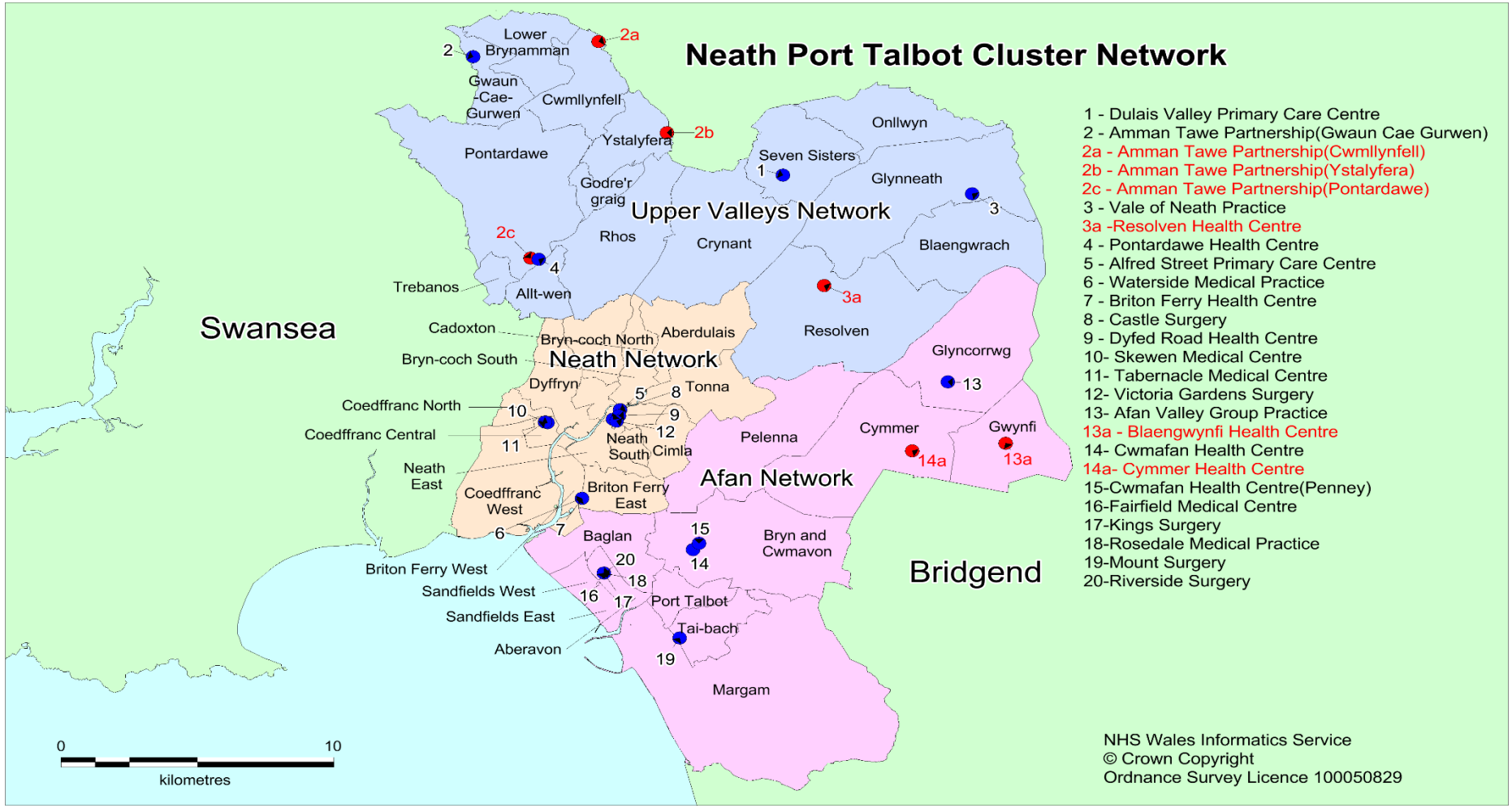
Three-Year Cluster Action Plan 2018 - 2021

Upper Valleys Cluster

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

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



Upper Valleys Cluster is made up of four general practices delivering services from 8 sites and working together with partners from social services, the voluntary sector, and ABMU health board. The cluster serves a population of 31,365 patients registered with the GP practices.

