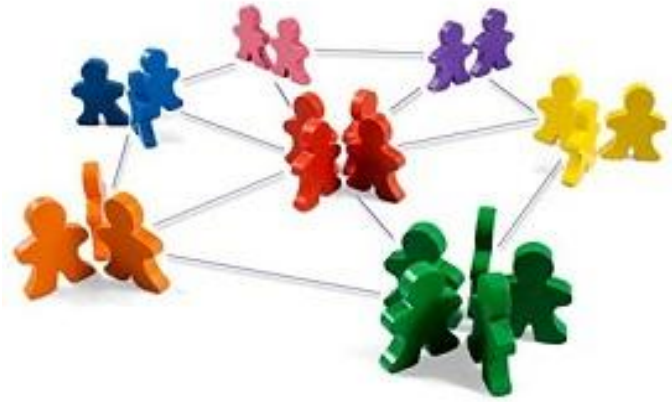
Annex 3

Three Year Cluster Network Action Plan 2017-2020

Central Vale Cluster



Highlight Park	West Quay	Waterfront	Vale Group
Practice of Health	Sully	Court Road	

The Cluster Network[1] Development Domain 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 Cluster Network Action Plan should be a simple, dynamic document and should cover a three year period.

The Cluster Network Action 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. 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 action plan may be grouped according to a number of strategic aims.

The three year Cluster Network Plan will have a focus on:

[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

(a) Winter preparedness and emergency planning.

(b) Access to 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 (CGPSAT) and inactive QOF indicator peer review.

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
1	We will use the resources we currently have – and of those we interact with – in a more coordinated and joined up way. We will meet with our partner agencies to discuss ways of reducing waste, targeting resources at those who need them most.	OOH WAST DNs Maternity and HV Teams	Cluster Leads	Joined up service delivery Prioritising services for those most in need.	The cluster meets regularly. We have invited key stakeholders from other agencies to aid the progression of our work and will seek to continue to do this in the future.	
2	Given the expected increase of 7 – 8% in population in Central Vale, but difficulty in recruitment of GPs due to current workload, radical change is needed in how patients are looked after. Consider best ways of providing care for	OOH WAST A&E Workforce planning facilitators	Cleona Jones Practice of Health	Appropriate access to healthcare when needed. Appropriate use of GP services and utilising alternative providers to ensure prudent healthcare model.	Practices participated in Primary Care Foundation work reviewing workloads and ways of working within individual practices. This was reviewed and evaluated at cluster level to share ideas about methods of	

	acutely ill patients. Representation at UHB Frequent Fliers meetings for the cluster				working to meet demand. Subsequently cluster has participated in workforce planning, sharing workforce potential issues in future years and work can commence on considering if there are options to share resources, provide access to shared services.	
3	Perceived poor support from UHB on current state of general practice, issues faced and sustainability problems. Need to ensure UHB is aware of current problems of workload, inappropriate consultations, public expectations.	UHB RCCP Wales Pharmacies Dental Opticians	Cluster Leads	Access to care for those who need it. Signposted/ direct access to alternative service providers who best meet the needs of the patient.	Primary Care Support services have been approached by some practices in the cluster who are affected by these issues. Practices have provided a staff training session at CPET time for administrative staff on signposting.	
4	Improve coordination with other partners,	VoG Council	Cluster Leads	Better outcomes overall	Links in place within practices for third	

	e.g. VoG Council, voluntary sector and DWP to identify more efficient ways of working. Consider forum for social care managers, voluntary sector leaders and practice managers	Voluntary Sector			sector organisations within the cluster.	
5	Prevalence review across all cluster practices to ensure that patients with LTC have been identified.	NWIS INPS EMIS	Cluster Practices	Patients with LTC identified and known to practices to ensure maximisation of management of healthcare conditions	Disease prevalence has been reviewed within the cluster and focus for practices for a number of years. There is still some disparity across practices for disease registers and all cluster practices are in agreement to a project to carry out tidy up work to ensure patients have been identified for registers where appropriate.	

