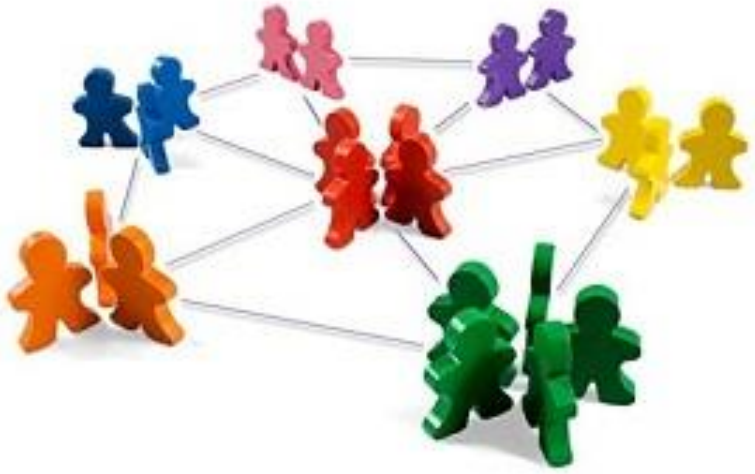
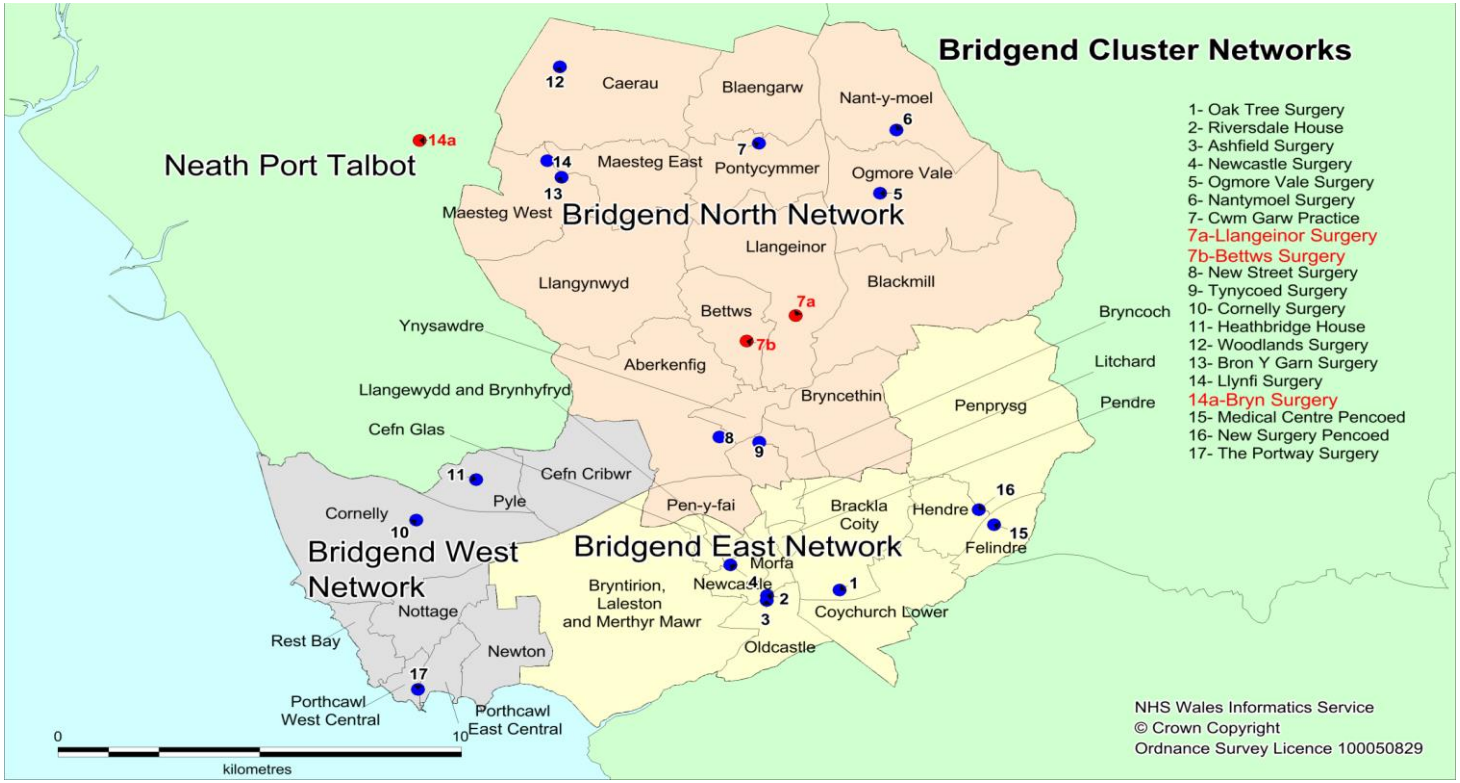
Three-Year Cluster Action Plan 2018 - 2021