GP Practice	Practice Registered population
Amman Tawe Partnership	3416
Dulais Valley Primary Care Centre	6012
Pontardawe Health Centre	12404
Vale of Neath Practice	9533

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 Upper Valleys 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 Upper Valleys 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, Upper Valleys Cluster will continue to explore areas for development and in the first year will focus on the following priorities:

- Increasing uptake of the flu vaccination
- Reducing the onset of diabetes
- Supporting patients to quit smoking
- Increasing the uptake of childhood immunisations
- Supporting Patients to manage their weight
- Supporting the development of Primary Care MDT Hub
- Supporting the GP Fellowship Scheme
- Improving GP practice back office workflow
- Signposting patients to the most appropriate professional
- Identifying learning needs of practice staff
- Supporting the NPTH rapid cancer diagnosis centre pilot

- Engaging in prescribing management schemes
- Improving EOL for patients and their family
- Utilising CRP testing in the diagnosis of upper respiratory tract infections.
- Engaging with patients to understand their experience of services and to identify their needs
- Exploring areas of collaboration between GP practices and with partners
- Ensuring robust validated clinical governance process
- Promoting shared learning and good practice
- Addressing cross border problems in relation to service delivery

3. ***Demographics***

Key Population Features

- 31,365 GP registered Patients
- 49.4% female; 50.6% male
- Increasing elderly population (22.8% aged 65+ and 10.0% 75+)
- 11.8% live in a Lower Super Output Area (LSOA) that is classified as rural.
- 49% live in the most deprived two fifths (40%) of areas in Wales
- 4.6% aged 65+ live in a nursing, non-nursing or other local authority care home
- 33.1% aged 65+ live alone
- 7.3% aged 16-74 are both economically active and unemployed
- 78.64% of People Aged 16 and over have a GP a record of alcohol intake (5th Highest)
- 28.8 % are on the Public Health Wales smoking register for Wales (4th 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 semi-rural with beautiful county side and natural features
- Widely dispersed population
- 4 GP practices delivering services from 8 sites
- 10 community pharmacies
- 3 Dental practices
- 3 Optometry services

Health Profile

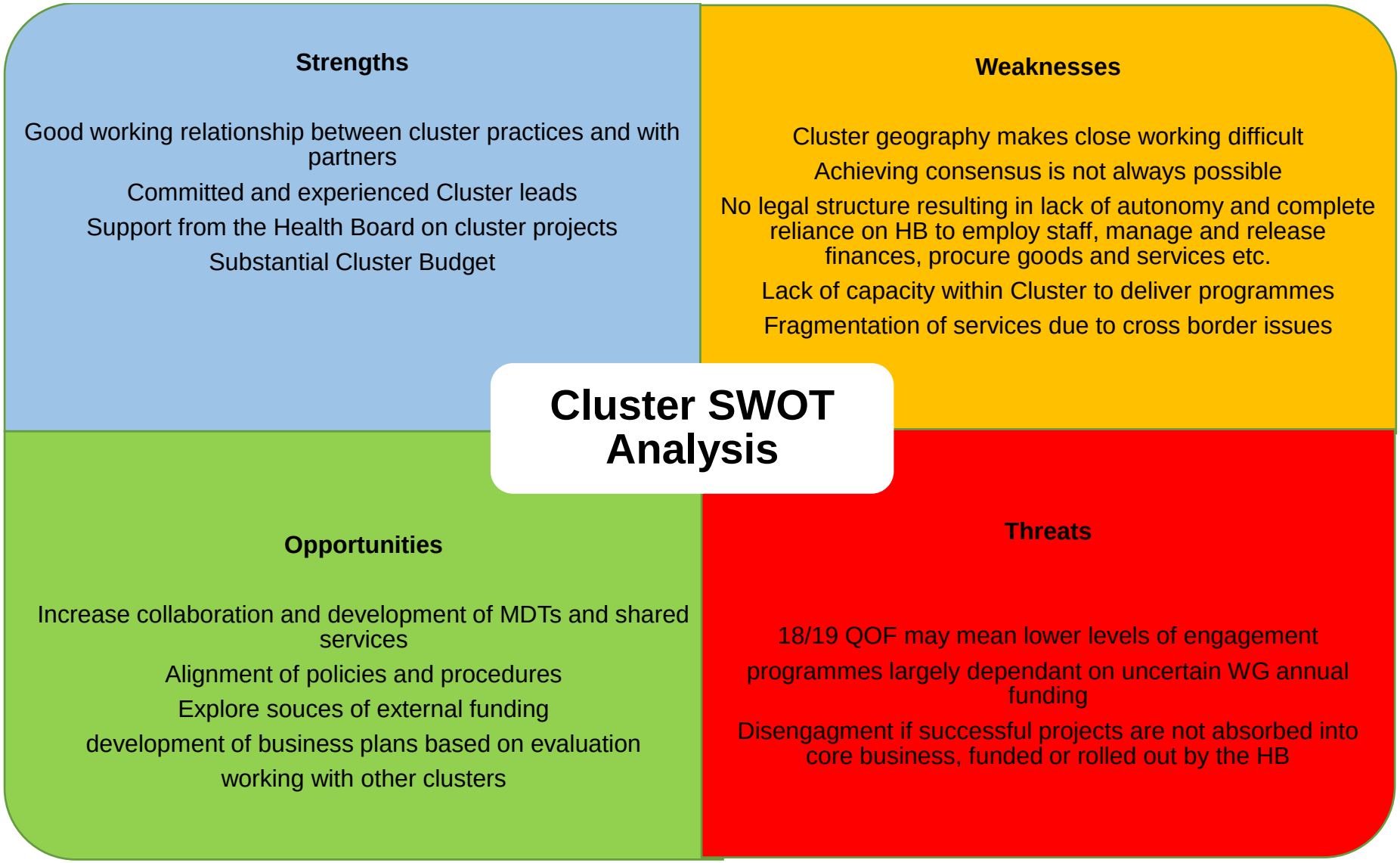
- Data from GP recorded diagnosis shows when compared to the 11 clusters of ABMU HB that
  - 2.7% of patients have COPD (3rd highest)
  - 6.9% of patients have Diabetes (3rd highest)
  - 3.3% have Cancer (2nd highest)
  - 2.22% have CVD (3rd Lowest)
  - CHD
  - Pre Diabetes
- IVOR data flu uptake date (Apr 2018) shows
  - 60.5% in patients 65+ (ranked 11th)
  - 43.9% in patients <65 at risk (ranked 7th) [36.2% in 2017 ranked 11th]
  - 45.4% in 2-3 year olds (ranked 9th) [32.5% in 2017 ranked 9th]
- 29.7% aged 16+ reported undertaking at least 30 minutes moderate exercise on five or more days in the previous week
- 32.6% aged 16+ reported consuming five or more portions of fruit or vegetables on the previous day
- 59.4% are Obese and overweight (PHW Observatory)

