Cluster Network Action Plan 2016-17

(Second year of the Cluster Network Development Programme)

Central and South Denbighshire Cluster

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

- Understand local health needs and priorities.
- Develop an agreed Cluster Network Action Plan linked to elements of the individual Practice Development Plans.
- Work with partners to improve the coordination of care and the integration of health and social care.
- Work with local communities and networks to reduce health inequalities.

The Action Plan should be a simple, dynamic document and in line with CND 002W guidance.

The Plan should include: -

- 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.

[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

To understand the needs of the population served by the Cluster Network

The Cluster Profile provides a summary of key issues. Local Public Health Teams can provide additional analysis and support. Consider local rates of smoking, alcohol, healthy diet and exercise – what role do Cluster practices play and who are local partners. Is action connected and effective? What practical tools could support the delivery of care? Health protection- consider levels of immunisation and screening- is coverage consistent- is there potential to share good practice? Are there actions that could be delivered in collaboration- e.g. Community First to support more effective engagement with local groups

No	Objective	For completion by: -	Outcome for patients	Progress to Date
1	To review the needs of the population using available data	Completed annually prior to Cluster plan submission (September) – to align with BCUHB Planning Cycle.	To ensure that services are developed according to local need	PHW Cluster Profile used to identify the following priorities: social isolation; smoking cessation; Falls Management and support for an ageing population & chronic disease management.
2	To identify additional information requirements to support service development	Completed annually prior to Cluster plan submission (September). This is work in progress, as further information is awaited from Public Health Wales to support the Cluster and wider locality team priorities.	Improved support for service development	Practices are developing mechanisms to gather patient feedback, including: Web based patient forums, learning & good practice has been shared across the Cluster.
3	To consider learning from previous analyses to identify any outstanding service development needs	This is ongoing. Previous examples, including learning from the Smoking Cessation plan, where a particular service developed differently from expected & led to differing outcomes.	Improved patient care and health prevention	• Practices have undertaken early detection of Cancer. Reviews and shared with the Cluster. The Cluster has extended and expanded contraceptive services within the Cluster. Further learning will involve

		Extrapolating the model of the falls service to other new services.		sharing with wider community, including school nurses, health visitors etc with the aim of reducing teenage pregnancies.
4	To continue to develop the smoking cessation plan, to contribute to the reduction in prevalence of smoking.	Completed.	Improved health outcomes Improved quality of life	Smoking Cessation plan to be continued to be developed with the cluster. (please refer to priority 1 below).

PLEASE NOTE THIS PIECE OF WORK WILL BE SUPPORTED BY PUBLIC HEALTH WALES AND YOUR LOCAL AREA TEAMS

Cluster Overview

Central and South Denbighshire

Population – 42,220 people are registered with a GP, of whom 21% (8,960) are aged 65 or over, and 2.8 % (1,180) are aged over 85. 4% of the population live in the most deprived communities, 31% live in the least deprived communities. The area is relatively affluent, although there are pockets of deprivation, linked to agriculture and rural poverty, exacerbated by poor access to public transport.

Rurality & Language - Within C&S Denbighshire only 3% of the population are classified as living within an urban area. 97% of the Cluster population live in a rural area (including isolated dwellings, village or small town, and 25% of the population are Welsh speakers.

Chronic Disease – The Chronic disease registers show that the prevalence of COPD is slightly higher than average in other areas of North Wales and Wales. Other chronic conditions are within the lowest 25% or the lower end of the middle 50%.

Care Home Provision - The area has been well served by three Denbighshire Care Homes, in Denbigh, Ruthin and Corwen, which are supported by the GPs. DCC will be consulting on the future provision of care for the elderly and the Cluster is keen to be involved in the consultation and informing the future service model for care of the elderly.

There are also in the region of 20 Independent Care Homes and two Community Hospitals (Denbigh and Ruthin) in the area, which are served by GPs within the Cluster area.