Bridgend East Cluster



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

The Bridgend East Cluster is one of three clusters within Bridgend of which geographically covers five GP practices. The population is made up of 71,248 people living in mainly urban areas with pockets of severe deprivation.



Bridgend East Cluster is made up of five main general practices sites, two branch surgeries, with practice populations ranging from 5,450 to 18,686; the East Cluster also includes three nursing homes and six residential homes. There is also eleven community pharmacies and ten dental practices. All working together with partners from social services, the voluntary sector and ABMU health board.

Practices included in the Bridgend East Cluster are:

- Bridgend Group Practice
- New Surgery, Pencoed
- Oaktree Surgery
- Riversdale Surgery
- The Medical Centre, Pencoed

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.*

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 East 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 the Practices of Bridgend East 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 the Third Sector and Social Services.

Demography

- High levels of deprivation / unemployment is some areas of the cluster
- Poor housing and high numbers of housing related concerns
- Ongoing population growth due to housing and local development plans

Needs Profile

- Increasing older multi- morbid population
- Increasing prevalence of chronic diseases such as asthma, diabetes and health risk indicators such as smoking, obesity and low physical activity levels

Service Provision

- Delivery of Counselling Provision to address low level mental health needs

Access Arrangements

- GP Recruitment remains challenging
- Email and telephone advice lines in development

Urgent Care

- Use of Choose Well messages
- Pen Y Bont Health website and use of social media to promote health messages, support options and prevention information

Training and workforce

- Consideration of GP Triage approaches
- Recruitment of medical and other staff remains challenging

3. SWOT analysis

Key Population Features

- 71,248 GP registered patients
- 49.9% female; 50.1% male
- Ageing elderly population (19.5% aged 65+ and 8.6% 75+)
- 4.6% live in a Lower Super Output Area (LSOA) that is classified as rural.
- 24.7% live in the most deprived two fifths (40%) of areas in Wales
- 2.3% aged 65+ live in a nursing, non-nursing or other local authority care home
- 29.7% aged 65+ live alone
- 5.9% aged 16-74 are both economically active and unemployed
- 71.24% of people aged 16+ with a record of alcohol intake (10th highest)
- 29.92% of people are on the Public Health Wales Smoking Register (highest)

Population and Community Assets

- Several Community Centres
- 2 Libraries
- 2 Leisure Centres
- Voluntary Sector organisations including mental health, physical activity and other charities aimed at supporting health and wellbeing
- 4 out of the 5 Practices are engaged with the Care Home DES

Cluster Features

- Mainly urban population with small rural areas
- Pockets of severe deprivation
- 5 GP practices delivering services from seven sites
- 11 community pharmacies
- 10 Dental practices
- 10 Optometrists
- 9 residential and nursing homes

