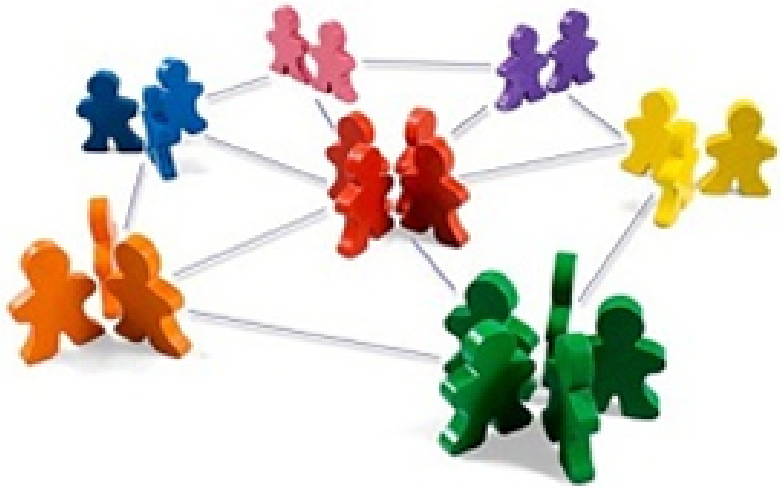
Three Year Cluster Network Action Plan 2017-2020

North Pembrokeshire Cluster



The Cluster Network[1] Development Domain supports GP Practices to work to collaborate to:

- Understand local health needs and priorities.
- Develop an agreed Cluster Network Action Plan linked to elements of the individual Practice Development Plans.
- Work with partners to improve the coordination of care and the integration of health and social care.
- Work with local communities and networks to reduce health inequalities.

The Cluster Network Action Plan should be a simple, dynamic document and should cover a three year period

The Cluster Network Action Plan should include: -

- 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
- Issues for discussion with the Health Board

For each objective there should be specific, measureable actions with a clear timescale for delivery.

Cluster Action Plans should compliment individual Practice Development Plans, tackling issues that cannot be managed at an individual practice level or challenges that can be more effectively and efficiently delivered through collaborative action.
This approach should support greater consistency of service provision and improved quality of care, whilst more effectively managing the impact of increasing demand set against financial and workforce challenges.

The action plan may be grouped according to a number of strategic aims.

The three year Cluster Network Action Plan will have a focus on:

[1] A GP cluster network is defined as a cluster or group of GP practices within the Local Health Board's area of operation as previously designated for QOF QP purposes

(a) Winter preparedness and emergency planning.

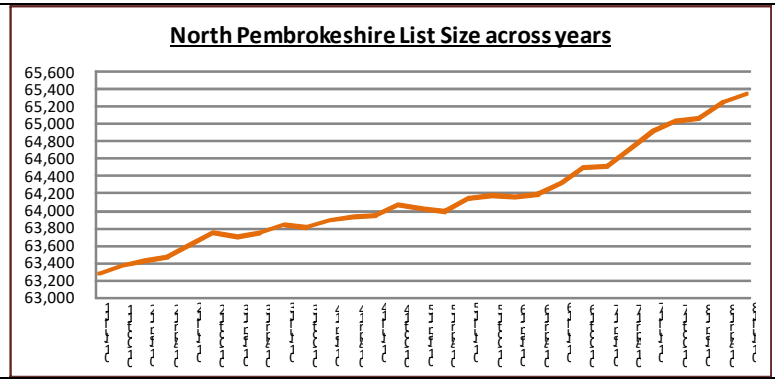
(b) Access to services, including patient flows, models of GP access engagement with wider community stakeholders to improve capacity and patient communication.

(c) Service development and liaising with secondary care leads as appropriate.

(d) Review of quality assurance of Clinical Governance Practice Self Assessment Toolkit (CGSAT) and inactive QOF indicator peer review.

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to date	RAG Rating
1	To review the needs of the population using available data	Local Public Health Team Public Health Observatory	September 2017	To ensure that services are developed according to local need	The Cluster serves a population that is older than the Welsh average. This is potentially the greatest impact on primary care due to more chronic illness that will need active management. The chronic condition burden is comparable to other clusters within the Health Board area but varies against the all Wales average.	
					There are no stand out issues areas of chronic disease management but some practices within the cluster with prevalence for COPD, Diabetes and Heart Failure being higher in some GP Practices.	
					The Cluster is in line with the Health Board average for patients 65+ and 85+ but is higher than the Welsh average for both age groups.	
					The list sizes across practices within the cluster continues to grow – see graph below:	

						
					In September 2013 approval was granted for 720 new homes to be built in Haverfordwest, whilst building work has not yet commenced the two town practices have expressed their concern with regard to their capacity for additional patients alongside the current recruitment difficulties.	
					Individual practice populations range from 2,500 to 14,500.	
					The locality is a tourist area with a population that significantly increases during the holiday seasons.	
					There is little mixed ethnicity within the cluster.	
					Deprivation at 8.4% is less than the Welsh average but his higher than the Health Board average.	
					55.7% of the population are considered as living in a rural area. There is a 29 mile distance between the most northerly & most southerly practice within the cluster. It takes approximately one hour to travel this	