Childhood Obesity – Compared to the rest of Wales, C&S Denbighshire has higher than average rates of Childhood obesity. According to the Child Measure Measurement Programme for Wales 2013-14 (PHW) (2015). In particular along the Dee Valley, 35% – 39% of children aged 4 – 5 years who are overweight or obese. Around Ruthin and Denbigh the rate is 30% - 35%.

Mental Health and Learning Disability – C&S Denbighshire has a long tradition of providing for people with mental health and learning disability, through the North Wales Hospital. Although the hospital closed in 1995, significant number of patients settled in the area, and care provision was developed to meet their needs in the community. In Denbighshire, 12,580 adults over 16 are reported as having a common mental health disorder, although PHW identifies that 25% of the population have a common mental health disorder.

The number of adults aged 18 and over with a learning disability is predicted to rise from 1,750 in 2013 – 1,870 in 2030.

Housing Developments – Significant housing developments are proposed at Bodelwyddan, St Asaph and Denbigh, with other smaller developments identified. In total the predicted increase in housing is 2,842 units, with an estimated population increase of 4,500 – 5,000 residents.

Central and South Denbighshire Cluster summary of population health need				
		Central and South Denbighshire	**BCU HB**	**Ref**
Total list size		Approx 42,220		GP Cluster profiles BCUHB (2013 Public Health Wales NHS Trust)
% of patients 65 +		21.2% (8,960)	20.4%	
% of patients 85+		2.8% (1,180)	2.8%	
% patients living in the most deprived fifth of areas in Wales		3.7% (1,560)	12.7%	
% patients living in areas classified as rural		97% (40,940)	49.6%	
Asthma		6.1%	6.6%	
Hypertension		16.1%	15.7%	
CHD		4.3%	4.2%	
COPD		2.5%	2.4%	
Diabetes		5.0%	4.9%	
Epilepsy		0.7%	0.7%	
Heart Failure		1.0%	1.0%	
Flu ; uptake 65+		Denbighshire – 66.6%	68.7%	
Flu ; under 65+		Denbighshire – 46.5%	49.3%	Seasonal Influenza in Wales 2015-6 Annual report
Smoking (Cluster performance against 5% target)	5.1%	2.6%	4.1%	BCUHB – Central Area Smoking Cessation Profiles July 2016
At least 30 minutes moderate exercise on five or more days in the previous week	28.4%	28.8%	29.2%	GP Cluster profiles BCUHB (2015 Public Health Wales NHS Trust)
Adult obesity (BMI 25+)	59.4%	57%	57.8%	
Heavy (binge) drinking on the heaviest day in the past week	25.2%	26.1%	26.1%	
Older people living alone	33.3%	30.6%	32.8%	

POPULATION NEED (Priority 1 – Smoking Cessation)					
Priority 1	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Smoking cessation	24% of adults in Denbighshire are smokers 6,127 smokers are recorded in C&S Denbighshire practices Health Board Tier 1 target is to treat 5% of adult smokers annually; with a 40% quit rate at 4 weeks 160 (2.6%) of adult smokers were treated by specialist services in C&S cluster during 15/16. 306 smokers need to be treated annually to achieve the target. Patients are 4 times more likely to quit if they access support from specialist services. Quitting smoking offers better improvement to healthy life expectancy than almost any other medical or social intervention.	**Aim:** Increase demand for specialist Pharmacy services **Objectives:** Raise profile of pharmacy cessation services in the cluster Raise profile of Quit for Them campaign in the cluster	Purchase promotional materials for all pharmacies to promote their services – outdoor banner/pop up/posters to meet their needs Business promotional cards with cover letter sent to all pharmacies in the area to be placed in respiratory patients' perspiration bags for a 4 week period. Communication toolkit sent to all key stakeholders promoting pharmacy encouraging them to promote service, display posters and share the NRT voucher. Case studies from the area written up and promoted widely in local media and social media Use text messaging to encourage smokers to access services Publicise 'Quit for Them' social media campaign on practice television screens	Cluster leads with support from PHW team	October 2016 October 2016 October 2016 October /November 2016 November/ December 2016 December 2016