Health Profile

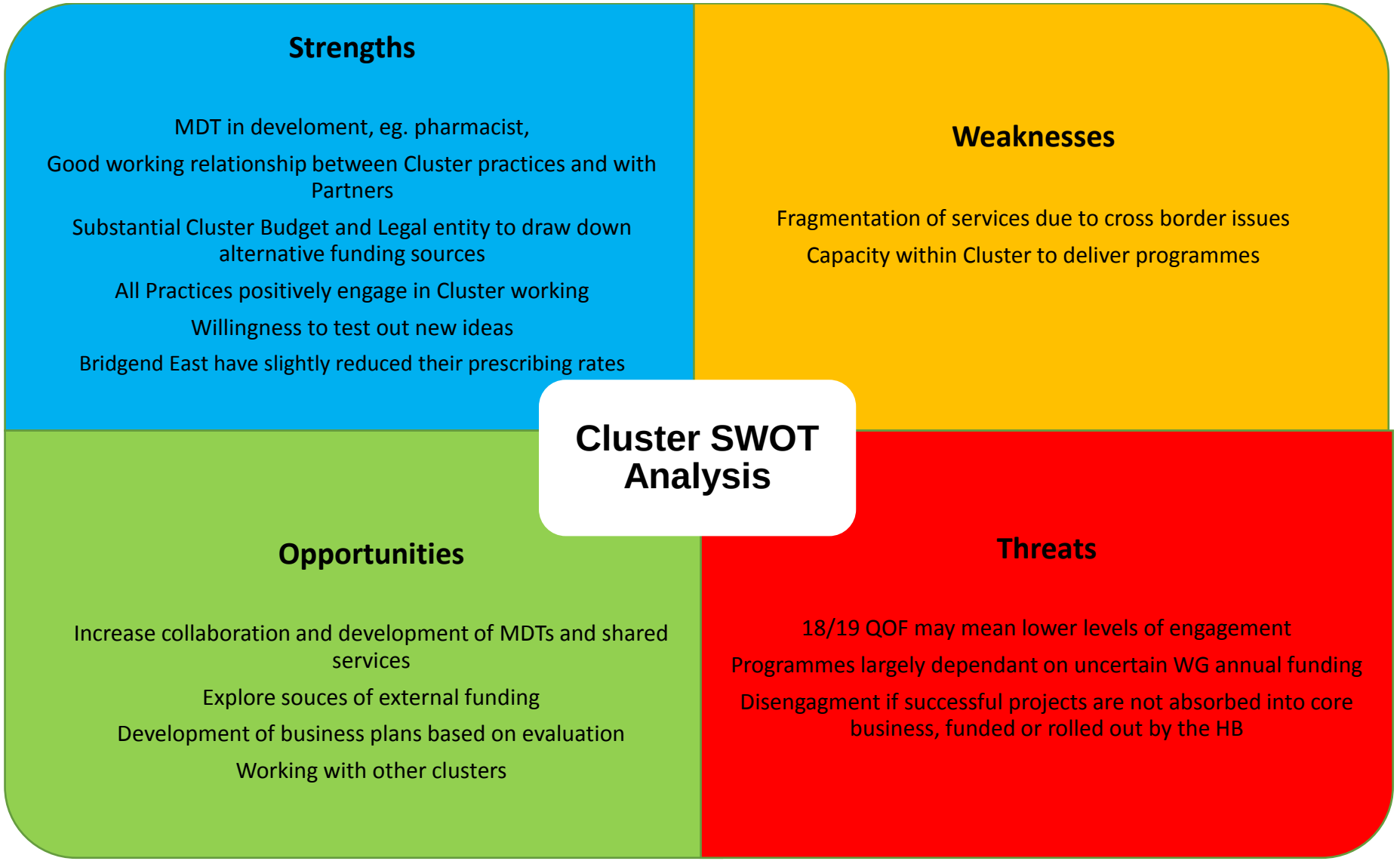
- Data from GP recorded diagnosis shows when compared to the 11 clusters of ABMU HB that
  - 1.9% of patients have COPD (9th highest)
  - 6.1% of patients have Diabetes (9th highest)
  - 8.6% are Obese (9th highest)
  - 2.9% have Cancer (5th highest)
  - 43.38% have CHD (3rd highest)
  - 9.70% have CVD (4th highest)
  - 23.81% have Pre Diabetes (highest)
- IVOR data flu uptake date (Apr 2017) shows
  - 71% in patients 65+ (ranked highest)
  - 47% in patients <65 at risk (ranked 2nd highest)
  - 49.6% in 2-3 year olds (ranked highest)
- 29.4% aged 16+ reported undertaking at least 30 minutes moderate exercise on five or more days in the previous week
- 33.9% aged 16+ reported consuming five or more portions of fruit or vegetables on the previous day