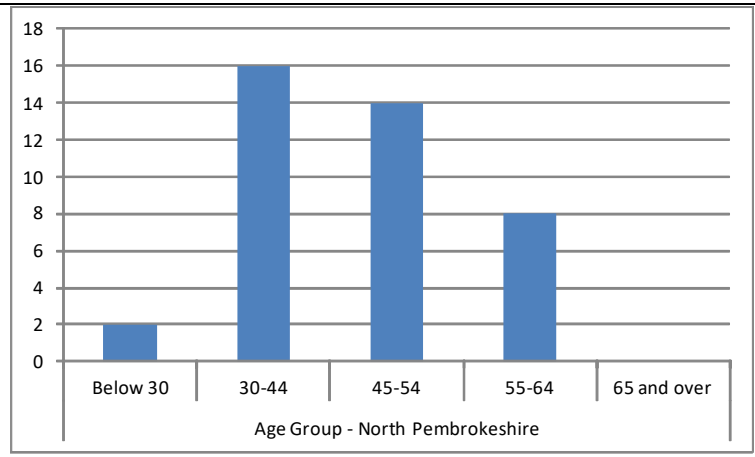
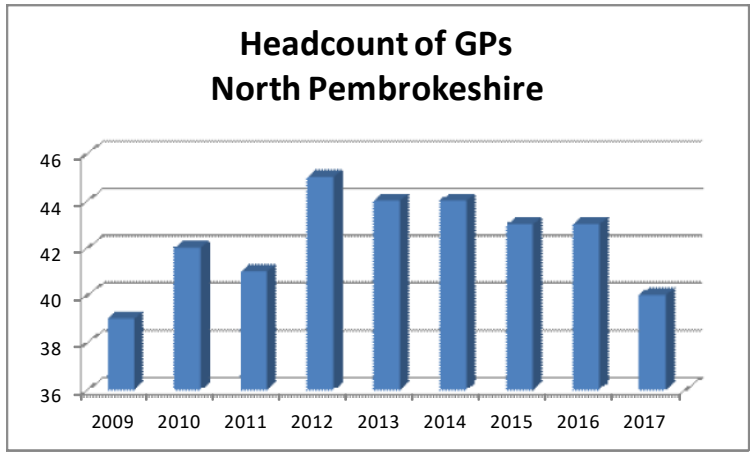
					journey.	
					Public Health Wales have a standing agenda item on each cluster agenda.	
2	Welsh Language	Practices / HB	Ongoing		2/9 practices have a bi-lingual patient registration form, 1 /9 practices had a bilingual practice leaflet and 1/9 practices had a bilingual website. All practices have at least one member of staff who speaks Welsh.	
3	Syrian Refugees	Practices/HB/LA	Ongoing		To date four Syrian Refugee families have settled into North Pembrokeshire. Work to provide services to meet the needs of the patients and to integrate them into the community is ongoing between the Local Authority, the Health Board and practices where the patients are registered.	

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

<table>
<tr><th>No</th><th>Objective</th><th>Key partners</th><th>For completion by: -</th><th>Outcome for patients</th><th>Progress to Date</th><th>RAG Rating</th></tr>
<tr><td>1</td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>Barlow House</td><td>24</td></tr>
<tr><td>Robert Street</td><td>73</td></tr>
<tr><td>St Thomas</td><td>75</td></tr>
<tr><td>Winch Lane</td><td>28</td></tr>
<tr><td>Solva</td><td>69</td></tr>
<tr><td>St Davids</td><td>33</td></tr>
<tr><td>Goodwick</td><td>87</td></tr>
<tr><td>Fishguard</td><td>41</td></tr>
<tr><td>Preseli</td><td>67</td></tr>
</table>

The table above outlines North Pembrokeshire GP Practice scores based on the Welsh Government sustainability framework which provides a weighted score against a risk matrix. The outcome of the risk assessment matrix score has been set as follows:
- High risk of unsustainability > or = 80
- Medium risk of unsustainability >55 -79
- Low risk of unsustainability <55</td><td></td></tr>
<tr><td>2</td><td>To review current demand and</td><td>GP Practices Patient Participation</td><td></td><td>Services to be developed to reflect local</td><td>Consultation rates are increasing along with telephone consultations and nurse contacts. Some practices report a significant increase.</td><td></td></tr>
</table>

	capacity	Groups CHC Social Services DNs County Team		need.	All practices within the Cluster are meeting the Welsh Government Tier 1 target where appointments with a GP or a Nurse are offered after 5pm on 2 or more days per week. 8/9 practices within the Cluster are meeting the Welsh Government target where practices have theirs doors open to patients for a minimum of 47.5 hours per week.	
					Six practices within the Cluster have implemented My Health Text with some Practices reporting a reduction in their DNAs.	
2	My Health Online	Practices	Ongoing	Additional way to access appointments	7 out of the nine GP Practices have implemented My Health Online. All seven are using it for repeat prescribing and four are using it for appointments.	
					In 2017 20% of the GPs working with Hywel Dda Health Board are aged 55 and over. In North Pembrokeshire the age group of GPs is as follows:	

