CLUSTER News

Welcome to the autumn edition of ABMU's Cluster News.

It has been a busy time for clusters in the last few months as all 11 clusters have been developing and agreeing and beginning implementation of their three-year plans for 2017 – 2020. Some **KEY Priority Areas** for development include to:

- Invest in early years ' best start in life'
- Reduce the incidence of chronic conditions and co-morbidities and improve health outcomes
- Strengthen third sector links through gaining a better understanding of third sector provision and how it can be accessed for the benefit of patients e.g. social prescribing
- Improve vaccination uptake and targeted interventions based on public health priorities using best practice
- Raise awareness of the needs of individuals living with dementia
- Develop services and access by consulting with patients; patient engagement through participation groups/survey methods
- Increase access to counselling/CBT to address deficit of Tier 0/1 services with reasonable waiting times
- Improve support for carers through raising awareness
- Develop further collaborative working/ peer support within clusters to share best practice and influence quality, access and sustainability
- Review skill mix/develop workforce plans to meet the changing needs and demand of the population and ensure sustainability of services
- Continue/extend employment of cluster based multi-disciplinary staff (physio, nurses, pharmacists, paramedics) and the number of practice staff education programmes to ensure individuals are able to work prudently ensuring quality and safety

• AFAN – Dr Mark Goodwin

Support Manager: Dawn Burford

Even though each Afan Cluster practice uses Vision, they have each had their own way of working with the clinical system. Standardised templates and data entry facilities enable healthcare professionals to work across the cluster and instantly be familiar with systems within each practice.

To enable the future collaborative approach of cluster working, Afan Cluster has introduced the role of IT Liaison to work across all cluster practices. The aim of the scheme is to standardise, as well as improve the speed and efficiency, of data entry into the patient record. As a tool to reach this goal we have adopted the use of Autohotkey software, which enables the entry of standardised Read Coded entries as well as pre-defined approved free-text entries on clicking an on-screen button. These Autohotkeys can be embedded into Vision guidelines or operate as free-standing programs. These programs were originally developed for the efficient entry of flu immunisations along with the risk group and batch number, considerably cutting down the time per immunisation appointment to just 1 minute. The software was then developed to enable standardised data entry for many areas, including the pre-diabetes scheme consultations, childhood immunisations, minor surgery injections, ear syringing as well as many others.

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• BAY – Dr Kirstie Truman

Support Manager: Gemma Jones

Bay Health Cluster Network are working with the local community to increase activities for older adults and reduce social isolation. There are currently two initiatives running for patients in the Bay Health area;

The Balanced Lives programme and Bay Interest groups.

The Balanced Lives programme classes have particular benefits if patients:

- have a long-term health condition
- have recently experienced a fall
- are seeking to improve their balance
- are experiencing a loss of confidence in physical abilities
- are feeling low, and want to improve their mental wellbeing

Run by the charity Action for Elders in partnership with the Bay Health GP Cluster Network, the classes are completely free.

In addition Helen Hunter from the Red Cafe is offering two interest groups one based in Scurlage, Gower, the other in the West Cross community centre.

The interest groups are for all patients whether they have an interest to share, want to learn something new or even just to have a chat over a cuppa! Helen can tailor the session to the group's needs with contributions from outside speakers if required.
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• BRIDGEND EAST – Dr Ian O' Connor Support Manager: Joanne Halse

In the Bridgend East Network Cluster (BECN), Clinical Pharmacists have been contributing to usual GP medication review workload for the last 15 months. The Cluster Pharmacists hold practice based clinics (offering telephone & face to face appointments) for medication review and chronic disease management. However, Pharmacist time is also utilized to process acute prescribing requests, process repeat re-authorizations and respond to patient problems, where they relate to medication and/or prescribing. From within consultations, pharmacists conduct patient assessment, conduct relevant clinical examinations (were proven competent), formulate treatment plans and independently prescribe medications where appropriate.

Typically, consultations are based within the GP practice itself, but Pharmacists are also able to perform home visits to enable domiciliary / care home medication reviews for housebound patients.

