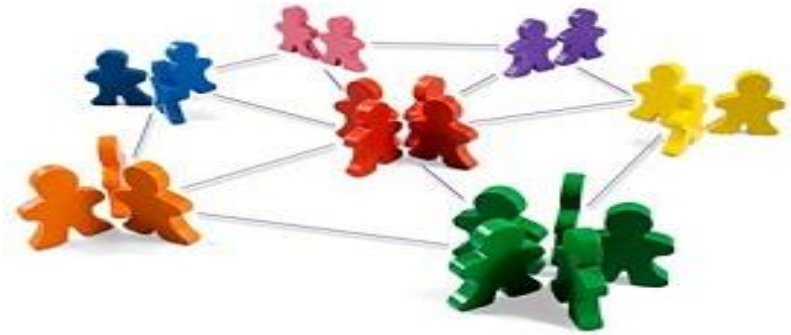
Three Year Cluster Network Action Plan 2017-2020

Bridgend West Cluster



VERSION CONTROL: July 2017

Introduction

The West Cluster is the smallest of the networks across ABMU. It includes a cluster of 3 GP Practices, with one being a training practice, serving a population of 34,400 patients. The cluster network estate includes 3 main practices and two branch surgeries. The West Cluster network area also contains four nursing homes and six residential homes. There are eight community pharmacies and 5 dental practices. The network covers a high proportion of elderly residents in parts and although some areas of affluence exist there are also a number of areas with high deprivation. Porthcawl is also a holiday resort and is home to a large static caravan park.

Since the last Cluster plan in 2016-17 the Cluster is now a network of 3 practices instead of 4. The single handed GP Practice with a list size of approximately 1,900 patients terminated its contract with ABMU and the Practice closed on the 30th of June 2017. In line with the WHC (2006) 063 General Medical Services Practice Vacancy – A Guide to Good Practice, a panel was convened on 28th April 2017 and considered a detailed options appraisal specifically focusing on the impact of the termination of this contract on patients, neighbouring practices and the Health Board. The Panel agreed that a dispersal of the 1900 patient list to the neighbouring practices, North Cornelly and Portway Surgery which are already well established and delivering general medical services to the local population, would offer the most viable option to ensure patients are able to continue to access general medical services safely and effectively from 1st July 2017.

The Cluster achieved a number of objections during 16/17 including:

- All registered patients having an updated smoking status on their medical records.
- Numed screens across the four practices showing national and local public health messages to patients which include smoking, flu and screening programmes.
- Patient education and signposting to Third Sector continues via the Numed screens.
- Cluster support to the Health Homes Project. This service provides a casework services within practices to enable older people to remain living independently within their own homes and within their local communities through the improvement of their housing conditions.
- Cluster GP completed the RCGP course to enable the delivery of a cluster based substance misuse service.
- Cluster pharmacist role now embedded into the cluster way of working.
- Liaising with Care Homes across the Cluster area to improve and find a more consistent approach to the referral and treatment of care home patients.
- Liaising with local Clinical Dental Advisor on how we can work together smarter.
- Recruitment of a chronic disease nurse for housebound patients in order to provide a person centered, holistic approach to the management and education of patients with chronic morbidities.

- All GP Practices within the cluster have become dementia friendly practices.
- Antimicrobial stewardship – there has been a 0.28% reduction in antibiotic items.
- Implementation of a digital referral pathway for early identification, diagnosis and referral for those patients presenting with dermatological needs.
- Introduction of an anticipatory model of care. Practices working closely with the local integrated community team.
- Datix incident reporting system now being used by all Cluster GP Practices.
- Funding of a Portable bladder scanner to support the DN service to review long standing patients with catheters.