						
					 This is a reduction of 3 GPs to the previous year.	
					Taking into consideration the increasing workload for GP Practices within the cluster, as well as increasing list sizes combined with the age of the	

					current GP workforce, the number of GP and Nurse retirements currently being experienced and the current recruitment difficulties means that general practices within North Pembrokeshire are all experiencing sustainability issues. This is a real threat to the viability small rural practice. All of the above are contributing to patients experiencing a longer wait for a routine appointment.	
					There is a shortage of locums working within the area and the cost of employing a locum has increased significantly.	
					Practices with vacancies are engaging with the Health Board in their recruitment campaigns.	
					The Cluster has nine GP Practices, one is a Health Board managed Practice and two are single handed Practices.	
	Recruitment	Practices/ HDUHB			**Discussion at the North Pembrokeshire Cluster Development day identified this as a priority:** Actions agreed: • Ensure Health Board include primary care in recruitment/ education sessions • Encourage / support GP Practices in taking medical students – discussion at Cluster • Begin discussions with Elaine re secondary care jobs for GP trainees (capacity)	

					• Nurse Practitioner training for primary care for training program community integrated team – establish cost to practice to support nurse and expenses	
	Skill mix	Practices / HDUHB			**Discussion at the North Pembrokeshire Cluster Development day identified this as a priority:** • Review DN Service provision for Solva & St Davids Surgery • Develop ART role to support limited capacity of DN and other teams • Improve provision by Social Care agencies – lack of provision in North Pembrokeshire – to help patients stay living in their own home	
3	Training	Practices	Ongoing		The vocational training scheme is full for 2018. Between the training practices within the locality students are accepted for Year 2, 3 & 4 and come from both Cardiff and Swansea University.	
					All GP Practices now have wifi installed The cluster had purchased Vision 360 and Vision Anywhere - Vision 360 was a shared patient record and appointment system which will, in the initial stages be used only by projects established with the cluster ie the Cluster Pharmacists and the Home Visiting Service. Data Sharing Agreements have been signed and submitted by all practices. In addition Vision Anywhere will allow clinicians to view patient records whilst undertaking a home visit with any amendments to the record updating the patient	

					record as soon as the device hits 3G or an internet connection.	
					There have been significant difficulties in getting both the software and hardware to work efficiently for both the practices and the Home Visiting Service and work was ongoing to resolve this. Practices confirmed that due to the issues in establishing the project and the slowness of the service they had been unable to use or rollout the project and notice on the contract has been served and the project terminated.	
	Clinical Records – Community staff accessing, sharing and updating systems	GP Practices HDUHB			**Discussion at the North Pembrokeshire Cluster Development day identified this as a priority:** Actions agreed: • Organise access to clinical system and provide training for community staff • Check data sharing agreement to ensure it covers community teams entering and seeing patient data • Talk to IT regarding access on Health Board systems for Vision • Set up a SWOT group with 1-2 operational users to analyse the benefits, risks and function of either 1. Community Teams using Vision 2. Using share point which is shared and pilot preferred approach in Fishguard team.	
	PT4L				A PT4L protocol for North Pembrokeshire was being developed and will be circulated to all members for	

					approval.	
	Training for Administrative Staff				Funding has been secured to run a course for both North & South Pembrokeshire Practice staff to access training in the form of a course entitled “Certificate in Communication and Signposting in Primary Care”. The Wrexham Glyndwr University has been running a diploma course for Primary Care Practices in mid and North Wales for the past two years. The course, which was planned in conjunction with their local GP practices and Clusters in the area, runs for 4 weeks and seeks to develop staff core skills and knowledge in regards to the patient experience, the integration of Health and Social Care and social prescribing/signposting. The North and South Pembrokeshire Cluster’s have brought this course to Pembrokeshire for the benefit of all practice staff. There has been no cost to practices and while the course is directed towards reception staff, we anticipate that is may appeal to reception and admin staff or assistant managers, in fact anyone involved in administration for General Practice. Feedback from participants has been very positive.	
					Following the success of the above course the cluster has accessed Pacesetter funds to provide	

					the following training: **We can't NOT Communicate -** This programme is specifically created for healthcare staff, to improve patient experience and, in so doing, to improve the experience of staff too. The workshop will help participants to: - Understand the power of our thoughts and language in creating connection with patients; - Gain the confidence and trust of patients through building rapport and active listening; and - Feel confident in handling difficult conversations and behaviours.	
	General training				Each practice within the cluster received £400 towards training in 2018/18. This was used for various courses including nurse training, data protection and webinars for GP and practice staff.	
4	Patient Engagement	Practices / HB	Ongoing	Enable better engagement with patients	St Thomas Surgery & Preseli Practice both have an established Patient Participation Group.	
5	Working across all primary care contractors	HB/Practices/ Community Pharmacy	Ongoing	Increased access and integrated working	The Common Ailment Scheme was now running in 12/17 Pharmacies in North Pembrokeshire. The remaining five would be live by the end of September 2018.	
6	Networking arrangements	Practices	Ongoing	Increased collaborative working	The IUCD networking arrangement within the Cluster continues. PDPs included details of practices exploring the opportunity to provide	