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 partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
6	Further to work already completed by the cluster in 2016/17, we now have a better understanding of workforce issues that are likely to affect practices in the next 5 years and this information will be utilised to facilitate discussion about resource needs either with an individual practice supported via cluster practices, alternative services that need consideration in the future or inform UHB for support.	Sustainability Team	Cluster Leads	Better planning of care/ workforce increases access to healthcare and advice. Recruitment difficulties in the future may result in patients regularly seeing alternatives to GP such as advanced practitioners, minor illness nurses etc.	Work has been carried out with the cluster in 2016/17 with support from the UHB Primary Care Workforce Manager. This has enabled practices to prepare a workforce plan and share this at cluster level. Practices have submitted their sustainability reports to the UHB individually.	

7	Review and report on activities of cluster Physio	Physio	All Cluster Practices	Patients are able to access acute physiotherapy within 5 days of presentation to practice for an acute injury.	Some practices signpost patients directly without the need to consult with a GP, thus maximising the benefits for practice as well as patients for this service. For other practices, sound referrals are made ensuring that only appropriate injuries are referred. There continue to be adhoc issues with technology where the iPad does not enable access to records, but largely this is overcome. The EMIS practice patients do not benefit from the technology as notes are unavailable through the iPad solution. Vision 360 enabling access for	

					the physio to all patients regardless of system used is considered too costly at this time for investment. The booking system via shared outlook email appears to work well. We shall request a service update from the physio service. Funding has been requested to secure the service for a further 12months.	
8	Review and report on activities of cluster Pharmacist	Pharmacist	All Cluster Practices	The Cluster Pharmacist is largely cemented within practices and utilised by patients for annual medication reviews ensuring full and robust review of medicines, usage and compliance.	Agreed that Cluster Pharmacists are now established within practices and assisting with workload in completing medication reviews for patients, including homes and housebound patients. Added value for practices and patients.	

9	Ensure wide awareness of MIND service for patients with mild/ moderate anxiety and depression. Promote to all GPs and monitor take up levels by each practice.	MIND	All Cluster Practices	Local support available to central vale patients providing easier access to mental health services, with a relatively short waiting time. Access to help and support at a time when it is needed before problems escalate.	MIND is now widely recognised as a useful service for this group of patients to be referred to and funding has been taken away from the cluster to secondary care, which has demonstrated the benefits of the service both to patients and the impact on referrals to secondary care. GPs to continue referral to the service for the most appropriate patients.	
10	Share resources or bid for additional resources, where there is clear mutual benefit.		Individual cluster practices	Higher/ More targeted resources to ensure patients benefit from a full complement of services regardless of the surgery they are registered with.	Practices have already undertaken to support each other in bidding for and sharing enhanced services such as minor op procedures, where a practice may not have a clinician able to provide those services.	

11	The cluster will explore ways of collaborating to ensure the needs of patients are met Explore desire to enter into inter-practice agreements, collaboration – even merger – to ensure patient needs met Identify areas where collaboration most likely to lead to mutual gain	Community Director Senior Partners	All Cluster practices	Broader range of health needs in local area can be met. Patients will benefit from receiving services locally, regardless of practice capacity to provide a service. Reduction in referrals to secondary care	Some discussions among individual practices. Most practices providing most enhanced services. Consideration of future collaborative opportunities with new enhanced services.	
12	Improve awareness of appropriate use of antibiotics, including when antibiotics are not appropriate and review telephone prescribing of antibiotics. Target national/ international awareness days to ensure message passed to patients.	PHW	Dr. Louise Jenkins Cluster Practices	Reduced antibiotic resistance, more appropriate treatment including "wait and see" approaches.	The cluster produced materials including leaflets to target antibiotic prescribing. Practices handed out the leaflets to all patients collecting prescriptions during the same time frame so that a consistent message was portrayed. Left over stock can be reused to reinforce	

					the same messages.	
13	Identify existing sources of healthcare promotion materials e.g. choose well, antibiotic prescribing, smoking cessation, OTC education and adopt across the cluster in coordinated campaigns.	PHW	Cluster Leads	Increase awareness and increased uptake of services through greater awareness.	Practices to acquire materials including leaflets, posters etc. to reinforce key messages. Ensure adequate signposting. Promote information via websites/ FB/ Social media.	