Service Demands

- Increasing of practice list sizes (4.0% change between 2011 – 2017)
- Increasing number of patients with co-morbities and complex presentations
- Difficulties with GP and other HCP with recruitment
- 20,485 A&E attendances (Apr 17 – Mar 18)
- 56.9% Bowel Screening uptake
- 78.5% Cervical Screening uptake
- 82.4% AAA Screening uptake
- 74% Breast Screening uptake

Other influencing factors

- New Housing developments as part of LDP
- Cross border working
- Upcoming boundary change
- Increasing number of non UK citizen patients and managing their needs appropriately


Strengths
MDT in develoment, eg. pharmacist,
Good working relationship between Cluster practices and with Partners
Substantial Cluster Budget and Legal entity to draw down alternative funding sources
All Practices positively engage in Cluster working
Willingness to test out new ideas
Bridgend East have slightly reduced their prescribing rates
Weaknesses
Fragmentation of services due to cross border issues
Capacity within Cluster to deliver programmes
Cluster SWOT Analysis
Opportunities
Increase collaboration and development of MDTs and shared services
Explore souces 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 East 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 East area and its practices. The process included consideration of and an ability to:

- 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 East Cluster to improve the coordination of care and integration of health and social care.
- Work with local communities and networks to reduce health inequalities.

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)

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

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	Set out the priority population level needs of the Cluster to inform programme development	All	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.	
2	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.	

3	Continue to positively promote the benefits of flu immunisation 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 a proactive phone call programme to patients to encourage flu immunisation uptake	
4	Raise awareness of national health screening programmes including • Cervical • Bowel Screening	General Practice	Ongoing	Improved uptake of screening and more people diagnosed at earlier stage of disease	• Actively promote screening services to all patients using Pen Y Bont website and social media • Prompt patients as opportunities arise (Making Every Contact Count)	
5	To reduce childhood obesity through the design, development and delivery of a Healthy Children's Project	Dr Price (Lead)	Ongoing	Reduced levels of obesity through the positive engagement of children and their families in a bespoke diet and exercise programme	• Project Group formed • Project Outline formulated • Pilot school identified	

6	Support the development of Bridgend Wellness Centre and the integration of the social model of care to meet patients' needs	All	Ongoing	Prevention and wellbeing will be central feature of meeting population needs in the cluster		

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

- Develop links with the voluntary sector to promote self-care and independence

- 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

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	Increase wellbeing, resilience and early intervention to support the health and wellbeing of the population	All	Ongoing	More individuals able to manage their conditions effectively	• Use of Pen Y Bont Health website and social media	
2	Increase integration with other sectors to provide a key focus on wellbeing and prevention through	All	Ongoing	Patients are more informed and empowered to manage		

	engagement and active promotion of Social Prescribing			their own health and prevention of ill health		
3	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 • Develop direct link to Info Engine / DEWIS on GP systems	
4	Extend the range of professionals and maximise the skill mix within the cluster including the development of the cluster pharmacist role	All	Ongoing	Diversification of workforce to support practice sustainability and ensure patients sees the right professional in a timely manner	• Ongoing review of the role of the pharmacist within the cluster • Consider future roles and responsibilities	
5	Delivery of Pilot Physiotherapy service for patients to access MSK assessments closer to home	Practices Health Board	to June 2018	Diversification of workforce to support practice sustainability and ensure patients sees the right professional in a timely manner – proof of concept	• Pilot complete	
6	Consider alternative models of patient care and access	Practices	Ongoing	Ability to better manage patient demand	• Further information gathering and site visits needed	