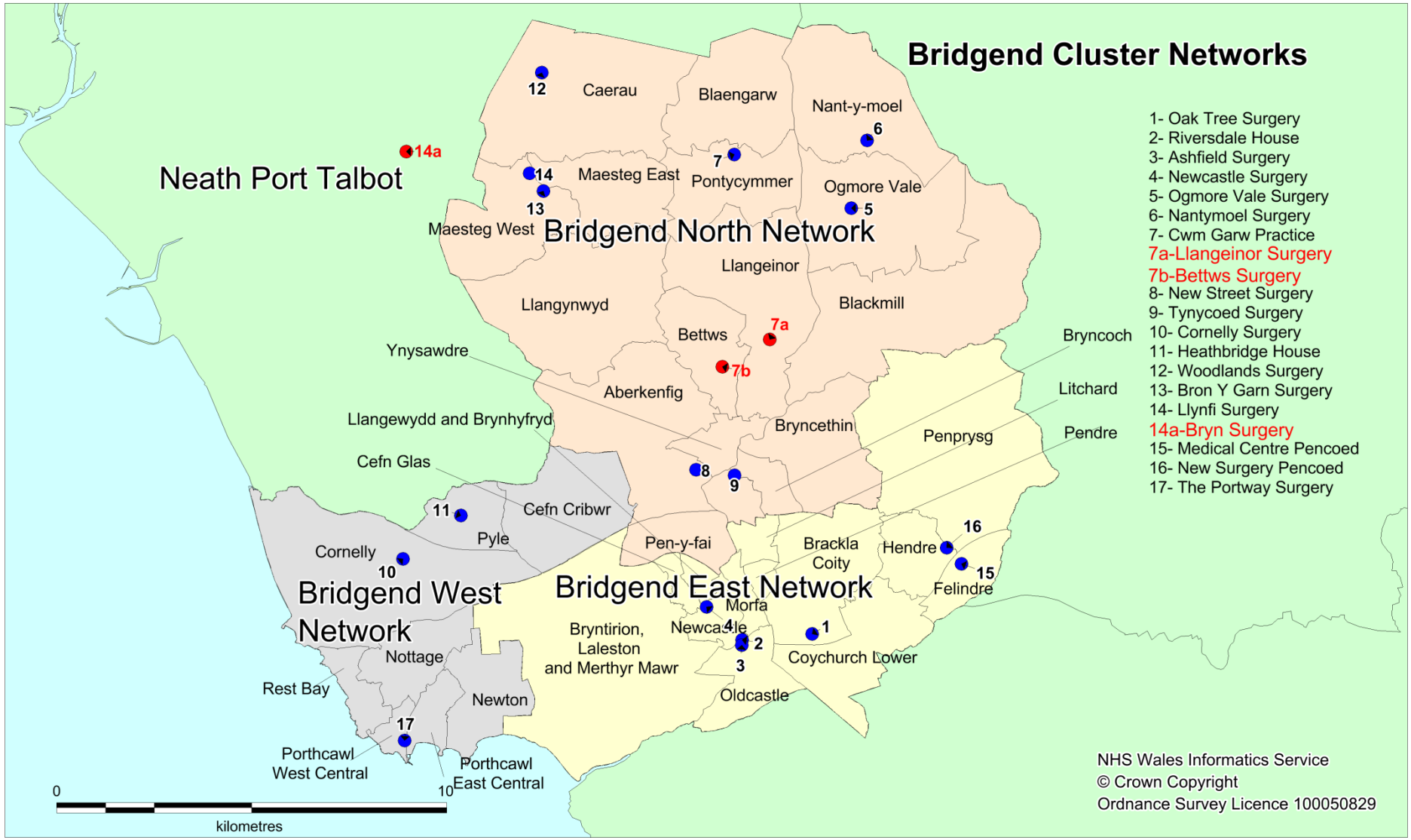
The budget allocation for the West for 2017/2018 is £112,065.00. The majority of the budget has been allocated to fund the Cluster Pharmacist and the Community Chronic Disease Nurse.

Sustainability and workforce challenges faced by the Cluster include the impact of additional patients registering at both North Cornelly and Porthcawl Group Practice following the closure of the single handed GP in July 2017. Following the dispersal of these patients workload for both GP Practices has increased. The Practices are actively seeking to recruit additional GPs to their workforce and are assessing the skill mix within their practices and cluster due to the ongoing GP recruitment issues.

Premises is also an issue for North Cornelly and Porthcawl Group Practice. The capacity to develop services within the Cluster is largely dependent on the development of new premises for Porthcawl and an improvement grant for North Cornelly.

By 2020 it is anticipated that the Cluster will still have 3 GP Practices with no branch surgeries. Once the new build is completed for Porthcawl Group Practice all services will be delivered from one main site. It is hopeful that the improvement grant for North Cornelly will be approved and completed by 2020 with this Practice also delivering services from one location.