Service Demands

- Increasing of practice list sizes (1.2% change between 2011 – 2017)
- Increasing number of patients with comorbities and complex presentations
- Aging workforce
- Difficulties GP and other HCP with recruitment
- Bowel screening
- Cervical Screening
- AAA Screening
- Breast Screening

Other influencing factors

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


Strengths
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
Cluster geography makes close working difficult
Achieving consensus is not always possible
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
Fragmentation of services due to cross border issues
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

4. ***Cluster Vision***

In 2018, Upper Valleys 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 Upper Valleys Cluster area and its practices.

Our Vision is:

To work collaboratively with partners and patients to improve the health and wellbeing of our local community by providing good, safe standards of care in the community, closer to our patients.

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)

5. *Upper Valleys 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.	Review the needs of the population using available data Consider the demographics of the cluster population and the impact on service delivery Proactively utilise the Primary Care Portal to identify areas for improvement and share data with cluster clinical lead Agree priority areas and develop projects to meet needs	UVCN UVCN UVCN	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. The cluster held workshop on to agree some of the priorities for 2018/19 Priority Population needs are currently identified as: Increasing the uptake of the flu vaccination Preventing the onset of diabetes Reducing obesity Supporting patients to quit smoking Increasing uptake of MMR vaccine	

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
2.	Implement a cluster flu plan Regularly review IVOR flu vaccination uptake data on cluster basis Develop Cluster Flu plan Ensure all practice flu plans are completed to reflect cluster actions	UVCN	March 2019 and ongoing	Increase in number of flu vaccines delivered Increased protection from flu	IVOR data 2017 reviewed A 'flu to housebound patents specification has been developed Arrangements have been made to phone patients to attend for the vaccine and to understand why decliners do not want the vaccine Partners have agreed to publicise the benefits of having the vaccine	
3.	Continue the implementation of the cluster pre diabetes project	UVCN	March 2019	Patients with pre diabetes are identified and receive appropriate lifestyle advice The onset of diabetes is prevented or slowed down	UVCN practices continue to participate in the project	
4.	Support patients to quit smoking through increase referrals to Help me Quit services Review cluster referral data Increase referrals rates to Smoking Cessation services Introduce electronic referral to HMQ via 'hot key' tool to auto populate form with relevant info.	UVCN Community Pharmacies	March 2019 & Ongoing	Smokers are supported through their quit attempt via evidence based services Improved opportunities to improve health	Cluster referral data has been reviewed	

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
				through quitting smoking.		
5.	Increase the uptake of childhood immunisations Review uptake data on cluster basis Agree Cluster approach to increasing uptake of MMR	UVCN	March 2019	Improved health and wellbeing of children. Reduced morbidity & mortality		
6.	Support Patients to manage their weight Review compliance, attrition and completion of programme in conjunction with NERS Increase referrals to NERS Participate in the pre-diabetes project Practices to Sign up as park run practices	UVCN NERS	March 2019	Improved health and wellbeing Reduced obesity	Practices to become 'park run' practices by identifying practice champions and promoting within practice and with 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 resolve
- 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? What is the patient outcome?	Current position	RAG Rating
1.	Support the development of an Upper Valleys Primary Care Multidisciplinary Hub including Pharmacy, Physiotherapy and Mental Health and Wellbeing support	ABMU HB	March 2018	A MDT of AHP is employed and serving the cluster practices	A hub Steering group has been established Services to be included in the MDT have been agreed	
2.	Actively support and engage as part of the multiagency Safe & Resilient Communities Programme in identified areas of the cluster	UVCN	Ongoing	The population will be supported and empowered to recognise the importance of prevention and take responsibility for their own health.	Programme in development	

