Three Year Cluster Network Action Plan 2017-2020

Cwmtawe Cluster

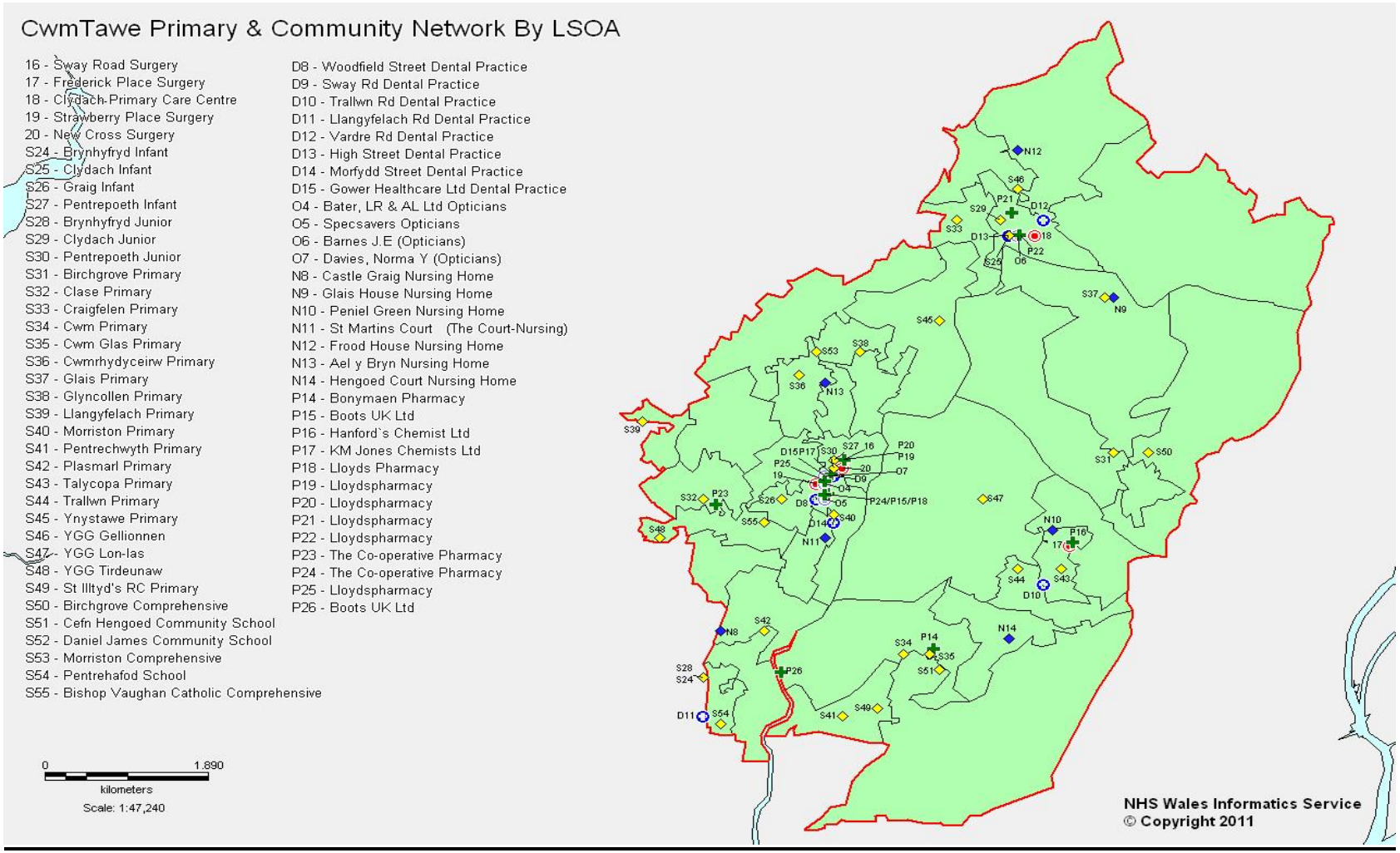
Welcome to the Cwmtawe network/cluster plan for 2017/20.

The Cwmtawe network based in Swansea is made up of five general practices working together with partners from social services, the voluntary sector, and the ABMU health board. Cwmtawe covers the area of Bonymaen, Clydach, Landore, Llansamlet, Morriston and Mynyddbach.