The Bridgend County Borough Local Development Plan for 2006-2021 details an uplift of approximately 1500 housing units planned for Porthcawl some of which have already been built. Many of the sites are already cleared therefore development is likely to proceed quickly once commenced.


Bridgend Cluster Networks
1- Oak Tree Surgery
2- Riversdale House
3- Ashfield Surgery
4- Newcastle Surgery
5- Ogmore Vale Surgery
6- Nantymoel Surgery
7- Cwm Garw Practice
7a-Llangeinor Surgery
7b-Bettws Surgery
8- New Street Surgery
9- Tynycoed Surgery
10- Cornelly Surgery
11- Heathbridge House
12- Woodlands Surgery
13- Bron Y Garn Surgery
14- Llynfi Surgery
14a-Bryn Surgery
15- Medical Centre Pencoed
16- New Surgery Pencoed
17- The Portway Surgery
Neath Port Talbot
Bridgend North Network
Bridgend West Network
Bridgend East Network
Caerau
Blaengarw
Nant-y-moel
Maesteg East
Pontycymmer
Ogmore Vale
Maesteg West
Llangeinor
Llangynwyd
Blackmill
Bettws
Ynysawdre
Aberkenfig
Bryncoch
Litchard
Pendre
Llangewydd and Brynhyfryd
Bryncethin
Penprysg
Cefn Glas
Cefn Cribwr
Pyle
Cornelly
Pen-y-fai
Brackla
Coity
Hendre
Felindre
Morfa
Bryntirion,
Laleston
and Merthyr Mawr
Newcastle
Coychurch Lower
Oldcastle
Nottage
Rest Bay
Newton
Porthcawl
West Central
Porthcawl
East Central
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KEY THEMES & PRIORITIES IDENTIFIED FROM PRACTICE DEVELOPMENT PLANS

- Capacity to develop services within the cluster is largely dependent on the development of new premises.
- Assessment of workforce and skill mix within practices/cluster required due to ongoing GP recruitment issues
- Closure of single handed practice and dispersal of patients could potentially impact on sustainability of services.
- High elderly population
- High level of substance misuse and alcohol dependency
- Continue to improve availability of smoking cessation advice and further develop links with stop smoking Wales.
- Significant levels of deprivation, with high levels of low income and unemployment.
- High number of sheltered accommodation and care homes, including 4 new sheltered housing developments recently
- High number of temporary residents and patient list turnover
- Continue referring older people and people with disabilities to the Cluster funded Healthy Homes Scheme.

- High prevalence of chronic illness/high disease risk
- High prevalence of patients with dementia
- Increasing prevalence of mental health issues and patients with depression
- Need to consider further collaboration with partners, particularly 3rd sector who might be able to provide advice and support for vulnerable groups.
- Need to improve domiciliary services for preventative care and structured chronic condition management.
- Need to manage demand and identify innovative ways of meeting demand imposed by multi-morbid population with high expectations
- Consider potential opportunities for collaborative cluster services including; diabetes, cardiology and obesity.
- Improve access the secondary care services, in particular cardiology.
- Plans to implement a wound care protocol to enable nursing homes to liaise directly with practice nurses for wound care/dressing advice/prescriptions
- Work with local Clinical Dental Advisor to improve patients oral health care

Services Delivered

	Portway	North Cornelly	Heathbridge			
Additional Clinical Services						
Cervical Screening	Y	Y	Y			
Contraceptive Services	Y	Y	Y			
Vaccinations & Immunisations (Non Childhood)	Y	Y	Y			
Childhood Vaccinations & Immunisations	Y	Y	N			
Child Health Surveillance	Y	Y	N			
Maternity Services	Y	Y	Y			
Minor Surgery	Y	Y	Y			
Directed Enhanced Services						
Childhood Immunisations	Y	Y	N			
Influenza for those 65 and over and others at risk groups (2-3 year olds)	Y	Y	Y			
Extended Minor Surgery	Y	Y	Y			
Care of People with Learning Disabilities	Y	Y	Y			
Care of People with Mental Illness	Y	Y	N			
National Enhanced Services						
Anti Coagulation (INR) Monitoring	Y	Y	Y			
Shingles Catch- Up Programme	Y	Y	Y			
Services to patients who are drug/alcohol misusers	Y	N	N			
Local Enhanced Services						
Shared Care	Y	Y	Y			
Gonadorelins / Zoladex	Y	Y	Y			
Immunisations during outbreaks (MMR)	Y	Y	Y			
Care Homes	Y	Y	N			
Care of Homeless Patients	N	Y	N			
Hep B Vaccination of at risk groups	Y	Y	Y			
Wound Management A	Y	Y	Y			
Wound Management Part B	Y	Y	Y			
Wound Care SLA Feb 17 – June 17	Y	Y	Y			

