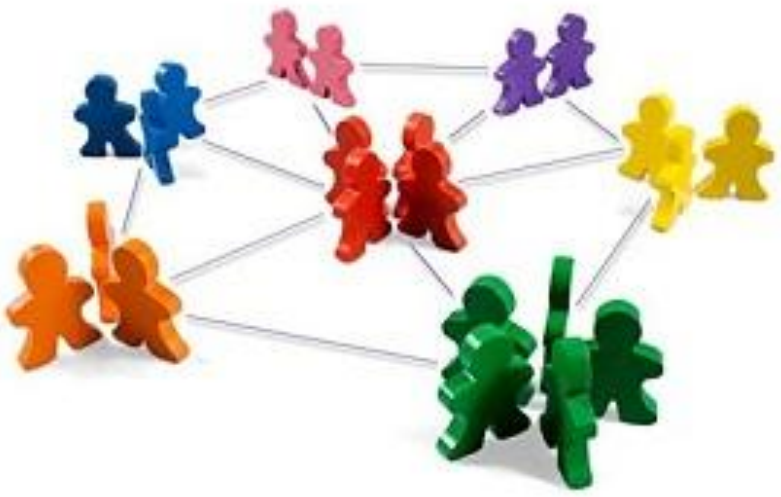
Annex 3

Cluster Network Action Plan 2017-2020

Eastern Vale Cluster



The Cluster Network4 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 Action Plan will have a focus on:

(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 (CGSAT) and inactive QOF indicator peer review.

4 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

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.	Review needs of local population using available data	Local Public Health Team Public Health Observatory EVCGP ECAS Population needs assessment	July 2017	To ensure that services are developed according to local need	The Cluster Network serves a population that is : - •Older than Welsh average 20.9% compared to Wales 18.7% •The population aged over 85years is projected to increase to 36.2% by 2026. •Established •Little mixed ethnicity, particularly in four out of the five practices. Frail. Higher prevalence of dementia. Multiple co-morbidities. •Deprivation	

					significantly less than Welsh Average (0.4% compared 20.0% in Cardiff and Vale and 23.5% in Wales. It was felt to be more or less consistent across the area though the practice with a wider (including parts of Cardiff) practice area probably would show a slightly higher deprivation figure. . •Chronic condition burden is higher than other Cluster areas The Eastern Vale covers a population list size of 36,580 according to the PHW Observatory. Conclusion: - The population is increasing in age and the demands on doctors are generally increasing.	
2.	Language translation service	GP practice UHB	Ongoing	Improved communication for patients with English as a second language	We have access to Language line	
3.	Support use	UHB	Ongoing	Improve	The proportion	

	of Welsh Language	Population needs assessment		communication for patients	of fluent Welsh speakers in the Vale is 10.8% (Welsh average is 19%). 5.8% of GPs on the Cardiff and Vale Performers list are listed as Welsh Speakers. Continue to offer bilingual documents eg. Med3 notes. Display the Working Welsh (Iaith Gwaith) symbol in applicable surgeries.	
4.	SAIL	GP practice UHB	Ongoing		Currently Albert Rd, Station Rd and Dinas Powys have signed up	

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.	Tackle DNAs	Practices UHB	July 2017	Reduce no. of DNAs to increase no. of available appts	Agreed cross cluster DNA policy	
2.	All practices to use health on line	EMIS VISION	July 2017	Electronic reminders for patients. Improve compliance	All practices are using.	
3.	Text reminders	EMIS VISION UHB	July 2017	Electronic reminders for patients. Improve compliance	Funds agreed for two texts per patient per year	
4.	Reduce the	Practices	Ongoing	Reduce	Each	

	nos. of inappropriate frequent flyers	NWIS		demands on OOH and emergency services	practice reviews their frequent flyers. Currently awaiting updated figures from the LHB.	
5.	Cardiff and Vale Access Meeting	CL		Improve patient access	CL is cluster representative. Awaiting date of next planned meeting	
6.	GP recruitment	WAG	Ongoing	Maintain service provision	Unable to recruit a GP for the cluster. Stanwell surgery has a full time GP vacancy. Station Road surgery has a 7 session GP vacancy.	
7.	To review current demand and capacity	UHB PMs	Ongoing	Services developed to reflect local need. Improve patient access	Each practice reviews its OOH data when it is received. UHB have stated they will only be sending out data for frequent flyers.	