The Cluster currently has a total of 42865 listed patients, an increase of 141 on last year's figures. Individual practice list sizes range from between 6735 to 10807. Within its network area Cwmtawe has, 8 Dental Practices, 10 Pharmacies, 6 Nursing Homes, 4 opticians, 26 schools.

Cluster Networks work together in order 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.


CwmTawe Primary & Community Network By LSOA
16 - Sway Road Surgery
17 - Frederick Place Surgery
18 - Clydach Primary Care Centre
19 - Strawberry Place Surgery
20 - New Cross Surgery
S24 - Brynhyfryd Infant
S25 - Clydach Infant
S26 - Graig Infant
S27 - Pentrepoeth Infant
S28 - Brynhyfryd Junior
S29 - Clydach Junior
S30 - Pentrepoeth Junior
S31 - Birchgrove Primary
S32 - Clase Primary
S33 - Craigfelen Primary
S34 - Cwm Primary
S35 - Cwm Glas Primary
S36 - Cwmrhydyceirw Primary
S37 - Glais Primary
S38 - Glyncollen Primary
S39 - Llangyfelach Primary
S40 - Morriston Primary
S41 - Pentrechwyth Primary
S42 - Plasmarl Primary
S43 - Talycopa Primary
S44 - Trallwn Primary
S45 - Ynystawe Primary
S46 - YGG Gellionnen
S47 - YGG Lon-las
S48 - YGG Tirdeunaw
S49 - St Illtyd's RC Primary
S50 - Birchgrove Comprehensive
S51 - Cefn Hengoed Community School
S52 - Daniel James Community School
S53 - Morriston Comprehensive
S54 - Pentrehafod School
S55 - Bishop Vaughan Catholic Comprehensive
D8 - Woodfield Street Dental Practice
D9 - Sway Rd Dental Practice
D10 - Trallwn Rd Dental Practice
D11 - Llangyfelach Rd Dental Practice
D12 - Vardre Rd Dental Practice
D13 - High Street Dental Practice
D14 - Morfydd Street Dental Practice
D15 - Gower Healthcare Ltd Dental Practice
O4 - Bater, LR & AL Ltd Opticians
O5 - Specsavers Opticians
O6 - Barnes J.E (Opticians)
O7 - Davies, Norma Y (Opticians)
N8 - Castle Graig Nursing Home
N9 - Glais House Nursing Home
N10 - Peniel Green Nursing Home
N11 - St Martins Court (The Court-Nursing)
N12 - Frood House Nursing Home
N13 - Ael y Bryn Nursing Home
N14 - Hengoed Court Nursing Home
P14 - Bonymaen Pharmacy
P15 - Boots UK Ltd
P16 - Hanford`s Chemist Ltd
P17 - KM Jones Chemists Ltd
P18 - Lloyds Pharmacy
P19 - Lloydspharmacy
P20 - Lloydspharmacy
P21 - Lloydspharmacy
P22 - Lloydspharmacy
P23 - The Co-operative Pharmacy
P24 - The Co-operative Pharmacy
P25 - Lloydspharmacy
P26 - Boots UK Ltd
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1.890
kilometers
Scale: 1:47,240
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Cwmtawe Local Health Needs and Priorities

In order to support the development of the network cluster plan, information has been collated on a wide range of health needs within the Cwmtawe area. The summary below highlights the key points and characteristics of the Cwmtawe Cluster Network. The health needs information has been taken into account when developing the priorities for this plan.

- 8625 patients aged 65+ and a further 3831 patients aged 75+.
- Low student population
- Low ethnic minority patient numbers
- Low asylum seekers numbers
- Deprivation greater than Welsh Average and variable across the area. (Cwmtawe has 23% of patients living in the most deprived fifth of areas in Wales, compared to the Wales average of 20% using Welsh Index of Multiple Deprivation 2017)

The population of Cwmtawe exhibits a wide range of health and well being issues:

- Swansea has 25.9% of 4-5 year olds that are overweight or obese. There are 56% of adults (aged 16+) who are also classed as overweight or obese.
- Below is an extract of the Disease Register relating to the cluster (2017)

Disease Register	Cwmtawe Register Total 2017	Cwmtawe Register Changes 2011 – 17 (%)	Swansea Total	ABMU Total
Cancer	1082	63.7	6620	15040
Dementia	271	68.3	1734	3925