	Smoking is linked to social class and accounts for a high proportion of the inequalities in health outcomes.		Promote public health messages on ipads		January 2017

POPULATION NEED (Priority 2 to be chosen by Cluster)					
Priority 2	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Lifestyle management	Many long term conditions can be prevented, delayed or better managed by the choices people make in life. Helping people make positive changes involves skills that all primary care staff can use and improve. These interventions are among the most cost effective health care interventions, especially if linked to other services and community assets. Making Every Contact Count (MECC) is a training program to improve motivational interviewing skills	Develop and implement a planned approach to 'Making Every Contact Count' in the cluster area	Identify priority staff cohorts (i.e. those who have the opportunity to have conversations about health behaviour change with people they are in contact with). Secure commitment from Practices and Community staff managers that 'MECC' can be included as an integral part of identified staff core role and be released for training Liaise with North Wales Local Public Health team (NWLPHT) contact to arrange delivery of MECC training Provide monitoring information as requested, to evaluate impact	Cluster Leads [redacted]	

POPULATION NEED (Priority 3 to be chosen by Cluster)					
Priority 3 The issues	**The Issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Timescale**
Vaccs and Imms	Vaccination is highly cost effective. Childhood uptake is good but is drifting down Adolescents and young people at risk of measles Children up to date by age 5:	Improve childhood vaccination uptake to above 95% at age 5 for whole Cluster population	Review progress against targets at Cluster meetings: • consider data re inequalities in uptake of childhood immunizations • review flu vaccination season • consider how to achieve 100% offer across Cluster population • consider text reminders across all Practices • consider actions to improve uptake by pregnant women		**January 2017** **March 2017**

ACCESS (to ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients)					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Understand the needs of patients.	CHC has advised that access to primary care services can be problematic. The cluster has consistently high satisfaction rates when population surveyed. Patients being navigated to the correct service first time.	To establish that if concerns are experienced throughout Cluster population, they are fed back via CHC at Cluster meetings. Utilize IT solutions to better engage patients and their needs.	Using innovative ways to engage service users in informing service provision, through practice forums, surveys, website feedback. "Notice Board TV's" Wifi in surgeries, text services and staff navigation training to be purchased with Cluster funds with the aim of improving patient flow.	[redacted]	April 2017.
New Housing developments	Proposed new housing developments will impact on primary care services; lack of detail re timescales makes it difficult to plan for future demand. It may be challenging to recruit to meet additional demand.	Maintain high quality core services & meet future demand.	Meetings arranged with Developers and DCC to understand timescales and implications with regard to Bodelwyddan.	[redacted]	April 2016.
My Health on Line.	Practices to adopt "My Health on Line."	Improve patient choice access & to services	Practices will be encouraged & supported to adopt the technology. NWIS to update hardware and software.	[redacted]	April 2017.

Primary Care Counselling	Poor access to primary care counselling services.	To .improve patient flow through the system	Utilising cluster funds to reduce waiting lists for primary care counselling. To work with MH SPOA, Parabl and GP practices in the cluster to improve patient flow.	[redacted]	November 2017
Stroke Prevention	To reduce stroke risk in patients with AF.	Utilise and promote through the cluster the Anticoagulation in A project.	Through project team headed by [redacted], pharmacist. Use cluster funds to cover costs of partaking in this project pending agreement from health Board.	[redacted]	April 2017

WORKFORCE					
Important Note: Each Practice has submitted practice specific plans to detail what will be done in order to meet any practice specific workforce needs e.g. to cover a period of maternity leave, recruit to a specific vacancy. The table below refers to matters that can be taken forward at a Cluster level and/or require HB input.					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Female GPs.	Not all practices have access to female GPs.	Offer choice to patients.	Encouraging female GP trainees & salaried posts as well as partnerships.	LMC	Ongoing
Availability of Locum GPs.	Fewer GPs available generally across Wales.	Maintain service provision.	Working with LMC.	LMC	Ongoing
Decreased income in General Practice.	Less income available to pay increased locum rates.	Maintain service provision.	GMS negotiation around contracts.	LMC	Ongoing
	Please refer to Access Section with regard to new Housing Developments.				

