly urban settings but with some semi-rural areas
- 8 GP practices delivering services from 8 sites
- 10 community pharmacies
- 7 Dental practices
- 5 Optometry services

Health Profile

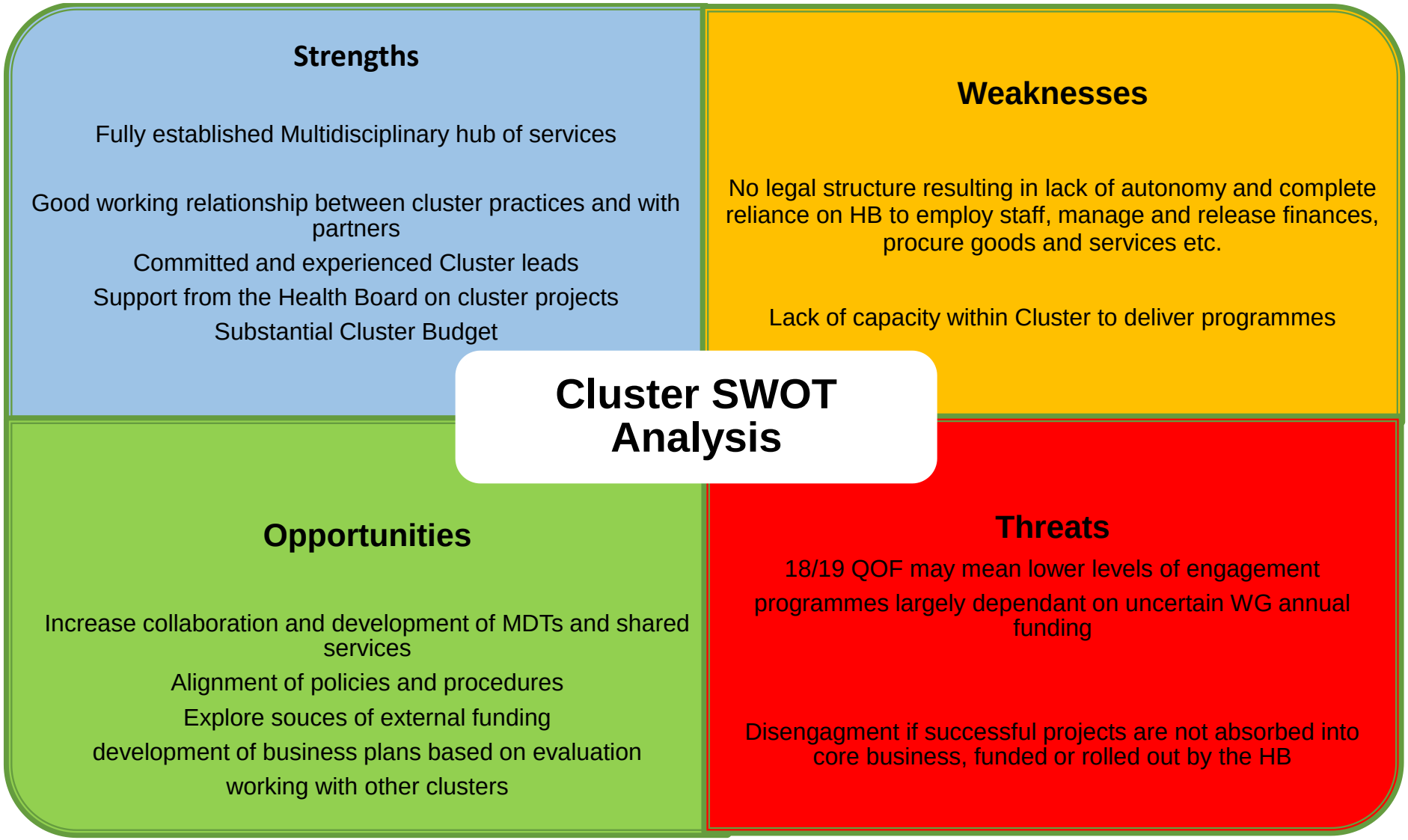
- Data from GP recorded diagnosis shows when compared to the 11 clusters of ABMU HB that
  - 2.3% of patients have COPD (7th highest rate)
  - 6.6% of patients have Diabetes (4th highest)
  - 14% are Obese (highest)
  - 2.9% have Cancer (5th highest)
  - 2.03% have CVD (5th lowest)
  - Pre Diabetes
- IVOR data flu uptake date (Apr 2018) shows
  - 67.9% in patients 65+ (ranked 5th)
  - 49.1% in patients <65 at risk (ranked 3rd)
  - 47.6% (ranked 7th)
- 28.5% aged 16+ reported undertaking at least 30 minutes moderate exercise on five or more days in the previous week
- 32.5% aged 16+ reported consuming five or more portions of fruit or vegetables on the previous day