Mental Health	392	17.4	2704	5955
Chronic Obstructive Pulmonary Disease	817	19.8	4886	12212
Obesity	4863	15.6	21608	54284
Diabetes	2698	13.7	14181	33851
Hypertension	6251	7.1	34593	84010
Rheumatoid Arthritis	255	-8.6	1425	3596

- **Smoking** remains the biggest cause of premature death and the Welsh Government has also set a target to reduce the prevalence of smoking to 16% by 2020, with an interim 2016 target of 20%. Cwmtawe has;
  - An estimated number of smokers of **7,390 = 18.1%** of the cluster population
  - The number of smokers who accessed Stop Smoking Wales from the cluster was **207**
  - The number of smokers who accessed the Level 3 pharmacy service from the cluster was **76**
- **Bowel Screening** - Cwmtawe has 3618 people eligible for screening, 1985 were screened. 54% of those eligible.
- **Breast screening**- there are 5614 eligible for screening, with a 73.5% uptake
- **AAA screening** – there are 174 people eligible for screening with a 79.3% uptake
- **Cervical screening**- there are 10712 eligible for cervical screening with a 78.7% uptake
- **Flu Immunisation** 11th April 2017
  - At-risk under 65s: 37.4% - Lowest uptake out of Swansea networks. The target is 55%.
  - Over 65s: 61% - the lowest uptake out of Swansea networks. The target is 55%.
  - For 2-3 year olds the take-up was 42.2%, whilst above the Swansea figures, it is still well below 75%

Cwmtawe Practice Development Plans – consistent themes identified 2017

As a result of the analysis of the Cwmtawe Practice Development Plans, the following have been identified as issues affecting most if not all of the practices:

- **Sustainability** – continued increased demands on all staff within the NHS, retention and recruitment of GP's, the need to develop the role of administration and reception staff
- **Planned Care -** Referral management and awareness of care pathways.
- **Unscheduled Care -** A need to increase Flu vacs, Development of cross cluster cover during periods of bad weather
- **Prescribing** - Reduce waste in ordering of drugs, access to on-line ordering of prescriptions.
- **Practice Developments -** Develop the way in which patients with Chronic Conditions are managed, address health issues arising from patient lifestyles

Developing the Cluster Network Development Plan

The Cluster Network[1] Development Domain supports GP Practices to work to collaborate to:

- To understand local health needs and priorities.
- To link elements of the individual Practice Development Plans that are common across the cluster.
- Work with partners to improve the coordination of care and integration of health and social care.
- Work with local communities and networks to reduce health inequalities.

The Cluster Network Action Plan should be a simple, dynamic document and cover a three year period and include: -

[1] A GP cluster network is defined as a cluster or group of GP practices within the Local Health Board's area of operation as previously designated for QOF QP purposes

- Objectives that can be delivered independently by the network to improve patient care and to ensure the sustainability and modernisation of services.

- Objectives for delivery through partnership working

- Issues for discussion with the Health Board

For each objective there should be specific, measureable actions with a clear timescale for delivery.

Cluster Action Plans should compliment individual Practice Development Plans, tackling issues that cannot be managed at an individual practice level or challenges that can be more effectively and efficiently delivered through collaborative action.

This approach should support greater consistency of service provision and improved quality of care, whilst more effectively managing the impact of increasing demand set against financial and workforce challenges.

The three year Cluster Network Action Plan will focus on:

(a) Winter preparedness and emergency planning.

(b) Access and sustainability of services, including patient flows, models of GP access engagement with wider community stakeholders to improve capacity and patient communication.

(c) Service development and liaising with secondary care leads as appropriate.

(d) Review of quality assurance of Clinical Governance Practice Self Assessment Toolkit (CGSAT) and inactive QOF indicator peer review.

This is the fourth cluster network development plan that has been produced by the network and it is the aim to further develop it over the coming years. The network will also be regularly monitoring progress against the actions contained within the plan.