REFERRAL MANAGEMENT AND CARE PATHWAYS					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
SPOA (See Cluster Priority above)	Continue to promote and utilize appropriately.	Streamline services for patients. Support GPs with timely referrals and responses.	Through closer working with SPOA staff. Joint LLT and GP Cluster meetings. SPOA staff will identify key social services managers to link with MDT meetings.	[redacted]	April 2017
Falls (See Cluster Priority above)	Secure & Enhance Falls Service.	To sustain the Falls service and enhance through training and development.	Through investment in the service and workforce development. GP practices well placed to identify those at risk of falls and to refer on to the service	[redacted]	April 2017
Third Sector Co-ordinator	Continue to promote and utilize appropriately.	Provide information and advice for patients about 3rd Sector Services. Support GPs with timely referrals and responses.	Through closer working with SPOA staff. Joint LLT and GP Cluster meetings.	[redacted]	April 2017
Mapping Specialist GP Services available within the Cluster.	Potentially untapped resource.	Making greater use of the skills available within the Cluster, whilst ensuring resources follow.	Mapping specialist GP Services.	[redacted]	April 2017
Increased availability of Counselling Services	Lack of capacity in counseling services for Tier 0 and 1 patient to access psychological	Improve choice and access for patients with common mental health disorders.	Utilization of Cluster funds for 18 months. Measure outcomes and secure on-going funding once the services has become embedded (subject to outcomes)	[redacted]	April 2017

	therapies.				
Navigation			Up skill Reception staff Using cluster funding	Practice Manager [redacted]	March 2017

UNSCHEDULED CARE (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, co-ordination of care and effectiveness of risk management)					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Consultant Hotlines/Kinesis Messaging Service	Need to improve communication between primary and secondary care.	Reduce referral rates & increase patient satisfaction & quality of care & education.	Working with Clinical Informatics Group within YGC to push forward use of software & engagement of primary and secondary care physicians. Accessing IT funding from Technology Innovation Fund.	[redacted]	April 2017
Enhanced Care at Home	Encourage GP engagement.	To reduce admissions to hospital and provide better care at home.	Through continued monitoring through the Cluster & LLT meetings.	[redacted]	April 2017.
ANP for Care Homes	Unscheduled admissions from Care Homes & demand on WAST & GP services.	To reduce admissions to hospital and provide better care at home.	Through recruitment of ANP to support the Cluster.	[redacted]	Dec 2016.
AF	Reduce unscheduled admissions with stroke or bleed.		Please refer to above information		

TARGETING THE PREVENTION AND EARLY DETECTION OF CANCERS (Refer to National Priority Areas CND 006W)					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
CND 006W	To identify trends, inconsistencies & deficiencies in services	To improve patient care	Escalate findings from last year and this year's results.	[redacted]	Ongoing
			Complete requirements for CND 006W Cancer care within the Cluster Network Development Domain 16/17	All Practices	March 2017
			Implement learning from 16/17 reviews of patient care and lessons learned through inclusion in PDPs for 16/17	All Practices	July 2017
			Share findings from 15/16 review at Cluster Meeting and report findings and responses within the Cluster Annual Report for 15/16	[redacted]	March 2017
Individual case reviews for Cancers (lung, digestive, ovarian) Diagnosed in 2015			To receive progress reports and updates from on the 2015 (SEA findings) action plan.	[redacted]	Quarterly

IMPROVING THE DELIVERY OF END OF LIFE CARE (Refer to National Priority Areas CND 007W)					
Priority	**The issues**	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
CND 007W		To improve patient care	Complete requirements for CND 007W Improving End of Life Care within the Cluster Network Development Domain 15/16	All Practices	March 2017
Enhanced Care at Home	Encourage GP engagement.	To enable patients to end their life in the place of their choice.	Through continued monitoring through the Cluster & LLT meetings.	[redacted]	April 2017.
ANP for Care Homes	Unscheduled admissions from Care Homes & demand on WAST & GP services.	To enable patients to end their life in the place of their choice.	Through recruitment of ANP to support the Cluster.	[redacted]	On-going now in post.
Ensure high quality End of Life Care.	The Cluster will review significant events and learn through sharing examples at Cluster meetings.	To improve consistency in best practice.	Reviewing the significant events analysis & share at Cluster level. Education on EOLC provision and the new care decisions documentation.	[redacted]	April 2017.

