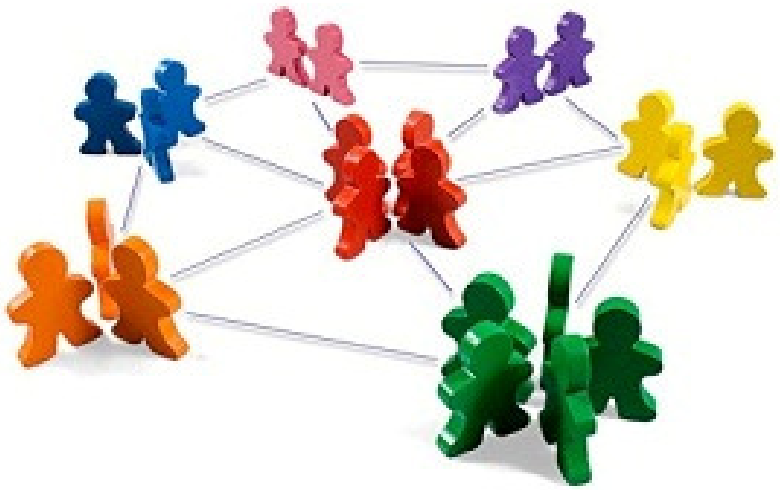
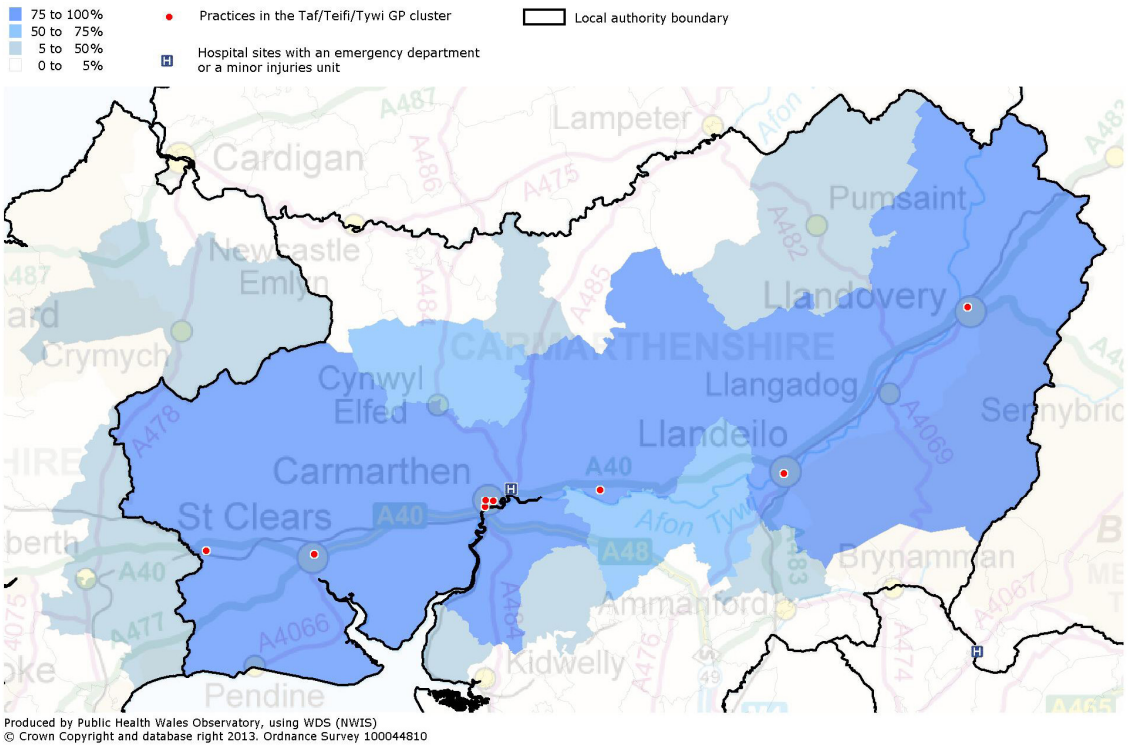
# GP Cluster Network Action Plan 2016/17

## Tywi / Taf Cluster



This plan has been developed by the following 8 practices which operate in the Tywi /Taf  Cluster:

Meddygfa Taf
Coach & Horses Surgery
Morfa Lane Surgery
Furnace House Surgery
St Peter's Surgery
Meddygfa Tywi
Meddygfa Teilo
Llanfair Surgery




We agree our main issues for the cluster appear to be:-

1. Recruitment and retention
2. Rurality
3. Capacity
4. Ageing population with multiple complex needs
5. Communication

This is the third  GP cluster network development plan that has been produced by the cluster**.**

**Outline of Cluster Population Profile**

Tywi/Taf has a registered population in June 2016 of 57,812 (a slight rise from 57,422 in 2015/16) and is the fourth largest cluster group of the seven cluster groups in HDUHB. However, on reviewing the individual practice list size for the 2Ts area in the last four years: **five practice list sizes** have increased with one practice reporting a **5% increase pa** for last three years. Three practice list sizes have decreased. From 2010 to 2014, there has been an overall increase in the number of registered patients in Wales while there has been a decrease in Hywel Dda, Carmarthenshire and the 2Ts area have both increased during this time

The 2Ts has a **significantly higher older** population at **22.1%** compared to the Welsh average of 18.7%. An older person profile heavily impacts on the work of general practice. The ageing population could lead to the need for an increase in the workforce, both clinical and administrative within the next 5 years.

| | **65yrs+** | **85yrs+** |
|---|---|---|
| **Wales** | 18.7% | 2.5% |
| **Hywel Dda** | 21.4% | 2.8% |
| **2 T's** | 22.1% | 2.9% |

Frailty, dementia and the effects of multiple chronic conditions are more prevalent in this population group and can lead to increased demand for both acute and community care services for older people, particularly those aged 85 and more.

The cluster area is recognised as a retirement option and as such imports a lot of patients with chronic conditions and illness.
There is little mixed ethnicity.

**Deprivation** in the cluster is less than the Welsh average but is variable across the area. Average social deprivation in the 2Ts is **2.2%** compared with a Hywel Dda deprivation average of 8.1% and a Wales deprivation figure of 20%. However, whilst there is a low percentage of social deprivation there is no formula for rural deprivation; also as these people co-exist with more affluent people it often has a worse effect as the deprivation is not recognised. The equations are based on urban conurbations and some practices do have patients living in small pockets of deprivation. Welsh Index of Multiple deprivation (WIMD) is not heavily weighted towards access to services – which affects people in rural areas.

**Rurality** is the biggest issue facing the cluster. **70.2%** of cluster patients are considered to be living in a rural area which is significantly higher than the Welsh average of 33.9% and the HDuHB average of 66.5%.

