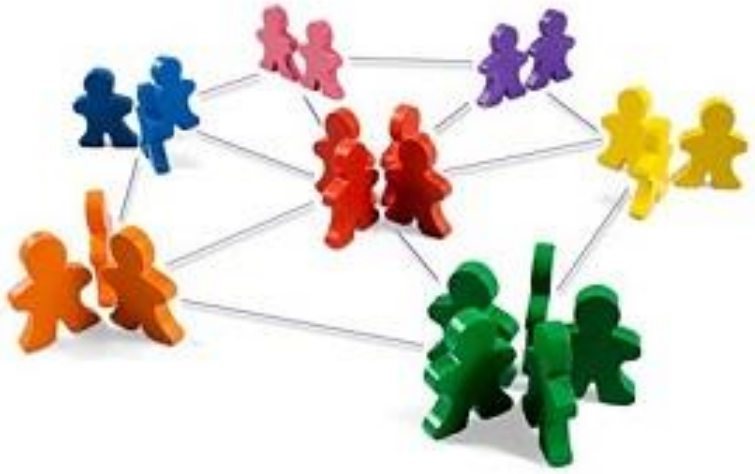
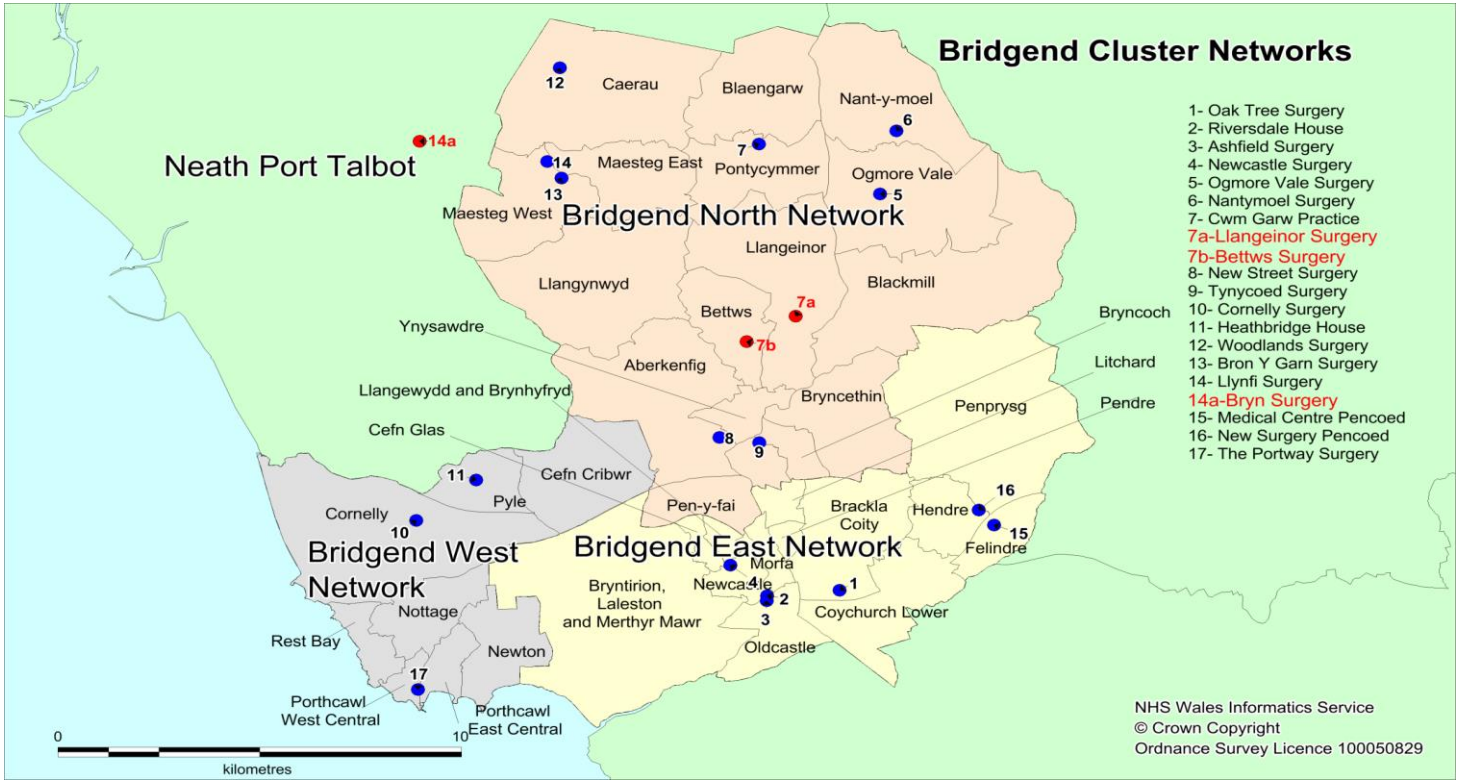
Three-Year Cluster Action Plan 2018 - 2021