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

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
1	To reduce increasing obesity levels	Identify the feasibility and costs for dietician sessions within the cluster. Identify links to sites providing healthy menu's utilising the QR codes. Develop a diet control sheet to be provided with portion control plates to patients with diabetes Continue to encourage patients to be referred to Weight Watchers. Outcome of the meeting with Dietetics. They will bring together a	Public Health GP's, CC nurses C&D Manager	March 2018 March 2019 March 2018 September 2017	Improved health for diabetics Better health for patients with chronic diseases Improved lifestyle choices leading to a less medicalised model of care Patients to take responsibility of own health care	A sample guide plate has been ordered to aid cluster discussions. Cost per plate circa £1, although it is expected that this cost could reduce for ordering a larger quantity. Public Health has reviewed evidence regarding portion control sheets. Results –no evidence of them being distributed to patients, only of them being used within the clinic as an example. Cluster agreed to develop a scheme with dietetics, portion control plates and other support information. Will need to identify specific improvement measures. 10/08/17 Meeting held with the Dietetics unit to discuss how and what the project could look like. They have agreed to come back with some options	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
		basket of options for the cluster to consider				by mid September.	
2	To reduce smoking rates within the cluster population	**Year 1** To increase awareness of the Help me Quit service. To include QR info boards to be used to ensure the information is included Ensure practices have to update 'business cards' for GP's to distribute.Practice Managers to raise awareness with the GP's Contact ASH stop smoking campaign to discuss potential project in Cwmtawe regarding CO machines **Year 2** Ensure QR info boards are updated with information. Continue to monitor smoking rates assess action to date and implement changes. **Year 3** Ensure QR info boards are updated with information Continue to monitor smoking rates	Public Health Wales GP's CC Nurses	March 2018 June2018 October 2018	Healthier lifestyle Help to reduce the number of COPD patients within Cwmtawe	Once approved to be printed./added to the QR boards –awaiting confirmation of the content. PM meeting has shared practice amongst themselves. Strawberry place has best quit rates. GP's are distributing the 'business cards' to patients Additional supply requested from Public Health at cluster meeting Contact Made with ASH. Action suspended pending clarification of who supplies the monitors to ASH.	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
		assess action to date and implement changes.					
3	To address the lack of counselling services available for young people	**Year 1** To monitor performance/outcomes of patients referred to the scheme on a quarterly basis To consider extension of increase counselling services to young people **Year 2** Evaluate and decide on re commissioning service	GP practices. Voluntary Sector	April 2017 October 2017	Improved access to service Better patient care and prognosis	Grant scheme now in place and service accepting referrals. To investigate whether or not New Pathways are able to increase resources into the current scheme and the estimated costs. Awaiting decision regarding procurement i.e does the cluster need to re-issue requests for bids.	
	To identify the needs of the long term sick and those living with disabilities identified within the PSB area assessment and improve their health and wellbeing where necessary.	**Year 1** Ensure markers are placed on patient notes in advance to the work to commence next year**.** **Year 2** Develop a patient questionnaire to identify the needs of those who are long term sick or living with disabilities. Once needs identified develop and implement improvements to pathways.	GP practices, Voluntary sector. Social Services	March 2019	Improved access to service Better patient care and prognosis Healthier lifestyle	PSB assessment obtained	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
		Year 3 Review and embed improvements and adjust any alterations that are not working quite as well.					

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	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Assess potential list size increase with growth of further housing developments	**Year 1** Continue to monitor developments in partnership with the LHB	Primary and community services delivery unit Local Authority Planning Department	Ongoing	Avoid difficulties in accessing GP appointments due to higher demand	HB are working to identify key areas that this will affect. Key areas identified, several are within the current boundary of the cluster.	
		Year 2 Continue to monitor developments in partnership with the LHB, including monitoring likely build dates					