Strategic Aim 3: Planned Care - to ensure that patients' 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 partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
14	Continued progress to reduce unnecessary generated work from secondary care – e.g. requests to send expedite letters, re-referral to another specialism which is still problematic.	Secondary Care UHB LMC	All Cluster Practices	Treatment by one professional, not directed elsewhere for results, further referral Less opportunity for duplication of tasks, less opportunity for onward care to be over looked.	Review of interface incident reporting to take place in August 2017 between practice representatives and UHB, as current system is Cluster standard letter	

	Continue to forward feedback to secondary care, interface incident reporting and LMC.				to return requests is widely used between practices and should continue. Funding to be available in 2017/18 for practices to complete requests for blood tests.	
15	We will aim to further utilise My Health Online and text messaging within all practices, and other technologies such as automated telephone systems, to improve the ability of patients to self-serve for appointment bookings and repeat prescription requests	NWIS INPS System Suppliers	Individual Practices	Able to book appointments when practice telephone systems busy / unavailable Communication with practices using alternative methods.	Meetings with INPS in attempt to progress vision 360 Review of telephone messages within practices, where desired, to try to synchronise messages and signposting of patients to alternative services appropriately.	
16	Investigate use of Skype for either patients within care homes or those that are housebound to enable best use of resources.	NWIS Care Homes Patients Attached Staff	Dr. A. Kuczynska/ Clare Evans	Flexibility for housebound patients to be able to consult with GPs using alternative technology, in place of a physical home visit.	Meeting with a potential care home to pilot skype for patients. Investigating resource options and encryption to ensure option	

					provides security reassurance for all users.	
17	Improve knowledge of processes surrounding palliative care or end of life care such as DNACPR consent, advanced care planning. Review benefits and barriers to implementation of GSF for palliative care Current DNACPR process is not considered fit for purpose – with carbon copy multiple sheets being completed by hand and shared.	Palliative Care Nurses MacMillan GP Facilitator	All Cluster Practices Dr. Crouch	Improved end of life care with dignity and patient/ family preferences at the forefront.	Training through the MacMillan GP Facilitator/ CPET Neighbourhood sessions has taken place. Further training opportunities can be adopted should the need arise. Feedback has been given on the lack of input at practice palliative care meetings from CPNs and the anticipation is that this will improve going forward. Feedback has been given to UHB/ WG that current DNAPR process is not fit for purpose. Practices considering participating in care homes enhanced service will have an	

					impact on advanced care planning and DNACPR in this group of patients.	

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 partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
18	The cluster will bid to utilise funding for winter flu nurse as a good example of working together in a cost efficient way.	PHW	Nicola Gilbert	Early vaccination against influenza which will reduce the likelihood of acute flu illness during the winter months and improve health outcomes overall through avoiding hospital admissions relating to flu.	The cluster has previously secured a flu nurse to provide flu vaccinations for housebound patients. This has worked successfully to ensure housebound patients are vaccinated to protect against flu early in the winter season. Practices will identify housebound patients in good time to enable early vaccination to be co-ordinated.	