Bridgend North Cluster



1. ***Welcome to the Bridgend North Three Year Cluster Plan, 2018 - 2021***

The Bridgend North Cluster is one of three clusters within Bridgend of which geographically covers eight GP practices and includes a population of 52,040 in rural and urban areas with pockets of severe deprivation between Caerau and Pen y Fai.



Bridgend North Cluster is made up of **eight** main general practices, three branch surgeries and one dispensing practice, with practice populations ranging from 3,145 to 10,452 amounting to a cluster total of **52,040**; the North Cluster also includes **nine** nursing/residential homes, **one** community hospital situated at Maesteg, **thirteen** community pharmacies and **five** dental practices. All working together with partners from social services, the voluntary sector and ABMU health board.

Practices included in the Bridgend North Cluster:

- Bron y Garn Surgery
- Cwm Garw Practice
- Llynfi Surgery
- Nantymoel Surgery
- New Street Surgery
- Ogmore Vale Surgery
- Tynycoed Surgery
- Woodlands Surgery

Clusters aim to work together in order to:

- *Prevent ill health enabling people to keep themselves well and independent for as long as possible.*
- *Develop the range and quality of services that are provided within the community.*
- *Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.*
- *Improve communication and information sharing between different health, social care and voluntary sector professionals.*
- *Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community-based services and vice versa.*

Through the delivery of our plans we will work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales in 'a Healthier Wales' (2018):

- ✓ improved population health and wellbeing
- ✓ better quality and more accessible health and social care services
- ✓ higher value health and social care
- ✓ a motivated and sustainable health and social care workforce

The Cluster will work collaboratively with Public Health to achieve the outcomes noted in the 'Burden of Disease' Action Plan by adopting the five ways of working as outlined in the Wellbeing of Future Generations Act. (Long term, integrated, involving, collaborative, prevention)

2. ***Our Local Health, Social Care and Wellbeing Needs and Priorities***

Information has been collated on a wide range of health needs within the Bridgend North Cluster area in order to develop the priorities for this plan. Agreement on the objectives and actions within the plan has been reached through a combination of analysis of individual Practice Development Plans, a review of Public Health Priorities, QoF data, audit reports and a series of cluster meetings.

The development of the plan has presented an opportunity for GP Practices in Bridgend North to build on the progress made in 2017/18 and has involved partners from Public Health Wales, other Health Board teams and directorates namely medicines management, physiotherapy and Nutrition and Dietetics; and the Third Sector and Social Services.

Demography

- Areas of high deprivation, unemployment / social issues, alcohol / drug abuse

Needs Profile

- High rates of chronic diseases in comparison to other ABMU clusters in particular COPD and CVD
- High rates of smoking and obesity

Service Provision

- Improve service to frail elderly / housebound patients
- Anticoagulation monitoring
- Reduce Antibiotic prescribing
- The current CAMHS pathway is unclear/ lack of CAMHS service provision
- Continue to monitor Urgent Suspected Cancer downgrades

Access Arrangements

- Increased patients demand / lack of clinicians to meet demand of complex patients
- Patients requesting emergency appointments inappropriately/ Patient education required
- Reduce DNA rates
- Increase use of minor illness nurses

Education & Training

- GP training for USS and MSK injections
- Palliative Care training for staff in Nursing and Residential homes
- Staff training on Welsh Clinical Communications Gateway (WCCG)
- Dermatoscope training
- Training asthma diagnosis Nitric Oxide machine