Men C Catch Up for University	Y	Y	Y			
Cross Border Patients	N	N	N			
Anti Coagulation Level 4	Y	N	N			

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

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Review the needs of the population using available data.	To ensure that services are developed according to local need	March 2018	GP Practices Public Health Third Sector Integrated Community Network Team Dental Practices Community Pharmacy	• Proactively utilise the Primary Care Portal and local knowledge to identify areas of improvement.	**G**
2.	Improved communication and integration with the third sector	Increase signposting to voluntary services that support self care and independence	March 2018	BAVO GP Practices Health Board	• Patient education and signposting to Third Sector services to continue via the NUMED screens • Third Sector organisations to be invited to the ABMU GP and Practice Nurses Protected Learning Time event to raise awareness of what services are available. • Awareness of Third Sector services to be highlighted to GP Admin and Clerical staff.	**A**
3.	Increase wellbeing and resilience to reduce inappropriate appointment and home visits.	Patient access to support and information	March 2018	GP Practices Third Sector Health Board	• Inform patients via the NUMED screens of health and practice information.	**A**

4.	Enable older people and people with disabilities to remain living independently within their own homes and within their local community through the cluster Healthy Homes Scheme	Comprehensive financial advice and assistance to older people with regard to housing repair, maintenance and/or adaptation work required to enable them to remain living independently and safely in their own homes.	March 2018	GP Practices Community Integrated Team Care and Repair	The Cluster have funded this scheme for a further year to run from April 2017 – March 2018. From April to June 2017 (Quarter 1) the number of referrals made to the scheme was 68. Outcomes during this quarter have been: • Number of falls assessments 19 • Number of falls pack distributed 10 • Number of telecare assessments 16 • Number of aids and adaptations 71 • Number of grants accessed to fund aids and adaptations 42 • Number of fuel poverty assessments 27 • Number of benefit checks 19 • Number of boilers on prescriptions 7 (Welsh Government Funding) • Number of signposting – 52 Care and Repair will continue to update the Cluster with Update Reports at Cluster Meetings.	**G**
5.	Delivery of a Cluster based substance misuse enhanced service.	Providing a local service and utilising network skills to improved patient services and care	March 2018	GP Practices CDAT	• One Practice to deliver a network based Enhanced Service on behalf of the other two Practices. • Point of contact for GP Practices with substance misuse patients.	**G**

6.	To provide a person centered, holistic approach to the management and education of patients with chronic morbidities	Improve the quality and structure of chronic disease monitoring for housebound patients	March 2018	GP Practices CCM Nurse Community Integrated Network Team	• CCM Nurse to undertake annual review at home for housebound patients. • Increase flu immunisations for housebound patients to improve uptake amongst elderly and 'at risk' who are unable to attend the Surgery.	**G**
7.	Extend the pathway of care for dementia support within Primary Care	Support for people living with dementia	March 2018	Community Integrated Network Team BAVO	• Nostalgia cafe based in Pyle Life Centre – Victoria • Kenfig Hill area to become a dementia friendly community – Kay.	**A**
8.	Increase resilience in care homes, improve liaison with appropriate services and reduce the requirement for GP visits	More consistent approach to the referral and treatment of care home patients	March 2018	GP Practices Community Integrated Network Team ABMU	• Progressing with the opportunity for a Care Home Nurse. • Consider opportunities to implement a wound care protocol to enable nursing homes to liaise directly with practice nurse for wound care/dressing advice/prescriptions • Dietitians to provide comprehensive training to care home staff and implement the Community Nutrition Pathway for clients in Care homes. Once Care Home staff have received training they will be able to refer directly to the Nutrition and Dietetic Service using the direct care home referral form instead of contacting GP. Trialling with a second care home in Porthcawl.	**A**

