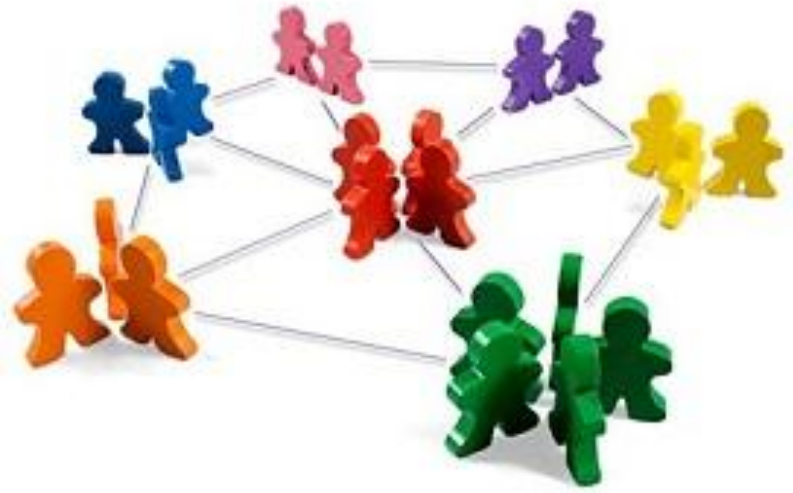
Three Year Cluster Network Action Plan 2017-2020

Cardiff South East Cluster



Cardiff City and South

This is the second Network plan that has been produced by the Cluster and once again this plan has been developed at Cluster level across the following seven practices:

- North Road Medical Practice
- Clifton Surgery
- Roathwell Surgery
- Cloughmore Medical Centre
- Four Elms Medical Centre
- Cathays Surgery
- The City Surgery
- Albany Surgery

Outline of Cluster Population Profile

The demography of Cardiff South East is complex and includes areas of the highest rates of unemployment, social deprivation, a high population of University Students and one of the six UK immigration centres. Common issues exist which cut across our specific vulnerable groups and include lack of work & meaningful activity, lack of money leading to a cycle of poverty with poor housing and poor diets leading to poor health. There is poor engagement in education and the worst levels of educational attainment in Cardiff in the South East. Language is a key problem for community cohesion and not enough ESOL provision, leading to low level racial tension.

The transient nature of the population living in the area also creates a barrier to addressing some of the deep rooted service delivery challenges found in this neighbourhood. A large number of projects exist in the area, all providing support, information and services for specific vulnerable groups and for those from diverse ethnic backgrounds. Whilst older people make up only 16% of the total population in the neighbourhood, local research and intelligence shows that the level of need to address isolation, poverty and their safety is proportionally high.

The Plan

The plan is the second network plan to be developed and as in the previous document (2014/2017), is informed by the practice development plans, public health information on key health needs within the area; a knowledge of current service provision and gaps within the area and an understanding of key UHB priorities for the next three years. The plan details service plans for years 1-3 (2017/2020), providing where relevant background to current position, planned objectives and outcomes and actions required to deliver improvements. The cluster views this plan is a dynamic and evolving document and therefore, the plan itself will be reviewed and updated as required.

A number of key principles underpin the plan:

- Winter preparedness and emergency planning.
- Access to services, including patient flows, models of GP access engagement with wider community stakeholders to improve capacity and patient communication.
- Review of quality assurance of Clinical Governance Practice Self- Assessment Toolkit (CGSAT) and inactive QOF indicator peer review
- Maximising use of Local Cluster Resources
- Promoting integration/better use of health, social care and third sector services to meet local needs
- Considering and Embedding New Approaches to Delivering Primary Care: this includes increased use of technology, new roles and service models considering embedding new approaches to delivering primary care: this includes increased use of technology new roles
- Maximising opportunities for patient participation: this includes consideration of models of good practice that exist with within/locality/cluster and nationally and within the rest of the UK.

- Maximising opportunities for more efficient and effective use of resources: this includes consideration of current resources, opportunities to utilise current and new services more efficiently and effectively

It should also be noted that a key objective in 2017 is to ensure that the Cluster matures and operates in a more business like way and will shortly be developing terms of reference for the Cluster. This will ensure that decision making is appropriate, enable sound governance and support the ongoing and sustainability of primary care services.

This plan builds on and compliments each individual Practice Development Plans and sustainability assessments.