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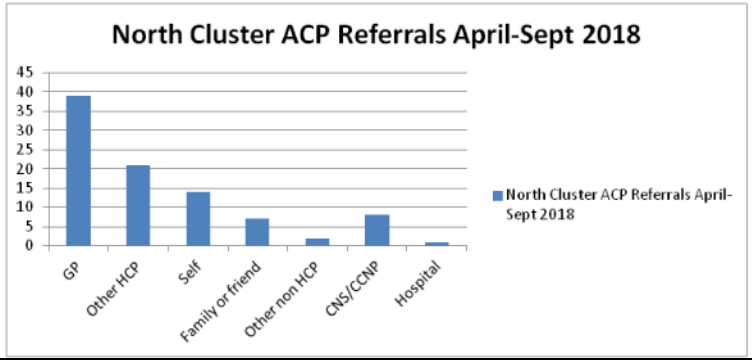
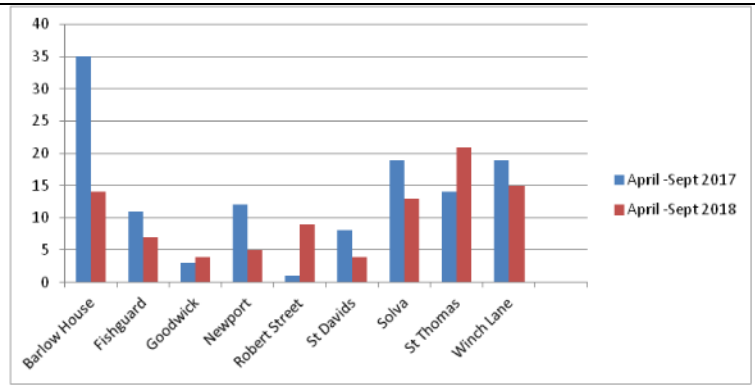
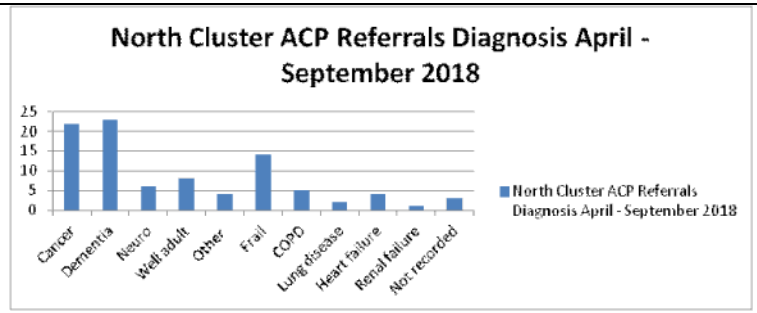
<tr><td></td><td></td><td></td><td></td><td></td><td>networking arrangements for insulin initiation and joint injections. To be moved forward on a cluster level.</td><td></td></tr>
<tr><td>7</td><td>Cluster funded projects</td><td>Practices/HB</td><td>Ongoing</td><td></td><td>The Cluster funded projects for 2018/19 are:

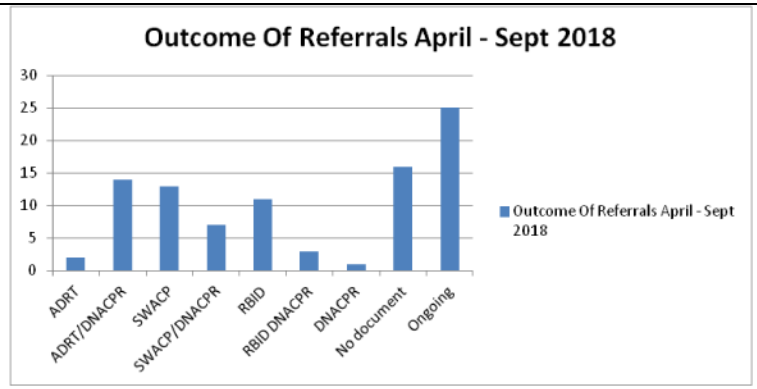
Cluster Pharmacists – feedback from Practices were that the posts were assisting with sustainability and were a valuable resource. Both Pharmacists would provide update reports to their practices on work undertaken.

