## Our Network: -

We are a Network with 7 main Practices; and 2 branch surgeries

- There are 3 practices recognised for GP Training
- There is 1 practice recognised for Nurse Training
- There are 5 practices offering placements to Cardiff University Student Doctors
- There are GPWSIs in Minor Surgery, Diabetes, Sports Injury Medicine, Contraceptive Services
- There is 1 LMC Representative
- 85% of practice uptake of My Health Online
- Partnership cluster members from:
  - District Nursing
  - Community Resource Team (CRT)
  - Community Mental Health
  - Health Visiting
  - Local Authority
  - Communities First
  - GAVO

## Our community: -

We serve a population of 60,385 in a predominantly urban county with 92% of the population residing in the main towns of Blackwood, Newbridge and Risca. The NCN has boundaries with Blaenau Gwent, Torfaen, Newport and Cardiff.

Particular features of our population are:

- Growing older population;
- High number of residents live within the Most or Next Most deprived areas in Wales
- Many households have very low income
<table>
<thead>
<tr>
<th><strong>We looked at the needs of our community:</strong></th>
<th><strong>Our agreed priorities for 2015/16 were:-</strong></th>
</tr>
</thead>
</table>
| • The prevalence of depression, East Caerphilly is 5th joint highest in Gwent with Torfaen South and Newport East at 8.7%, and between Central and South Caerphilly.  
• Disability-free life expectancy in Caerphilly county borough is amongst the worst in Wales.  
• Many households have very low income, with five LSOAs ranking in the lowest 20% in Wales for household income in 2011. Overall 70% of households in the Local Authority area are in the top 50% of the most deprived category for the income domain across Wales  
• This NCN area is within the highest 25% in Wales for hypertension | • To Improve communication and utilisation of Mental Health / Mental Wellbeing services in the Locality  
• Establishment of an NCN Web based solution that provides information for local, available services for Dementia patients.  
• Increase awareness of dementia friendly communities  
• To improve utilisation of available data sources to review activity for the NCN |

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<thead>
<tr>
<th><strong>What we have achieved : -</strong></th>
<th><strong>Our plans for 2016/17:-</strong></th>
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</table>
| • NCN funding of GP Practice Based Pharmacists  
• NCN funding of Primary Care Based Social Workers  
• NCN funding of training for GP practices, both clinical and non-clinical  
• NCN funding of Bowel Screening pilot to increase the opportunity for early detection of cancer  
• Provision of Smoking Cessation services  
• Have established 6 smoking cessation champions in GP practices  
• Agreed that all local agencies will refer to smoking cessation services.  
• Dedicated sessions for National Audits: End of Life Care, Early detection of Urgent Suspected Cancers, Poly-pharmacy  
• Reviewed the prescribing budget on a regular basis, Appropriate switches and substitutions have been made.  
• Dedicated session at NCN meeting for Access LES  
• Dedicated session at NCN meeting for Care Closer to Home | • Care Homes  
• Improve uptake of Flu Vaccinations  
• Building capacity within Primary Care for Childhood Immunisations  
• Use of Primary Care Investment Funds |
Neighbourhood Care Network Annual Report 2015-16
Caerphilly East NCN
## Strategic Aim 1: To understand the needs of the population served by the Network

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<th>No</th>
<th>Objective</th>
<th>Key Partners</th>
<th>For Completion by</th>
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<th>Progress to Date</th>
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</table>
| 1.1 | Smoking | NCN, PHW, Smoking Cessation Wales, Housing Associations, Communities First, Community Pharmacy | 31.03.16 | Increased numbers of staff who have access to brief intervention training  
Increased access for patients to staff trained in brief intervention techniques  
Patients will be motivated to make a quit attempt and will receive effective treatment to quit smoking | • Up to date data from Stop Smoking Wales not available  
• Brief intervention training for staff – 42 staff across Caerphilly have been trained during 2015/16 with future training planned for 2016/17  
• 6 out of 7 practices currently have a Smoking Champion  
• 3 Stop Smoking Wales Clinics held at various venues in the East NCN  
Progress of Level 3 Smoking Cessation:  
• 2014/15  
3 Pharmacies offer level 3 Smoking Cessation Services  
• 2015/16  
5 Pharmacies offer level 3 Smoking Cessation Services | A |
| 1.1.1 | Achieve/work towards the National Tier 1 target of 5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks | | | | |
| 1.2 | Obesity | Communities First  
NCN | 31.03.16 | Increase in patients making a quit attempt as service can be offered on a 1-2-1 basis  
Delivery staff will have established relationships with patients | • Programme of Maudsley Smoking Cessation advice did not commence in Caerphilly via Communities First.  
• NCN Funding was redirected for provision of X-POD in Caerphilly East NCN (see 1.2) | R |
| 1.1.2 | Communities First  
Staff to offer Maudsley Smoking Cessation advice to patients across Caerphilly funded from NCN monies for 2015-16 | Communities First  
NCN | 31.03.16 | | |

