South Cynon Cluster GP Network Action Plan 2017-20

SOUTH CYNON NETWORK CLUSTER ACTION PLAN 2017-20

This plan has been developed by the following 6 practices which operate in the South Cynon Cluster Area, through facilitated discussion with the Local Medical Director and Primary Care UHB Locality Management :-

- Abercwmboi Surgery
- Cwmaman and Cwmbach Surgery
- Cynon Vale Medical Practice
- Rhos House Surgery
- Penrhiwceiber Surgery
- Abercynon Health Centre

The Plan The plan has been informed by the practice development plans produced by practices; public health information on key health needs within the area; information provided by Cwm Taf uHB re current activity/referral patterns; an understanding of our localities baseline services (current service provision) and identification of potential service provision unmet needs. The plan also embraces key UHB priorities for the next three years. The plan details cluster objectives for years 2017- 2020 that have been agreed by consensus across practices, providing where relevant background to current position, planned objectives and outcomes and actions required to deliver improvements. The plan is by its very nature fluid /flexible and evolving over the next 3 years the plan itself will be reviewed and updated in response to changes in cluster planning. The RAG rating score indicates progress against planned action (Red-future work, Amber- in progress, Green- completed). A number of key principles underpin the plan:

- **Management of variation/reducing harm/sharing good practice:** in acknowledgement of the fact that healthcare must be delivered on the basis of safety, effectiveness and efficiency, the practices have considered and analysed variation in performance and where appropriate have considered steps by which to map standardise practice based on clinical guidelines.

- **Maximising use of Local Cluster Resources**: practices have taken into account the capacity, capability and expertise that exists within primary care, community services and voluntary/third sector services to deliver more care closer to home and reduce unnecessary demands within the acute care services.

- **Promoting integration/better use of health, social care and third sector services to meet local needs:** practices have considered current arrangements/links with RCT Council and the voluntary sector and will also consider any action plans from stakeholders that evolve over the 3 year cycle of this plan.

- **Considering and Embedding New Approaches to Delivering Primary Care**: this includes increased use of technology, new roles and service models considering and embedding new approaches to delivering primary care: this includes increased use of technology, new roles and collaborative working.

- **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.

Additional contributors to the plan/potential evolving contributors to the plan subject to evolution of plan

- Health and social care facilitators.
- Primary care practice managers.
- Practice Nursing and allied health professions representatives.
- Local voluntary sector providers and third sector.
- Relevant secondary care consultants.
- Prescribing advisers.
- Potential educator partners including third sector.
- Primary Care Support Unit Nursing advisory expertise/local university school of health care.
- Cluster employed pharmacists, & community pharmacists (including those with UHB funded independent prescribing status and involvement in the common aliments pilot scheme).

Data from the 2016-2017 Welsh Health Survey show that:

- 20% of adults in Cwm Taf reported drinking more than 14 units a week, compared to 20% for the whole of Wales.
- 21% of adults in Cwm Taf reported being a current smoker with 19% in Wales reported being a current smoker.
- 38% of adults in Cwm Taf reported being active less than 30 minutes a week compared with an all-Wales figure of 32%, further those in CwmTaf reporting that they were active for 150 minutes a week was 45% compared with an all Wales figure of 54%.
- Those respondents classified as overweight or obese in Cwm Taf were 64% the all Wales average was 59%.
- Healthy behaviours – 13 % of adults reported less than two out of five healthy behaviours compared to 10% across Wales where healthy behaviours are 'not smoking, average weekly alcohol consumption 14 units or lower, eating at least 5 portions fruit and vegetables the previous day, having a healthy body mass index, being physically active at least 150 minutes the previous week'.

The areas of concern identified by the cluster through this analysis of our cluster populations' health status are therefore:

OBESITY/OVER WEIGHT STATUS, PROBLEMATIC ALCOHOL USAGE, RATES OF CURRENT SMOKERS, LOWER LEVELS OF PHYSICAL ACTIVITY

Strategic Aim 1: to understand the needs of the population served by the Cluster Network

No	Objective	Key partners	completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To understand and highlight actions to meet the needs of the population served by the Cluster Network	Local Public Health Team Public Health Observatory	April 2020	To ensure that services are developed according to local need	Initial analysis complete Continuing to liaise with Public Health Wales to present to the Cluster regular updates.	A