The geographical area covered by the cluster is 19,385km2 compared with Amman & Gwendraeth at 3,294km2 and Llanelli at just 1,189km2., this equates to **81% of the total land** mass of the county. The population is dispersed with an average of just 36 persons per $KM^2$ compared with the county at 78 persons per $KM^2$ and Llanelli locality at 521 persons per $KM^{2.}$ This can lead to problems with **rural isolation** and current projections indicate that the increase in the proportion of older people will be greater in rural areas. This will have a significant impact on local service needs and support systems across health and social care. As well as having an older age structure, the population in rural areas is by definition more dispersed leading to difficulties in respect of access to, or the provision of, services. In addition, primary care services are presented with challenges in respect of integrating the services provided for the individual, some of which are NHS based with the remainder emanating from local government.
Combined with this rural environment is a poor transport network in terms of time required to get between locations north of Carmarthen, Whitland and St Clears; much of the area north of Carmarthen has a travel time of at least **twenty minutes** and some greater than **thirty minutes** to the nearest GP surgery, clinic, or health centre. Travelling distances for health and social care staff limit time spent engaged in direct patient contact, which disadvantages the clusters as staff compliments tend to be mirrored across the three CRTs within Carmarthenshire.

The Chronic condition burden is comparable to other Cluster areas. The Welsh Health Survey reported that 82% of respondents aged 65 years and over suffered from a chronic condition, of whom 54% suffered from two or more conditions. If current trends continue the number of people living with chronic conditions will continue to increase in the future, with people living longer and developing more than one chronic condition which in turn will mean increasing numbers of patients requiring monitoring in chronic disease management clinics. Tywi /Taf has a higher disease prevalence than the Health Board average in CKD, AF, HTen, Can, LD, MH, OST, STIA & HThy. It is notable that anecdotal evidence suggestions that 2Ts have greater numbers of patients with more complex care needs.

Tywi / Taf has the second highest coverage of breast screening at 76.5% ; cervical screening at 78.4% and second highest uptake of Bowel Screening in Hywel Dda at 53.1% but this is still below the 60% target

The smoking prevalence for 2Ts is 16.7%.

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

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | To review the needs of the population using available data | Local Public Health Team<br><br>Public Health Observatory | Ongoing for cluster development | To ensure that services are developed according to local need | Review of the population needs completed as detailed above and services are being identified according to local need. Cluster funding has been invested in a Frailty project, setting up a pre diabetes screening programme, and the development of COPD+ Programme. | **G**  |
| 2. | Identification of additional information requirements to support service development needs | HB/WG/PHW /LA | ongoing | Improved service development & delivery | Learning has been identified and considered from previous analysis and it is important that interdependencies of service are recognised, services need to be robust to ensure continuity of care and ongoing sustainability.<br>**Action:**<br>There are ongoing problems with information sharing e.g. discharge summaries which need to be addressed. Work is ongoing here; some progress has occurred with the pilot on one ward per acute site of electronic discharge information through WCCG. | **A**  |
| 4. | Education and development through an agreed PLT process | HB/WG/PHW | Ongoing | A co-ordinated education and development programme will enhance practice staff knowledge and performance | Currently the HB provides protected time for learning for GPs and nurses but we do not have any administrative staff or practice manager sessions Locality sessions for GPs are held quarterly aligned with the cluster identified training and education needs and the current national priorities.<br>**Actions:**<br>▪ HB to develop process to plan PLT for all practice staff and develop other local educational | **A**  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | opportunities and provision.<br>▪ 2015-16 -Work with Cluster Practice Manger Lead to develop educational collaboration and an education plan for the cluster, utilising PMS monies as a training budget to strengthen PLT sessions for administrative and other practice staff.<br>▪ 2016-17 – The future of PLT sessions is uncertain due to the planned implementation of 111. Clarification is required from the Health Board of continued support going forward. | |
| 4. | To increase knowledge of Diabetes amongst practice staff | All Practices | March 2017 | Improved practice knowledge to assist with improved identification of patients with Diabetes | **Actions**<br>▪ 2015-16 Three diabetic training sessions were held for cluster GPs, nurses and registrars in September 2015. 83% of attendees rated the training as excellent and 17% as good.<br>▪ Link in with practice lifestyle advisor programme | G |
| 5. | Obesity - Promote healthy living and educate on benefits | WG/PHW/3rd Sector/HB | Ongoing | Improved health outcomes<br><br>Better health for those patients with chronic diseases<br><br>Improved lifestyle choices | People who are overweight face a higher risk of many health problems.<br>**Action 2014/15 –ongoing for 2016-17**:<br>▪ Practices need to be conscious of the support available to enable people to make better food choices by improving diet, increased opportunities for physical activity, etc. to help reduce the health problems - The cluster has utilised cluster funding to sign up to the PHW Lifestyle Adviser project over the next 3 years.<br>▪ Promotion of Foodwise and exercise programmes through lifestyle adviser | A |
| 6. | Promote smoking cessation services among patients | PHW | Ongoing | Healthier lifestyle choice | Smoking is one of the biggest preventable causes of premature death in the UK. It is linked to a range of serious and often fatal conditions; including heart disease and lung cancer. Currently the 2Ts has the lowest smoking prevalence at 16.7% of the seven | A |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | clusters and is ranked 9th out of the 64 GP Clusters.<br><br>**<u>Actions 2014-17:</u>**<br>▪ Practices to advise on smoking cessation where possible – ongoing<br>▪ √ PHW to provide smoking cessation training / update at GP PT4L session – attended PT4L session on 10th September 2014<br>▪ PHW to ascertain the effectiveness of smoking cessation services | |

## Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1. | To review current demand and capacity | Patient participation groups if present/CHC / HB | Ongoing | Services developed to reflect local need | Practices have developed different ways of dealing with demand to ensure best practice enabling patients to have good access arrangements and standard of service.<br><br>100% of GP practices offering appointments after 5pm on 2 or more days per week<br><br>**Actions:**<br>▪ 2014-16 - Patient Satisfaction Survey was undertaken by 7/8 practices from January to July 2015:<br>92% of respondents stated that they had access to same day / urgent availability of a doctor. 86% rated satisfaction with opening hours as good to excellent 84% rated as good to excellent the ability to speak to a doctor on the phone. A large number of respondents (539 patients) were unaware they could or had never tried to phone to speak to a GP<br><br>Some practices reported seeing an increase in the number of requests for home visits for patients that are not necessarily bed bound but who are unable to access transport. Whilst a lot of work has been undertaken in respect of transport this has previously all been focused at secondary care level. | **A**  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | ▪ 2014/15- Meeting to discuss transport, rural plan, etc. Practices were informed of the single point of literature and information literature has been disseminated to GP practices. Cluster updated on non emergency transport initiatives and as a result a transport initiative involving the third sector was piloted in Meddygfa Tywi. This involved a responsive community car service to meet the demands of frail elderly people living in remote areas accessing routine and emergency GP appointments and specialist clinics held at the Practice.<br>▪ September 2015 - Rural transport scheme has now been rolled out to Coach & Horses Surgery.<br>▪ 2016/17 - Consider further roll-out to rural practices. | |
| 2. | Establish local data collection systems to monitor trend | NWIS | | Capacity more effectively matched to local demand | 7/8 practices agreed data extraction via Audit + to give comparative and trend data to inform local planning. Some concerns have been highlighted with data accuracy and using this to plan services and developments<br>7/8 practices agreed data extraction with SAIL<br>There are however issues with data extraction which need to be resolved to ensure data is received in a timely fashion at no cost<br>**Actions 2014/15:**<br>▪ Use comparative analysis to inform local planning<br>▪ Meeting held with SAIL to discuss what information is available to the clusters - EoL report was made available to practices in February 2015. Discussed at Cluster meeting on 5.03.15.<br>▪ Sept 2015 – Cluster has purchased MSDi risk stratification tool for all practices | A  |
| 3 | Identify waste in local | Practices | Ongoing | Release more | There are numerous examples where outside | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | systems e.g. DNA appointments, Discharge Summaries, | Health Board | | capacity for patient care | influences affect productivity and patient care within practice which can take time to address or which could have been time better spent – key examples are: increasing bureaucracy, patients who DNA appointments and chasing up information on poorly completed or never received discharge summaries<br>**Actions:**<br>▪ 2014/15 Practices undertook GPC Wales data collection exercise to enable greater understanding of capacity and demand issues<br>▪ Practices to display DNA information in waiting room to encourage patients to cancel unwanted appointments<br>▪ Practices to consider writing to repeat offenders<br>▪ Health Board to encourage more timely and legible discharge summaries. Electronic Discharge Summaries are being piloted through WCCG although currently limited to one ward per acute site. | R |
| 4. | We would like improved referral management within secondary care | Health Board | ASAP | Management of patient expectations. Clarity over waiting times, reduced waits | There are numerous issues with the secondary care referral management system which impact on primary care causing a huge increase in administrative work for practice staff. In some areas referrals e.g. MSK are being sent back to GPs for onward referral – it is not sensible or appropriate to bounce back such referrals to primary care. This is time consuming for the GP and involves the patient being put onto a second waiting list.<br>Practices were not being notified when referrals were being downgraded from urgent to routine. Patients are not receiving follow-up appointments or appointments are cancelled by the hospital and not re-arranged. If such appointments were arranged it would make working administratively easier for GPs | A |

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Actions:<br>▪ √2014/15 -The Cluster wrote to the Associate Medical Director to highlight problems<br>▪ As of December 2014 practices receive a report of all patients where a referral has been changed. However, Consultants are not always prioritising patients so the report is not as useful as it could be. Patients should remain on the list until prioritised. Issued raised with Dr Collier, Cancer Lead.<br>▪ HB to notify practices if an expedite letter has altered the patient's waiting time<br>▪ √2014/15 - Improved understanding of referral processes for orthopaedic specialities - Representative from CMAT attended cluster meeting to discuss the service and clarify the referral process for practices.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>To develop local workforce development plans</td>
<td>WG/ HB/Deanery</td>
<td>Ongoing</td>
<td>Service modernisation to meet changing needs<br><br>Ensure sustainability of local services</td>
<td>Potential retirement of GPs within the cluster over the next five years is estimated to be 38.8% with the figure for practice nurses predicted to be 35.5%. It is extremely difficult to recruit and retain staff In rural areas both in primary and community care and social services – there therefore needs to be a more sustainable and robust solution to the workforce issue. The inability to recruit practice staff will impact on patient care as practices will no longer be able to provide services to meet demand.
<table>
<tr><th></th><th colspan="4">% Potential GP Retirement</th><th colspan="4">% Potential PN Retirement</th></tr>
<tr><th>Locality</th><th>≤ 1yr</th><th>1 - 3 yrs</th><th>3-5yrs</th><th>Total</th><th>≤ 1yr</th><th>1 - 3 yrs</th><th>3-5yrs</th><th>Total</th></tr>
<tr><td>Llanelli</td><td>6.3</td><td>18.2</td><td>6.3</td><td>30.8</td><td>0.0</td><td>7.2</td><td>18.6</td><td>25.8</td></tr>
<tr><td>Amman Gwendraeth</td><td>5.0</td><td>10.0</td><td>5.0</td><td>19.9</td><td>15.9</td><td>0.0</td><td>18.2</td><td>34.1</td></tr>
<tr><td>2Ts</td><td>4.2</td><td>2.8</td><td>31.8</td><td>38.8</td><td>0.0</td><td>20.7</td><td>14.6</td><td>35.3</td></tr>
<tr><td>N Pembs</td><td>1.2</td><td>11.1</td><td>10.9</td><td>23.3</td><td>12.1</td><td>3.6</td><td>6.4</td><td>22.0</td></tr>
<tr><td>S Pembs</td><td>4.5</td><td>8.8</td><td>14.6</td><td>27.9</td><td>0.0</td><td>3.6</td><td>10.2</td><td>13.8</td></tr>
</table>
</td>
<td>A</td>
</tr>
</table>

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| N ceredigion | 9.2 | 7.1 | 0.0 | 16.3 | 0.0 | 39.5 | 28.9 | 68.4 |
| S Ceredigion & Teifi * | 8.0 | 8.2 | 23.5 | 39.8 | 9.0 | 24.0 | 4.0 | 37.0 |
| **Hywel Dda** | 5.1 | 8.7 | 15.4 | 29.2 | 4.2 | 12.8 | 12.8 | 29.9 |

There are concerns over OoHs with gaps appearing on the rota. Currently the vocational training only requires 72 hours training; as a result some doctors do not feel competent/confident to join the on-call rota.

**Actions 2014 - ongoing**:

- Work with the Health Board on devising solutions for the current issue of GP recruitment and succession planning.
- Explore having specialist training in Carmarthenshire for those undertaking VTS training in the hope that this would encourage them to remain in general practice; cluster practices could offer some mentorship/experience in areas of sub specialism for those on the VTS Scheme e.g. Diabetes, minor surgery, ENT etc.
- Review roles of nurses and health care assistants
- HB to ensure OoHs rota is covered
- New group of First 5 run by Dr Alun Davies, supported by RCPG meeting every month in Furnace House

2014-15 Links established with medical school - CJ addressed a cohort of Swansea University Students on opportunities of working in a rural community

2015/16 – Revitalised and ongoing Hywel Dda recruitment campaign aimed at primary care.

Establish data collection to monitor scale of difficulty and trend – already in hand through dashboard, Annual Returns, etc.