The two Cluster Pharmacists have reported activity for 2018/19 as follows:
<table><tr><th></th><th>Q1</th><th>Q2</th></tr><tr><td>Reauthorisations</td><td>1,168</td><td>912</td></tr><tr><td>Acute medication requests</td><td>151</td><td>464</td></tr><tr><td>Medication reconciliation from secondary care</td><td>230</td><td>791</td></tr><tr><td>Face to face appointments</td><td>23</td><td>60</td></tr><tr><td>Total quantifiable patient contacts</td><td>1,967</td><td>2,227</td></tr></table>
In addition to the above additional project work has included the following:

• NOACs – reviewing patient lists, prioritising patients to recall and reviewing bloods
• Valproate safety alert – calling in patients and referring to secondary care.
• Flu training</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Advance Care Planning – Continuation of the project to assist practices in identifying people for whom ACP might be most urgent and relevant, and</td><td></td></tr>
</table>

					working with those patients to complete ACPs. This project aims to ensure that patient's maintain their dignity and autonomy while being offered support with care directed by the patient's wishes. • Advance Care Planning – 195 new referrals & total number of contacts was over 1,000 (12 months) • 81% increase in Advance Care Plans from previous year A business plan was in the process of being developed to put forward to the Health Board to enable this service to be core funded. From April to September 2018 there have been 92 new referrals (122 referrals, Q2 2017 and 58 referrals, Q2 2016) 	
					North Cluster Referrals by Practice	

						
					 **Average age at referral: 83** **Range of 52-98**	

					 We have started gathering evidence with regards to the outcome of our referrals to the Advance Care Planning Service. In total there were 16 planners that we were referred that did not complete a document. Generally for the no document outcomes the reasoning for these are either that the referral came to our service too late and we were unable to see the planner before they died or because the planner did not wish to continue.	
					Pembrokeshire Counselling Service – Continuation of the project to fund the running costs of Pembrokeshire Counselling Service enabling it to continue in its primary stated aims of providing free counselling for people living in Pembrokeshire and thereby ensuring continued and easy access for referred patients from Hywel Dda Health Board services.	

					In 2017/18 Pembrokeshire Counselling service received 299 referrals, had over 1,000 patient contacts and provided counselling for 229 patients with a further 90 patients signposted to alternative services	
					Home Visiting Service - The cluster invested in a three month pilot to run an Acute Home Visiting Service to address an element of GP workload. The pilot was extended for a further three month via Prescribing Management Savings. The aim of the pilot was to release practice capacity for other work, and develop shared clinical services across practices. Visiting is a demand on practice resources because of rurality and ageing population. The pilot, which runs from January 2017 too July 2017, aims to establish if organisational barriers can be overcome and if further work is worthwhile. Visits will be carried one day per week for the pilot by a locum GP and an Advanced Paramedic Practitioner. The pilot will be evaluated fully upon completion. During the North Pembrokeshire Sustainability Event held in June 2017 it was fed back that a cluster home visiting service was felt to be a very valuable service but that the current model was unaffordable to practices. Alternative models would be discussed within the cluster.	
					Preliminary talks had taken place with the County team with a view to them extending the ART team by employing an ANP to provide the acute home	

					visiting service. It was noted that the current staffing would not have the capacity or skills to pick up this roll but it would be possible to achieve with recruitment. This would also allow the ART team to up skill their current remit and roles. A draft Job Description had been produced and sent to the County Team.	

Strategic Aim 3: Planned Care- to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Minimising waste and harm	GP Practices/ HB	Ongoing		Discharge summaries from secondary care continue to be a cause for concern to primary care. Whilst the average length of stay had reduced from 80 plus days to around 10 days GP Practices still report that discharge summaries continue to be delayed and are often illegible. MTED has been piloted within Withybush General Hospital and has now implemented on three wards. Practices felt that the rollout of MTED needed to be expedited to cover the whole hospital as a priority. The Cluster have fed back to secondary care that as a minimum they require every discharge summary, whether paper or electronic, to include a list of new, stopped or changed medications.	
2	Collaborative working	GP Practices/ HB	Ongoing		A number of Advanced Paramedic Practitioners are working with GP Practices as part of the Primary Care Support Team. The roles are undertaking home visits and seeing acute on the day presentations.	
3	MDT Working	GP Practices / County	Ongoing	Improved integrated care	A three month pilot of practice based MDT meetings with the GP is being undertaken from Jun to August	

		Teams / Social Services			2017 in Solva/St Davids with representation from Social Services, OT, Physio, DNs, CCNPs & CPNs, Third Sector. Practices will identify patients who would benefit from a multi disciplinary approach to prevent admission. Should the pilot be successful the model will be rolled out across Pembrokeshire. The pilot was deemed very successful and the MDT meetings have continued to run following the end of the pilot. Solva & St Davids GP Practices were part of the team shortlisted for an NHS Award for their work on the pilot project. A Pacesetter funding bid has been submitted to rollout the MDT working across practices within the locality and will be established in Winch Lane, Barlow House and Fishguard Surgeries should the bid be successful. This would be open to any other practice should they will to become part of the project.	
	Falls / Frailty	GP Practices WAST 3rd Sector Community			**Discussion at the North Pembrokeshire Cluster Development day identified this as a priority:** • Falls framework – WAST Framework with three tier response o Level 1 – non injury falls – explore options for PIVOT response o Level 2 – possible injury – need further assessment, could include OT / Therapist o Level 3 – injury – WAST response • Develop (or revisit) falls pathway for non injury	

					falls • Ensure co-ordinated approach to all falls • Prevention of falls – everyone • Links to MDT meetings The following actions were agreed: • WAST framework to be shared • Task & Finish Group established to scope / revisit falls pathway with membership from GPs, WAST, Locality Managers, OT Therapy Team, Head of Community Nursing, 3rd Sector & A&E. • Explore options for level 1 response • Explore options for level 2 response • Presentation to County Management Team • Known fallers to be discussed at MDTs.	
	Referral forms	HB / Practices	Ongoing	Improved efficiency of electronic referral system	Concern raised by GP Practices within the cluster over the difficulty in referring patients into secondary care services due to increasing number of referral forms. The electronic referral system requires streamlining. Kate Iceton, Service Improvement Manager, had attended the Cluster Practice Managers meeting and reported that that WCCG could be used for electronic referral into 33 specialities. It was also reported that had over 80 different referral forms had been identified in paper format. Urology would be the next speciality to be added to WCCG. Practice Managers agreed to encourage the increased usage of WCCG.	