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	To proactively work with the local community to and improve screening and immunisation rates across the Cluster.	Public Health Colleagues	October 2017 to March 2018	✚ Improved education and understanding of the importance of screening ✚ Early detection and diagnosis of Cancer ✚ Improved outcomes ✚ Improved health and wellbeing	✚ Discussed and agreed at Cluster meeting July 2017. ✚ Screening Lead in each practice identified	AMBER
2	To support patients experiencing mental health problems.	MIND Cardiff University Counselling Services		✚ Improved outcomes ✚ Improved health and wellbeing	✚ Service in place with MIND but being reviewed	AMBER
3	To support patients experiencing Dementia	Alzheimer's Society		✚ Earlier Diagnosis and intervention ✚ Support for carers and family members		AMBER
3	To support patients suffering from Domestic Abuse – improve staff	Cardiff Women's	Sept to	✚ Reduce levels of stress and anxiety	Proposal approved and	AMBER

	skills and knowledge via bespoke training programme	Aid	March	• Feel safer and more able to cope • Reduced need to seek medical appointments	training programme to commence Sept 2017	

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
1	To understand workforce profile across the Cluster and develop a workforce profile to ensure that patients are seen by the most appropriate member of staff.	Workforce Colleagues	Oct to Dec 2017	✚ Better access to services ✚ Reduced waiting times ✚ Improved clinical outcome	WOD colleagues attended Cluster meeting.	RED
2	To work across the Cluster to ensure access arrangements are sustainable.		Ongoing	✚ Appropriate use of urgent slots/high consultation rate ✚ Reduce non attendance ✚ More realistic expectations		AMBER
3	To promote the use of technology solutions for patients e.g. MHOL, VISION 360					AMBER

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
1	To ensure that all Advanced care Pathways are reviewed and followed to provide best outcome for patients. Consider impact of pre-testing/investigations prior to referral and the impact on GP time.	Secondary Care Leads	March 2018	○ Appropriate referrals to secondary care ○ Early diagnosis ○ Improved outcomes		Amber
2	Consider liaise with secondary care to ensure smooth and better access for advice/discussion			Reduction in referrals and requirement to visit hospital		RED

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
1	To work across the Cluster to ensure that patients with the greatest clinical need are prioritised, and that appropriate sign-posting (choose well) is used to direct patients to the most appropriate health professional for their need.	3rd sector groups Neighbourhood partnerships	Ongoing	Improved wellbeing Better understanding of ways to address non-medical issues Improved self help Avoidance of unnecessary GP appointments	Social prescribing proposal agreed	RED
2	To Work with the Cluster frailty nurse to manage patients who are most at risk from hospital admission ensuring there are support measure in place to reduce secondary care admission	Frailty Nurse Cluster Pharmacist		Reduced need for GP visits Hospital admission avoidance Early warning for patient declining health Medication reviews/rescue packs available	Frailty Nurse recruited	Amber

4	To promote the importance Flu vaccinations for both staff and patients - Work with Cluster to maximise opportunities to exploit cluster initiatives that lead toward improved uptake (e.g. shared Community events, shared visits to Elderly Day Centres, Toddler Groups, Nurseries, etc)			• Less respiratory illness • Better engaged population		Amber
5	To ensure that staffing levels are appropriate during winter	ALL	October	• Sustainable access for patients		Amber

Strategic Aim 5: Improving the delivery of Clinical Priority Areas - Dementia and Liver;

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To improve the management of patients with Dementia across the Cluster. To have consistent pathways across the Cluster and support services across cluster Work with PHW to determine prevalence in cluster	The Dementia Delivery Plan has enabled Dementia support workers available to each Locality and work is ongoing to up skill GPs in early diagnosis.		• Access to support services • Early diagnosis • Support for carers and families • Signposting	• Toolkit to be agreed. • Discussed at Cluster meeting in July 2017.	Amber
2	To improve the management of patients with Liver Disease across the Cluster.	Secondary Care Colleagues		• Early diagnosis • Better prognosis • Early intervention • Reduce testing • More appropriate referrals		Amber

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To maximise opportunities to improve patient outcome via pathway.	Secondary care Colleagues		• Better management of COPD • Improved health and wellbeing • Better engagement	Agreed at Cluster meeting in July 2017	RED
	To work across the Cluster to share best practice Improve patient outcomes and services by following common themes and discussing at Cluster level and producing an informed Action Plan to address issues identified across the pathway.			• Improved outcomes • Reduced mortality		RED

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
1	Strengthen quality assurance in relation to clinical governance and assurance on specific indicators designated as “inactive” QOF	Primary Care team	Sept and March each year.	Appropriate and consistent care provided	Discussed at Cluster meeting and schedule agreed.	RED
2	To utilise learning from each practice CG Self-Assessment and consider any issues highlighted across the Cluster.		March 2018	Sound Governance Structures Safe Clinical Practices	Discussed at Cluster meeting and schedule agreed.	

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To work with partner organisations to ensure the social issues of the populations are supported as an alternative to seeking medical advice/care. The Cluster has not benefitted from working with Wellbeing Co-ordinators and is keen to seek support to assess the benefits to patients and practices	??? Wellbeing Co-ordinators	Ongoing	• Improved wellbeing • Better understanding of ways to address social issues	Proposal agreed	RED