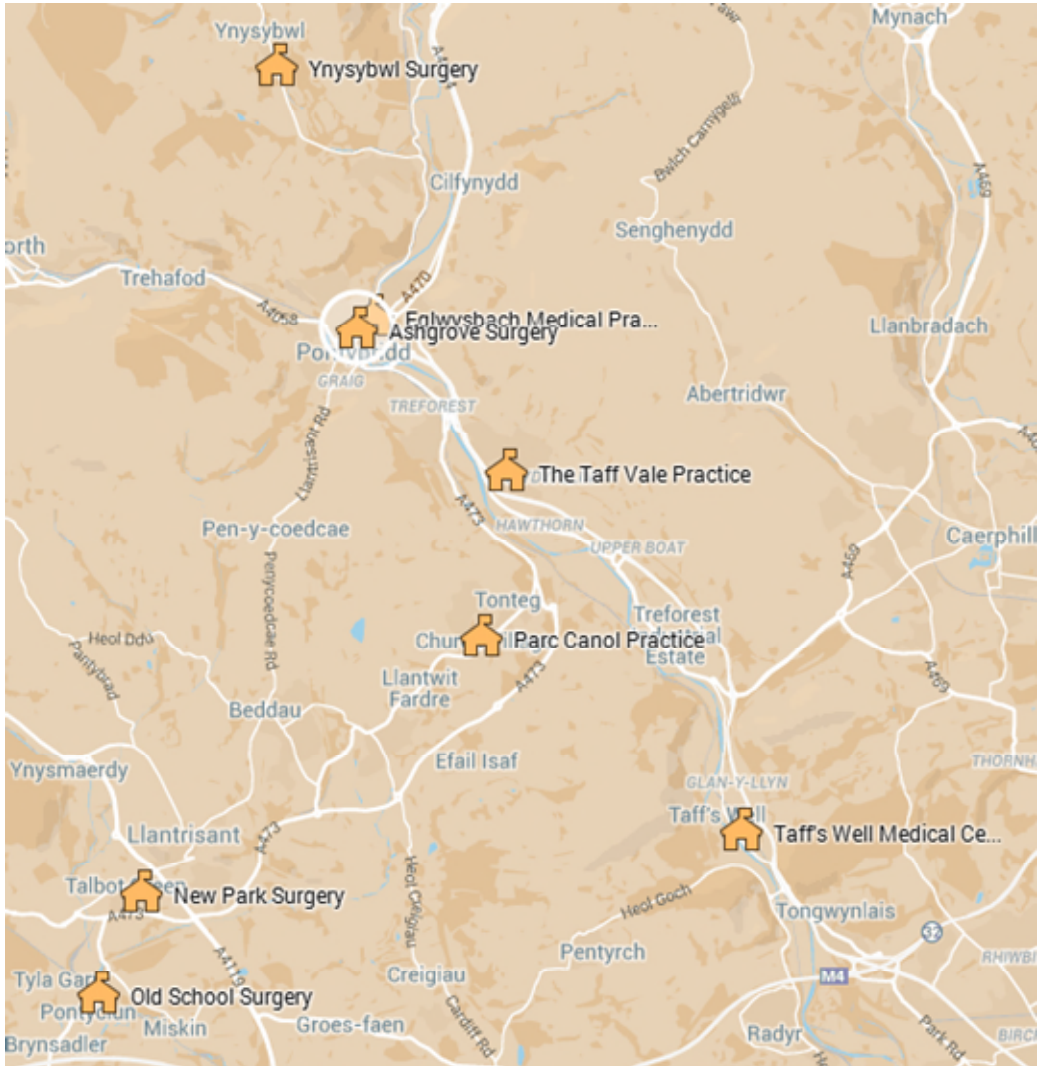
Taff Ely GP Cluster Network Action Plan 2017-20