This service aims to ease GP workload pressures at the same time as offering added value to patients through improved access to prescribing and specialist pharmaceutical advice. Results from a recent service evaluation suggests that BECN Cluster Pharmacists are saving a considerable amount of GP time (with an estimated 30mins of GP time saved for every hour invested). This is improving patient access to services and freeing GP time to spend on patients with complex medical needs. In addition, data collected from pharmacist interventions as well as analysis of CASPA prescribing data suggests that BECN Cluster Pharmacists are helping to contain /reduce prescribing expenditure.

Currently BECN have two full time Cluster Pharmacists working together across the 6 GP practices of the Cluster (70,000 patient population). Despite this resource, a large (and increasing) amount of medication review workload remains. BECN are currently formulating plans for further Cluster Pharmacist service expansion.

For further information, please contact Neil Sugden (Senior Cluster Pharmacist) neil.sugden@wales.nhs.uk

• BRIDGEND NORTH – Dr Geoffrey Smith Support Manager: Andrew Carrick

General Practice is under significant pressure and one factor that contributes to this is an increasing older population with multiple and complex health and social care needs. The added value that other professionals, including caseworkers and occupational therapists bring to General Practice is increasingly recognised as part of the solution to maintaining and improving patient care within our local communities.

Therefore the North Cluster have commissioned Bridgend Care & Repair to deliver a Primary Care Healthy Homes service that delivers an alternative, proactive model of care which focuses on early intervention and prevention.

A Caseworker and Occupational Therapist who are employed by Bridgend Care and Repair work together to provide patients with a holistic, housing focused service which offers practical solutions for the home environment, provision of aids and adaptations as well as

practical advice and support to help them live more comfortably, safely and independently at home. The Caseworker and Occupational Therapist work across all 8 GP practices in the North Cluster in Bridgend.

The Caseworker works proactively with the staff within the practices to identify patients and collect referrals, as well as liaising with GPs following home visits if necessary.

The Caseworker and Occupational Therapist provide a bespoke person centred service that includes comprehensive financial advice and assistance to older people with regard to housing repair, maintenance and/or adaptation work required to enable them to remain living independently and safely in their own homes.

Recently a promotional video for the Cluster Healthy Homes OT project has been produced (please see below). This is a great example of how clusters have embraced the wider determinants of health agenda and link with the Third Sector to address Health and Housing issues to improve the wellbeing of local citizens. Andrew.Carrick@wales.nhs.uk https://www.youtube.com/watch?v=6w8fvzCwJCw

- **BRIDGEND WEST – Dr Romilly Rees** **Support Manager: Sarah Thornton**

The West Cluster has been funding a Community Chronic Disease Nurse to help address potential health inequalities amongst housebound patients living in the Cluster area. The Nurse is responsible for providing a domiciliary service for the coordination, management and monitoring of the care of housebound patients with long-term chronic illness (heart disease, COPD and diabetes).

The emphasis of this role has been on service quality, through the optimisation of care where multi-morbidity exists, with the aim of maximising wellbeing, self-empowerment, quality of life and mobility.

Since the Chronic Disease Nurse has been in post the benefits to both Patients and GP practices has been:

- a single point of contact for community chronic disease management
- improved access to pre-planned chronic disease management services amongst housebound patients
- Improved clinical dialogue between GP and the chronic disease nurse enabling holistic care of the patient in the home environment.
- Patients developing a relationship with one nurse for chronic disease reviews leading to continuity of care and knowledge of the patient as an individual
- Increased delivery of preventive and seasonal immunisations amongst housebound patients with respiratory disease, heart disease and/or diabetes

Practices have been able to systematically build a formal register of patients who are housebound to ensure effective call and recall for services. Sara.Thornton@wales.nhs.uk

- **CITY HEALTH – Dr Ceri Todd** **Support Manager: Richard Williams**

The City Health Cluster welcomes Dr Ceri Todd as its new Chair.

Ceri has been an active member of the City Health Cluster, representing High Street Surgery and the new Abertawe Medical Partnership since the birth of Cluster Networks in ABMU. Over the years of attending these meetings, Ceri formed good working relationships with not only the GP representatives and their practice managers, but also members of the management and administration team of the Health Board.