9.	Provide proactive, timely care for those patients that are most vulnerable and complex to manage	Co-ordinated and improved care Less crisis appointments	March 2018	GP Practices Community Integrated Network Team	• Continue with the anticipatory model of care. • Continue to meet with GP Practices to assist in identifying patients for co-ordination. • Potential to roll anticipatory model of care to residential homes.	**A**
10.	Consider opportunities for partnership working to improve access to oral health services	Improve access and increase oral health	March 2018	ABM GDPs GP Practices	• Continue to liaise with ABMU Dental Team	**A**
11.	Management of diabetes patients	Improve care	March 2018	GP Practices Community Integrated Network Team ABMU	• Upskilling of care home staff- District Nurses and Cluster GP – Victoria to update. • Changes to the referral and administration process for access to the Type 2 Structured Diabetes Education Courses available in ABMU HB provided by the Nutrition and Dietetic Service. Patients are able to self refer. GP can still refer patients to the programme.	**A**
12.	Smoking	Support to the smoking population to make a quit attempt	March 2018	GP Practices Community Pharmacy Public Health Wales	• Promote Help me Quit • Information to be displayed on NUMED Screens • Quarterly and practice level data to be discussed at Cluster Network Meetings.	**G**

13.	Flu	Continue to increase flu immunisation uptake within the Cluster to protect patients at risk and the wider population	March 2018	GP Practices Public Health Community Pharmacy	• Discuss IVOR flu vaccination uptake data on Cluster basis. • Engage with the third sector to maximise publicity and encourage take up.	**G**
14.	Screening Uptakes	Improve uptake of screening programmes to improve diagnosis and better outcome for patients	March 2018	GP Practices Public Health Community Pharmacy	• Proactively encourage screening uptakes across all screening programes. • Publicise screening programme information on NUMED screens.	**G**
15.	Obesity	Reduce Obesity in the cluster	March 2018	GP Practices Public Health	• Promote healthy living messages via NUMED screens • Signpost to community based services as apppropriate	**G**
16.	Immunisation uptake	Improve uptake of immunisation for the population of the West Cluster	March 2018	GP Practices Public Health	• Improve percentage of children who have received 3 doses of the 5 in 1 vaccine by age 1 (target 95%) • Percentage of children who received 2 doses of the MMR vaccine by age 5 (target 95%) • Improve influenza vaccinationuptake of Patients aged 64 years and under with chronic conditions (target 55%) • Improve uptake for staff with direct patient contact (target 60%)	**A**

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	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Improved communication and integration with the third sector	Increase signposting to voluntary services that support self care and independence	March 2018	BAVO GP Practices Health Board	• Patient education and signposting to Third Sector services to continue via the NUMED screens • Third Sector organisations to be invited to the ABMU GP and Practice Nurses Protected Learning Time event to raise awareness of what services are available. • Awareness of Third Sector services to be highlighted to GP Admin and Clerical staff.	**A**
2.	Provide proactive, timely care for those patients that are most vulnerable and complex to manage	Co-ordinated and improved care Less crisis appointments	March 2018	GP Practices Community Integrated Network Team	• Continue with the anticipatory model of care. • Continue to meet with GP Practices to assist in identifying patients for co-ordination. • Potential to roll anticipatory model of care to residential homes.	**A**
3.	Support training and development opportunities to increase workforce resilience and skill mix	Enhance skills and improve efficiency of services.	March 2018	GP Practices	• Assessment of workforce and skill mix within practices/cluster required due to ongoing GP recruitment issue • Identify training and development needs of core practice staff. • The closure of a single handed GP Practice within the cluster. Practices dealing with workload associated with these additional patients.	**A**

4.	Consider opportunities for cluster based service provision	Providing a local service and utilising network skills to improve patient services	March 2018	GP Practices Care Homes	• Opportunity for collaborative working across the network including the implementation of a wound care protocol to enable nursing homes to liaise directly with practice nurse for wound care/dressing advice/prescriptions	**A**
5.	Enable older people and people with disabilities to remain living independently within their own homes and within their local community through the cluster Healthy Homes Scheme	Comprehensive financial advice and assistance to older people with regard to housing repair, maintenance and/or adaptation work required to enable them to remain living independently and safely in their own homes.	March 2018	GP Practices Community Integrated Team Care and Repair	• Continue partnership working with Bridgend Care and Repair.	**G**
6.	Cluster Pharmacist dealing with medicine related queries where possible	Practice utilising facility extensively.	March 2018	GP Practices	• Releases GP time as patient and Pharmacist able to intercept and discuss other medication problems where contact made.	**G**