TAFF ELY NETWORK CLUSTER ACTION PLAN 2017-20

This plan has been developed by the following 7 practices which operate in the Taff Ely cluster area, through facilitated discussion with the local Clinical Director and primary care HB management:

- Ashgrove Surgery
- Eglwysbach Surgery
- New Park Surgery
- Old School Surgery
- Parc Canol Surgery
- Taff Vale Surgery
- Taffs Well Surgery

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, specifically focused on:

- Strengthening the sustainability of core services, referring to sustainability assessment frameworks completed by each practice
- Strengthening the focus on access to services, winter preparedness and emergency planning and improved service development
- Strengthening quality assurance in relation to clinical governance and assurance on specific QOF indicators designated as “inactive”
- Developing more effective collaboration working with community services, including nursing, local authority and third sector to improve quality of care
- Encouraging the development of new models of care, including federations, practice mergers and shared practice support

The plan details cluster objectives for the 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- work in progress

Green – work completed

Note that commitment for resources included within the plan for external organisations e.g. third sector is dependent on resources they are able to provide.

<u>Additional contributors to the plan/potential evolving contributors to the plan subject to evolution of plan</u>

- Health and social care facilitators
- Primary care practice managers
- Practice nursing and allied health professions representatives
- Local voluntary sector providers and third sector
- Prescribing advisers
- Public Health

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

Outline of cluster population profile

The Cwm Taf uHB population estimate in 2007 was 289.4 thousand with 233.7 thousand in the RCT locality .Approximately 10% of the population of Wales live within Cwm Taf uHB, the uHB locality is the second smallest in Wales but the second most densely populated area (Cardiff is first) The Taff Ely Valley in recent CMO for Wales reports and based on recent Public Health Wales data is an area of high social deprivation .We also due to our high deprivation status have high rates of mental health issues long term disability/morbidity ,a high rate of poverty/benefits uptake and high rates of chronic illness from legacy heavy industry particularly mining. Recent CMO reports have indicated a low level of car ownership with an obvious impact on service planning. The neighbourhood has a higher proportion of persons aged 0-15 and 30-44 than the Cardiff average. Public Health Wales indicate that our area consists mainly of most deprived and next most deprived classifications. 34% of Cwm Taf as a whole is designated most deprived on the Welsh Index Multiple Deprivation Scale (WIMD). Within our cluster this figure rises to 38.2% in the Taff Ely Valley. The Public Health Observatory for Wales publications in the field of child health highlight for our locality that: our rate of low birth weights is significantly higher than the Welsh average 1 in 15 c.f. all Wales 1 in 18; and the % of children (<20 years old) living in poverty is 26.6% c.f. all Wales 22.2%. Particularly relevant to our area is the identification of Rhydyfelin and Glyncoch as areas of greatest deprivation in Wales by the public health observatory (ranked 17th and 27th respectively). All Wales public health observatory data on levels of unemployment in the 16-24 yr old age group show a rate of 18.4% for CwmTaf c.f. all Wales 15.7%. With regard to our older population the data for those living alone at 43.9% is near to the all Wales average of 43%. Our localities Black and ethnicity population data suggest an LHB rate of 1.1% lower than the all Wales average of 2.1 % which in turn is lower than England's data. Finally Public Health Wales Data indicates that for Cwm Taf's population as a whole, life expectancy is reduced by 1.5 years for males c.f. the welsh national average i.e. 75.3yrs as opposed to 77 years old. Our locality has in recent years seen and will see several large scale residential developments with obvious impacts on primary care provision planning. Recent public health presentations to our locality identify several top challenges to morbidity and mortality:

- Malignancy (Cancer survival levels in Cwm Taf are amongst the lowest in Wales)
- Cardiovascular disease/circulatory disease
- Smoking levels

Subsequent review of Welsh statistics highlighted further areas of concern (see next page)

Data from the 2016-2017 National Survey for Wales show that:

- 20% of adults in Cwm Taf reported drinking above weekly average levels on a par with 20% for the whole of Wales
- 21% of adults in Cwm Taf reported being a current smoker, compared with 19% in for Wales
- 45% of adults in Cwm Taf reported being active for less than 150 minutes during a week, compared with 54% at an all-Wales level
- 38% of adults in Cwm Taf reported being active for less than 30 minutes during a week, compared with 32% at an all-Wales level
- Adults classified as overweight or obese in Cwm Taf were 64%, the all-Wales average was 59%
- 21% of adults in Cwm Taf had eaten five or more portions of fruit or vegetables on the day prior to the survey date compared to 24% for the whole of Wales

The areas of concern identified by the cluster through this analysis of our cluster populations health status and needs - OBESITY/OVER WEIGHT STATUS, EXCESSIVE DRINKING/PROBLEMATIC ALCOHOL USAGE, HIGHER RATES OF CURRENT SMOKERS & its relationship to higher levels of respiratory illness in our cluster, LOWER LEVELS OF PHYSICAL EXERTION lead us to focus on health and wellbeing messages and campaigns through our cluster plan.

No	Objective	Key partners	Completion by: -	Outcome for patients	Progress to date	RAG rating
1a	Update a review the needs of the population using available data	Local Public Health team	November 2017 2018/19 Ongoing Dec 19	To ensure that services are developed according to local need	Analysis complete and outlined in detail above, subsequently used by cluster to develop action planning on key priorities. See above text. Cluster representatives to work with PHW to undertake a cluster wide population needs assessment. Initiatives to be planned and prioritised to target those communities with the highest need. Invite speakers and schedule agenda items based on initiatives and priorities highlighted in needs assessment. Population health management (segmentation and risk stratification, as per pilot in Rhondda) work presented to the Cluster by PHW in April 2019. All practices have signed the data sharing agreement with PHW.	
1b	Implement health promotion signposting and support mechanisms, which will help to	GPs All primary care community service	March 2018	Health improvements Improved take-up by patients in funded services	Cluster practices are increasing collaboration with third sector organisations via Community Co-ordinator staff in order to encourage the signposting of patients to existing funded services within the community	

	address: • Obesity • Smoking • Alcohol dependence • Physical exercise • Unhealthy lifestyles • Better management of chronic conditions • Unemployment / benefit support • Mental health & wellbeing	providers 3rd sector partners, including Hapi, Community Co-ordinators, Interlink. Local community initiatives, venues.	Ongoing	Increased collaboration between practices and 3rd sector Increased engagement by practices in public health promotion Increased awareness & education for patients on 'choices' available to them for other health, social care & voluntary sector services	as well as Public Health services. To work with Hapi project to deliver specific sessions based on identified needs from the plan and by practices for the cluster population. To continue to implement practice 'Making every contact count' (MECC) training principles. Specific piece of work taking place with Old School surgery to allow PHW to understand what works, any barriers, processes needed to support implementation in GP practices Investing cluster funds to support "Care Navigation" training for all frontline staff including GP Practices, Dental and Optometrist Practices. Initial training March 2018. • *Phase 1 implemented* • *Phase 2 planning underway to review and increase the number of providers.* *'Champions' group established. Need to consider potential roll out of training to other contractors/services* Cluster funds have been invested to	

	Support for those that are homeless to allow them access to advice, support, treatment To support social prescribing and education of population on health & wellbeing, to raise awareness support community opportunities for engagement. To raise awareness of the				support community initiatives development Drink Wise Age Well, Valley and Vale arts therapy, Men's and Women's Sheds projects (Wlaking Rugby & Football, Film Club, Grow for it gardening group, Pontypridd Canal Society, Beddau & Tynant Bowling Club. 2 events held in local church and supported by agencies to provide advice and support to anyone attending. Also through funding and donations there was access to clothing, essential items e.g. toothbrush, holdalls and also food. This was also supported by local community police officers who helped engaging with individuals in the town centre. Community Wellbeing Co-ordinator appointed in Feb 2019 for 15 months to • Promote health & wellbeing messages across primary care, community settings and groups. • Act as screening and immunisation champion for the Cluster • To link with GP practices and other health professionals as necessary to support identified individuals.	

