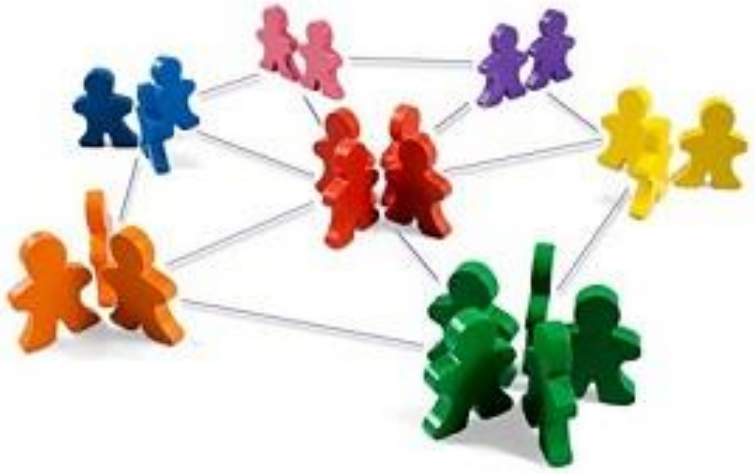
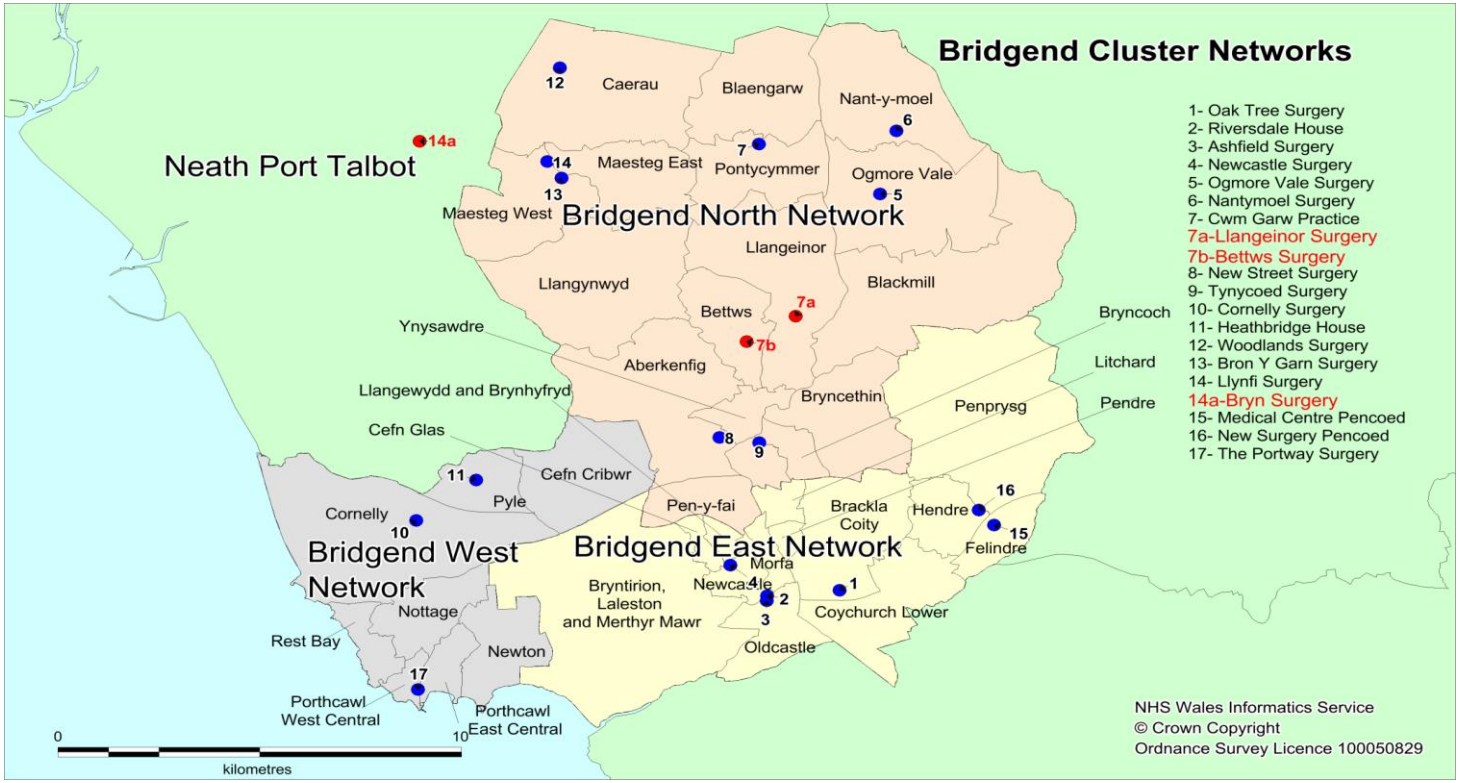
Three-Year Cluster Action Plan 2018 - 2021