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 any improvements for primary care/ secondary care interface

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
2.	ACS pathways	UHB Practices	Ongoing. Audit of usage of pathways will be undertaken following relaunch	Patients continue to receive high quality evidenced based medicine. Reduce unnecessary admissions.	The ACS Template pathways are now embedded. The ACS pathways have are in the process of being relaunched. Stanwell and Station Road Surgery have signed up to the pathways. However, the remaining practices may still sign up to the pathways if they wish to do so.	
3.	Robust SEA process	Practices UHB	Feb 2017	Identify SEAs across the cluster to prevent recurrence	Each practice in the cluster will bring a SEA involving a prescribing incident to the Feb 2018 Cluster meeting.	
4.	Prompt discharge letters	Hospital UHB	Ongoing	Medical needs identified and medications updated	Practices have agreed to keep a list of failed/ unsafe discharges. Which with be fed back to the UHB	
5.	Discharge Medication Reviews	Community pharmacists Hospital pharmacists	Ongoing	Medications changed promptly	Delays have been identified by practices and	

					chemists advised	
6.	E-advice service	Practices Hospital departments MD (IT)	Ongoing	To reduce length of hospital clinic waiting list times. Prompt advice from secondary care	E-advice service has been extended and includes a wide range of clinical specialities.	
9.	Telederm	Practices RM (Derm) REW (CD)	Ongoing	To reduce length of dermatology waiting times.	All practices now have cameras for Telederm. All Telederm referrals are now made via WCCG to ensure robust referral chain.	
10.	Telehealth (Florence)	UHW ANC	Ongoing	Allows two way communication for patients via text	Currently been used for hospital patients with gestational diabetes.	
11.	Review of CMHT service	Practices. Psychiatry CPN	Consultation process is still ongoing	Make referral process more timely and efficient	JP CD attended roadshow in Sept 2015	
12.	Optometry Wales	SD Practices Optometry Prescribing advisers.	Ongoing	Prompt treatment of minor eye conditions.	Continue to refer to WECS. Local optometrist for the cluster to lead on developing pathways for eye conditions eg. Ocular lubricants. Post not yet appointed.	
13.	Vision 360	UHB JP JB	April 2018	Portable access to computerised patient records across the cluster. To improve patient	Cluster money is to be made available to purchase	

				safety and record keeping. Aid MDT working (Cluster pharmacist and Cluster nurse) across the cluster.	VISION 360 software across the 5 practices. INPS attended our cluster meeting in July to provide a demonstration of the VISION 360 software.	
14.	Docman 10	Practices	March 2018	Hospital correspondence will be read code and recorded in patients' notes in a more timely fashion.	Vision will be attending our Neighbourhood CPET in September 2017 to provide a demonstration and training on the new Docman 10 software.	
15.	Direct access to physiotherapy pilot	Practices. Receptionists Nurses GPs Physio	Ongoing	Reduced waiting times for physiotherapy services. Reduce unnecessary GP appointments. May reduce analgesic usage.	A pilot is being undertaken by the physiotherapy department in Llandough hospital. Patients can attend a walk in physiotherapy service two mornings each week for assessment. It is proving very popular but some patients have been turned away as there were	

					insufficient slots available.	

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.	Determine levels of patient satisfaction	Practices PM Receptionists Patients	July 2017	Patients can voice their opinions on the service offered	Station Road Surgery undertook the annual cluster patient satisfaction questionnaire in June 2017. Station Road Surgery continues to pilot a virtual PPG.	
2.	Use of ART	Secondary care ART	Ongoing	Enable patients to have IV abxs etc. at home. Offer LMWH bridging service.	Currently ART will only accept referrals from secondary care.	
3.	PICT service	PICT (CRT) nurses WAST		Medical / Social care.	Despite repeated advertisement we have been unable to recruit a PICT doctor. The cluster therefore created the position of a new Cluster GP post (EVCGP). We were again unable to	

					recruit to this post. As there are currently a shortage of GPs. Initial discussions have been held with WAST and it was hoped that advanced practice paramedics could be attached to the cluster to undertake housecalls to support the service. The timescale is limited by the duration of the specialist training required by the paramedic. There has been no further progress in this area. The paramedic pilot has been completed in the Western Vale Cluster but there are insufficient funds to continue the service.	
4.	Care Home Directly Enhanced Service	UHB EVCP EVCN Practices	April 2018	Continue to provide high quality care. Continuity of care	Cluster monies will be used to employ a cluster pharmacist and cluster nurse to help	