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		Year 3 Continue to monitor developments in partnership with the LHB, including monitoring likely build dates					
2	To develop a MDT to address how sustainability issues and identify the best model for the cluster.	To continue to employ multidisciplinary Cluster based team flexibly across the cluster, particularly to assist struggling practices To commission a sessional based respiratory physiotherapist depending on budget available	Cluster Lead Practice Leads	September 2017	Improved access to services,	CCN's, pharmacist and C&D Manager have been employed. Awaiting HB procurement issues to identify budget available to commission physiotherapist.	
		Year 2 Evaluate MDT model and consider best model for year 2					
		Year 3 Evaluate MDT model and consider best model for year 3					
3	In cases of urgent need develop arrangements for Practices to see patients from other practices	Develop protocol to be agreed by the practices	Health Board/GP practices	March 2018	Improved access to services	To be commenced	
4	Ensure CCN's are fully utilised and integrated into	**Year 1** To establish work plan for the	GP practices. Patients	August 2017	Better care within the	Need to identify a timetable for review	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
	the wider cluster team	chronic conditions nurses employed by the cluster Design, develop and implement method for patients to make direct access with CCN's Indentify, monitor and evaluate benefits and challenges of experienced by CCN's, by patients, by the practice. **Year 2** If the cluster decides to extend contracts –continue to build CCN role. Embed and monitor for any perverse outcomes **Year 3** Embed and monitor any perverse outcomes and build on successes.		October 2017 January /early 2018 February 2018 March 2018	community Improved access to services	of patients Leaflet developed and quotes for printing being obtained. - Data collected by the CCN's, -Patient feedback also being collected	
5	Workforce development	SCVS to develop a directory of training available within the community	GP's Health Board Training providers	November 2017	Improved patient care from experienced	To utilise the training courses developed by the SCVS to develop a calendar of training for cluster staff.	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		Practice Managers to undertake the e-learning bronze IQT e learning course Identify a project evaluation course for cluster staff to undertake Front of house staff to under - take Flu myth busting training to promote take up of flu vacs. Practice staff to undertake MECC training provided by public health Consider programme of training opportunities being developed by Business Support Manager		October 2017 October 2017 October 2017 December 2018	and knowledgeable staff	2 practice managers have completed the IQT e learning course Quotes are currently being obtained for an evaluation training course. Discussion held with Public Health regarding Flu myth busting and MECC training.	
6	Sustainability of general practice. To raise issues relating to the need for additional investment into primary care highlighting increased expenses , e.g. superannuation costs	**Year 1** Appoint a social prescribing link worker**.** Establish an evaluation framework. Collect and analysis the evaluation framework Cluster to consider if the contract is to be extended.	GP's Health Board	Ongoing	Improved access to services Effective use of the MDT	Appointment of CCN's, grants for counselling services. Interview date set for recruitment of a social prescribing link worker. Interviews on hold pending resolution of procurement issues	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		Year 2 Embed changes and monitor for any perverse outcomes Depending on the cluster decision either extend or make permanent Reassess MDT model					
		Year 3 Continue to monitor and evaluate outcomes Reassess MDT model					

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	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To obtain patient and care views on network services	Develop a patient engagement calendar to inform decision	SCVS GP practices,	March 2018	Responsive and	Questionnaire in the process of being developed to identify areas for service	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
	and priorities programme to inform service provision and improvements	making. Initial suggestions are: -Vacs and Imms -Repeat prescriptions - Obesity	Health Board	August 2017 November 2017 January 2018	effectively commissioned services by using user and care feedback	improvement for Vacs and Imms. With the aim for delivery towards the end of August, which will assist in identifying 3 step changes for QOF.	
2	PMS plus Respiratory prescribing	CCN to review patient lists to identify -appropriateness of treatment. -over ordering of inhalers.	GP's within networks/ support from Medicines Management to be determined at a practice level	March 2018	Improvement in patient symptom control	All practices agreed to undertake PMS Plus –extended until Mar 2018. CCN's have made links with practices, Referrals are now being made by most practices.	
3	To develop a primary care dietary service within the Cluster to help assess obesity/diabetes issues	To initiate a meeting with the dietetic service, with a view to developing a primary care service within the Cluster within the budget available.	Secondary care- dietetics. GP practices	March 2018	Increased access to a dietician closer to home.	Email sent to Dietetics to request a meeting to discuss. Meeting arranged 10th August 2017	
4	To develop an information sheet for clinical and practice staff regarding the remit of the various nursing teams working within the community, improving the interface between teams	For each area of nursing to provide a brief overview of their remit to be collated into the information sheet. Once developed share with other Clusters	ACR team, CCNs, District nurses.	December 2017	Improved access and communication between services	To be commenced	
5	To utilise the protected learning time scheme to share good practice	To continue to hold PLTS sessions, by funding a locum to cover the sessions	Cluster Lead Practice Managers Health Board	Throughout 2017/18 and beyond	Patients have a fully trained MDT working to	Use PLTS to raise awareness of care pathways and discuss ideas to reduce referrals to secondary care.	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		PM group to develop a calendar of learning for practices and organise the booking of locums.			improve practice outcomes.		