Bridgend West Cluster



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

The Bridgend West Cluster is one of three clusters within Bridgend of which geographically covers three GP practices and includes a population of 34,528 in coastal, rural and urban areas with pockets of severe deprivation.



Bridgend West Cluster is made up of **three** main general practices, two branch surgeries including one training practice, with practice populations ranging from **2,094 to 13,689** amounting to a cluster 34,528; the West Cluster also includes **four nursing homes and six residential homes**, **nine community pharmacies and four dental practices**. All working together with partners from social services, the voluntary sector and ABMU health board.

Practices included in the Bridgend West Cluster include:

- Heathbridge House
- North Cornelly Surgery
- The Portway 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 West 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 West 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, district nursing and the Third Sector and Social Services.

Demography

- High older population
- Significant levels of deprivation with high levels of low income and unemployment
- High level of substance misuse and alcohol dependency
- High number of temporary residents and patient list turnover

Needs Profile

- High prevalence of chronic illness / high disease risk
- High incidence of dementia
- Increasing demand for support relating to mental health and depression

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

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

Education & Training

- Ongoing diversification of workforce to meet client needs e.g. Cluster Pharmacist
- Plans to work with local care homes to develop the skill base of staff to ensure patient care in their own home can be provided as appropriate

Workforce

- Ongoing recruitment challenges
- Succession planning proactively managed by constituent practices

3. SWOT analysis

Key Population Features

- 34,528 GP registered Patients
- 50.5% female; 49.5% male
- Ageing elderly population (25.2% aged 65+ and 12.1% 75+)
- 6.9% live in a Lower Super Output Area (LSOA) that is classified as rural.
- 54.5% live in the most deprived two fifths (40%) of areas in Wales
- 4.9% aged 65+ live in a nursing, non-nursing or other local authority care home
- 32.6% aged 65+ live alone
- 7.6% aged 16-74 are both economically active and unemployed
- 66.60% of people aged 16+ with a record of alcohol intake (lowest)
- 29.92% of people are on the Public Health Wales Smoking Register (highest)

Population and Community Assets

- Numerous Community Centres offering a range of community led sessions
- 1 Leisure Centre
- 2 Libraries
- Voluntary Sector organisations including mental health, physical activity and other charities aimed at supporting health and wellbeing
- 2 out of the 3 Practices are engaged with the Care Home DES

Cluster Features

- Coastal, rural and urban areas with pockets of severe deprivation
- Pockets of severe deprivation
- 3 GP practices
- 9 community pharmacies
- 4 Dental practices
- 4 Optometry
- 10 Nursing and residential homes

Health Profile

- Data from GP recorded diagnosis shows when compared to the 11 clusters of ABMU HB that
  - 2.5% of patients have COPD (6th highest)
  - 6.6% of patients have Diabetes (5th highest)
  - 8.0% are Obese (10th highest)
  - 3.8% have Cancer (highest)
  - 44.76% have CHD (2nd highest)
  - 9.76% have CVD (3rd highest)
  - 19.98% have Pre Diabetes (7th highest)
- IVOR data flu uptake date (Apr 2017) shows
  - 64% of patients 65+ (ranked 3rd highest)
  - 67% of patients <65 at risk (ranked 5th highest in uptake)
  - 24.2% in 2-3 year olds (ranked lowest)
- 28.4% aged 16+ reported undertaking at least 30 minutes moderate exercise on five or more days in the previous week
- 32.8% aged 16+ reported consuming five or more portions of fruit or vegetables on the previous day

Service Demands

- Increasing of practice list sizes (1.8% change between 2011 – 2017)
- Increasing number of patients with co-morbidities and complex presentations
- Difficulties GP and other HCP with recruitment
- 11,270 A&E attendances (Apr 17 – Mar 18)
- 55.9% Bowel Screening uptake
- 25.18% Cervical Screening uptake
- 81.8% AAA Screening uptake
- 74% Breast Screening uptake