Workforce

- Cluster pharmacist employed
- Reduced access to District Nursing input

3. SWOT analysis

Key Population Features

- 52,040 GP registered Patients
- 49.4% female; 50.6% male
- Increasing elderly population (19.9% aged 65+ and 8.7% 75+)
- 6.8% live in a Lower Super Output Area (LSOA) that is classified as rural.
- 65.8% live in the most deprived two fifths (40%) of areas in Wales
- 0.7% aged 65+ live in a nursing, non-nursing or other local authority care home
- 32.1% aged 65+ live alone
- 8.6% aged 16-74 are both economically active and unemployed
- 75.38% of people aged 16+ with a record of alcohol intake (9th highest)
- 29.63% of people are on the Public Health Wales Smoking Register (2nd highest)

Population and Community Assets

- Green Space Community Projects available
- Several Community Centres
- 6 Libraries
- 4 Leisure Centres
- 7 out of the 8 Practices are engaged with the Care Home DES
- Voluntary Sector organisations including mental health, physical activity and other charities aimed at supporting health and wellbeing

Cluster Features

- Rural and urban areas with beautiful countryside and natural features
- Pockets of severe deprivation
- 8 GP practices delivering services from 10 sites
- 13 community pharmacies
- 5 Dental practices
- 7 Optometry
- 9 Nursing Homes

Health Profile

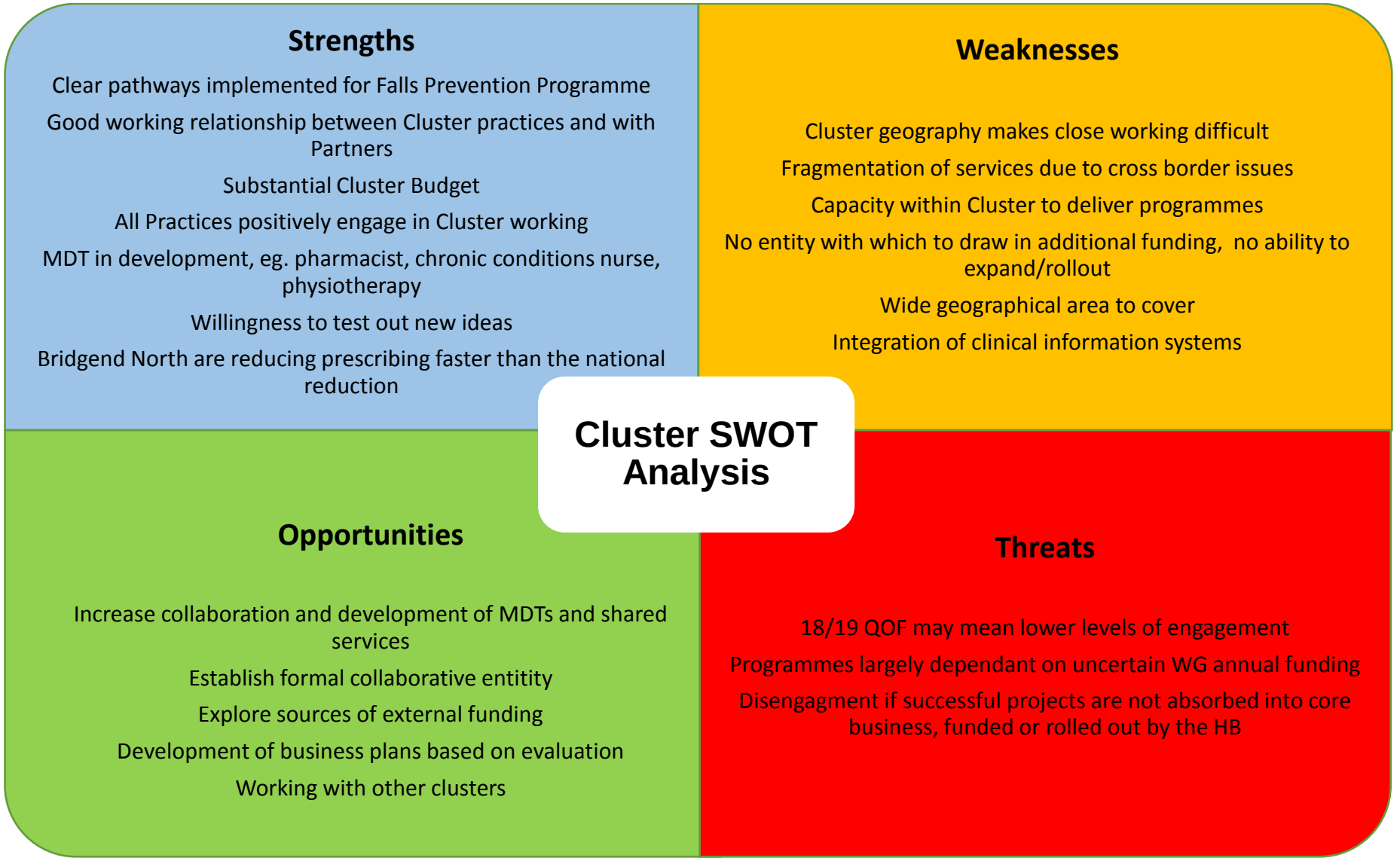
- Data from GP recorded diagnosis shows when compared to the 11 clusters of ABMU HB that
  - 3.1% of patients have COPD (highest)
  - 7.1% of patients have Diabetes (2nd highest)
  - 10.2% are Obese (6th highest)
  - 2.8% have Cancer (8th highest)
  - 35.49% have CHD (lowest)
  - 9.16% CVD have CVD (6th highest)
  - 21.06% have Pre Diabetes (5th highest)
- IVOR data flu uptake date (Apr 2017) shows
  - 63.3% in patients 65+ (ranked 7th uptake)
  - 42% in patients <65 at risk (ranked 7th uptake)
  - 47% in 2-3 year olds (3rd lowest)
- 29.7% aged 16+ reported undertaking at least 30 minutes moderate exercise on five or more days in the previous week
- 32.6% aged 16+ reported consuming five or more portions of fruit or vegetables on the previous day