					support practices to provide a universal Care Home DES to all patients within the cluster. It is anticipated that with time the roles of the cluster pharmacist and cluster nurse could be extended to cover patients within their own homes. All practices have signed up to the nursing home DES but we have not submitted claims as the positions are currently vacant. Transitional arrangements for GP cover for the nursing homes will continue until the positons have been filled.	
5.	ECAS service	ECAS Dr OT Physio Day hospital	Ongoing	Prompt assessment in local community based service to reduce need for in-patient admission	Continue to refer to ECAS service or day hospital as appropriate. There have been discussions about moving the service into Llandough	

					hospital.	
6.	CRT	PICT nurses OT Physio	Ongoing	Prompt assessment in local community based service to reduce need for in-patient admission	Continue to refer to CRT. Also ensure any referrals to PICT nurse are also left in their pigeon hole.	
7.	Bimonthly palliative care meeting	Practices DNs MC nurse	Ongoing	Needs of palliative care patients identified and addressed	Continue to attend palliative care MDT meetings. Some practices report that there may be limited specialist nurse involvement as the MC nurse has cancelled at short notice which is out of the control of the practice.	
8.	Inform OOH if patient on EOL pathway	Practices	Ongoing	OOH aware of situation and can prioritise care.	Continue to inform OOH. We are still waiting for electronic referral form to be made available as this would make the transfer of information easier and less time consuming.	
9.	Winter pressure services.	Practices PMs	October 2017-February 2018	To increase appointment capacity during the winter months. To improve patient access.	Cluster monies will be spent to backfill up to 2 additional GP sessions (pro-rata list size) per practice	

					over the winter months.	

Strategic Aim 5: Improving the delivery of dementia, cancer and liver disease.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1.	Improving the delivery of dementia	District nurses. Gerontology. Mental Health Services for Older People. Nursing homes EV Cluster pharmacist EV Cluster nurse CRT PICT nurse	March 2018		Practices undertook an initial audit using the Toolkit 1 proforma. (Dementia Management in Primary Care). The initial findings were presented and discussed in our July cluster meeting. It was felt that whilst the information was being recorded in patients' records, the suggested read codes were not being applied. Phil Rowe is in the process of creating a Vision/ EMIS template containing all the suggested read codes to help capture the data. We intend to employ a cluster pharmacist to undertake polypharmacy reviews for our patients residing in care homes.	

					Also to employ a cluster nurse to help provide a standardised Care home DES to patients residing in our care homes. Practices have signed up to the Care Home DES and it is anticipated the service will commence once the positions are appointed.	
2.	Improving the delivery of liver disease	GPs Hepatologists Biochemistry labs Radiology EDAS CAU	March 2018		Practices have agreed to undertake an initial audit and present and discuss their findings at our September 2017 Cluster meeting. Unfortunately the C+V biochemistry lab are unable to provide practices with an AST/ ALT ratio which is the entry point on the flowchart. Therefore the flowchart/ audit cannot be followed in its present form.	

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
1.	Cancer audit	Diagnostics All practices Secondary care. District nurses. Cancer MDTs Macmillian GP facilitator.	March 2018	Improve the rates of early detection and treatment. To achieve	All practices are engaged with collecting new cancer diagnosis in the preceding 12 months. And to complete SEA proformas on the last 10 patients who were not referred as urgent suspected cancers. Each practice will bring their cancer audit to the November Cluster meeting to present and discuss their findings.	

				prompt diagnosis	Links to be strengthened with MacMillan GP facilitator. Review and discuss the NICE guidelines on cancer. To follow the Cardiff and Vale Ovarian Cancer Pathway when it is approved. Continue to follow the C+V Lung cancer protocol. GPs will counsel patients and document this on the CXR request form when referring for the CXR. This will enable the radiology department to recall patients directly for CT thorax scans.	
2.	Continue to promote cancer screening programmes to patients	GPs Practice nurses	Ongoing	Raise awareness of screening programmes and early diagnosis of cancer	Eastern Vale currently has high uptake of cancer screening programmes.	
3.	Screening for Life Campaign	Public health Wales	July 2017	Increase aware of national screening programme	The Cluster promoted the public health campaign to increase awareness of national screening programmes	

4.	Macmillan Cancer Decision Support tool (CDS)	Macmillan Macmillan nurse facilitator UHB GPS Louise Driscoll	September 2017	Early investigation and detection of cancer.	CDS tool is available. The UHB are facilitating software training in its use. Session has been provisionally requested for the next Neighbourhood CPET session.	
5.	Promote "Help me Quit" all Wales smoking cessation service	Public Health Wales. GPs PN	Ongoing	Patients able to access smoking cessation services.	Continue to promote smoking cessation services available to patients.	