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
3.	Continue to support the GP Fellowship Scheme	ABMU HB	Ongoing	GP Fellows recruited and available to support practices facing sustainability issues	3 GP Fellows have currently been employed by ~ABMU HB They are currently working in NCN and ACN	
4.	Improve back office practice workflow through HERE workflow project	UVCN	Ongoing	Practice efficiency improved and GP time saved	UVCN practices have received training and are implementing the programme	
5.	Continue to signpost patients to the most appropriate professional	UVCN	Ongoing	GP time saved Patients are seen a the right time by the right person at the right place	Practices continue to triage appropriate MSK patients to the Cluster physio service Links have been made with the LACs and referrals made to them	
6.	Identify learning needs of practice staff and put them forward for relevant course	UVCN	Ongoing	Practices have a skilled work force		

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:

- engage effectively and make improvements between the primary and secondary care interface;
- 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;
- prolong independence of elderly patients through the development of anticipatory care plans.

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.	Improve Cancer diagnosis	NPTH	March 2019	Patients with suspected cancer receive a rapid diagnosis	Support the NPTH rapid cancer diagnosis centre pilot UVCN practices have actively been referring patients with suspected cancer to the RDC The RDC lead has presented data at the cluster meeting of 4/7/18 Cancer Red Wales training Explore improving bowel cancer screening	
2.	Engage in prescribing management schemes	UVCN	March 2019	Reduction in wastage of medicines and	Practices have signed up to the cluster prescribing	

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
		Med management team		Improved prescribing practice	benefits share scheme and to the PMS	
3.	Improve EOL for patients and patient's family	UVCN	March 2019			
4.	Improve the care of frail patients				The cluster has discussed compassionate communities and have agreed to identify their frail patients	
5.	Engage with patients to understand their experience of services and to identify their needs and facilitate their participation in the development and evaluation of services	UVCN		Patients have the opportunity to influence service development Projects are developed based on patient need	Patient engagement to date includes **Feedback from patients on MSK project** **Feedback from patients on CRP project** **Cancer questionnaire** – worked with Macmillan to ask patients recently diagnosed with cancer about their experience of primary care during their cancer journey **Phoning of patients as part of the flu project** – asking patients who did not have their flu vaccination last year why not, to try to establish their reasons so this can be addressed in future years.	

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.	Improve anti-biotic prescribing.	UVCN	Ongoing	Reduction in antibiotic prescribing rates for Upper Respiratory conditions Patients receive appropriate care	Utilise CRP testing in order to reduce the use of antibiotics for adult patients with upper respiratory tract infections 3 out of 4 practices are participating in the project Co-amoxical audit conducted	
2.	Promote 'My Winter Health Plan'	UVCN	April 2019	More patients engage with the plan to provide timely information to be available to HCP in patients own homes	Awaiting delivery on My Winter Health Plans from WG	

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 collaboration options to widen 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.	Explore areas of collaboration with community pharmacies	UVCN Community Pharmacies	Ongoing	GP time saved Patients are seen a the right time by the right person at the right place	Practices are now referring to the pharmacies under the common ailments scheme	
2.	Explore areas of collaboration with Social services	UVCN Social Services	Ongoing	GP time saved Patients have a wraparound service	Social Services are now participating in GP practice MDT as requested	
3.	Explore areas of collaboration between the UVCN GP practices	UVCN	Ongoing	Increase joint working across practices	Practices have collaborated in the bulk ordering of their flu vaccines	

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.	Continue to engage with a robust validated clinical governance process ensuring that practices are GDPR compliant	UVCN	Ongoing	Improved safety and quality	DSA in place for MSK project Consent to share audit data in place GDPR leaflets and material distributed	
2.	Promote shared learning and good practices through regular incident reporting	UVCN	Ongoing	Improved safety and quality		
3.	Ensure that inequities and inconsistencies of referral mechanisms are minimised for practices and patients affected by cross border problems		Ongoing	Appropriate channels of referrals through improved cross border working arrangements		
4.	Improve practice premises to enable capacity to deliver new pathways and increase capacity Health Board to be approached to support renovation/upgrade/relocation to alternative premises		March 2018 and ongoing	Improved facilities and sustainable services		
5.	Support the Delivery of three Business Cases for IMTP	All	Dec 2018	These three area have been piloted by	• The three cases are to be included for consideration in	

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
	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			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	this years IMTP process in both ABMU & Cwm Taf.	