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | **Action:**<br>√Included in HB Risk Register. | |
| 5 | Promote Cluster working arrangements among neighbouring practices | GP Practices/ Health Board | Ongoing | Patients should be able to more readily access services locally in primary care | Two practices already have a collaborative working arrangement in place for IUCDs. Two further practices are exploring similar collaborative working arrangements which will lead to improved services for a number of patients. The Health Board needs to support financial arrangements for cluster working<br>**Action:**<br>▪ Work with cluster to explore possibilities for further cluster working e.g. ENT, Dermatology – ongoing for 2015/16 | **A**  |
| 6 | To help patients choose the right NHS service practices within cluster to promote the Choose Well Campaign and Out of Hours service | GP Practices/ Health Board | Ongoing | Choose Well will help patients decide if they need medical attention It explains what each NHS service does, and when it should be used. Choosing Well means that patients will receive the best treatment. It also allows busy NHS services to help the people who need them most. | Cluster has previously worked with A&E to develop the Transfer of Care pathway to advise patients that they can be seen in GP practices for certain complaints. This was launched in GGH on 7th January 2013<br>**Actions:**<br>▪ √Practices to promote Choose Well advice leaflets and display posters - ongoing for 2015/16<br>Choose well promoted at Health Board Engagement Events across the cluster<br>▪ Encourage use of external community services where appropriate e.g community pharmacy who provide a number of enhanced services, to help deliver patient care. (Medicines Use Review; Discharge Medicines Review; Advice / Sign-posting; Just in Case Box Scheme; Smoking Cessation; Return of Patient Sharps Boxes; Emergency Hormonal Contraception Services ; Influenza Vaccinations (*only available during influenza season);* Advice to Care Homes; Substance Misuse; Needle Exchange & Supervised Consumption) | **G**  |

| | | | | | | |
|---|---|---|---|---|---|---|
| 7. | Improved working with other agencies such as local authority, 3rd Sector, PHW to ensure efficient and timely use of services and understanding of procedures | Local Authority/ 3rd Sector/ Health Board / PHW | Ongoing | Services working together to give the best care based on a person's personal circumstances | Integrated services will ensure easy and rapid access to services and support that are effectively co-ordinated and simple to use. This requires integrated working between local authorities, health and housing, the third and independent sectors. Primary care has a key role to play in relation to supporting people within the community setting. It is essential therefore that all partners are involved in the development and delivery of services, care and support.<br>Multi-disciplinary working has been introduced across the 2Ts locality focusing on the identification of frail elderly in need of a co-ordinated, multi -disciplinary approach to promote their independence and reduce risk of hospital admissions. However for integrated working to be a success CRTs need to be properly resourced. In 2014/15 per head of population Hywel Dda had the least number of OTs and physiotherapists and this was reflected in Carmarthenshire where staff levels for OTs and physiotherapists were very low. This lack of capacity impacts heavily on assessment waiting times. GPs in the cluster feel it is disheartening to keep identifying needs which cannot then be met.<br>**Actions:**<br>▪ √Practices to continue to work with other Agencies to deliver appropriate patient care – ongoing through MDT meetings<br>▪ √Practices to develop their MDT meetings (these need to be flexible to meet the needs of all) – Sept 2015 MDT Best practice guide developed to optimise MDT working.<br>▪ 2015-16 Cluster funding used to purchase Wi fi to enable easier exchange of information from colleagues during MDT Meetings. PT4L session in March 2016 extended to MDT colleagues to discuss | A  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | MDT working. Funding provided for administrative backfill to facilitate MDT meetings<br>▪ HB/LA to ensure that CRTs are fully resourced and have capacity to meet the care needs identified Recruitment of a number of OTs and Physios has taken place as part of the IMTP, however the CRT continues to experience fluctuating staff levels due to staff retention.<br>2015-17 - As part of the cluster funding a generic OT technician has been employed for two years to support MDT working and to undertake low level assessments and aspects of care co-ordination | |
| 8. | HB to provide up to date information on waiting times across all specialities | Health Board | Ongoing | Manage patient expectations | Excessively long waits for secondary care investigations and services mean patients are returning for further consultation for the same problem and a large number of requests for expedite letter are made. The impromptu cancelling of elective surgical lists e.g orthopaedics adversely impact on patients and practices.<br>**Action:**<br>▪ Health Board to ensure that patients receive appropriately timed investigation and surgery. 2014/15 Carmarthenshire waiting times were published in the GMS Newsletter – needs to be repeated at timely intervals | A |
| 9. | Introduction of MHOL for booking appointments and ordering prescriptions where appropriate | GP Practices | 2015/16 | Patients can take a greater involvement in their own healthcare via the internet, in a similar way to shopping or banking online | My Health Online is being introduced this is a secure, web-based portal that allows patients to access portions of their health record and communicate with their GP practice about non-urgent matters when it is convenient for them.<br>**Actions:**<br>▪ Practices to develop MHOL facilities where able<br>▪ Practices to promote MHOL to their patients | A |