Previously Ceri served as a Deputy Chair and found the experience rewarding: ‘ I take pride in taking a fair and honest style with everyone in progressing the cluster agenda, understanding and acting on individual’s thoughts and opinions to arrive at successful outcomes for our cluster and our patients. This experience enabled a smooth transition into the role and Ceri is driving forward the current and proposed City Cluster projects with enthusiasm and passion. Ceri’s passion is working with the Homeless, Vulnerable and Substance Misuse population in Swansea. She and her team have led a unique primary care service for the last 10 years supporting this difficult to engage with group. Richard.Williams16@wales.nhs.uk

- **CWMTAWE – Dr. Iestyn Davies** **Support Manager: Karen Edwards**

Cwmtawe Cluster have recruited a Chronic Conditions Nurse to enhance the multi-disciplinary team, providing support and help to people with chronic conditions such as COPD / Heart Failure / Severe Asthma and Type 2 Diabetes to manage their conditions within the community and maintain independence.

Over 155 patients to date have been seen with over 347 consultations. Patients have been really positive about the service and we have received the following feedback for example: 'Having a specialist Chronic Conditions nurse visit helped me gain confidence and manage my condition more effectively'.

Cluster Lead Iestyn Davies believes the role has been a great addition to the team "The CCN's chat to patients about recent flare-up's in their conditions and help patients recover but also to recognise the symptoms of a flare up earlier, ensuring that patients can get treatment quicker and hopefully prevent an admission to hospital or GP visit.

The progress of the project is being reviewed quarterly at each cluster meeting, this is to ensure the most effective and efficient use of the resources. For example next quarter it is expected that the role will assist with the COPD pathway work.

For more information please contact:karen.edwards@wales.nhs.uk

- **LLWCHWR – Dr Kannan Muthuvairavan** **Support Manager: Carwyn Davies**

In the spending plan for 2017/18 Llwchwr GP Cluster has allocated funds for the provision of physiotherapy within the 5 practices. The service has been provided at Gowerton and Talybont on a trial basis (paid for by the practices themselves) to establish the benefits to the patients – and to the working patterns of the practices.

As a result of the success, it was felt that cluster funding would now be made available to each of the five practices on a per capita basis to allow a number of sessions to be commissioned.

Although there is a walk-in service for physiotherapy, patients appreciate the professional assessment they receive through the provision of this service within the GP practice. Patients are seen by highly qualified physiotherapists who can properly assess their condition, diagnose and – for many patients – recommend some simple exercises that can relieve the condition without the need for them to travel to the walk-in service. They will also refer, if appropriate, for radiological investigations – or to MCAS – with the added advantage of a detailed assessment, which can help prioritise the referrals. GPs can select patients from triage and refer in to the physiotherapy service avoiding the need for an additional GP appointment. Carwyn.Davies@wales.nhs.uk

- **NEATH – Dr Deborah Burge-Jones** **Support Manager: Marie Amanoritsewor**

GP endorsement increases participation in bowel screening

Results are in from a recent pilot study looking at whether GP endorsement affected participation in bowel screening among non-responders in ABMU. 32 practices from 4 cluster areas participated in the pilot, which led to over 600 non responders saying they would consider taking up screening as a result of the pilot and 251 additional test kits being returned.

The drive behind the pilot was the recognition that colorectal cancer is the third most common cancer in Wales, with 1000 people in Wales every year dying from the disease. Early detection increases treatment options and reduces mortality. As of 1st October 2015, ABMU had 87,617 residents who were eligible for bowel screening, 44,506 of whom had been screened in the previous 2.5 years, giving ABMU a bowel screening coverage of 50.8%.

A cohort of 1647 non responders from 32 general practices were identified and lists of names sent to each participating practice.

The intervention was a phone call from the surgery with a trained member of staff using a set script for the call. 1647 non responders were identified and 1043 (63.1%) successfully contacted, 636 (61.0%) of whom stated that they would send off a bowel screening kit as a result of the phone call. 251 kits were returned following the study, a return rate of 15.2% of all non responders identified. There was no statistically significant association between returning a test kit and age or gender.