See 1.1.1
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</table>
| 1.2.1 | To address Obesity issues within the NCN Network through Partnership working | NCN, Social Services/ Communities First, Adult Weight Management Service, PHW, GAVO | 31.03.16         | NCN membership and stakeholders will be able to plan for integrated service provision across the Caerphilly NCN areas. Families will have access to a wide range of children and young people’s services, initiatives and projects addressing obesity issues | • Community DSN’s receiving patients and planning discharge from secondary care services  
• Diabetes Consultant email advice line introduced  
• Diabetes Consultant/DSN telephone advice line introduced  
• Programmes such as Foodwise and National Exercise Referral Scheme (NERS) promoted within the Network  
• Childhood Obesity Strategy Event held 28th April 2016. Further workshop planned.  
• X-POD  
  - 3 full courses held (6 sessions each)  
  - 18 community sessions completed  
  - 26 participants enrolled on the courses  
  - 100% reported via evaluation that the course has increased their knowledge of obesity (heart disease, diabetes, cancer)  
• Adult Weight Management Service referral and activity data under development  
• Directory of available services being developed with MECC/PHW | G          |
| 1.3   | Bowel Screening                                                           | NCN, PHW, National Screening Services, GP Practices                          | 31.03.16         | Earlier detection of bowel cancer with improved chance of survival                                                                                                                                    | • NCN funding agreed  
• Lists provided by Bowel Screening Wales via PHW  
• 1144 patients identified (over 2 cohorts of lists)  
• 980 contacts made  
• Evaluation to be undertaken by PHW to show impact against national target of 60% target | G          |
| 1.4   | Public Engagement                                                          | Network Team, NCN, GP Practices, Communities First                           | On-going         | Formal and informal consultation opportunities for all residents to influence the development and improvement of all services (including integrated services) across ABUHB. | • GAVO Rep attends NCN meetings representing the Third Sector  
• ABUHB Engagement Team established 2015-16  
• Ongoing work needed to create greater links with the team and to identify local impact and influence  
• NCN wide newsletter developed to share new developments and current issues across 12 NCNs | G          |
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<tbody>
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<td></td>
<td>seeking / collecting information on service provision and change from the wider Gwent resident population.</td>
<td>GAVO</td>
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<td>• NCN Leads and Network Manager attending an ABUHB Engagement &amp; Listening event at Asda Caerphilly on 06/05/16</td>
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<tr>
<td>1.5</td>
<td><strong>Influenza</strong></td>
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</table>
| 1.5.1 | Achieve the national target of 75% for immunisation against influenza    | GP Practices                      | 31.03.16         | Decrease in hospital admissions               | Progress 2015/16:  
  • 62.2 % achieved as at 07.03.16 for immunisation against influenza for 65yrs and older  
  • 45.7% achieved as at 07.03.16 for immunisation against influenza for 6months to 64yrs  
  • Flu regularly discussed at NCN meetings with best practice shared.  
  • Update provided via IVOR data at NCN meetings  
  • Action plan to improve uptake and share best practice being progressed by NCN Mangement Team 2nd June 16.                                                                 |            |
| 1.5.1 |                                                                           | NCN                               |                  | Decrease in morbidity                          |                                                                                                                                                     |            |
| 1.5.1 |                                                                           | Contractor Services               |                  |                                               |                                                                                                                                                     |            |
| 1.5.1 |                                                                           | DNs                               |                  |                                               |                                                                                                                                                     |            |
| 1.6  | **NCN Management Team**                                                  |                                   |                  |                                               |                                                                                                                                                     | G          |
| 1.6.1 | Establish a Management Team Structure for Caerphilly East NCN            | NCN Lead                          | 31.03.16         | Improved guidance, co-ordination and development / skills, knowledge and engagement    | • Initial scoping workshop held with key stakeholders to present the context for a Management Team  
  • Membership and remit agreed  
  • Following initial assessment a single Management Team for Caerphilly has been established.  
  • Data supports work programme priorities/ developing bespoke performance report  
  • Agreed priorities include Flu up-take/Smoking Cessation/Obesity.  
  • Team currently meets on a monthly basis                                                                 |            |
Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients

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<tr>
<td>2.1</td>
<td>Access</td>
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| 2.1.2 | Achieve LMC agreed access figures | GP Practices, NCN Lead | 31.03.16 | Practices to engage with project to optimise access in keeping with emerging guidance to be agreed with CHC, Health Board and LMC | • Presentation on Clinical Futures - Care Closer to Home by Adele Gittoes planned for NCN meeting on 05.05.16.  
• Workshop planned for practices.  
• Dedicated session held at NCN meeting on the 09/03/16 for practice taking up the Access LES  
• Uptake of the Access LES:  
  - Avicenna Medical Centre  
  - Pontllafraith Health Centre  
  - St Lukes Surgery  
  - Wellspring Medical Centre | A |
| 2.1.3 | Monitor the continuation and uptake of My Health Online | NCN, Practices | 31.03.16 | Ease of access to GP services | • 100% uptake from practices of My Health Online in Caerphilly East NCN.  
  - 100% of practices using for Prescribing  
  - 86% of practices using for Appointments  
  • 92% of all ABUHB practices using elements of MHOL. | G |

2.2 Workforce

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</table>
| 2.2.1 | Improve locum arrangements and ensure that practices in difficulty have access to NCN salaried support team to ensure continuity of service in the short term. | ABUHB, GP Practices, PC&ND | 31.03.16 | Patients experience shorter waits for GP appointments and increased patient appointment capacity  
Increased access to appointments, measured through audit  
Continuity of services  
Support against potential practice fragility | • Primary Care Operational Support Team (PCOST) established 2015-16.  
• Currently comprising 6 GPs, 4 nurses, 2 health care support workers, a pharmacist and pharmacy technician and 3 managerial/administrative staff.  
The aim of this team is to support fragile practices, who may be in difficulty for a variety of reasons, on a time limited, transformational basis to assist practices to become sustainable in the medium to long term. | G |
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</table>
| 2.2.2 | To support relevant education and development opportunities across the NCN | NCN Lead | 31.03.16 | Sharing education sessions across practices providing up to date enhanced skills to provide better patient care  
Utilise the NCN Training Plan from NCN slippage monies | • Various education opportunities have been funded through NCN funding slippage including:  
- PN/HCSW Clinical training  
- Community Nurse training  
- Non-clinical practice staff training  
- IT Training  
- Diabetes training  
• Where opportunities arose, shared education sessions across practices were held | G |
| 2.2.3 | To enhance the delivery of NCN based services, specifically dental, optometry and pharmacy. | AMD CDs  
NCN Leads | 31.03.16 | Patients will benefit from the appointment of Independent Advisors and the value of debate they will bring from across ALL Primary Care Services in the development and delivery of NCN Work Programmes. | • 3 Independent Contractor Advisors for Dental, Optometry and Pharmacy appointed and started in post.  
• The Advisors will ensure these services development will be enhanced at NCN levels | G |
| 2.2.4 | Provide Practice Based Social Workers (Pilot) | NCN Lead  
Social Services Identified practices | 31.03.16 | Better GP Access  
A greater focus on achieving people’s well-being outcomes through holistic integrated assessment and co-productive solutions  
Increased capacity for GP’s where people can access the right person, with the right skills and at the right time. | • Three social workers appointed across Caerphilly, (1 in Caerphilly East NCN based at Risca Surgery). Feedback to date extremely positive  
• Funding allocated as non-recurrent for 2015-16  
• Receiving regular 3 monthly update review reports outlining activity and savings | G |
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<td>Increased patient safety and the promotion of carer’s needs</td>
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<td>Avoidance of admissions to hospital through community support via Frailty, increased care at home, innovative co-productive solutions or access to step up beds</td>
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<td>Patients have local access to and benefit from evidence based interventions; Patients benefit from reduced waiting times from increased GP capacity</td>
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</table>
|    |                                                                           |                                                    | 31.03.16          | • NCN funding agreed to support the role.  
• 1 WTE Pharmacist appointed to Caerphilly East NCN commenced in role on the 12th October ‘15  
• Induction & training programme in place e.g. Independent prescribing training completed.  
• Timetable of mentorship agreed and funded.  
• Outcomes and priorities agreed including face to face medication reviews with a specialist undertaken.  
• Practice pharmacists’ activities replaced 1842 hours of GP time over three months, equivalent to 110,460 minutes or 11,046 x 10 minute appointments. Working on the assumption that a GP provides two 3-hour long surgeries per day [as suggested by the recent paper by Hobbs et. al in the Lancet], this equates to 4.72 GPs working for three months.  