Service Demands

- Increasing of practice list sizes (0.1% change between 2011 – 2017)
- Increasing number of patients with co-morbities and complex presentations
- Difficulties GP and other HCP with recruitment
- 17,143 A&E attendances (Apr 17 – Mar 18)
- 55.4% Bowel Screening uptake
- 77.1% Cervical Screening uptake
- 75.6% AAA Screening uptake
- 74.8% Breast Screening uptake

Other influencing factors

- Limited access to transport especially over the weekend
- Coal mining community
- Due to distance from Bridgend Centre has become an area of significant deprivation
- Plenty of open Green Spaces
- New Housing developments as part of LDP


Strengths
Clear pathways implemented for Falls Prevention Programme
Good working relationship between Cluster practices and with Partners
Substantial Cluster Budget
All Practices positively engage in Cluster working
MDT in development, eg. pharmacist, chronic conditions nurse, physiotherapy
Willingness to test out new ideas
Bridgend North are reducing prescribing faster than the national reduction
Weaknesses
Cluster geography makes close working difficult
Fragmentation of services due to cross border issues
Capacity within Cluster to deliver programmes
No entity with which to draw in additional funding, no ability to expand/rollout
Wide geographical area to cover
Integration of clinical information systems
Cluster SWOT Analysis
Opportunities
Increase collaboration and development of MDTs and shared services
Establish formal collaborative entitity
Explore sources of external funding
Development of business plans based on evaluation
Working with other clusters
Threats
18/19 QOF may mean lower levels of engagement
Programmes largely dependant on uncertain WG annual funding
Disengagment if successful projects are not absorbed into core business, funded or rolled out by the HB

4. ***Cluster Vision***

In 2018, Bridgend North Cluster jointly agreed a Cluster Vision for the next three years. The Vision set out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the Bridgend North area and its practices.

Our Vision is:

To work collaboratively together and with other partners to meet local patient needs, as well as support the ongoing work of a locality network.