					Kate to email out guidance.	
	Flu	GP Practices / Health Board/ Public Health		Increased uptake in immunity To be updated	2017/18 PHW reported uptake of flu vaccinations:	
				To be updated		
				To be updated		
					Practices felt that the changes to the flu vaccination programme in 2018 with three different types of flu vaccination for different age groups with short supply of vaccines will make the delivery of flu more difficult than in previous years. Flu clinics would need to be arranged later than normal.	
	Cross cover between GP Practices	GP Practices	Ongoing	Sustainability of Services	Six GP Practices within the Cluster provide cross cover – Fishguard & Goodwick and Barlow House & Robert Street cover each other between the period of 8am & 8.30am and 6pm & 6.30pm on a rota basis. Solva & St Davids cover each other between the period 6pm & 6.30pm	
	Community based education programmes	HB/Practices	Ongoing	To improve healthy living	A number of patient education programmes run within the community which Practices refer into. These include Self Management for chronic diseases such as COPD and Diabetes, X-Pert Programmes for Diabetes, Foodwise and Stress Control.	
	Community Optometry	Practices / local Optometrists		Integrated service with seamless provision for	Andy Britton is the Local Representative for Community Optometrists for the Cluster. Details of free training which could be made available to GP	

				patients	Practices for their receptionists with regard to triaging out eye care problems to the Optometrists had been provided by Andy and shared with practices. Andy confirmed that he would become an Independent Prescriber later in 2018 and proposed that rather than him writing letters to GPs to request that they prescribe a medication for a patient that he could write a prescription for ocular conditions without recourse to a GP if he had access to a prescription pad. Clarity was sought on whether access to a prescription pad could be made possible and link with Shared Services.	
	Community Pharmacy	Practice / local pharmacy		Integrated service with seamless provision for patients	Phil Parry is the Local Representative for Community Pharmacists. Phil is also the Chair of Community Pharmacy Wales. A meeting was held on 22nd November between the Cluster and Community Pharmacists from across North Pembrokeshire. Issues raised **Discharge Summaries** Discharge summaries were raised as an issue by the	

					Community Pharmacists, this is an ongoing issue noted within the Cluster action plan. It was agreed that concern would again be escalated with regard to the length of time to receive a discharge summary, the illegibility of the discharge summaries and also to request a timeframe for the rollout of MTED across the rest of WGH. A request would also be made to secondary care pharmacy staff to reiterate to patients to give letters to their GP Practices ASAP and also to notify their pharmacist. It was noted that patients discharged from Morriston had one letter for their GP Practice and one letter for their Community Pharmacist. No discharge summaries were received by Community Pharmacy for patients discharged from South Pembs Hospital. **Common Ailment** Discussion took place with regard to a communication slip being devised for the Pharmacist to refer a patient back to the GP if they had been assessed and deemed not appropriate for treatment via the common ailment scheme. It was noted that activity figures were available. Training would be provided for GP Practice receptionists on the scheme and what was appropriate for referral.	

					IT Query to be put forward to Vision as to whether Pharmacists could action Priority 1's and medication/allergies via IHR for all patients not just those for common ailments. **Repeat Scripts** It was requested that Pharmacies give patients the repeat slips rather than retaining them as they often had messages which should be relayed to the patient.	
	Voluntary Sector			Better availability of information to enable patients to be aware of and access additional services.	Strengthen relationships with the voluntary sector and increase knowledge of voluntary sector services available to the North Pembrokeshire population. Community Connectors in post and working from some GP Practice premises. Continued increase in referrals to the Paul Sartori Foundation who work with patients to implement Advance Care Plans – see end of life section.	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Improve co-ordination of care	Practices/ HB	Ongoing	Integrated service without delays in treatment	GP Practices within the cluster continue to report requests from secondary care to primary care to perform additional tests and investigations, chase referrals, organise referrals, refer onwards and follow up on results when these actions should be carried out by the Consultant requesting the action. This results in a time delay for actions being taken and is putting an additional workload pressure on practices.	
	Chronic Conditions Management in the Community	Practices/ Community Teams	Ongoing		Practices who have regular access to the Chronic Conditions Nurse Practitioners report that they are making a difference in modifying GP contact with the most complex of patients thus reducing the frequency of revisiting rates	
					There has historically an inequity of service provision across the Locality with two practices having no access to this service and others reporting low access. With ongoing financial challenges facing the health board coupled with a lack of additional resources to meet this increased demand, it has been necessary	