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	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To reduce waste in the ordering of drugs	To liaise with HB pharmacist and Pharmacy technician to prevent PRN medications being prescribed that are not needed. Practices to get patients/pharmacies to sign and date script that they have been checked if needed –if not signed then return scripts to the pharmacists. Meds Management to include in the newsletter	Medicines Management Practices/ Practice Managers Pharmacists Patients	December 2017 June 2017 and ongoing September 2017	Ensures that patients don't receive drugs they haven't ordered. Reduces confusion for vulnerable patients	To be commenced	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		that the Pharmacies are being audited. Develop a standardised receptionists response when dealing with patients requesting repeat medication		October 2018			
2	As part of winter preparedness improve uptake of vaccinations and flu immunisations, particularly for those aged 65+, and those under 65 at risk, and children aged 2-3.	**Year 1** Develop, design and produce a questionnaire to identify why patients are not having flu vaccinations. SCVS to distribute questionnaires to patients. Establish a work group to address issues identified and implement step changes Include information on the QR Boards to myth bust flu issues **Year 2** Evaluate steps of change from year 1	Public Health GP's Practice Managers	Annually July – January. Step changes to be decided and implemented during this period at Practice Managers October 2017	Improved health Improved immunisation levels	Questionnaire in the process of being developed. Awaiting resolution of procurement issues prior to commencement. QR Boards in the process of being purchased and developed for the cluster. Contact made with SCVS to promote free flu vacs for unpaid carers. SCVS will develop a template in conjunction with the cluster to issue to voluntary and charitable organisations for them to confirm that the person is an unpaid carer.	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		Year 3 Evaluate steps of change from year 2					
3	Reduce inappropriate visits/frequent users of secondary care services	To design and develop a leaflet to be issued with prescriptions and put on QR boards	Practices	October 2017	Increase consultation activity to inform patients about the services available	A leaflet has been agreed and is currently being translated into Welsh. It will be given out with prescriptions and will be put on to TV's in practice receptions and web site	
4	Reduce prescribing of antibiotics	The 4 participating practices to continue to use CRP machines. Practices to be encouraged to refer patients to the nurses for testing Nurse to be encouraged to record data. Include information on the QR Boards	GP practices	June 2017 and ongoing	Increased knowledge and confidence to self care and reduce disease resistance	Evaluation not being undertaken consistently by nurses. May 2017: Inconsistency in GP's referring patients to nurses for testing in 2 practices and machine broke in 1. Two practices are using machines. Evaluation for the first year will be limited. Four practices participating in the project.	
5	National Chronic Kidney Disease Audit. Summary document. http://www.ckdaudit.org.uk/index.php/download_file/view/117/299/	Audit report issued January 2017 actions needed Cluster to agree to implement the recommendations from the report	GP practices	June 2017 July 2017	Increased knowledge and understanding, improving patient care	Discussed at PM meeting –it was felt that a clinical perspective was needed regarding whether or not to regularly undertake urinary testing for ACR to identify CKD All practices confirmed that they undertake the urinary test –Action completed	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
6	'Keeping well this Winter Campaign' Public Health	To contact Public Health regarding winter campaigns.	Public Health, GP practices	October 2017	Reduce to need for primary care and improved patient health.	Spoken to Public Health -no plans developed yet. Watching brief to be held pending development of the plans.	
7	To address the complex medical needs and to provide an enhanced provision of care for residents in Care Homes. Delivering best-evidenced treatment and services to ensure a decrease in unplanned transitions of care and poly pharmacy	Assessments and regular reviews of the mental and physical health of the residents	Key Partners: GP Practices Health Board Cluster Pharmacist GP OOHs	July 2017 and Ongoing	Collaborative working with other local health services throughout the primary care clusters to provide overarching leadership of multi-professional teams. Wraparound services provided for the patient, i.e OT, Podiatrist, Dental, Optometry, Audiologists, Dieticians, Mental health care. A decrease in Unscheduled admissions A decrease in polypharmacy	All practices within the cluster have signed up for the DES. Reporting measures currently being ratified.	

Strategic Aim 5: Improving the delivery of liver disease, COPD

	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Liver Disease To participate in a clinical priority pathway focusing on **liver disease or cancer**	To engage with the priority work at a cluster and practice level To discuss any data provided to the practice/cluster To agree small steps of change to test out any new ways of working To share the results of small tests of change within peers in the cluster	GP Practices / Health Board	31 March 2018	To deliver quality improvement to enhance care	Priority area to be further discussed and agreed –Awaiting baseline data	
2	To participate in a clinical priority pathway focusing on COPD	To engage with the priority work at a cluster and practice level To discuss any data provided to the practice/cluster To agree small steps of change to test out any new ways of working To share the results of small tests of change within peers in the cluster.	GP Practices / Health Board	31 March 2018	To deliver quality improvement to enhance care	Priority area to be further discussed and agreed. Collection of the base line date for the PDSA cycle has been commenced	

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority.