19	We will aim to achieve greater consistency of approach to prescribing patterns, use of NHS resources etc. through review of prevalence and prescribing patterns to understand common themes and adopt common approaches. Undertake public awareness campaigns across the cluster e.g. OTC medication	Welsh Health Observatory Prescribing Advisors Prescribing Leads Wellbeing co-ordinators Cluster Pharmacists		Consistency in treatment across cluster. Better use of resources to target those most in need Better education around when to see a GP, how to manage minor illnesses at home without needing to see a GP and items which can be purchased OTC.	The Cluster will participate in the National Education Campaign in winter to education patients through use of an Antibiotic leaflet provided during winter months to educate patients on when to request, when to see GP and how long symptoms would take to resolve without need to be seen. Review of prescribing patterns may reduce demand for services, including during winter months as reliance on GP services for items that can be purchased readily OTC in place of requesting an appointment with a GP. Prescribers will be reminded of the need to follow the NICE guidelines for common	

					illnesses and formal prescribing protocols.	
20	Undertake awareness and education campaigns to improve take up of common screening procedures such as bowel screening, breast screening and AAA screening.	PHW Wellbeing co-ordinators	Individual Practices	Early diagnosis leads to better outcomes for health	Practices have shared a "footer" for use on patient correspondence as an education tool on screening opportunities. Waterfront Medical Centre hosted a "Man Van" to promote male health Use of prompts within patient medical records to act as a reminder of those patients who have not participated in screening to try to encourage this.	
21	Practices will consider participation in the care homes enhanced service which will provide practices with a better understanding of care needs and patient status during winter months which	Care Homes Cluster Pharmacist	GP Practices	Elderly patients better known to practices. Management of patients throughout the year	Individual practices to consider if the enhanced service is appropriate for them to participate in and determine how best to resource this service. Optimisation of service will enable practices to	

	will reduce pressures.				have a better knowledge of patients residing in homes to make decisions in relation to their care during winter months, when practices may be under more pressure – e.g. reduced need to visit if patient is known to the practice.	
22	Training and Education of practice administration staff to assist with signposting to relevant clinicians	Opticians Pharmacies Dentists Other Healthcare providers UHB Training Organisations	Cluster Practice Managers	Consistent information and education passed to patients from practice teams to better inform patients where services can be obtained and how to utilise services appropriately	The first signposting training session for receptionists in central vale cluster took place in May 2017, which included carers, local optician and cluster pharmacist signposting. We will build on this training over the next three years to provide more support and education to staff on best professionals to help patients with certain problems.	
23	Vision 360 to assist with sustainability of practices e.g. to enable "buddy" system if a	NWIS INPS EMIS	Cluster	Sustainability of services	Discussion within the cluster in relation to the adaptability of the cluster with vision 360.	

	practice within the cluster is having difficulties, or cross cover e.g. Christmas eve/ new years eve				Enabling access to patient records to all practices potentially, which, at times of shortage of GPs/ Nurses etc. could enable "buddy practices" to help with workload or to provide cross cover	

Strategic Aim 5: Improving the delivery of dementia; mental health and well being; cancer; liver disease; COPD (delete as appropriate)

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
24	COPD – improve COPD care through ensuring accurate diagnosis, coding and treatment. Identify patients not diagnosed via spirometry and complete. Review spirometry results of those with diagnosis to ensure between 20 – 70% and	Respiratory Teams CREW	All Cluster Practices	Accurate diagnosis coding and treatment. "know their numbers" Quality of life assessment, ability and confidence to use inhalers and understanding how to help themselves through access to and involvement with self-care documentation and action plans.	Agreement to engage in pathway by cluster practices. All cluster practices will need to participate in the national COPD audit for 2017/18 Standardised set of codes and templates shared between cluster practices to aid	

	no further action Review those where spirometry not confirmed diagnosis and review coding, treatment and referral needs.				accurate peer review	
25	Liver Disease – to facilitate appropriate management of abnormal ALT tests and more timely diagnosis of patients with liver disease Reduce number of repeat LFT following abnormal ALT Increase appropriate testing following abnormal ALT.	Biochem Lab Hepatology team CAU	All Cluster Practices	Prudent testing for liver disease – by reducing repeat tests following abnormal ALT and increase appropriate testing following abnormal ALT. Increase appropriate referrals to hepatology for patients with abnormal ALT indicative of hepatic fibrosis	Agreement to engage in pathway by cluster practices. Cluster practices to complete baseline audit of raised ALT levels in a specified two month period. Practices will then follow the pathway for two months Audit again after two months to review outcome of management of patients with raised ALT Further discussion will need to take place on how to manage patients with risk factors for liver disease, including excess alcohol	