## Strategic Aim 3: Planned Care- to ensure that patients' needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1. | To provide care for the frail elderly, to maintain their independence and reduce risk of falls<br><br>Development of Stay Well Plans | MDT partners / 3rd Sector | Ongoing | Managing these patients more effectively and pro-actively in their own home will enhance their experience of care and improve their outcomes<br><br>Improve anticipatory care<br><br>Reduce admissions and re-admission to hospital | Frailty is the most significant growth area of patient need within the Health Board and was identified as one of the main challenges in the 2014/15 Cluster Plan. These are the patients most likely to be admitted and re-admitted to hospital.<br>Action 2014-5<br>Practices to continue to use the Falls and Frailty Pathway<br>Promotion of the falls prevention pathway for those at low risk of falls<br>Actions 2015-16 & Ongoing<br>▪ As part of the cluster funding proposal, practices were asked to nominate a clinical frailty lead and to identify frail patients.<br>▪ Identified patient's to have a written Stay Well plan which includes details of carer, health and social care summary, optimisation and maintenance plan, escalation and urgent care plan.<br>▪ Dr A Haden Consultant Geriatrician provided training in frailty recognition.<br>▪ Optimised MDT working through the adoption of the MDT best practice guidance and the appointment of a generic OT Technician who will attend all MDT meetings and undertake low levels assessments. | A |
| 2. | Clarity around the diabetic pathway and what support is available | HB | March 2016 | Improved care | There has been a significant increase in the diagnosis of patients with this chronic disease. No extra resources have been allocated within Primary Care however within secondary care there have been increased consultant | R |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | posts and additional clinics. Diabetes and the resulting large increase is a huge problem with practices creaking under the weight of this workload. Prevalence is predicted to increase to 10.3% by 2020 and to 11.5% by 2030. Treating patients with diabetes is very complex and time consuming. The Enhanced Service for diabetes does not address this.<br>**Actions:**<br>▪ Re-direction of funds into primary care to ensure appropriate patient care in the correct setting.<br>▪ Practices to explore establishing in-house diabetic MDT meetings to discuss complex patients such as those in Llanfair surgery | |
| 3. | Reduce variation in standard of referrals | | Ongoing | Ensure that referrals are appropriate to reduce waiting lists | There is variation across GP practice i.e. not practice decision but individual doctor decision, also perception that referral rates tend to be higher among registrars.<br>**Actions:**<br>▪ Ensure practice protocol where applicable is adhered to e.g Registrars to run urgent referrals via GPs<br>▪ Ensure in practice support for younger colleagues | G  |
| 4. | Practices to use email service to reduce avoidable referrals | HB/ NWIS | Ongoing | Ensure that referrals are appropriate to reduce waiting lists | Some practices have found the email advice service very helpful and feel it has made a difference. Rheumatology, Dr Ennis (Orthopaedics), Dr G Owen (Paediatrics), Dr A Raybould (Cardiology) and Dr G Collier (Respiratory) are known to be receptive to email queries.<br>**Action:**<br>▪ Cluster to encourage use of email service<br>Cluster undertook an audit of cardiology OPD referrals between 1St October and 31st 2014 December in an attempt to improve the quality of referral letters to allow Cardiologists to prioritise their referrals without the need to request further information. Dr E Edmunds attended PT4L Session in May 2015 to discuss the audit | G  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | findings. | |
| 5. | Continue to follow previous QP care pathways | HB/LA/PHW | Ongoing | Improved care | There has been some positive feedback about changes that have been made to improve patient care and experience as a result of the QP process. Critically, the overall level of focus on the three core pathways of End of Life, Frailty/Falls and Dementia has led to improved case finding and diagnosis, more consistent read coding and enhanced integration with other community, social care and third sector professionals.<br>**Actions:**<br>▪ Practices to continue good work introduced from previous pathways despite these being removed from the contract.<br>▪ Look at possibility of easy data comparison across cluster to facilitate cluster learning from good practice | G |
| 6. | Roll out of GP test Requesting | HB/NWISS | | This will help to avoid duplicating the requesting of tests | GPTR is a system which will allow staff at a General Practice to electronically request tests and view test results from their local hospital laboratory. Eight practices from across Ceredigion, Carmarthenshire and Pembrokeshire are taking part in the pilot project, for 2Ts these are Meddygfa Tywi, Furnace House and Meddygfa Teilo.<br>**Action:**<br>▪ 2014-15 Awaiting feedback from formal evaluation to be undertaken by Hywel Dda Health Board. Feedback from pilot at Meddygfa Twyi – GPTR is good for looking at blood tests on Myrddin and the accompanying Handbook is useful, however the system is very slow and cumbersome and there is a long way to go before it could be rolled out | A |

<table>
<tr>
<td>7.</td>
<td>Cluster to have access to Rapid Assessment Multi-disciplinary Services for patients for frail and elderly patients</td>
<td>HB/DN Services</td>
<td>2015</td>
<td>Equity of services</td>
<td>Currently Llanelli & Amman Gwendraeth have access to SCRAMS based in PPH. This service is not available in GGH and GPs within 2Ts are not allowed to refer to this service, this lack of service is both inequitable and unfair to patients<br><u>Action:</u><br>▪ Health Board to ensure equity of service across the county - Roll out of Frailty Clinic for patients within 2Ts Cluster - Discussions have been held and while it was hoped to trial a clinic in GGH in December 2014 this has not happened to date.</td>
<td>R</td>
</tr>
<tr>
<td>8.</td>
<td>Early diagnosis of dementia</td>
<td>HB/3rd Sector</td>
<td>Ongoing</td>
<td>Improved patient care</td>
<td>It is estimated that only 37% of people with dementia have a formal diagnosis. Early diagnosis of dementia can provide better outcomes for patients, families and carers and save money. As at 2012, the number of people in Carmarthenshire with dementia was 2,764 and it is anticipated that by 2015 this will increase to 2,956. The 2Ts has the highest levels of dementia in Carmarthenshire , anticipated numbers in 2015 are illustrated below using [1]2008-based local authority population projections for Wales, 2008 to 2033 from www.statswales.wales.gov.uk this
<table>
<tr><td>Carmarthenshire</td><td>2012</td><td>2015</td></tr>
<tr><td>AG</td><td>800</td><td>856</td></tr>
<tr><td>Llanelli</td><td>906</td><td>969</td></tr>
<tr><td>2Ts</td><td>1058</td><td>1131</td></tr>
<tr><td>Total</td><td>2764</td><td>2956</td></tr>
</table>
</td>
<td>A</td>
</tr>
</table>

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | **Action:**<br>Dr G O'Connor attended a Cluster meeting on 27.11.2015. Discussion took place on when to diagnose, who was best placed to discuss treatment with patients, medication, etc. | |
| 9. | Assess potential list size increase with growth of further housing development | HB/LA/PHW | | Avoid difficulties in accessing GP appointment due to higher demand | There are numerous large housing developments planned around the cluster in particular Llandeilo and Carmarthen west which could heavily impact on practice workload.<br><br>**Actions:**<br>▪ 2014-15 Ascertain the current position with regard to these proposals<br>▪ Included on cluster risk register<br>▪ initial discussions commenced with HB planning dept, primary care representative and the local authority to explore section 106 arrangements to secure a financial contribution towards the extension, improvement or construction of primary care facilities. – A meeting took place on 10th September 2015 with Carmarthenhsire County Council with regard to a Health Care contribution linked to the Carmarthen West development and the Community Infrastructure Levy (CIL) legislative framework which has been introduced. Whilst previous discussions had been held around the Section 106 planning agreement and the possibility of a Health Care contribution, the focus has shifted to the recent introduction of the CIL legislative framework. General costs, such as education and health, should be addressed via the CIL. If successful this would be one of the first health authority's in Wales seeking to include a contribution to health via the applicable CIL. | R  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Unfortunately to date (Sept 16) the Health Board has not submitted any application under a CIL or Section 106 despite invitations to do so from the local authority and the deadline has now passed for application to the CIL process<br>2016-17 – Update to be requested from HB at cluster meeting. | |