Other influencing factors

- Limited access to public transport especially over the weekend
- Plenty of open and green spaces
- New Housing developments as part of LDP
- Transient and seasonal patient population variation due to the partial coastal position of the cluster


Strengths
MDT in develoment, eg. pharmacist, chronic conditions nurse
Good working relationship between Cluster practices and with Partners
All Practices positively engage in Cluster working
Willingness to test out new ideas
Bridgend West are reducing prescribing faster than the national reduction
Weaknesses
Limited 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
Cluster SWOT Analysis
Opportunities
Increase collaboration and development of MDTs and shared services
Establish formal collaborative entitity
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 West Cluster will:

- 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 West Cluster Practice Priority Issues

- **Ongoing development of multidisciplinary working to support practice sustainability, aligned with prudent healthcare principles and to ensure timely access to an appropriate professional.**

- **Increase in Cluster Pharmacist capacity to facilitate and improve prescribing, patient experience and compliance.**

- **Development of the Chronic Conditions Team remit to provide proactive support to individuals living with multiple co-morbidities and allowing them to be empowered to manage their condition.**

- **Continued progress and engagement with the West Cluster Healthy Homes Project to allow patients to access support to aids and adaptions, financial advice**

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):

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 Rates**

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	Increase wellbeing and resilience of the patient population through prevention and self-care education including social prescribing and the wider social model of care	All	Ongoing	Patients are more able to manage their conditions and prevention is recognised as a key feature		
3	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 and reduction in smokers	• 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	Reduce obesity in the cluster through patient education and the promotion of wellbeing and prevention messages	All	Ongoing	Reduction in the obese population		
5	Actively promote the importance of screening programmes to improve early diagnosis and timely treatment for patients	All	Ongoing	Increased uptake of relevant screening programmes leading to early diagnosis and treatment		

6	Delivery of a Chronic Disease Management service, including patient education to create resilience and a focus on prevention to support the proactive management of patients with Chronic Diseases.	Cluster & Chronic Conditions Team	Ongoing	Patients living with a chronic disease will be able to manage their condition effectively	• Band 6 Nurse and HCSW in place undertaking patient reviews and developing support plans.	
6	Delivery of a cluster based substance misuse enhanced service	Practices	Ongoing	Individuals can access a quality service in a timely manner		
7	Proactive identification and signposting of people living with dementia	All	Ongoing	People living with dementia and their carers are able to access appropriate care and support in a timely manner and proactively manage their own health and wellbeing as appropriate		

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.

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 integration with the third sector to provide a key focus on wellbeing and prevention through engagement and active promotion of: • Infoengine • Dewis • Social Prescribing	All	Ongoing	Patients are more informed and empowered to manage their own health and prevention of ill health		
2	Extend the range of professionals and maximise the skill mix within the cluster through the development of the cluster multidisciplinary roles	All	March 2019	Increased access and signposting to voluntary services that support self-care and independence	• Consider future roles and responsibilities • Develop a physiotherapist role • Develop CCN Service • Explore the use Tier 0 Mental Health and wellbeing support	

3	Increase wellbeing, resilience and early intervention to frail elderly individuals through a primary care occupational therapy (Healthy Homes)	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.	
4	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	
5	Increase resilience in care homes, improve liaison with appropriate services to meet the need of residents	General Practice	Ongoing	Reduction of GP attendances for residents and patients feel more able to manage and understand their conditions		

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	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	
2	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	
3	Reduce wastage of medicines and achieve better health outcomes through prudent prescribing linked to the work programme of the Cluster Pharmacists	Practices Health Board	Ongoing	Reduced demand on practices for prescribing needs Reduced medicines wastage		

4	Delivery of Diabetes gateway and NOACS	Practices	Ongoing	local rapid management of care, minimising waste and harms;		

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 and health and wellbeing messages to the public using Numed screens and patient engagement	All	Ongoing	Patients understand and are aware of how to access alternative healthcare pathways	• Active promotion ongoing	
2	Promote Practice websites 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		
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	Increase collaboration between GP practices and other primary care providers, social services, Community Resource Team and other Cluster partners			GP practices are better able to manage demand & improve patient care / experience		

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 will transfer to Cwm Taf on 1st April 2019.	All	1st April 2019	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 using a whole System approach including transferring resources into the community focussing on health and wellbeing	All	Ongoing	Improved facilities and sustainable services	Porthcawl Group Practice transfer to a new integrated health and wellbeing focussed site in January 2019.