1a	Pilot Obesity Scoping measures to reduce the levels of obesity in our cluster Representation on steering group for development of obesity pathways	UHB: Dietetics/ EPP. Dr Sue Kennealley Public Health. Third Sector Local authority: Leisure Centre NICE approved weight loss programme	April 2020	Effective identification of and targeting of existing health promotion for weight reduction at those identified as obese. Collaborative developmental work with the UHB to develop an Obesity Pathway with specific emphasis on tier two interventions	Developmental work is in progress to integrate the Educating Patient Programme with the wider dietetics education programme. Slimming World Vouchers scheme has been explored and identified as an investment option for any funding slippage. Exploration of a patient led walking group to address loneliness and weight management – January 2019 contact has been made with a local organic gardening project.	A 
1b	Effective linking with 3rd Sector	Interlink Care Co-Ordinators, Care & Repair, MIND, Representation at Cluster meetings.	March 2020	Engaging with the 3rd sector to seek funding for innovative schemes to improve patient care/public health measures/social wellbeing	Ongoing work to Complete of the Dementia Roadmap – possible inter- cluster working with ABUHB. Continued joint projects with third sector. Social prescribing initiatives – commissioning of a Wellbeing Co-Ordinator from January 2019 m- March 2020 with a social prescribing and community development brief. Re commissioning Of MIND Active Monitoring Intervention for 2018/19 and	Amber 

					19/20	
1c	Address Five Key lifestyle behaviours of the population of CYNON VALLEY effecting the clusters population health: smoking, alcohol, physical activity, diet and immunisation/ screening	Public Health Wales Practice Staff Practice Managers Community Pharmacists	All cluster practices March 2020	Staff awareness of key public health messages and signposting patients to helpful resources and services.	MECC complete. Lifestyle Champion training complete. Explore Care Navigation training to facilitate sustainability via workforce development, prudent healthcare and social prescribing. Development of a system to identify in house patients over/due health screening programmes Active links with the 'reducing cancer inequalities in Cwm Taf' group. Peer review of practice level screening uptake figures for improvement purposes; consent collected and reviews starting March 2019 Vaccination & health fayres	Amber
1d	**Older People/ Management of General Frailty/**	Care & Repair Rhondda Cynon Taf Ltd	April 2020	Maintain independence in a safe home environment with access to reliable	Active engagement with Care & Repair with several aspects to the scheme including urgent adaptations to facilitate hospital discharge. Overall this aims to maintain	Amber

	Maintaining Independent living	Occupational Therapists Links with community volunteer scheme with schools (ABMU model)		advice and maintenance for the older members of our cluster Befriending Services	independent at home and via adaptations minimise falls and self care difficulties. GP's can refer to this service. OT commenced in February 2019 to develop primary care services across the cluster Completion of a five month pilot of a Community Nurse Home Visiting Service to include frailty and falls assessment.	

1e	Further areas may be identified during 3 year cycle of cluster plan	To be considered by the cluster if time/resources allow	Ad hoc /no time scale	Improvements in care delivered	Potential RCGP dementia practice based all staff training. ‘ Autism Friendly’ practice training Domestic abuse 3rd sector state agencies improvements in interactions/advertising help availability. IRIS training completed on a UHB wide and successfully implemented and maintain profile of the service. Funding for the continuation of the IRIS scheme has been secured post march 2018. IRIS funding extended to end March 2021.	Amber 

Strategic Aim 2: To ensure Sustainability of Core GP Services and Access Arrangements that Meet Reasonable Need of local patients including any agreed collaborative arrangements.

Cluster practice members have considered this area already in their individual Practice Development Plans, with a range of access and sustainability issues considered including number of GP appointments provided, hours of services, inappropriate use of A+E, unscheduled admissions +GP Out of Hours services by patients, DNA rates, Promoting use of technology such as My Health on Line/Texts messaging and use of new technology. In addition to practices individual development plans in this area those areas of common interest across the Cluster are identified in this section.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
2a	I.T. Greater use of My Health Online to improve appointment access; and prescription services in accordance with WAG planning	Individual cluster Practice Managers To lead	March 2020	In the cluster there is varying patient Increase practice uptake of technology to improve access Promotion of My Health Online to improve appointment access; and prescription services and drive forward WAG planning	Individual practices are engaging with the process and promoting Particularly repeat prescription management, plan is to promote this and ultimately consider practice appointment management re this process. Promote shared working and consistency of approach across the Cluster. Explore evaluation of Merthyr Cluster GP web investment for possible development within Cynon Patient engagement in the process.	Amber
2b	To develop local workforce development plans	LHB Primary Care Foundation. Deanery. Schools of Nursing. Professionals	March 2019	Service modernisation to meet changing needs. Ensure sustainability of local services. Timely service delivery by a multi – skilled multi –	Within the cluster there are increasing reports of recruitment difficulties with a GP retirement time bomb. ***Actions*** • Practice engagement in demand & capacity audit (PCF) • Discussion around collaborative working in the Cluster following up the workforce planning meeting	Amber