7	Consider workforce and skill mix training opportunities to extend the range of professionals within the cluster	All	Ongoing	Improved multi skilled multidisciplinary Practice team and improved efficiency of services	• Identify training and development needs of core practice staff • Consider opportunities for network based professionals • Identify specific training needs for individual professions and support workers across the Cluster – **development of a training needs analysis**	
8	Development of the Prescribing Hub	Practices Health Board	Ongoing	Reduced demand on practices for prescribing needs. Reduced medicines wastage and maintain patient safety	• Prescribing Hub roll out remains ongoing	

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 e.g. Diabetes Gateway and NOACS facilitating local rapid management and minimising waste and harms;

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	Improve access to mental health and wellbeing services	General Practice Health Board	31st March 2019	Timely local access to low level counselling services to address mental health needs and wider resilience	• Counselling provision delivered across the cluster at a variety of venues 75hrs per week • Business Case in development	
2	Diversification of the workforce to ensure patients are able to see the most appropriate professional in a timely manner and GP'S can focus on the most vulnerable. E.g. Physiotherapist	All	Ongoing	Individuals can access a the most appropriate professional in a timely manner	• Business Case in development	
3	Sustained use of telephone advice lines	Practices	Ongoing	Decrease in inappropriate referrals to secondary care therefore reducing demand and waiting times for more appropriate referrals	• All practices promote the use of advice lines on a regular basis	
4	Reduce wastage of medicines and achieve better health outcomes through prudent prescribing by	Practices Health Board	Ongoing	Reduced demand on practices for prescribing needs.	• Prescribing Hub roll out remains ongoing	

	engagement with the Prescribing Hub			Reduced medicines wastage		
5	Delivery of Diabetes gateway and NOACS	Practices	Ongoing	local rapid management of care, minimising waste and harms;	• All practices engaged	

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:

- Using a making every Contact Count approach, advise and educate 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	Promote Choose Well to all patients	All	Ongoing	Patients understand and are aware of how to access alternative healthcare pathways	• Active promotion ongoing	
2	Promote Pen Y Bont Health website and associated resources to all patients	All	Ongoing	Increased awareness of the website and ability of patients to manage their long term conditions	• Active promotion ongoing	
3	Publicise the Community Pharmacy Common Ailments Scheme	All	Ongoing	Patients are aware of and access the Common Ailments Scheme as an alternative to GP's where appropriate	• Active promotion ongoing	

4	Use of QR Information Boards to provide standardised, evidence based patient information	Practices	Ongoing	Ensure patient information is high quality, standardised and evidence based	• Info Boards in place across all practices and usage monitored to ensure relevance	
5	Delivery of Flu vaccinations to housebound patients	Practices	Dec 2018	Protection from flu for vulnerable patients at risk and the wider population	• Nurses will be released to deliver flu vaccinations to housebound patients across the cluster during November 2018	
6	Promotion of Digital Technology such as My Health Online	Practices	Ongoing	Wider range information and access models available to patients		

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:

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	Pen Y Bont Health Ltd is a federation of the five practices in Bridgend East Cluster and as such has the ability to draw down alternative sources of funding to progress activity where needs are identified.	Pen Y Bont	Ongoing	Pen Y Bont is able to secure funding and develop projects to meet its identified priorities		

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	Proactive communication with both Health Boards as the Cluster borders two health boards and will transfer to Cwm Taf on 1st April 2019.	All	1st April 2019	Clarity on patient pathways and access to services despite health board border. Clarity on transfer to new health board and its impact on services	• Communication ongoing	
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.	
3	Engage with a robust validated clinical governance process	General Practice	31stMarch 2018	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.	
4	Promote shared learning and good practice through increased incident reporting.	General Practice	Ongoing	Improved quality and safety of services	• Encourage use of DATIX for incident reporting • To explore a feedback mechanism to primary care	
5	Update and maintain a cluster risk resister	Cluster	Ongoing	Mitigate risks as appropriate	• Identify and agree risks	
6	Premises improvement to enable capacity to deliver new pathways and increase capacity., including Bridgend Wellness Centre	ABMU HB	Ongoing	Improved facilities and sustainable services