7.	Cluster Pharmacist assisting with medication reviews following the transfer of patients from the single handed practice	To ensure timely resolution of any anomalies	March 2018	GP Practices	• Practices extensively using facility. • Practices also using facility for care home patients.	**G**

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	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Cluster Pharmacist carrying out medication reviews of care home patients and other selected patient cohorts	Reviews achieved in a timely manner. Reduces harm and waste with medications being stopped/changed/started	March 2018	Cluster Pharmacist GP Practices	• All GP Practices using facility which releases GP time. • Cluster Pharmacist liaising with secondary care/other agencies including Pharmacies where appropriate.	**G**
2.	Pharmacist maintaining NOAC register	Ensures risk reduced (prevents critical incidents)	March 2018	Cluster Pharmacist GP Practices	• All GP Practices using facility which releases GP time. • Cluster Pharmacist reviewing doses/blood monitoring intervals, raising awareness to practice staff via medical record alerts/messages for new NOAC patients. • Liaising with secondary care when necessary • Dealing with concurrent medication problems.	**G**

3.	Pharmacist assisting use of Practice formulary	Assisting staff to achieve prescribing cost-effective switches while minimising confusion to patient/carers /community pharmacies	March 2018	Cluster Pharmacist GP Practices	• Practice formulary revised. • Prescribing Clerk in 2 practices regularly liaising for assistance. • One practice utilising technician to achieve changes in liaison with Pharmacist.	**G**
4.	Provide proactive, timely care for those patients that are most vulnerable and complex to manage	Co-ordinated and improved care Less crisis appointments	March 2018	GP Practices Community Integrated Network Team	• Continue with the anticipatory model of care. • Continue to meet with GP Practices to assist in identifying patients for co-ordination. • Potential to roll anticipatory model of care to residential homes.	**A**
5.	Management of diabetes patients	Improve care	March 2018	GP Practices Community Integrated Network Team ABMU	• Upskilling of care home, District Nurses and Cluster GP – Victoria to update. • Changes to the referral and administration process for access to the Type 2 Structured Diabetes Education Courses available in ABMU HB. Patients are able to self refer.	**A**

6.	Increase resilience in care homes, improve liaison with appropriate services and reduce the requirement for GP visits	More consistent approach to the referral and treatment of care home patients	March 2018	GP Practices Community Integrated Network Team ABMU	• Progressing with the opportunity for a Care Home Nurse. • Consider opportunities to implement a wound care protocol to enable nursing homes to liaise directly with practice nurse for wound care/dressing advice/prescriptions • Community Nutrition Pathway for clients in Care homes. Care Home staff will be able to refer directly to Dietitian using direct care home referral form instead of contacting GP. Trailing with a second care home in Porthcawl.	**A**
7.	To provide a person centered, holistic approach to the management and education of patients with chronic morbidities	Improve the quality and structure of chronic disease monitoring for housebound patients	March 2018	GP Practices CCM Nurse Community Integrated Network Team	• CCM Nurse to undertake annual review at home for housebound patients. • Increase flu immunisations for housebound patients to improve uptake amongst elderly and 'at risk' who are unable to attend the Surgery.	**G**

8.	Enable older people and people with disabilities to remain living independently within their own homes and within their local community through the cluster Healthy Homes Scheme	Comprehensive financial advice and assistance to older people with regard to housing repair, maintenance and/or adaptation work required to enable them to remain living independently and safely in their own homes.	March 2018	GP Practices Community Integrated Team Care and Repair	• Continue partnership working with Bridgend Care and Repair.	**G**

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support continuous development of services to improve patient experience, co-ordination of care and the effectiveness of risk management. To address winter preparedness and emerging planning.