		represent ative Organisations . Skills for Health Workforce planning pilot. Consider Housing developers	March 2019	agency workforce	to explore options for collaborative GP networks. - there are a number of reciprocal arrangements in place between neighbouring Practices to share on calls. Joint interest in Practice sustainability in the Cluster – develop local solutions in collaboration with the UHB. • Consider collaborative winter planning models • Develop an out of hours/bank holiday/business continuity cover co-op. • Buddying of Practices. • Engagement of Practices in providing mentorship to ANPs and Practice Nurses in training. • Engagement of the Cluster in completing a whole cycle of workforce planning to	

					devise a South Cynon Custer Workforce Plan in partnership with WEDs & Skills for Health. • Population growth through housing development	Green 

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.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
3a	Review of Enhanced Service provision across the Cluster with a view to greater networking to ensure equitable	Cwm Taf GP's with the required skill set Primary Care Directorate LHB Individual Practice Managers	March 2020	Local rapid provision of procedure without the need to attend hospital freeing up capacity in secondary care.	The Cluster have already scoped enhanced service provision now need to identify practitioners willing to engage in providing networked services.	 Amber

	service provision.					
3c	CYNON CLUSTER PILOT to improve early cancer diagnosis in patients with non specific symptoms but clinically there is a strong suspicion of an underlying malignancy	WAG UHB: Acute /speciality physicians Patient participation groups Radiology 3rd sector charities (Tenovus MacMillan) Cancer nurses Bath University	April 2018	Earlier detection and diagnosis of cancer. Improved survival rates. One stop shop for tests and scans and investigations.	Pilot due to start in July 2017 A number of Cynon GPs have become involved in the delivery of this service which has been rolled out to include the other Cluster areas to accept referrals. The evaluation of this project is ongoing.	Green 
3b	Support the development of intermediate clinics and support groups	Practices Third sector EPP Patients	April 2020	Diabetes Community Clinic Delivering services closer to home/ reducing wait times/improving patient experience and outcomes	. Clinic established with positive initial evaluation.	Green 

				Fibromyalgia & chronic pain group	A networked service with EPP and other partners – engage patient participation.	

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
4a	Scope Welsh Medium primary care Consultation availability	Practice Managers UHB Welsh Language team	April 2019	Improvements to the availability of Welsh medium primary care consultation	We are already aware that language line can be employed to facilitate Welsh Medium Consultations. Following on from the Welsh Language Commissioners reports “My Language My Health”, “More Than Just Words” and the key message of aiming for widespread availability of the “active offer” of a Welsh Language consultation. We will initially scope practice level availability. After this we will involve our UHB Welsh Language team re training/recruitment /translation/signage/literature opportunities.	Amber 
4b	Remote Working	NWIS INPS EMIS	March 2019	Continuity of service provision and care.	Accessing the clinical system from romote locations VISION anywhere & 360 Telephone triage possibilities	Amber 

4c	Links with Primary Care Partners	Community Pharmacy Community Optometry Community Dentistry	March 2019	Appropriate care	Utilising positive relationships with Primary Care Partners to ensure a robust primary care service delivery in times of pressure. Representation of Primary Care providers at Cluster meetings.	Amber
4d	Cluster wide ANP Winter pressures Team	INPS NWIS EMIS All Practices	March 2018 March 2020	Efficient and targeted service provision.	The commissioning of a Home Visiting Service is being considered by the Cluster for the winter period to be staffed by either Paramedics, Advanced Nurse Practitioners or Occupational Therapists or a combination of all. This would pioneer a Cluster wide initiative facilitated by VISION 360. This service was redesigned to be a Community Nurse Home Visiting Service and operated between November 2017 and march 2018 inclusive. Number of Patients seen = 400 Number of GP appointments saved = 152 Develop a networked MDT to meet demand specifically frail elderly and nursing homes Planning for this has progressed as a result of the workforce planning pilot and MDT	Green

					preferences survey (March 2019)	Amber 
4f	Practice collaborative approach to Business Continuity Planning	All Practices Practice Managers	March 2019	Continuity of service provision and care.	Use of 'buddy practice' and 'network' agreements to ensure business continuity in times of pressures. Use of Significant Event Audits to review the circumstances where emergency plans have been invoked.	Amber 