**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**

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Discuss patients who are at high risk of admissions | HB/LA/3rd Sector | Ongoing | Co-ordinated care | Emergency admission data has identified the significant number of older people admitted to hospital with injury following a fall, many of which could have been prevented with efficient identification, assessment and consequent intervention for those at risk.<br>**Action2014-17:**<br>▪ Practices to utilise MDT meetings for the identification and discussion of patients who are at high risk of admission and the frail elderly in need of a co-ordinated, multi disciplinary approach to safeguard their continued independence and prevent hospital admissions.<br>▪ Completion of Stay Well Plans to promote anticipatory care | A  |
| 2 | To have computer systems which work accurately and effectively | HB/NWIS | Ongoing | Minimise risk, duplication | Frequent problems occur with the different IT packages e.g. previously IHR had not bben working for OoHs (now resolved), practices unable to log onto Myrddin.<br>**Action:**<br>▪ HB to ensure that computer systems and packages are reliable and effectively maintained | A  |
| 3 | Primary care to utilise ART where appropriate | HB | Ongoing | Patients will receive the appropriate care | Practices need to be aware of what services ART provide, capacity, etc.<br>**Actions:**<br>▪ √ART team to attend PT4L session to update GPs | A  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | – Craig Jones, ART Manager attended PT4L session on 10th September to update on the role of the service, how to refer to and to address any queries | |
| 4. | Development of pre-diabetes screening programme<br><br>Establishment of Foodwise programme for the 2Ts | Practices<br><br>Chronic Conditions Team | 2016-2017 | Delay or possibly prevent development of diabetes in those at high risk | The prevalence of Diabetes in the cluster is between 6-7% and continues to rise annually. The projection for Hywel Dda is a prevalence of 11% within 10-15 years. Evidence suggests that Diabetes can be delayed or possibly prevented in up to 60% of those at high risk by helping individuals to change their lifestyle.<br>**Actions 2016/17:**<br>▪ Develop a cluster consensus on care to those at the highest identified risk.<br>▪ Commission Foodwise course for patients in 2Ts with HbA1C 42-47 mmols and BMI 25. The course is two hours for one session a week for eight weeks<br>▪ Lifestyle Advocate Programme training to support awareness of healthy living choices | **A** |
| 5. | Fund a community based service for respiratory patients (COPD+) utilising community available to improve disease awareness and physical outcomes for patients | Chronic Conditions Team | March 2017 | Improved Management of Chronic Disease<br><br>Wider accessibility | Action 2016-17<br>Provision of combined education and exercise classes for people with COPD with MRC <3 in order to slow progression of the disease process, prevent deconditioning and ensuring there is better access for the relevant people with COPD to full pulmonary rehabilitation.. | **A** |

## Strategic Aim 5: Improving the delivery of End of Life Care

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Prepare and plan for the End of Life to improve the delivery of End of Life Care | HB/LA/ 3rd Sector | Ongoing | Helps to manage the worry and stress present at the end of life | The primary care team is central to the delivery of high quality end of life care<br>**Actions:**<br>▪ Practices to continue to develop palliative care meetings.<br>▪ Increase awareness of Advanced Care Plan.<br>▪ Where possible to continue to provide palliative care at home for patients. | A |
| 2 | Cluster to monitor progress in the delivery of EoL care | Primary / secondary care / 3rd Sector | March 2016 | Having open and honest conversations (where they are wanted) is essential to giving patients and their carers the time to adjust and make plans for deaths | **Actions 2014-17**<br>▪ √Practices to review the delivery of EoL care using individual case review.<br>▪ √Ensure that any learning from the EoL reviews is discussed and shared - EOL reviews discussed at Cluster Meeting on 05.03.12 – learning themes identified as per EOL Priority Summary Sheet<br>▪ √EOL reviews discussed at cluster meeting attended by Dr Croft Palliative Care Consultant and learning shared | A |
| 3. | Co-ordination of OoHs Care | HB | Ongoing | Continuity of care | **Actions:**<br>▪ Rotas to be fully staffed<br>▪ Ensure sharing of good quality of data<br>2016-17 – monitor impact of the 111 service – due to be implemented in Carmarthenshire on 7th November 2016 | A |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4. | Improving Access To Palliative Care Medication – Just in Case Boxes | Community Pharmacy | Ongoing | Avoid distress caused by poor access to medications in the Out of Hours (OOHs) period, by anticipating symptom control needs and enabling availability of key medications in the patient's home. | The effective management of pain and other symptoms is an essential element of Palliative Care. Currently the Gold Standard Framework has been adopted by the majority of GP practices , this means that people with palliative care needs and those that are in the last weeks of their life will receive care that is standardised and based on best practice.<br><br>**Action:**<br>▪ Encourage the use of JiC boxes where appropriate – ongoing for 2016/17. | |
| 5. | Cluster to be able to electronically benchmark EoL care | HB/SAIL/Audit + | Ongoing | Improved EoL care | **Actions:**<br>▪ Cluster to utilise data systems (SAIL, Audit+, MSDI?) to benchmark data<br>▪ 2014-15 SAIL EOL reports disseminated to practices – will be useful to benchmark data once system issues have been resolved and data is refreshed to include data up to 2014. | A  |

## Strategic Aim 6 : Targeting the prevention and early detection of cancers

| No | Objective | Key partners | For completion by: - | Outcome for patients | Progress to Date / Key Action | RAG Rating |
|---|---|---|---|---|---|---|
| 1. | To target the prevention and detection of digestive, lung and ovarian | HB/PHW | March 2016 | Early detection of cancer greatly increases the chances for successful treatment | Cancer is one of three leading causes of death in Wales, lung and digestive system cancers being the major contributors.<br>The 2Ts has the 3rd lowest rate per 100,000 population of the clusters at 71.9 which compares to the Hywel Dda average of 77.6.<br>**Actions 2014-2017:**<br>▪ Practices to adhere to the Cancer Delivery Plan<br>▪ √Practices to carry out significant event analysis.<br>▪ √Themes gathered and shared with cluster and wider Networks as per National Priorities Cluster Cancer Summary –<br>▪ √Issues and barriers highlighted to Health Board to address<br>Dr Collier and Miss Singh attended Cluster meeting on 05.01.2015 to discuss findings arising from significant event analysis. Cluster report on priority area to be shared with Dr Collier at year end<br>▪ √Themes / barriers, etc. gathered and shared with cluster and wider Networks. Discussed at Cluster Meeting Jan 2016 with Dr Collier Cancer Lead.<br>▪ Discussions around the downgrading of USC referrals | A |
| 2. | Have a greater understanding of the cluster population with regard to cancer screening programmes | PHW | March 2016 | Better prevention of cancers for our patients. | Screening tests can help find cancer at an early stage before symptoms appear. When abnormal tissue or cancer is found early, it may be easier to treat or cure. 2Ts has the 3rd highest uptake of bowel screening of the 7 clusters at 53.1% which is higher than the national uptake rate of 50.8% but lower than the target 60% . The cluster has an average uptake rate of 78.4% for cervical screening.<br>**Actions 2014/15:**<br>▪ PHW to look into the difference in cytology rates across the | A |