Service Demands

- Relatively stable practice list sizes (-0.6% change between 2011 – 2017)
- Increasing number of patients with comorbities and complex presentations
- Aging workforce
- Difficulties GP and other HCP with recruitment

Other influencing factors

- Relatively good road and transport links
- Aging primary care infrastructure
- Limited employment opportunities
- New Housing developments as part of LDP


Strengths
Fully established Multidisciplinary hub of services
Good working relationship between cluster practices and with partners
Committed and experienced Cluster leads
Support from the Health Board on cluster projects
Substantial Cluster Budget
Weaknesses
No legal structure resulting in lack of autonomy and complete 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 and development of MDTs and shared services
Alignment of policies and procedures
Explore souces of external funding
development of business plans based on evaluation
working with other clusters
Threats
18/19 QOF may mean lower levels of engagement
programmes largely dependant on uncertain WG annual funding
Disengagment if successful projects are not absorbed into core business, funded or rolled out by the HB

3. ***Cluster Vision***

In 2018, Neath Cluster jointly agreed a Cluster Vision for the next three years. The Vision sets out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Neath Cluster area and its practices.

Our vision is:

To develop links within our community that will enable timely & appropriate care to those who require our services. To work together to ensure those services are sustainable & of the highest quality possible, and provided from within the community wherever possible.

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)

4. Neath 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

Priority areas for Cluster action for the next three years:
- Needs assessment
- Preventative work programmes

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.	**Set out the priority population level needs of the Cluster to inform programme development**	Health Board BSM	Refreshed when new data available, 6 mthly check Dec 2018	Services are developed according to local population need	Demographics have been considered during formulation of this cluster network plan. Priority Population needs are currently identified as: • Preventing the onset of diabetes • Increasing the uptake of the flu vaccine • Tackling obesity • Increasing referrals to Quit smoking services • Patient engagement	
2.	**Identify pre-diabetics & tackle problem of increasing levels of diabetes in Cluster population**	NCN practices	March 2019	The onset of diabetes is delayed or prevented.	The NCN continues to engage in the pre diabetes project	

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
	• Continue to engage with Pre-diabetes scheme to identify patients at risk of pre-diabetes • Train appropriate staff to deliver intervention • Monitor outcomes at regular intervals					
3.	**Actively support and engage as part of the multiagency Safe & Resilient Communities Programme in Neath**	NCN	Ongoing	The Neath population will be supported and empowered to recognise the importance of prevention and take responsibility for their own health.	• Programme in development	
4.	**Tackle obesity amongst patients in Cluster** • Link to pre-diabetes screening project • Improve NERS referral rates across the cluster • Work with ABMU nutrition and dietetics department to target obesity • Work with 3rd sector to develop signposting materials of local	NCN Dietetics Team	March 2019 (thereafter ongoing each year)	Patients engage in exercise programmes Improved education on healthy eating Reduction of obesity		

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
	services related to healthy lifestyles					
5.	**Develop a consistent approach within Cluster to reduce smoking** • 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. • Practices to take part in a cluster wide No Smoking day campaign	NCN Community Pharmacies Help to Quit	March 2019 (thereafter ongoing each year)	Increased referrals to "Help Me Quit" Reduced local prevalence of smoking – reduced morbidity / mortality		
6.	**Increase uptake of influenza vaccine in target groups** • Regularly review IVOR data for flu vaccination • Work with Local Public Health Team to develop and implement cluster flu plan • Practices to share "best practice	NCN PHW	March 2019 and ongoing	Reduce morbidity / mortality / hospital admissions due to influenza	Cluster flu champions identify Cluster has signed up to 2018 VPDP Flu plan developed and being rolled out	
7.	**Engage with patients to understand their experience of services and to identify their needs**	NCN NPTCVS CHC	Ongoing	Practice objectives are in line with patient needs	Patient engagement day being planned for 16th October 2018	

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
	• 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			Ensure good lines of communication between practices and patients.		

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

Priority areas for Cluster action for the next three years:

- Expand MDT team to meet the workforce needs of the Cluster

- Review of sustainability of core GP services across practices, sharing difficulties and addressing concerns with peers; developing access arrangements in line with current ABMU Access Standards to meet the needs of local patients; and exploring collaborative working arrangements

- Ensure MDT employment issues are resolved

- Form as a formal collaborative entity

- Ensure all practices are offered access to a Cluster package of support for sustainability 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
1.	**Manage demand in GP practices by utilising and supporting the development of services available at the Neath Primary Care Hub**	Hub Operational Manager GPs, clinical and admin staff Staff employed in Hub	March 2019 (thereafter ongoing each year)	Improved access to appropriate services and healthcare professional Reduction of GP workload that is not appropriate	The Hub continues to provide access to physiotherapist, MH support worker and audiologist. The new location at Dyfed Road has been opened and patient referrals taken. Business case for continuation approved further pacesetter funding approved to March 2019.	
2.	**Adopt a Whole System approach to healthcare and support the design, shift in**	NCN	Ongoing	Improved access to appropriate services and healthcare		