Strategic Aim 5 & 6: Improving the delivery dementia; mental health and well being; cancer; liver disease; COPD
Improving the delivery of the locally agreed pathway priority

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date The second phase of audit was due to take place in February 2018, the Cluster Clinical Pathways domain was however relaxed in January 2018.	RAG Rating
1	COPD	Cluster Pharmacists	March 2018	Care review. Appropriate & accurate diagnosis and treatment intervention.	Practice audits completed and discussed in the October 2017 Cluster meeting	Green 
2.	Liver Disease	Consultant. Path lab.	March 2018	Timely diagnosis and treatment.	Baseline audits completed and new pathway commenced 1st October 2017	Green

		Planning & Delivery Group				
3.	Cancer	Macmillan. Reducing Cancer inequalities group. Rapid Diagnostics Clinic. Screening services.	March 2018	Reduced wait times for diagnostic investigations via a one stop shop and timely treatment commencement if required. Increased awareness of cancer prevention initiatives and access to screening programmes.	Module 2 of the Macmillan Cancer Toolkit for GP in Wales completed by Practices. By October 2017 Practices had: • Reviewed current data regarding cancer presentation, referral and incidence. • Reviewed and critiqued current practice regarding recognition and referral of cancer, with particular reference to NICE suspected cancer referral guidance, at risk groups, and potential barriers to prompt referral. • Discussed learning points at a Cluster meeting and agreed three changes.	Green 
4	Mental health Dementia	MIND Valley Steps EPP	March 2019	Reduced wait times for therapeutic interventions. Increased choice of interventions. Integrated pathway approach.	Cluster recommissioning of an Active Monitoring Service from MIND for an additional twelve months until March 2019. Commissioning has continued into 2019/20 Initial meeting in January 2018 following a Co productive model with partners to develop a Cluster pathway. Follow up meetings with Valley Steps have taken place (January 2019) and the newly appointed wellbeing co-ordinator will progress this work.	Amber 

Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and information governance. To include actions arising out of peer review of inactive QOF (when undertaken)

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
7a	Engage with a robust validated clinical governance process specifically designed with Cluster planning in mind	Individual cluster practices Public Health Wales	April 2018	All measures/proposals outlined and assessed in a validated all Wales clinical governance tool	Clinical Governance Practice Self Assessment Tool Information Governance Toolkit.	Amber 
7b	Continue to engage with statutory emerging clinical governance	Health Inspection Wales	Ongoing rolling program of inspections.	Clinical governance oversight of their local practice	All Wales Cluster Governance requirements. Cluster has a terms of reference.	Amber 

	obligations					
7c	Inactive QOF	UHB	April 2018	Improved access and uptake of chronic condition care	Cluster peer review took place in September 2017 and actions agreed. Re audit was planned for February 2018 but was cancelled due to the relaxation of QOF in January 2018	Green 

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
8a	To increase the uptake of Primary Care Research within Cynon	Lead GP and Practice Manager LHB PiCRIS	March 2020	innovative medicine locally Enhanced patient care Greater attention to detail in conditions studied	PiCRIS support for practices to become research practices.	
8b	Development of a foot care assessment programme performed by Practice	Health care assistants Local podiatry department and/or local university school of nursing	March 2019	Improvements in provision of practice based feet assessment, freeing up practice nurse time increased job challenge for HCA's	. Foot care assessment programme provider identified.	

	based Health Care Assistants	Local primary care nursing management and nursing representative		(right person right place right time – prudent health care).	Enhanced Service requirements? Template?	
8c	Medication reviews, smarter working, develop role of pharmacist	Cluster Pharmacists	March 2019	Improved access. Providing medication reviews: house bound/residential/nursing home patients/improving repeat prescribing processes. Freeing up GP time to see patients. Ultimately by further postgraduate training e.g. independent prescriber status/ minor illness consultations i.e. service expansion with pharmacists embedded in primary care teams with direct patient benefit.	On going training to include prescribing and minor illness. Strategic Fit of this proposal: "Improving access and quality and new ways of working." Commissioning is continuing into 2019.20 and a new SLA has been agreed.	Amber