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>cluster and feedback<br>▪ Assess take up of GI screening to ascertain if there are differences between practice populations with regard to take up<br>▪ √Practices to have data regarding the take up of breast and AAA screening - Screening uptake data disseminated from PHW<br>▪ √<u>2015-16</u> Work with partners to promote cancer screening: e.g. Pharmacy Bowel Screening Campaign: Screening for Life; 1st—31st July. - Bowel Screening attended PT4L session in November 2014.<br>Hywel Dda screening uptakes /coverage by GP Cluster 2014/15
<table>
<tr><td></td><td>AAA<br>Target<br>80%</td><td>Bowel Screening<br>Target<br>60%</td><td>Breast Screening<br>Min.standard<br>70%</td><td>Cervical Screening<br>Target<br>80%</td></tr>
<tr><td>Amman/Gwendraeth</td><td>76.4</td><td>53.6</td><td>77.1</td><td>78.9</td></tr>
<tr><td>Llanelli</td><td>80.1</td><td>49.0</td><td>73.7</td><td>75.6</td></tr>
<tr><td>North Ceredigion</td><td>73.1</td><td>53.0</td><td>75.6</td><td>73.7</td></tr>
<tr><td>North Pembrokeshire</td><td>77.6</td><td>49.8</td><td>75.8</td><td>77.3</td></tr>
<tr><td>South Ceredigion</td><td>80.0</td><td>51.2</td><td>72.5</td><td>76.1</td></tr>
<tr><td>South Pembrokeshire</td><td>76.6</td><td>51.9</td><td>74.7</td><td>76.0</td></tr>
<tr><td>Taf / Tywi</td><td>72.0</td><td>53.1</td><td>76.5</td><td>78.4</td></tr>
<tr><td>Wales</td><td>74.4</td><td>50.8</td><td>72.8</td><td>78.0</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Improved education across the cluster</td>
<td>HB/PHW</td>
<td>Ongoing</td>
<td>People are aware of and are supported in minimising their risk of cancer through healthy lifestyle choices</td>
<td><u>Actions 2014/15:</u><br>▪ √PT4L sessions with Cancer Consultants attending to discuss review findings, barriers, etc. -<br>Dr G Collier Hywel Dda cancer lead attended PT4L session on 14.10.2014 giving a presentation on Early Diagnosis & Education.<br>Miss J Singh Colorectal Consultant attended PT4L session on 12.11.2015<br>▪ Practices to be aware of services to support healthy lifestyle choices (Smoking cessation, alcohol intake, diet, exercise,</td>
<td>A</td>
</tr>
</table>

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | weight - information is available in the F&F low risk pathway)<br>▪ Training Provision e.g. Brief Intervention, Macmillan, etc.<br>**Actions:**<br>▪ **2015/16**Dr Piskorowskyj attended PT4L session in November 2015 to provide education session on ovarian cancer<br>▪ Lifestyle Advocate Programmed to commence training to support awareness of healthy living choices<br><br>▪ 2016-17 Cluster funding has been allocated to PHW working with Third Sector partners to develop a programme to increase uptake of screening programmes (particularly bowel), to enable a robust, participative, evaluated project to target individuals and communities. Funding would be used to train Third Sector staff to talk about screening in their every-day contacts – with the knowledge skills and confidence to advocate for these programmes in appropriate (and sensitive) ways | |

## Strategic Aim 7: Minimising the risk of poly-pharmacy

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Effective medicines management - ensure that the most effective treatments are prioritised and used effectively | Medicines Management | March 2016 | Patients are assured that prescribing choices are well informed. Minimization of the risk of adverse events | It is widely recognised that elderly patients are often at high risk for significant mortality / morbidity and may have potential to benefit most from many treatments and preventative therapies however, it is noted that the concurrent use of multiple medicines or poly-pharmacy may increase risks for this risk group<br>**Actions 2014/15:**<br>▪ √Practice to undertake face to face medication reviews using the No Tears approach.<br>▪ √Themes and actions to be reviewed and discussed with the cluster –<br>▪ Increasing acceptance of not treating people<br>**Actions 2015/16**:<br>▪ Practice to undertake face to face medication reviews using the No Tears approach.<br>▪ Themes and actions reviewed and discussed at Cluster Meeting December 2015<br>▪ Action 2016-17 | G |
| 2 | Appointment of Cluster Practice based pharmacists | Medicines Management | December 2016 | Shared Cluster Pharmacist working in practice will help to reduce medicines wastage, ensure compliance with medication. Patients will benefit from enhanced provision | **Action 2016/17**<br>▪ Cluster funding has been allocated for the employment of three part time Pharmacists (2wte equivalent) on an 18 month contract to work with practice.<br>▪ Interviews were held on 3rd August and start dates are anticipated. These will differ due to notice period agreements | G |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | ensuring positive patient outcomes | | |
| 3. | Requirement for a pain management programme | Health Board | May 2016 | Patient will be assessed and supported earlier | Numerous problems with the pain clinic. The psychologist does not have a clinical role.<br>**Action 2014/17**<br>▪ Cluster to know: What is the pain management programme within the Health Board? What is it doing? How helpful will it be for patients?<br>▪ Dr Bethan Lloyd attended PT4L session in May 2016 to update on the New Pain Service Pathway which incorporates Chronic Pain management | **A**  |

## Strategic Aim 8: Deliver consistent, effective systems of Clinical Governance

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1. | Maintain and improve safe and robust systems within the practice | GP Practices | Ongoing | Improved service | Actions 2014-17<br>Continue use of the CGPSAT toolkit for yearly submission | G  |
| 2. | Improved communication across primary and secondary care | HB/NWIS | ASAP | More streamlined care. Less risk of harm | Poor communication between secondary and primary care creates unnecessary problems and barriers. Changes in secondary care are not being communicated to primary care, for example there is a hand clinic in GGH but GPs are unsure who is running this and how to refer.<br>**Actions 2014/15 – carried forward to 2015/16:**<br>▪ HB to provide a breakdown of the specialist side of orthopaedics (in particular hands and back). Requested 13th October 2013 and again in January 2015 (no response received) Request again Sept 2017<br>▪ HB to improve standard of discharge letters (see 2.3)<br>2016/17 – HB need to roll out pilot of electronic discharge. Initial feedback does report an improvement in the standard of letters received. | R  |
| 3. | Clarity on roles and responsibilities following numerous re-organisations | Health Board | ASAP | Less confusion for General Practice – contact should be more direct which should ensure improved information exchange | The Health Board has undergone numerous re-structures with personnel changing roles and titles which is confusing and time consuming when trying to contact departments/ individuals within the Health Board | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | **Action 2014/15**<br>Health Board to provide clarity on roles and responsibilities and up to date contact list for clinical leads, etc. - Acute services structure disseminated in January 2015 however in 2015/16 - Acute services currently going through new structure development – final structure not currently available | **A**  |
| 4. | Practices to record significant events on DATIX | HB | Ongoing | Ensure themes and trends are addressed leading to improved patient care | It is important that practices record significant events on DATIX, this will ensure that issues are highlighted to the Health Board and allow for the identification of any themes and trends which can be addressed.<br>**Actions 2014 -17**<br>▪ Practices to ensure that they record significant events on Datix<br>▪ Practices to hold meetings to discuss all significant events, concerns and complaints.<br>▪ Cluster to receive Quarterly DATIX reports from the HB in order to identify themes and trends, etc. | **A**  |
| 5. | Cluster to have effective medicines management process in place | Medicines Management | Ongoing | Patients are assured that prescribing choices are well informed.<br>Minimization of the risk of adverse events | **Action 2014-17**<br>▪ Practices to continue to work closely with Medicines Management Team to review prescribing practice – ongoing through prescribing leads. | A  |
| 6. | Health Board to ensure that the computer systems and packages in place work accurately and efficiently | HB/NWIS | Ongoing | Continuity of Care | Numerous problems are being experienced within practice due to ineffective computer systems and packages which can prove time consuming and impede effective patient care e.g. IHR not working in OoHs, problems unable to log into Myrrdin<br>**Action:**<br>▪ HB to ensure that computer systems and packages are reliably and effectively maintained. | **R**  |