MINIMISING THE HARMS OF POLYPHARMACY (Refer to National Priority Areas CND 008W)				
The issues	**Aims and objectives**	**How will this be done?**	**Named Lead**	**Time Scale**
Review of polypharmacy provision	To identify Themes	Following Review polypharmacy carried out in March 2016 the following themes were identified: • AKI risks: An educational meeting with the local Renal Physician took place. A patient leaflet on AKI which can be shared across the cluster. The needs to be rolled to be cluster • Stopping Statins. • Reduction in PPI and analgesic use • Reduction in items in general	Cluster Lead	March 2017

PREMISES PLAN					
Important Note: Each Practice has submitted practice specific plans to detail what will be done in order to meet any practice specific needs relating to premises. The table below refers to matters that can be taken forward at a Cluster level and/or require HB input.					
Issue	**Why?**	**What will be done at Cluster Level**	**How will this be done? (Practice; GP Cluster; Health Board)**	**Named Lead**	**Time Scale**
Practices are constrained from developing services.	Lack of space. Lack of grants/financial investment available to improve facilities. Not accessible/DDA compliant.	Work through with LHB.	• Practices & LHB.	Practice Leads	Ongoing.
Unable to take Medical Students.	Lack of space.	Work through with LHB.	• Practices & LHB.	Practice Leads/LMC	Ongoing.
General Maintenance Issues, e.g. flooring,			• Individual practices to resolve with LHB.	Practice Leads.	Ongoing

heating, decorating					
Increased demand for Primary Care Services.	Accommodation will not meet future demand for services envisaged as a result of new housing developments	Meeting with DCC and PCSU.	• Meetings with DCC, Developers and PCSU to plan for additional demand for Primary Care Services.	[redacted]	Ongoing

GP CLUSTER and LLT NETWORK ISSUES					
Issue	**Why?**	**What will be done?**	**How will this be done? (Practice; GP Cluster; Health Board)**	**Named Lead**	**Time Scale**
. Share priorities detailed above in Section Population Need (Priority 2).			• SPOA, • Social Isolation • Falls service • Smoking Cessation,	As above.	As above.
Obesity	Identified as higher than average issue for C&S Denbighshire area.		• Public Health to look for evidence base re interventions & work with LLT to inform GP Cluster for future working. • Aim to utilize SPOA for signposting to any future service.	[redacted] BCUHB	Ongoing

LHB Issues **(*in addition to any issues raised above requiring Health Board input)***					
Issue	**Why?**	**What will be done?**	**How will this be done? (Practice; GP Cluster; Health Board)**	**Named Lead**	**Time Scale**
Early detection of Cancer.	Trends & concerns identified through reviews.	Raise with BCUHB.	• Early detection of Cancer CND 008 W – need clarification from BCUHB regarding how the information and trends gathered is informing service delivery. • Feedback to GP Cluster.	[redacted]	Dec 2016.
Estate not fit for purpose	Unable to maintain or expand services.	Clarification with PCSU.	• Clarification with PCSU.	[redacted] /PCSU	April 2017
Inconsistencies in current services.	Seeking to develop LES	Raise with PCSU & LMC.	• Ambition to establish Locally Enhanced Service for Phlebotomy currently sitting with Welsh Government, GPC. • Make provision for phlebotomy services to continue should no decision be reached by April 2017.	PCSU & LMC & Dr [redacted].	April 2017
Planning for future developments.	Increased demand on services.	Raise with PCSU & Area Team.	• Support from PCSU to scope and model demand on primary Care based on additional housing developments.	[redacted] /PCSU	Dec 2016