					to review the existing service provision currently being offered across other practices and localities as it was clear that additional service provision could not be achieved without capacity being created. In view of this and in order to provide a more equitable service for all patients living in Pembrokeshire, there was a need to review the current referral criteria as well as undertaking a review of whether some current long term and more 'stable' patients on the ANP caseloads were suitable for discharge back to their GP / Practice Nurse. This would allow the ANP service to direct their skills and expertise towards patients who are 'unstable' or at risk of recurrent and avoidable hospital admissions as well as those patients who require intensive case management across the whole of Pembrokeshire.	
	Lack of mental health services within the Locality	Practices/ HB	Ongoing		Mental health consultations are now a large proportion of GP contacts due to a lack of community mental health services and results in the GPs having to provide additional consultations, reviews and lengthy consultations in order to provide reasonable and safe care. The Locality is aware of the current consultation for the transformation of Mental Health Services within Hywel Dda and will continue to support the service.	
	Request for review by paramedic	Practices/ WAST	Ongoing		There is a growing unease with GPs as they reported that the Ambulance Service were increasingly calling and asking for patient review. These can be delayed	

					until a post surgery review, which could be up to three hours and there was a question of responsibility for the patient during this time.	
	Joined up working with Out of Hours Service	Practices/ OOH	Ongoing	Integrated service with seamless provision for patients	Continue to strengthen communication with Out of Hours Service, notifying OOH of DNACPRs Practices encouraged to write up a PRN	
	MDT working	Practices/ HB/LA	Ongoing	Improved integrated care	The Solva/St Davids pilot was deemed very successful and the MDT meetings have continued to run following the end of the pilot. A Pacesetter funding bid has been submitted to rollout the MDT working across practices within the locality and will be established in Winch Lane, Barlow House and Fishguard Surgeries should the bid be successful. This would be open to any other practice should they will to become part of the project.	
	Business Continuity	Practices	Ongoing		All Practices have Business Continuity Plans in place which cover all aspects of winter planning such as flexible timetabling of doctor and nurse cover to ensure there is enough capacity to meet an increase in demand, promoting the uptake of flu vaccinations with staff members and ensuring all methods of access to medication and repeat prescribing are available.	
	Flu	Practices / HB	Ongoing		Ensure seasonal flu planning undertaken in timely manner with flu clinics well advertised.	

	Wider health community	Primary Care / HB	Ongoing		Patients with non-urgent medical problems to be encouraged to use the full range of services available including Community Pharmacy, Community Optometry and Community Dental services.	

Strategic Aim 5: Improving the delivery of dementia & early referral of cancer

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Cancer	GP Practices / Health Board	March 2018		Improved referrals Cancer diagnoses and new diagnoses reviewed at clinical meetings. Ongoing review of cancer care carried out at educational MDT meeting ensuring that all staff are aware of potential signs, symptoms and awareness of at risk groups. NICE guidelines shared with all GPs. Development of protocols, contact data sheets, referral pathways and a directory of resources Increase awareness of pancreatic cancer in the over 60s with non specific symptoms. Improved recording of and coding of USC referrals made rather than the diagnosis only, continue to review data from referrals and where referrals are down graded review these with referring clinician. WCCG referrals do not READ code into the clinical system which means that practices have to keep a register.	

					Lifestyle Advocates working with patients to promote awareness and general advice such as smoking and alcohol risk factors Promotion of screening programmes Use of websites, notice boards, Facebook and display initiatives, including the recent patient awareness regarding persistent coughs and the need to see a doctor Waiting lists for USC had improved with a vast reduction in the number of down grading of referrals. Delay in receiving USC lists from Health Board – occasionally up to a month. Highlighted to the Informatics Team. Always suspect the rare! Normal x-rays should be repeated if symptoms don't clear. Practices participated in the Lung Cancer awareness campaign and have linked with secondary care colleagues to arrange requested blood tests at point of referral to the Rapid Access Lung Cancer Clinic. It was reported that the number of lung cancers in non-smokers had increased.	

					Practices fed back positively on the Rapid Access Lunch clinic and reported that they felt it was the best service for cohesiveness. The Clinical Nurse Specialists reported that having practices use WCCG was working well with regard to secondary care receiving referrals and that referrals were now graded daily.	
2	Dementia	GP Practices / Health Board	March 2018		Improved dementia care Training sessions undertaken, raising awareness ensuring all staff have a role in identifying dementia. Review of flu uptake to ensure patients are protected, particularly those in care homes. Improvement in consistent coding of patients presenting with memory problems and dementia diagnosis. New Care Home DES providing resource to facilitate dementia review in care homes. Increased read coding for all carers especially for all those in a nursing home. Continued referral into Paul Sartori Foundation for Advance Care Planning	

					Additional support required by Practices included increased public awareness; breaking down social stigmas, additional capacity for the Community Frailty Team or introduction of CCNP for Dementia, access to full dementia service in Pembrokeshire.	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	End of Life	Practices/HB/Paul Sartori	31st March 2018		Palliative care was provided well in Pembrokeshire. Practices have up to date and accurate end of life care registers which are continually increasing. Palliative Care Registers historically were predominantly patients with cancer diagnoses but now also include patients with COPD, heart failure and dementia. Each practice has a named lead for palliative/end of life care. Regular MDT meetings are held as well as training and education sessions. There are systems in place for practices to notify Out of Hours to flag patients who are approaching end of life. Practices continue to increase the use of Advance Care Plans which are beneficial for patients and staff.	