Dr Heather Wilkes, CCB co-chair & ABMU Macmillan GP said,

'It is well documented that earlier detection of colorectal cancer increases treatment options and outcomes. In 2015 the Cancer Commissioning Board in ABMU recognised the need to improve early detection of colorectal cancer and made this one of its priority areas. We are delighted that 251 additional people have been screened as a result of the pilot, and want to say thank you to all participating practices'

Additionally valuable qualitative data was collected from the participating practices, who asked why non responders hadn't previously sent back the test kits.

911 of the 1043 people successfully contacted gave a reason for not completing the kit, and the most common reason given was that they forgot to complete the test (21.3%)

103 people (11.3%) stated that practicalities of the test were the main reason they did not want to do it. This category included people who felt that the test took too long, who did not like the thought of touching faeces and who did not like the idea of posting the test back. 52 people (5.7%) were having investigations or surgery for suspected or diagnosed bowel cancer.

The plan moving forward is to share the full details of the findings at cluster meetings over the coming months through presentations and sharing of the report. We are feeding results from the pilot into national discussions around a proposed bowel screening toolkit for Primary Care Practitioners, and working with Public Health Wales to ultilise findings from this and other pilots effectively to increase coverage of bowel screening across Wales.

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- **PENDERI – Dr Daniel Sartori** **Support Manager: Debra Morgan**

Penderi Network Gives Every Child the Best Start in Life

Research indicates that focussing on the health and wellbeing of a child especially the first 1,000 days of a child's life will give a solid foundation for good health. 'What happens during these early years…has lifelong effects on many aspects of health and wellbeing from obesity, heart disease and mental health educational achievement and economic status'. (Marmot Review).

The Penderi Network have appointed a Primary Care Early Years Worker to deliver parenting skills and interventions for young children within a Primary Care setting. The aim of this innovative project is to give every child the best start in life and ensure they are reaching developmental milestones 'ready for school'.

The project began in October 2016 and to date over 100 families (392 beneficiaries) have been supported by Penderi's Early Years Worker.

Feedback from service users has been excellent with all of the patients reporting improvement in their wellbeing and family life, and 100% indicating they would in future contact the EYDW rather than their GP. **It is estimated that the service has saved over 650 GP appointments so far**, amongst a raft of other benefits. It is planned to build on outcomes and lessons learnt to see how this model can be further embedded in Primary Care.

For further information contact debra.morgan8@wales.nhs.uk

- **UPPER VALLEYS – Dr Rebecca Jones Support Manager: Marie Amanoritsewor**

Upper Valleys cluster has the lowest uptake for influenza vaccination in those 65 years and older at 60.5% against the Welsh Government target of 75% and the lowest uptake for influenza vaccination in those under 65 years in clinical risk groups at 36.3% against the Welsh Government target of 75% across all 11 clusters.

As the winter season approaches, the Cluster is keen to improve its performance and has put plans in place to increase uptake of the vaccine. Each practice has reviewed its processes and in addition to offering the vaccine in the practice during surgery hours, vaccination sessions will be offered in community settings. Some pre-bookable Saturday sessions will also be available.

Rebecca Jones, Upper Valley's cluster lead said, ***'The cold and damp weather, ice, snow and cold winds can be bad for patients, especially those who are over 65 or already have a medical condition. The good news is that there are lots of simple things that patients can do to protect themselves including have the flu vaccination. The Upper Valleys flu campaign aims to help patients protect themselves'.***

Messages have been developed to raise awareness of the risks of developing the flu and are targeted at patients who

- Are over 65 years of age or
- Have a long term health condition
- Are a Carer of an elderly person or someone with a long term health condition
- Have problems with their immune system because of medication or illness
- Are very overweight (BMI of more than 40)
- Are pregnant

If you would like to know about the Upper Valleys flu campaign please contact Marie Amanoritsewor

Marie.Amanoritsewor@wales.nhs.uk

The annual influenza campaign in Wales was officially launched on 2 October by Rebecca Evans, Minister for Social Services and Public Health.

Sharing key information about influenza and flu vaccination are important factors in a strong campaign.

A Beat Flu media toolkit can be found here. It may be a useful resource in raising awareness of the potential seriousness of influenza and the benefits of flu immunisation. During this year's campaign the 11 clusters across ABMU are using various approaches to encourage uptake. This encompasses a wide range of professionals getting involved including:

Chronic Condition Nurses

Pharmacists

Flu Parties