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

The Cluster Network Action Plan includes: -

- 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, collaboration and co-production
- Issues raised for discussion with the Health Board

5. ***Bridgend North Cluster Practice Priority Issues***

- Roll out of CVD project across the Cluster, targeting lower super output areas of areas of high deprivation
- Funding of dermatoscopy courses and dermatoscopes for GP practices.
- Continued access to mental health and wellbeing services through provision of a local cluster counselling service.
- Continue to progress the development of a community based ultrasound-equipped musculoskeletal service that will enhance and relieve pressures on secondary care services.
- Ongoing anticipatory care across the cluster.
- Early identification and proactive management of respiratory patients Introduce point of care CRP Testing. Work in collaboration with the antimicrobial North Network pharmacist to develop protocols and agreed outcomes.
- Ongoing collaboration with the North Network pharmacist to develop and undertake a programme approach to improve antimicrobial stewardship.
- Continued access and development of Healthy Homes project to support the patient population to remain independent and safe in their own homes for as long as possible.
- Development of Chronic Conditions Team to support review of housebound patients living with chronic conditions and provide proactive and relevant support to help individuals to manage their conditions.

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

Priority areas for Cluster action for the next three years (through analysis of our cluster populations health and social status and needs):

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like? What is the patient outcome?	Current position	RAG Rating
1	Support the development and implementation of a cluster based CVD Primary Prevention Programme	General Practice Health Board Public Health Third Sector	March 2019	Increased primary detection of those at moderate and severe risk of developing CVD, triggering referral to appropriate local networks, contributing to the reduction of CVD inequalities in Bridgend North	Work collaboratively and in partnership with the Health Board to deliver CVD Health Checks • 3 HCSWs recruited to deliver CVD Health Checks • Collaborate with public health colleagues to develop onward referral mechanisms for the management of patients identified at increased CVD risk via the Health Check project • Engage with BHF and other appropriate third sector organisations to deliver appropriate CVD training to HCSWs employed to deliver Health Checks– complete.	

					March 2018 3452 patients identified and 1253 CVD checks completed 36% take up rate. Currently rolled out across 3 GP practices. **May 2018** Project paused to undertake process review	
2	To set out the priority population level needs of the Cluster to inform programme development	Health Board BSM	Refreshed when new data available, 6 mthly check Dec 2018	Services are developed according to local population need	Demographics have been considered during formulation of this cluster network plan. Bridgend North has significantly more deprived areas than Welsh average with pockets of deprivation amongst the highest in Wales. Priority Population needs are currently identified as • Chronic condition burden is higher than other Cluster areas • High rates of drug and alcohol misuse • High smoking prevalence • High rates of obesity in adults and children	

3	To ensure a consistent approach to the implementation of the public health agenda to support achievement of the NHS Tier 1 smoking cessation target	Stop Smoking Wales Community Pharmacy General Practice	Ongoing	Support to the smoking population to make a quit attempt	• Ensure all patients have an updated smoking status on practice records • Promote Stop Smoking Wales, Community Pharmacy Level 3 Service using available promotional material. • Promote stop smoking campaigns within practice • Consider opportunities for partnership work with Stop Smoking Wales and Community Pharmacies.	
4	Improve access to weight management interventions for overweight and obese patients within the cluster	Health Board General Practice	March 2019	Clinically beneficial weight change	• develop a cluster lifestyle coach, based with HALO leisure services, to deliver a weight management programme, based on NICE guidance, delivering in the community, taking referrals via, but not exclusively, from the CVD Health Checks Project. • HALO Lifestyle coach in place providing a 12 week food wise and exercise course for patients in North Cluster. Ongoing referrals from CVD project, to date 256 patients have been referred by the CVD project.	 

5	Continue to increase flu immunisation uptake within the cluster	General Practice	Ongoing	Protect patients at risk and the wider population	• Ensure practice flu plans are completed and submitted to Health Board • Practice staff to complete PHW flu e-learning module • Peer review IVOR flu vaccination uptake data on cluster basis • deliver fluenz parties in practices that feel this will increase uptake	

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

Priority areas for Cluster action for the next three years:

- Expand MDT team to meet the workforce needs of the Cluster

- Review of sustainability of core GP services across practices, sharing difficulties and addressing concerns with peers; developing access arrangements in line with current ABMU Access Standards to meet the needs of local patients; and exploring collaborative working arrangements

- Ensure MDT employment issues are resolved

- Form as a formal collaborative entity

- Ensure all practices are offered access to a Cluster package of support for sustainability issues