	population to access services that are appropriate to their need and avoid them seeing a GP for social issues.				• Look at community development opportunities to support populations and ensure access to groups and initiatives is provided across Taff Ely. In addition, the cluster is working with Public Health and the Communications team in Cwm Taf health board to produce training information for internal staff on signposting patients to available services. This work is being co-ordinated with primary care partners – including optometrists, dentists, community pharmacists to ensure that patients will be given a consistent message regardless of which organisation is signposting.	
						
1c	Support for community 'Big Bite' event to be held in August 2017	Cwm Taf Health Board Community Co-ordinators	August 2017	Opportunity to attend event aimed at improving community's health and wellbeing and to take learning and resources from the event	Funding committed to support 50% of stands in health and wellbeing tent. Stand representing the cluster was manned by members of cluster practices. Positive feedback received from members of the public. 2018 – Cluster to support the Primary Care stands at the Health & Wellbeing tent to provide information on the MDT teams working in primary care, choose	

					well and Health & Wellbeing	
1d	Increased screening uptake across Taff Ely by patients particularly targeting • Bowel screening • Breast screening • AAA Screening • Cervical Screening In support of PHW 'Screening for Life' Campaign.	GP practices Public Health Wales		Improved publicity and raised awareness for patients on the NHS screening services. Improved take up of screening opportunities	Consent received from each GP practice in Taff to share screening data. This will allow the Cluster in partnership with Public Health Wales & Screening for Life colleagues to target areas as necessary. The Cluster can share information and good practice to aid any practice areas. Community Wellbeing Co-ordinator to act as screening champion, working with PHW, Screening for life engagement team and Primary Care contractors to • promote screening opportunities • target areas of low uptake • link to specific campaigns through the year	

Strategic Aim 2: To ensure sustainability of core GP services and access arrangements that meet reasonable need (including new approaches to delivering primary care)

Cluster practice members have considered this area already in their individual Practice Development Plans and completion of the Sustainability Assessment Framework, 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/text messaging etc.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG rating
2a	Cluster wide signposting website	Cluster	March 2018	Ability to contact the right person first time. Cluster & practice information available in once place. Ability to develop and advertise Cluster wide policies and approaches to services to allow consistent message and access for patients.	Work is underway to design a cluster wide website. Initial review took place at the January 2018 cluster meeting with a view to "go live" with the initial content and build by end of March 2018. Welsh language translation option on the website. Site will continue to develop and is updated regularly in line with Cluster initiatives and additional Primary Care and 3rd sector information.	
2b	Cluster pharmacists	Cwm Taf health board medicine mgt. team	March 2018	Improved access to medication advice and reviews	Cluster pharmacists have been in place in all cluster practices since 2015. Business case for transferring the funding to business as usual was considered but not deemed practical to submit for 2017/18.	

					Work is underway to ensure that appropriate measurement data is captured in order to support a future business case. Practices to consider options for future service provision. Cluster funded posts to end March 2019. Some practices have employed directly following proof of concept and success of cluster project.	
2c	Enlarge membership of cluster to incorporate other community services	GP leads Practice manager leads Optometrist lead Dentist lead Community pharmacy lead Social Services Community nursing Third sector Public Health WAST	March 2018	Co-ordination of access plans across community services	Improved access provided by consistent approach across community services. Progress to date has been to include community dental, optometry, pharmacy colleagues in the cluster as well as Public Health Wales and community co-ordinators and social services. Community nursing representative to be. Cluster TOR has been developed and approved in order to ensure a sound governance framework / decision making process is in place. Meetings are held on a quarterly	