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
	infrastructure and transfer of such services to the community			professionals closer to home to meet a range of needs including the social model of care		
3.	**Provide standardised training for HCSW & Receptionists to ensure that they have the skills to perform their roles** • Cluster to fund courses aimed at upskilling HCSW and Receptionists • Practices to identify learning needs of HCSW and put them forward for relevant course	Practice Managers HCSW and Receptionists	March 2019	Standardised Cluster HCSW skills ensuring they are able to work at the top of their skills set.	Several courses have been attended including physiological BP, Physiological Measurements and ECG, Diabetes footcare, Venesection. Call handling and signposting course has also be organised for reception staff. Pt4L on Information governance and flu facts delivered on 12th Sept 2018	
4.	**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	Cluster pharmacy tech in post and working across practices (Repeat – reauthorisation, Medicines reconciliation, General Medicines queries, i.e., secondary care, community pharmacy and domiciliary care using remote access, Supporting Prescribing Management schemes and their actions,	

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
					Repeat Prescribing Systems, Prescriber Clerk Development)	
5.	**Improve recruitment and retention of GPs through support of the GP Fellowship Scheme** • Cluster to continue funding agreed proportion of the Fellowship incentive scheme**.**	Clinical Director (sustainability) GP practices	2019 and ongoing	Practices which have sustainability issues and are able to access GPs employed under the Scheme	2 GP Fellows have been recruited and both are currently working in two Neath Cluster practices Neath Cluster has benefited from the appointment of the 2 GP fellows currently recruited.	

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

Priority areas for Cluster action for the next three years:

- aim to reduce wastage of medicines and achieve better health outcomes through prudent prescribing;
- ensure patients have access to newly designed enhanced services, namely care homes and oral anticoagulation with warfarin;
- increase and improve signposting to the third sector

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
1.	**Continue improving prescribing and medicines management including engagement in Prescribing Management Schemes and improving performance against National Prescribing indicators**	GP practices Medicines Management Team	2019 and Ongoing	Improved Medicines Management Prudent use of finite resources Improved patient care	The cluster has signed up to the PMS+ Benefit share scheme	
2.	**Increase and improve signposting to Third Sector services** • Widen engagement with 3rd sector linked to identified cluster themes	GP Practices 3rd Sector Wellbeing Mental Health Support Worker	March 2017 (then ongoing)	To provide more specialist and appropriate support for patients	Hub development worker signposting to 3rd sector and other services Mental Health and Wellbeing small grants scheme instituted and referrals of 7-18 years to referrals to Bulldogs 3rd sector services to commence Oct 2018	

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

Priority areas for Cluster action for the next three years:

- utilising the time of multidisciplinary professionals, and educating patients in how to manage self-care and identifying the most appropriate place to receive treatment.

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
1.	**Better manage patients with COPD**	GP practices Medicines Management Team 3rd sector	March 2019 and ongoing	Unscheduled admissions of patients with COPD are prevented	The cluster has signed up to the 2018 VDPD programme	
2.	**Manage patients with common ailments in the community rather than in GP Practice.** **Improve patient education**	LHB Community Pharmacies GP practices	March 2017 and ongoing	GP practices see fewer patients with common ailments	Links made with Community pharmacies and referrals being made	
3.	**Promote self-care through patient education**	All Practice staff Public Health resources	March 2017 and ongoing	Generally improve health of patient population Reduce burden on GP Practices	Self-care to be promoted as part of the patient engagement event	

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.	**Delivery of flu vaccination to housebound patients**	Practices	November 2018	Increase numbers of patients vaccinated therefore reducing the risk of vulnerable patients contracting flu	Delivery commenced	

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

Priority areas for Cluster action for the next three years:

- Identify cluster specific benefits and scope potential for formal collaboration

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
1.	**Increase collaboration between GP practices and other primary care providers, social services, Community Resource Team and other Cluster partners**	GP practices Other primary care providers	2019 and ongoing	GP practices are better able to manage demand & improve patient care / experience		
2	**Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of:** • Infoengine	NCN	Ongoing	Individuals are more informed about how to manage their conditions and the importance of wellbeing and prevention		

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
	• Dewis • Local Area Coordination					

Strategic Aim 6: Other Cluster and area specific issues

Priority areas for Cluster action for the next three years:

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
1.	**To improve systems of clinical governance in GP practices**	GP Practices LHB (Datix)	March 2019 (then ongoing	Improve education of clinicians and hence improve patient care		
2.	**To facilitate and support the upgrading of practice premises where needed**	LHB Welsh Government		Ensure "safety / suitability" of premises Continuation of primary care services to all patients in Cluster		

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.	**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,** **c) Cluster Tier 0 Mental Health and wellbeing support**	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 there is a need to identify alternative funding for such projects where benefits have been demonstrated	• The three cases are to be included for consideration in this years IMTP process in both ABMU & Cwm Taf.	