					Continue to involve Paul Sartori Foundation and MacMillan in the end of life scenario which as been found to be very useful. The majority of patients died in their place of choice. Patients who were admitted tended to have an acute or unplanned admission. It was noted that preferred place of care is well recorded however concern remains that there are limited options for patients – hospital or home; this is why it is believed there are still many admissions. 29% of Pembrokeshire Patients had died at home and 52% had died in their normal place of residence. This was the second highest rate in Wales. The number of patients with an Advance Care Plan in place had increased significantly. Better uptake of DNACPR, this was thought to be related to the ACP cluster project which was valued by practices. Practices welcome the Fast Track discharge for palliation but feel that communication and patient preparation at discharge remains problematic. Family members were not always well informed or aware that patient may die when discharged,	

					predominantly via Fast Track. Conversation had often not been undertaken within the hospital prior to discharge. Practices would value further work with Nursing & Residential homes and there are still cases of homes admitting patients via 999 calls despite clear and extensive ACP plans. Practices had reported during the year that they were not receiving cause of death notifications from the hospital. An audit was undertaken and the situation had greatly improved. Notifications now scanned by GP Practice to patient record.	
					Continuation of the Paul Sartori ACP project to assist practices in identifying people for whom ACP might be most urgent and relevant, and working with those patients to complete ACPs. This project aims to ensure that patients maintain their dignity and autonomy while being offered support with care directed by the patient's wishes. In the period October 2016 to September 2017 Paul Sartori Foundation have reported that they received 195 new referrals. The average age was 78 with the ages ranging from 29 to 100 years old. The total number of contacts was just	

					over 1,000 with 221 clients – this was an 81% increase on the previous year. The biggest referrers into the service were GPs (37%). Self and family referrals were the second highest at 30%. Other' referrers were a wide range of CNSs, social workers, therapists and hospital doctors. At the outset of the project, most of PSF's work was with people who still had mental capacity to produce an ACP document. These were either a Statement of Wishes and Care Preferences (SWACP) or an Advance Decision to Refuse Treatment. Over the last year, they have reported that there has been an increasing demand to facilitate and record 'best interests' discussions for people without capacity. It is believed that this was due to closer working with care homes and the local Marie Curie Dementia Senior Nurse.	

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

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Downgrading of USC referrals	HB / Practices	Ongoing		Previously practices were not informed if a referral had been downgraded. Practices now receive weekly USC referral reports electronically confirming whether USC referrals have been downgraded, upgraded or upheld. In early 2017 reports had not been issued regularly, this issue has been highlighted and reports have recommenced on a weekly basis.	
2	Improve communication	HB / Practices		More streamlined service	HB to improve communication with Practices to ensure they are consulted upon and are aware of service changes. Reduction in staffing levels due to retirements and relocation of staff meant that Practices were experiencing a difficulty in linking effectively with secondary care to access advice, often communication was difficult and waiting for feedback had an impact on ongoing patient care.	
3	Datix	HB / Practices		Effective clinical care	Continue to report incidents on Datix	
4	Notification of death in hospital	HB / Practices	Ongoing		Practices reported that they continue to experience delays in receiving notification of deaths from the hospitals. When they are	

					received they often have not details for the reason of death included. Dr Burrell to feedback and liaise with secondary care colleagues.	
5	To review quality assurance of the Clinical Governance Practice Self Assessment Toolkit (CGSAT) and the inactive indicators in the QOF Peer Review.	Practices	March 2018	Quality of clinical care	All practices will update the Clinical Governance Practice Self Assessment Toolkit. Practices will peer review inactive QOF indicators for discussion at cluster meetings mid way through the year and at year end. The review will be shared with the Health Board and any appropriate actions will be included in Practice Development Plans in 2019.	

Strategic Aim 8: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Leg Ulcer Service Provision	HB / Practices			As of the 1st of September 2017 all leg ulcer care has been provided by the Health Board in Community Clinics. Six clinics operate within Pembrokeshire with the clinics in the North running from Milford Haven, Haverfordwest & Fishguard. No additional funding has been secured by the Health Board to provide this service and is an additional pressure on the District Nursing Team.	
2	Practice Boundaries	HB/ Practices			To try to address sustainability issues discussions were undertaken as to whether the cluster moved forward with an application to the Health Board for GP Practices within North Pembrokeshire to remove patients living outside their boundaries on a cluster level. It was noted that practices would have to enact a blanket approach to removing patients and agree any criteria that would be excluded such as patients at the end of life. After careful consideration the Cluster opted not to submit an application on a Cluster level but noted that all practices were able to apply on their own merit.	