					basis. Cluster event planned for 21/3/19 had to be cancelled due to lack of interest. It was being organised to allow an evening networking and updates for all sectors of cluster members.	
2d	Use the services of an external organisation, Vision in Practice (ViPC) to evaluate new models of care, cluster pilots and provide supporting data for business cases	ViPC	March 2018	This will help to ensure that implementation of new models of care are supported by robust data	This work is building on work delivered during 2016/17 and is focussed on supporting current year cluster initiatives e.g. cluster pharmacists and MIND active monitoring as well as data for the cluster clinical pathways. It has been agreed that services will be commissioned as and when required for 2018/19.	
2e	Workforce modelling	Participating in work co-ordinated by Cwm Taf Health Board	March 2018	Future sustainability of practices within the cluster providing the full range of GMS services and potential new models of care	All practices are participating in workshops held by Cwm Taf Health Board to review the structure of general practice with the aim of sustaining the service and future proofing. Next meeting is on 7 December 2017. Demand and capacity audits have been completed undertaken through work with Primary Care Foundation and the results will be discussed at	

					cluster level in order to share best practice. Cluster leads to attend Strategic Primary Care Planning Group. Cluster to agree plans to allow leads to present at SPCPG and ensure necessary support from UHB.	
2f	To provide mental health & wellbeing support for those presenting to GPs with low mood, anxiety due to bereavement etc.	Cluster Merthyr & the Valleys Mind	March 2020	Referral to Active Monitoring for those attending GP practices with early presentation, mild to moderate anxiety, stress, depression Earlier access to support and techniques to deal with issues and manage conditions.	Practitioners working in all GP practices. Quarterly progress reports provided by MIND to Cluster on activity Funding provided 2017/18 & 2018/19. Service now includes 16-18 year olds. Service to continue for 2019/20. Links with 5f to ensure patients are referred to most appropriate service in the first instance, including Primary Care Mental Health Team.	
2g	To work jointly with Merthyr & the Valleys MIND to support their social prescribing research project	Merthyr & the Valleys Mind Cluster	April 2021	Access to social prescribing advice and support for those suffering with low level mental health issues. Improved Mental wellbeing for those engaged in the service	Taff Cluster have agreed to be part of the Research project. Project leads identified – to attend Mind National Steering Group.	

Strategic Aim 3: Winter preparedness and emergency planning

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG rating
3a	Work with community co-ordinators to promote take-up by patients of seasonal flu vaccine	Community co-ordinators	October 2017	Protection against flu for elderly and medically vulnerable patients	Promote in • primary care – GP practices, dentists, optometrists, • local authority buildings • community premises/groups • big bite event	
3b	Ensure that front-line staff are protected against seasonal flu		September 2017	Staff resource within general practice	Completed as part of seasonal flu campaign.	
3c	Work with UHB pharmacy directorate/ Community Pharmacy Wales /Community Pharmacies to optimise take up by patients of	GP practices Community Pharmacies Cwm Taf UHB Pharmacy Managers CPW	September 2018	Increased level of uptake across the Cluster. Timely access to flu vaccination	Meeting held with CPW to discuss collaborative working. Cluster to work with Community Pharmacy representatives and UHB manager links to agree joint working.	

	seasonal flu	Committee				
3d	Support the rollout of the pharmacy Common Ailments scheme	Cwm Taf Health Board Community pharmacists	August 2017	Improved access for patients to health resources for prescribed list of minor ailments	Roll-out completed across all cluster practices. Promote on Cwm Taf health board website & through health board communications officer Signpost patients accordingly e.g. using care navigation skills	
3e	Winter Pressures	Cwm Taf Health Board Public Health	September 2017	Improved access for patients to health resources for conditions aligned to the Winter Season	Further review of resilience of key front line staff to be completed by individual practices to sustain expected increased demand in access	

Strategic Aim 4: Access to services, including patient flows, models of GP access, engagement with wider community stakeholders to improve capacity and patient communication