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.	Peer review of QOF (diabetes and COPD)	UHB CD PMs GP leads	March 2018	Patients will continue to receive high quality chronic disease management.	Two meetings have been put in place in September 2017 and February 2018 for peer review.	
	Complete GPSAT	PMs UHB	March 2017	Provide safe, high quality service to patients. To identify and provide a safer clinical environments for patients	All practices to complete GPSAT	
	SEA review	Practice PMs CD	Feb 2018	Identify SEAs within practices and across the cluster to prevent recurrence.	Practices SEA meeting and annual cluster SEA meeting. Each practice	

				Identify areas of weakness and improve the environment and processes for both patients and staff. The cluster have arranged a SEA review regarding medications in our November Cluster meeting	will bring along an SEA concerning a prescribing issue to the Feb 2018 Cluster Meeting.	
1.	Reduce the risk of harm, admission and cost	ECAS Community pharmacies, Pharmacy Advisors Practices Prescribing lead EVCP EVCN	March 2018	To reduce inappropriate prescribing. Aim to reduce admissions secondary to adverse effects of medications eg. Acute Kidney Injury	Continue to undertake polypharmacy reviews for patients residing in care homes and those with dementia.	
2.	Nursing Home medication/ waste audit.	UHB Prescribing Advisers GPs	Ongoing	To reduce inappropriate prescribing and waste. Minimise adverse effects.	UHB has agreed to fund a pharmacist to undertake this work. The pilot has been completed in Hazelhurst and will be extended to the Waverly. However the LMC has raised concerns regarding the extra demand on GPs time. But the GPs within the cluster didn't feel it significantly increased their	

					workload.	
4.	Patient poster for OTC medicines	UHB Prescribing advisers Practices	Ongoing	Inform patients which medications can be bought OTC	The cluster has agreed to display a poster designed by the UHB informing patients which medicines can be bought OTC.	
5.	Online no-prescription ordering service (ONPOS)	UHB Prescribing advisers Practices	Ongoing	Prompt wound management within nursing homes	The pilot has been undertaken in Barry and has been rolled out to Penarth. Enable nurses to order dressings without a prescription from a GP	

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1.	ECAS	ECAS Dr SS OT PHYSIO Day hospital	Ongoing	Prompt assessment Local service. Good transport arrangements	Continue to utilise service	
2.	High demands on D/Ns	D/Ns	Ongoing	Nursing care for house bound patients	A community phlebotomy service has commenced. However patients often require a visit by the D/N for simple tasks	

					such as BP monitoring.	
3.	Establish dressings clinic	UHB D/Ns	Ongoing	Improved access for patients. Increase practice nurse capacity by freeing up appointment slots.	A dressings' clinic has been established at Redlands House for patients who are not housebound during the working week.	
4.	Increase flu uptake	Media Public Health Cluster flu nurse	September 2017 October 2017	Reduce incidence of flu cases this year. Ensure all housebound patients have flu if they wish.	Locality to co-ordinated advert in local papers. Nurse funded by cluster monies to vaccinate housebound patients.	
5.	Standardisation of Care Home DES services across the cluster	UHB Practices JP CD	April 2018	Equal access to Care Home DES services across the cluster	Cluster monies to employ Cluster pharmacist and Cluster nurse to provide standardisation of Service to all patients within the cluster.	
6.	Management support structure to EV Cluster	UHB	October 2017	To provide management support to all members of the cluster to help achieve patient outcomes.	The positions of Locality Manager and Locality Community Director are currently vacant. Recruitment is	

					being undertaken.	
7.	New Practice Premises are being sort for Station Road and Redlands Surgeries	UHB	Ongoing	To enable high quality care to continue to be delivered from purpose built premises.	A suitable site continues to be sort.	
8.	Cluster prescribing Meeting	UHB Lead Prescribing adviser. Practice prescribing leads.	September 2017	To reduce cognitive effects of anti-cholinergic burden to the elderly patients within the cluster	Each prescribing lead to undertake the anti-cholinergic audit and present and discuss their findings at the Cluster Prescribing Meeting. The cluster has also identified the need for a protocol for the management of suspected UTIs in the care home population.	