The cluster plans to improve the delivery and uptake of vaccinations and immunisations this year and continue to look at national and local priorities in future years

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To improve the delivery and take up of Immunisations within the cluster with a specific focus on flu vaccinations".	**Year 1.** PM's to complete PDSA sheet and discuss at Cluster meeting To develop a patient questionnaire to identify areas for change/improvement. Ongoing monthly data from Public Health will be used to measure performance **Year 2.** Monitor increase in uptake Embed changes and monitor for any perverse outcomes	Medicines management? To be indentified	July 2017 October 2017 June 2017	Improve access to the service in line with patient preferences	PM's have agreed to take a cluster wide approach to the identification and implementation of the changes. Patient questionnaire is in the process of being developed to provide base line data, together with the Public Health data. Distribution date expected towards the end of August to allow analysis to be completed in time for the meeting on 3rd October. PDSA sheet is in the process of being completed	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		Year 3. Monitor increase in uptake Embed changes and monitor for any perverse outcomes					
	To continue to improve quality of dermatology services offered in Practices and reduce number of referrals to secondary Care	-Determine impact of investment in equipment and training attended by GPs across the network -Secondary care dermatology referrals to be requested for evaluation and review during 2017/18	GPs Health Board	March 2018	Appropriate and timely 'joined up' services offered within the community	Dermatology Training sessions have been attended by 4 GPs across Cwmtawe Practices. Dermatoscopes and cameras have been purchased for all practices	

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

No	Objective	Key Actions	Key	For	Outcome for patients	Progress to Date	RAG

			partners	completion by: -			Rating
1	To demonstrate governance within the practice through completion of the CGPSAT and Information Governance Self Assessment Toolkit	All practices within the cluster to update and submit the CGPSAT and IG Toolkit by 31st March 2018. To utilise the toolkits to share learning and outcomes at cluster meetings	GP Practices GP Practices / Health Board	March 2017 and ongoing August 2017	Assurance that practices have clinical governance procedures in place To improve systems of clinical governance	Health Board has agreed to share cluster results following CGPSAT submission dated March 2017	

Strategic Aim 8: Other Locality issues

The cluster aims to work over the next 3 years to support projects to increase the use of voluntary sector, including a social prescribing link worker.

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To continue to develop the third sector support projects to increase the use of voluntary sector within the Cwmtawe network population	**Year 1.** Grant schemes in place for young peoples' counselling. Increase investment into the scheme. Evaluate patient outcomes. Decide if the cluster wishes to continue services Appoint Link Worker for social	SCVS GP practices and Practice Managers	September 2017	Improved support and access to services for the Cwmtawe Network population Support to access non medical methods of care	Counselling Scheme now operating from Strawberry Place and is receiving referrals. Cluster is interested in increasing investment in the programme. Amy has been requested to see if New Pathways are able to accommodate this.	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
		prescribing. **Year 2.** Continue to refine counselling scheme to achieve best value provision Evaluate the outcomes on patients and the benefits for the cluster practices towards the end of the link worker post contract. Decide if the project is to be mainstreamed. **Year 3.** Review MDT and decide way forward				See strategic aim 2. Link Worker post now short listed. Interviews to take place in July. Interviews delayed- due to the need to clarify the procurement processes	
2	To improve prognostic indications in the delivery of the end of life care through the implementation of a prognostic indicator	Implement the traffic light system. (expand) Strawberry Place highlighted as having good practice within the Cluster –process to be shared	GP's Practice Managers	June 2017	Ensure patients receive a 'good death'	Report re-circulated in order that practices adopt the traffic light system. Practices to implement good practice identified within	

No	Objective	Key Actions	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
	system across all practices, i.e traffic lights.	with other PM's				Strawberry Place.	
3	To ensure, with the Health Board, that all network patients have access to the new Service for Oral Anticoagulation with Warfarin	To consider the provision of the enhanced service for oral anticoagulation with warfarin via the cluster to those practices not participating in the DES	Health Board, GP Practices, secondary care, medicines management team	May 2017	Safer services through not separating roles of monitoring and prescribing – in line with MHRA	3 out of 5 practices will be participating in the proposed model.	