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG rating
4a	Staff and GP training on community services available	Dentists Optometrists Community Care Co-ordinators	March 2018	Ability to contact the right person first time	This has been discussed at MDT meetings with cluster community colleagues. The focus will be on e-learning and on delivering this efficiently to staff and GPs. Consideration will be given to creating a module for GPs to undertake as part of their annual training requirements. Online WECS training is planned for delivery to GP staff. Care Navigation training underway to signpost patients appropriately. Training includes services and organisations providing information on their services. Phase 1 complete. Phase 2 planned April 2019 – where champions will come together to discuss progressing to next stage and inclusion of further service to actively promote and offer patients choice. Links available to Taff Cluster website.	
4b	Primary Care	GP practices		Ability to	Include welsh language translation options	

	to introduce the use of welsh language and provide an active offer for their patient population	Dentists Optometrists Pharmacists Cwm Taf UHB Welsh Language Unit		communicate in welsh language if preferred first language. Active offer to patients allows improved experience	on the Cluster Website, including information on welsh speaking staff. To encourage the following 'good practice' • Referrals to Secondary care – indicating where a welsh speaking patient/family would prefer a consultation through the medium of welsh • Practice leaflet –include information about communication needs and ability to ask for a copy in Welsh. • Identifying welsh speaking staff Bilingual element on the Cluster Website • Consider an initial bilingual greeting as part of telephone message • To work with the UHB to provide training for staff • Bilingual signage and information available	
4c	Introduction of sensory loss equipment across the Cluster	GP practices Dentists Optometrists Pharmacists Cwm Taf UHB Equality team and Sensory Loss Manager			Roll out of sonidos hearing loop systems across primary care premises by UHB Sensory loss manager –plus supporting posters, information and training. Practices to display posters	

Strategic Aim 5: Service development and liaising with secondary care leads as appropriate

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG rating
5a	Named consultant for diabetes	Secondary care diabetes leads	December 2017	Improved management of diabetes resulting from more immediate access to advice by GPs	Initial presentation given to cluster by secondary care – waiting for rollout. Contact has started to be made with practices. Most practices have confirmed that they are now working with a named consultant	
5b	Respiratory incentive scheme	Secondary care respiratory lead Cwm Taf Heath Board medicines mgt. team	March 2018	Improved management of respiratory conditions	Initial presentation given to cluster leads by secondary care – waiting for further details.	
5c	Management of AF patients in primary care	Public Health Secondary care AF lead	March 2018	Improved management of AF conditions	Initial presentation given to cluster leads by secondary care – waiting for further details. Update from PHW - Cwm Taf Stroke group has received funding from the national stroke plan to undertake a small pilot working in collaboration with primary care to look at the management of patients with atrial fibrillation, with a particular focus on reducing stroke risk. Tonypandy practices were chosen as a pilot based on data identifying this as a 'hotspot' area for stroke	
5d	Memory clinic services within practice	CNS memory nurses	March 2018	Improved and more timely access to memory clinic	An initial proposal has been made to the cluster for CNS memory nurses to work within practices. More detail is required together with	

				services within the community	responses to some concerns raised before a decision is made on whether to proceed with this proposal. Consideration is to be given to a central clinic resource to deliver sessions from the cluster hub, with a GPwSI working alongside CNS.	
5e	To achieve Dementia Friendly status for Practices and Cluster	Cluster GP practices, opticians,dental practices and community pharmacies. Dementia Friendly Cluster hub at Dewi Sant Health Park	March 2020		GP practices to undertake Dementia Friends training – this is already in place across the practices. Where necessary staff who require training are being identified and are attending sessions being organised at Dewi Sant. Practices to also identify any additional training for clinical staff. To encourage all Primary Care Health services to arrange Dementia Friends Training for their staff.	
	To improve the management of patients with Dementia across the Cluster. To have consistent pathways and support services across cluster Work with PHW to determine prevelance				The Dementia Delivery Plan has enabled Dementia support workers available to each Locality and work is ongoing to up skill GPs in early diagnosis.	
5 f	To work in partnership with Primary	GP Practices Cwm Taf UHB Primary Care	July 2019		Meeting held with Team leader. Draft Decision guide developed – this along with information on the PCMHT services	

	Care Mental Health Team to ensure that patients are directed to the most appropriate services	Mental Health Team leaders			circulated to GP practices. Offer of PCMHT to meet with practice staff to gain understanding of services, issues to support GP decisions and most appropriate referrals.	