					consumption. Then continue, re-audit after a further two months and discussion outcomes to include in year end report.	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
26	OOPS initiative to reduce smoking	Smoking Cessation Wales	Individual GP Practices actively from October - December	Identify patients with a BMI greater than 40 who are referred for surgery. Provide smoking cessation support and advice to those patients with the aim of reducing surgical risks associated with smoking and anaesthetic	Contact with All Wales Smoking Cessation Service to obtain engagement with provision of baseline data and data during period of activity that will demonstrate whether improvements can be influenced by primary care teams.	
27	OOPS initiative to reduce obesity	Exercise on Referral Team	Individual GP Practices actively from October - December	Identify patients with a BMI greater than 40 who are referred for surgery. Provide exercise referral and advice on increasing activity to those patients with the aim of reducing surgical risks	Contact with local exercise on referral Service to obtain engagement with provision of baseline data and data during period of activity that	

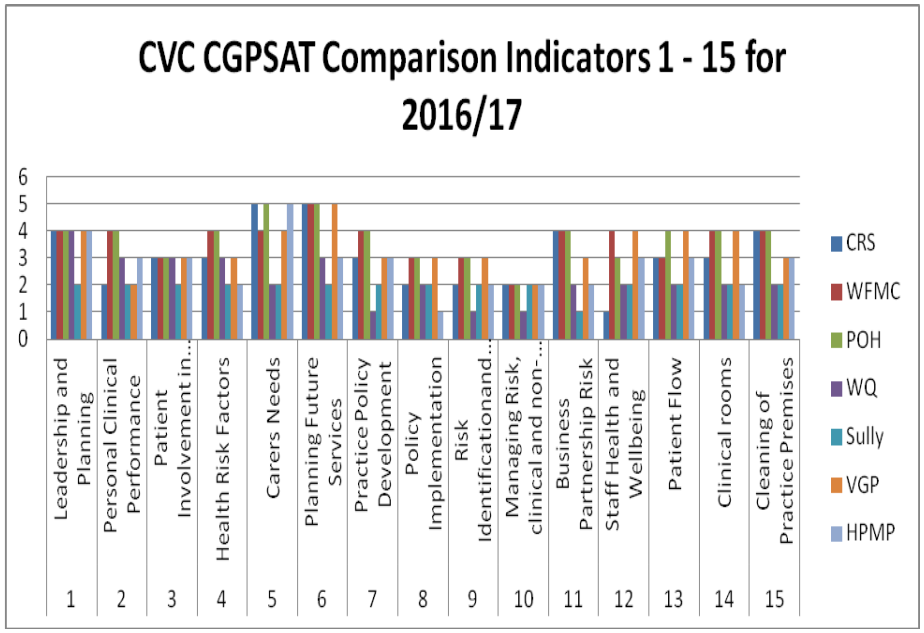
				associated with obesity and anaesthetic	will demonstrate whether improvements can be influenced by primary care teams.	