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Improved communication and integration with the third sector	BAVO General Practice Health Board	Ongoing	Increased access and signposting to voluntary services that support self care and independence	• Continue to link with BAVO and update local third sector resources for signposting • Refresh available information on the range of services available	
2	Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of: • Infoengine • Dewis • Social Prescribing • Local Community Coordination	All	Ongoing	Patients are more informed and empowered to manage their own health and prevention of ill health		
3	Extend the range of professionals and maximise the skill mix within the cluster through the development of the cluster pharmacist role	Health Board	March 2019	Increased access and signposting to voluntary services that support self care and independence	• Evaluate the outcomes of the role of the pharmacist within the cluster • Consider future roles and responsibilities • Develop a physiotherapist role • Develop CCN Service	
4	Increase wellbeing, resilience and early intervention to frail elderly individuals through a primary care occupational therapist	Bridgend Care and Repair General Practice	Ongoing	Enhanced skills and improved efficiency of services	• Using the Anticipatory Care Plans approach, identify individuals who are regular users of their service and are increasingly frail and isolated.	

5	Consider opportunities for network based service provision	General Practice	Ongoing	Providing a local service and utilising Network skills to improve patient services	• Referral process in existence within network for minor surgery and LARC is ongoing • Consider other Enhanced Services that could be delivered at a network level by cross practice referral	
6	Development of the Chronic Conditions Team to support the review and management of patients with chronic conditions	General Practice Health Board	Ongoing	Reduction of GP attendances for patients with chronic conditions and patients feel more able to manage and understand their conditions	• Band 6 Nurse currently in post • Housebound reviews underway • Recruitment of wider team underway	
7	Development of a cluster Physiotherapy Service	General Practice Health Board	Ongoing	Diversion of patients with MSK related conditions to the right professional at the right time	• Negotiation underway with physiotherapy at Princess of Wales Hospital	

Strategic Aim 3: Planned Care - to ensure that patient's 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.

Priority areas for Cluster action for the next three years:

- engage effectively and make improvements between the primary and secondary care interface;
- aim to reduce wastage of medicines and achieve better health outcomes through prudent prescribing;
- ensure patients have access to newly designed enhanced services, namely care homes and oral anticoagulation with warfarin;
- prolong independence of elderly patients through the development of anticipatory care plans.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	To drive forward the development of a community based ultrasound-equipped musculoskeletal service that will enhance and relieve pressures on secondary care services.	General Practice Health Board Secondary Care	ongoing	Shorter waiting times and more convenient local service.	• Plan developed to take forward MSK services for the North Cluster population Project currently progressing	
2	Improve access to mental health and wellbeing services	General Practice Health Board	31st March 2019	Local enhanced management of patients that require counselling	• Evaluation of cluster based counselling service • Develop closer links with health board mental health services; especially services for those with drug and alcohol addiction along with a Mental Health illness • Explore links with CAMHS to understand current care pathways and structures to help aid the recognition and treatment of mental illness in	

					young people – carry this over to next year's plan • Promote ABMU Living Life Well	
3	Extend the pathway of care for dementia support within primary care	General Practice Dementia Support Workers	Ongoing	Support for people living with Dementia	• Roll out dementia awareness training across the cluster.	
4	Drive changes in patient expectation / prescribing culture	Health Board General Practice	Ongoing	Minimise potential risks of increasing antibiotic resistance and C.difficile infection.	• Work in collaboration with community based pharmacy team – 'Big Fight'. • Engage with patients through established forums e.g. attendance at community groups etc to raise awareness of the dangers of inappropriate antibiotic use and associated antibiotic resistance.	
5	Continue to improve antimicrobial stewardship	General Practice Health Board	Ongoing	Improvement in antimicrobial stewardship	Support the North Network pharmacist to develop and undertake a programme approach to improve antimicrobial stewardship through: • Comprehensive, regular and consistent analysis of practices progress (including feedback to practices)	

					• Leading multidisciplinary prescribing reviews. • Providing education and awareness sessions with GPs and other relevant practice staff • Develop and co-ordinate a network of GP antimicrobial prescribing champions. • Develop and pilot a visible ongoing Cluster wide campaign to raise awareness of the dangers of inappropriate antibiotic use and associated antibiotic resistance. • Work in close collaboration with key-stakeholders such community pharmacies, care home staff, community teams etc through the development of engagement events and regular liaison	
6	Early identification and proactive management of respiratory patients	General Practice Health Board	31st March 2019	Improved management of potential respiratory disorders Early diagnosis of COPD, access to education and pulmonary rehab	• Improve reporting and interpretation of spirometry results	
7	Early identification diagnosis and referral for those presenting with Dermatological needs	General Practice	March 19	Improved management of dermatological	• Dermoscopy training has been undertaken.	