| | | | | | | |
|---|---|---|---|---|---|---|
| 8. | Health Board and Practices to put in place systems to ensure that patients are not lost to follow-up | HB | ASAP | | Practices within the cluster have raised concerns that patients are being lost to follow-up as a result practices have now put in place systems to monitor referrals. Secondary care needs to address this also:<br>**<u>Actions 2014-17:</u>**<br>▪ Practices to log on Datix all incidences of patients lost to follow-up as a means of highlighting to secondary care<br>▪ Health Board to investigate all DATIX reports and feedback to practices | **R**  |

## Strategic Aim 9: Other Locality issues

| No | Objective | Key partners | For completion by: - | Outcome for patients | Key Actions / Progress to Date | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Provision of equitable phlebotomy service across the cluster | Health Board | | Equity of service provision.<br>Reduction in taking of unnecessary bloods | Primary Care is under growing pressure from increased demand as well as constraints on funding. Some practices fund phlebotomy while others have trust phlebotomy services in place (this goes back to the setting of global sums in 2004 which were set on what practices were providing at that time). The Health Board are in the process of reviewing phlebotomy provision.<br>Practices in the cluster recognised that Phlebotomy is also impacting on the District nursing service used their PMS monies to develop a community phlebotomy service for housebound and temporarily housebound patients delivered by Healthcare Support workers across the locality. Evaluation showed that this service built up district nursing service capacity to work with and care for more complex patients; supporting GPs to improve patient care. Funding for the service in year two was met by the County Team.<br><br>**<u>Actions 2014/15</u>:**<br>▪ √Explore perception that there is an Increasing number of blood tests carried out for secondary care, practices to take part in an audit of the number of requests generated by secondary Care - initial audit undertaken in July 2014 re-audited in October 2014<br>▪ HB to consider possible LES for secondary care bloods | R |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | ▪ Roll out of GP test requesting – pilot underway | |
| 2 | WAST – Ambulance response times | WAST | | | Some areas of the cluster have the slowest ambulance response times for all Wales, this time delay is distressing for patients and their families and can impact on the practice with patients phoning to check on ambulances ordered. | |
| 3 | Cluster to work effectively and efficiently in providing care for patients residing in Care Homes | Local Authority/ DN/PHW | | | Tywi / Taf has a concentration of Care Homes whose residents have increasingly far more complex needs. Practices are experiencing increasing requests for visits to care homes and the cluster has reported current issues with regard to low morale, increasing bureaucracy and staff shortages within certain care homes. It is anticipated that new developments will increase the number of retired coming to live within Carmarthen which will create a strain on current health services alongside an ever increasing ageing population. There is not enough capacity/ resources among CRT, District Nurses and ART to manage the increasing work load.<br>**Actions 2014/15**:<br>▪ Consider admission process to a care home of which the GP element should be quite small given all the information that is already collected – Morfa Lane<br>▪ Cluster to request that HB reinstatement the Care Home Enhanced Service<br>▪ Determine if there is an index comparison for care homes in order to quantify workload and compare at practice level<br>▪ √ Problems highlighted with regard to lack of information for temporary patients Morfa Lane designed a form to be completed mainly with regard to patients in Care Homes, to give a little background information to help with recording information while | R  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | waiting for the notes. – Form shared with all practices with hope that if all surgeries were to adopt then it would become routine practice for Care Homes to complete. | |
| 4 | CAMHS to provide a timely, effective service for patients | | September 2015 | Ensure that patients are seen within an acceptable time | The current referral process to CAMHS is hugely problematic. Referrals are often rejected or when accepted young patients often have to wait an unacceptable length of time. The acceptance criteria appears to be too high and there are issues with patients who are within the moderate to severe category who need to be seen but fall outside the CAMHS remit.<br>**Actions 2014/15:**<br>▪ √CJ to speak to CAMHS for further clarification with regard to the pathways and protocols<br>▪ √Determine what are the alternative pathways for autistic spectrum disorder<br>▪ √Cluster to be informed of alternative services available within their locality<br>Dr Warren Lloyd Consultant Psychiatrist attended PT4L session on 9th September 2015 to discuss service developments and referral pathways which are currently under review – to return to a future PT4L cessation when finalised<br>▪ Provision of more formal training for GPS | A |
| 5 | Continuity of care for patients | Health Board | | Improved patient care | Lack of communication can impact on patient care e.g. lack of community paediatrician in certain areas, a situation not communicated to practices<br>**Actions 2014-17**<br>▪ HB must ensure timely and effective communication of information which directly effects patient care<br>▪ Speedier appointment of community paediatrician | R |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | and HB to determine a safe and reliable referral process during the unsupported months<br>▪ Discussed at cluster meeting 15th September – Linda Williams to feedback to cluster on paediatric service | |
| 6 | District Nursing | HB/DN service | | Seamless care | Some practices do not have district nurses based at their practices. Practice based district nursing would improve communication and continuity of care.<br>**Action:**<br>Improved information sharing / communication regarding patient care | A |
| 7. | Cluster to be informed of the Health Board's estates strategy for Primary Care | Health Board | ASAP | Services provided in premises which are fit for purpose | Cluster is currently awaiting decisions on the proposed development of the Community Resource Centres at Whitland and Carmarthen Town. Also clarity is required on the current primary care premises directions from WG together with the improvement grant process which has been devolved down to Health Boards. There are concerns regarding premises being or becoming substandard for delivery of modern primary care services with no investment into primary care estates in the foreseeable future.<br>**Actions:**<br>▪ HB to provide clarity on future of CRC schemes<br>▪ HB to produce Primary Care Estates Strategy<br>▪ Lack of investment in primary care premises added to cluster risk register | R |
| 8 | 3rd Sector Broker funding to be agreed to ensure role is maintained | HB/ CAVS/WG | Jan 2015 | GPs supported to ensure that patients receive appropriate direction and utilization of services available within the Cluster | The 3rd sector broker attends a number of the locality MDT meetings, this role and expertise is an excellent resource and the broker is very useful as a point of contact for information for patients on what services are available and what problems can be dealt with within the Voluntary sector.<br>**Action 2014/15 ongoing 2016/17:**<br>▪ Cluster to seek assurance from County Leadership Team regarding continuation of this role – Funding | A |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | for role has now been secured however the Cluster 3rd Sector broker left in April 2015 and post is still vacant pending recruitment. | |