Strategic Aim 6: Review of quality assurance of Clinical Governance Practice Self-Assessment Toolkit (CGPSAT) and inactive QOF indicator peer review

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
6a	Peer review of inactive QOF indicators will be carried out across the cluster	Health board	March 2018	Assurance that consistent level of chronic disease monitoring and care is being maintained despite changes to measurement of QOF	First peer review carried out – second scheduled before March 2018. We were on track to complete our cluster tasks however this was stopped following the decision by the WG to suspend all QOF activity, including Cluster Activities in January 2018	
6b	Identification of key areas for improvement from each practice's CGPSAT		March 2018	Improvement in governance and quality assurance processes within practices	Each practice to identify key action points from completion of their CGPSAT for 2016/17 for discussion at cluster meeting and agreement of if and how common themes can be addressed at cluster level. Any training needs will be addressed at cluster or cross-cluster level where appropriate. We were on track to complete our cluster tasks however this was stopped following the decision by the WG to suspend all QOF activity, including Cluster Activities in January 2018	

Strategic Aim 7: General practice national priority area – Liver disease

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
7a	This pathway is intended to support the overall goal of the National Liver Plan in relation to preventing morbidity and mortality in Wales due to liver disease		March 2018	Improved management of liver disease	Implementation of this pathway was delayed due to the fact that the pathway processes were not in place despite the pathway being published. Negotiation with secondary care and pathology colleagues have resulted in a modified agreed pathway and it has been agreed that the work on negotiations will represent 2 out of the 3 required small tests of change. We were on track to complete our cluster tasks however this was stopped following the decision by the WG to suspend all QOF activity, including Cluster Activities in January 2018	

Strategic Aim 8: General practice national priority area – COPD

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG rating
8a	The pathway is intended to improve COPD care and embed recently published national guidance – Quality Standard 10 – COPD (NICE) and 'An Outcomes Strategy for COPD and Asthma (Dept. of Health, England_		March 2018	Improved ability for patients to be involved in and manage their own care, through increased confidence, inhaler technique and understanding of how to help themselves using self-care documentation and action plans	Work underway to complete the required small tests of change under the PDSA cycle methodology. We were on track to complete our cluster tasks however this was stopped following the decision by the WG to suspend all QOF activity, including Cluster Activities in January 2018	

Strategic Aim 9: General practice national priority area – mental health and wellbeing

Note that the cluster is not adopting the mental health pathway specified by the health board but is using its own pathway.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG rating
9a	Implementation of MIND active monitoring will form part of this clinical pathway – see 9b. The cluster will need to specify the pathway and required small tests of change.	Non-clinical cluster lead Health Board Clinical lead	September 2017	See 9b below	Pathway has been drafted by the cluster, agreed by the health board and rolled out to all practices. Work is underway to complete. We were on track to complete our cluster tasks however this was stopped following the decision by the WG to suspend all QOF activity, including Cluster Activities in January 2018	
9b	Pilot the MIND active monitoring scheme in cluster practices for patients with mild to moderate mental health issues	MIND Cwm Taf health board	Funding in place until 31 March 2018	• Quicker access to service / talking therapy than accessing a GP appointment • Co-ordination with other services e.g. MIND counselling, PCMHS	Practitioners in place in all practices. Evaluation and monitoring systems in development through practice guidelines / templates. Funding has been applied during 2017/18 to extend the service to 16-18 year olds and this service will be implemented in Q4. Full service continued in 2018/19. Improved referral process to PCMHS.