		Health Board		conditions and detection of malignancy	• GPs to Familiarise themselves with the new webcams • Implement the new digital photography referral pathway.	
8	To improve the quality and structure of chronic disease monitoring in Primary care in particular access for non – acute chronic disease management services amongst housebound patients	General Practice Health Board	March 19	Addressing health inequalities existing for housebound patients with chronic disease who are currently limited in their access to primary care support	• Chronic Conditions Nurse recruited and recruitment underway for wider team	

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

Priority areas for Cluster action for the next three years:

- utilising the time of multidisciplinary professionals, and educating patients in how to manage self-care and identifying the most appropriate place to receive treatment.

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Provide proactive, timely care to those who are most vulnerable and complex to manage	General Practice Health Board MDTs	Ongoing	Co-ordinated and improved care. Less crisis appointments/attendances across the system Proactive support to address key issues	• Continue to collaborate across MDTs to assist in identify patients for co-ordinated care plans • Linking with Chronic Conditions Team	
2	Promote the use of Health and Wellbeing campaigns such Choose Well to increase awareness of the importance of prevention approaches	All	Ongoing	Co-ordinated and improved care. Less crisis appointments/attendances across the system		

				Proactive support to address key issues		
3	Continue the use of C-reactive protein (CRP) tests before prescribing antibiotics for suspected respiratory infections, to help determine if treatment with antibiotics is required	General Practice ABMU HB Path lab	On going	Reduction in prescribing of antibiotics unnecessarily	• Continue with POC testing • Evaluate antibiotic prescribing • Review patient feedback	

Strategic Aim 5: To develop the Cluster as a structure for delivery of identified priorities.

Priority areas for Cluster action for the next three years:

- Identify cluster specific benefits and scope potential for formal collaboration
- Identify key service areas the cluster would like to become

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Explore areas of collaboration with Physiotherapy Service	Health Board General Practice	March 2019	GP time saved Patients are seen at the right time by the right person at the right place	Currently liaising with Physiotherapy POWH to develop a community physio within the North	
2	Continue collaboration with the third sector	General Practice	Ongoing	GP time saved Patients are seen by the right person at the right time in the right place	Links made with third sector colleagues	

Strategic Aim 6: Other Cluster and area specific issues

Priority areas for Cluster action for the next three years:

No	What action will be taken	Who is responsible for delivering	When will it be completed by	What will success look like?	Current position	RAG Rating
1	Engage with a robust validated clinical governance process	General Practice	31st March 2017	Improved quality and safety and efficiency of services	• To complete the Clinical Governance Practice Self Assessment Tool and achieve at least level 2 in the areas of safeguarding (CND 005W) • Participate in peer review and governance lead meetings.	
2	Support the Delivery of three Business Cases for IMTP inclusion based on key service delivery schemes which support Primary Care: a) Cluster Physiotherapy b) Cluster Pharmacists, c) Cluster Tier 0 Mental Health and wellbeing support	All	Dec 2018	These three area have been piloted by Clusters over recent years and have been seen to provide benefits to access and patient experience alike. The principle that Cluster monies were provided to facilitate innovation now means there is a need to identify alternative funding for such projects where benefits have been demonstrated	• The three cases are to be included for consideration in this years IMTP process in both ABMU & Cwm Taf.	

4	Update and maintain a cluster risk resister	Cluster	Ongoing	Mitigate risks as appropriate	• Identify and agree risks	
5	Premises improvement to enable capacity to deliver new pathways and increase capacity.	Health Board	31st March 2019	Improved facilities and sustainable services	• Ongoing work with Primary Care Estates Manager to provide improvements as prioritised