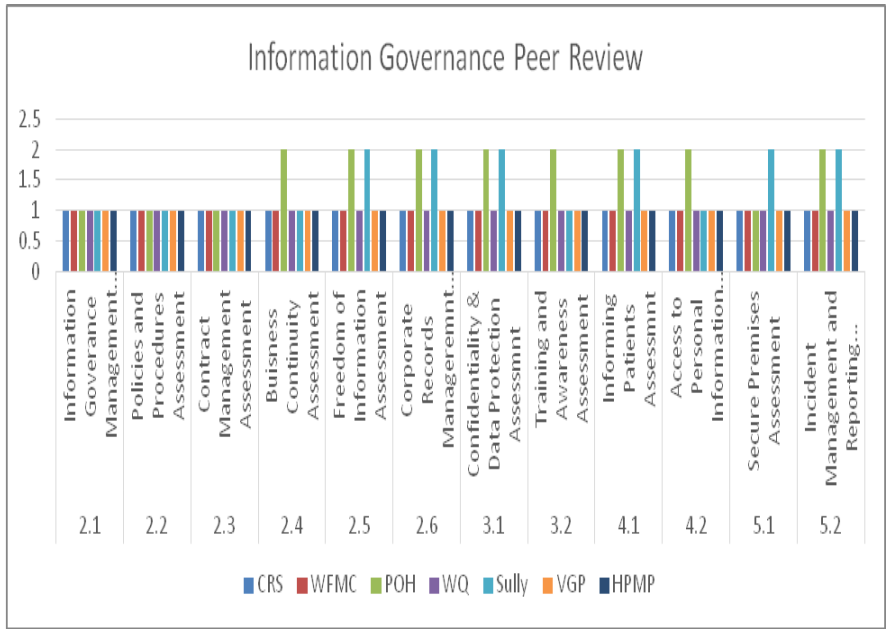
Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and Information Governance. To include actions arising out of peer review Quality and Outcomes Framework (when undertaken)

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
28	Peer Review CGPSAT	PHW UHB	All Practices	Robust systems in place within all cluster practices to provide reassurance on quality, safety and compliance	Peer review at cluster meeting 5.7.17 Discussion around variations between practices. Acceptance from practices that scoring will vary depending on individuals completing and perception of requirements. Some changes to scoring already identified by some practices in short time since completion. Agreed that PMs will meet with a view to sharing knowledge and experience to try to equalise scoring	

					between practices for indicators 1 – 15 in 2017/18. 16 – 30 in 2018/19 followed by 31 – 47 in 2019/20 PMs to meet 28.11.17 to review x2 indicators by each PM to share practice.	
29	Peer Review IG Toolkit	PHW NWIS UHB	All Practices	Robust systems in place within all cluster practices to provide reassurance on quality, safety and compliance with data and IT systems	Peer review at cluster meeting 5.7.17 Discussion around maturity of scoring due to IG toolkit requirement being relatively new for practices. Agreed that PMs will meet with a view to sharing knowledge and experience to try to improve scoring/ compliance between practices for indicators 2.1 – 2.4 in 2017/18 then 2.5 – 3.2 in 2018/19 and finally 4.1 – 5.2 in 2019/20 PMs to meet to review	

					x1 indicator per PM to share practice.	





Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
30	Stockpiling of medication continues to be an issue for patients within cluster	Pharmacies UHB Prescribing	All Cluster Practices	Improved Management of Medication	Polypharmacy medication reviews have been part of	

	practices. Through polypharmacy reviews, some over ordering was identified where pharmacies order on behalf of the patient. The cluster will seek to review ways of working together with local pharmacies to reduce over ordering and consequent stockpiling of medications to reduce over all wastage within the NHS prescribing budget.	Team		Safety concerns of stockpiling medication reduced	practice culture for past 2 years where stockpiling issues have been identified. Ongoing concerns about pharmacies ordering patient medications flagged to UHB. Consideration of alternative methods to reduce over ordering/ ordering of items not required ongoing.	
31	Review with UHB utilising local pharmacy to provide treatment OTC free of charge to patients to avoid the need for patients to attend the practice and the challenges posed by patients being able to obtain a prescription to have medication/ drugs dispensed free of charge as opposed to purchasing OTC, which has an impact upon the demand of patients on GP services.	UHB	Pharmacy	Improved access to an appropriate healthcare professional.	Awaiting announcement of specification from UHB in relation to pharmacy project to enable acute minor problems to be dealt with via pharmacy. Circa September/ October 2017.	

32	Consider creation of a Cluster Facebook page where health promotion across all practice patients could be provided, a long with information about services locally etc.	PHW NWIS	Dr. R. Hardwick	Increased awareness and circulation of relevant information.	Consideration whether the cluster would benefit from creation and maintenance of a facebook page to promote health and wellbeing topics to patients across all practices, ensuring consistency of messages.	