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Cluster Pharmacist dealing with patient urgent medication requests	Assists patients/practices with medication requests that have ambiguous formulary or availability on the NHS			• All practices using this facility.	**G**
2.	Provide proactive, timely care for those patients that are most vulnerable and complex to manage	Co-ordinated and improved care Less crisis appointments	March 2018	GP Practices Community Integrated Network Team	• Continue with the anticipatory model of care. • Continue to meet with GP Practices to assist in identifying patients for co-ordination. • Potential to roll anticipatory model of care to residential homes.	**G**
3.	To provide a person centered, holistic approach to the management and education of patients with chronic morbidities	Improve the quality and structure of chronic disease monitoring for housebound patients	March 2018	GP Practices CCM Nurse Community Integrated Network Team	• CCM Nurse to undertake annual review at home for housebound patients. • Increase flu immunisations for housebound patients to improve uptake amongst elderly and 'at risk' who are unable to attend the Surgery.	**G**

4.	Increase resilience in care homes, improve liaison with appropriate services and reduce the requirement for GP visits	More consistent approach to the referral and treatment of care home patients	March 2018	GP Practices Community Integrated Network Team ABMU	• Consider opportunities to implement a wound care protocol to enable nursing homes to liaise directly with practice nurse for wound care/dressing advice/prescriptions	**A**
5.	Enable older people and people with disabilities to remain living independently within their own homes and within their local community through the cluster Healthy Homes Scheme	Comprehensive financial advice and assistance to older people with regard to housing repair, maintenance and/or adaptation work required to enable them to remain living independently and safely in their own homes.	March 2018	GP Practices Community Integrated Team Care and Repair	• Continue partnership working with Bridgend Care and Repair.	**G**

Strategic Aim 5: Improving the delivery of dementia; mental health and wellbeing; cancer; liver disease, COPD (delete as appropriate).

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	COPD	Practices to enhance their care in this clinical priority pathway area	March 2018	GP Practices	• Engage with the clinical priority work at a practice and cluster level. • Discuss any data provided to the practice or cluster. • Agree small steps of change to test out any new ways of working in the practice or cluster. • Share the results of small tests of change with peers in the cluster (whether positive or negative).	**R**
2.	Cancer	Practices to enhance their care in this clinical priority pathway area	March 2018	GP Practices	• Engage with the clinical priority work at a practice and cluster level. • Discuss any data provided to the practice or cluster. • Agree small steps of change to test out any new ways of working in the practice or cluster. • Share the results of small tests of change with peers in the cluster (whether positive or negative).	**R**

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

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Mental Health & Wellbeing – Pharmacist reviewing patients with depression or anxiety and other indications where anti-depressants are being prescribed.	Ensure risks are	March 2018	All practices		**G**

Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and Information Governance. To include actions arising out of peer review Quality and Outcome Framework (when undertaken).

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Engage with a robust validated clinical governance process	Improved safety and quality	31st March 2018	All GP practices		**A**

Strategic Aim 8: Other Locality issues

No	Objective	Outcomes	Milestones	Assigned to (key partners)	Progress to date	RAG Rating
1.	Premises improvement to enable capacity to delivery new pathways and increase capacity	Improved facilities and sustainable services	2018	ABMU North Cornelly Surgery Porthcawl Group Practices	• Progression of an improvement grant • Progression of a Primary Care Health Centre for Porthcawl.	**A**
2.	Closure of a single handed GP Practice in Porthcawl	Dispersal of patients to both North Cornelly and Porthcawl Group Practice	2018	ABMU North Cornelly Surgery Porthcawl Group Practice	• Dispersal of approximately 1900 patients to two GP Practices • Monitor impact of dispersal and additional workload associated with these new patients.	**A**

RISK REGISTER

ID Number	Date	Description of Risk and Impact	Mitigation	RAG	Lead
1.	1.8.17	Closure of Dr. Eales Surgery in July 2017. 1900 patients dispersed between North Cornelly and Porthcawl Group Practice. Additional workload associated with re-registering of patients.	Monitor impact of dispersal and additional workload associated with these new patients.	R	Cluster Lead
2.	1.8.17	Premises improvement to enable capacity to delivery new pathways and increase capacity. • Progression of an improvement grant for North Cornelly and • Progression of a Primary Care Health Centre for Porthcawl.		A	Cluster Lead
3.	1.8.17	National GP Recruitment issues	Assessment of workforce and skill mix within practices/cluster required	R	Cluster Lead
4.	1.8.17	Funding Allocation. Funding for West Cluster allocated against Chronic Condition Nurse and Pharmacist.		A	Cluster Lead