• Evaluation to assess impact expected at 6 and 12 months                                                                                         | G                                                                                 |            |
| 2.2.5 | Recruit Primary Care Based Pharmacists from NCN funding to integrated with NCN and Partners (Also see 7.2.1) | NCN Lead Pharmacy NCN Practices                    |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                  |            |
| 2.2.6 | Increase access to Primary Care Community Phlebotomy Service              | NCN Community Nursing                              | 31.03.16          | • £4.4 million allocated from ABUHB Intermediate Mid-Term Planning (IMTP) funding to support implementation of the service  
• 2016-17 Funding will be allocated from NCN budget on a recurrent basis  
• 6 Phlebotomists have been appointed in January/February 2016                                                                                                                                            |                                                                                  | G         |
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</table>
|    |           |                                   |                   | Immunisations and other interventions  
Releasing DN time to support patients with complex needs who will require greater time spent with them and/or more frequent interventions.                                                                                                      | • 3.5 WTE @ 131.25 hours p/wk for Caerphilly  
• Commenced in roles in February 2016  
• Training requirements being addressed for new appointees  
• Evaluation expected at 6 & 12 months                                                                                                                                  | G          |
| 2.3 | Estates   |                                   |                   |                                                                                                                                                                                                         |                                                                                                                                                                                                                                | G          |
| 2.3.1 | Improve the management of estate issues, lack of space in buildings, lack of grants to be able to increase size of premises | Clinical Lead, PC & ND | 31.05.16 | High quality facilities available to best meet patient need  
Annual practice reviews and CHC statutory visit reports demonstrated facilities are to required standard.                                                                                                                    | • Network Manager has undertaken scoping work through discussions with practices, NCN Lead and Local Authority LDP to establish the needs for the NCN.  
• This work will inform the overall Primary Care and Community Estates strategy for ABUHB.  
• Discussed at practice visits with NCN Lead, Lead GP and Practice Manager.                                                                                             | G          |
| 2.3.2 | To consider accommodation requirements within primary care in relation to wider delivery of services | NCN                | 31.03.16 | Patients are able to local access services in high quality premises                                                                                                                                                                                                 | • Care Closer to Home Presentation by Adele Gittoes delivered at NCN meeting on the 05/05/16.                                                                                                                                       | G          |
### 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 harm

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<tbody>
<tr>
<td>3.1</td>
<td>District Nursing</td>
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</table>
| 3.1.1 | To maximise the effectiveness of the District Nursing (DN) workforce by appointing Community Phlebotomists. | Practices | 31.03.16 | Patients have improved access to both DN Team services and to newly established Community Phlebotomy Team services. | • Phlebotomists newly appointed. Will need to assess effectiveness once the first months data is received (see 2.2.6)  
• 24hr – 7 day service implemented | G |
| | | Community Division  
District Nursing Team Lead | | | | |
| 3.2 | Health Visiting | | | | | |
| 3.2.1 | To build up relationships between Health Visitors and practices | NCN, ABUHB Colleagues | 31.03.16 | Feedback from HVs and Primary Care demonstrates improved communication.  
Improved services for patients  
Consistency for patients in which members of staff they see when having a visit from the Health Visiting Service. | • HV representative regularly attends the NCN meetings  
The service is currently working toward an all Wales model for Health Visiting (Healthy Child Wales Programme). The service will continually update our colleagues in Primary Care with regard to this change in core Service delivery.  
Performance data will be provided to the NCN Management Team.  
There has been occasion due to reduced staffing levels that staff from outside of the immediate team may be required to visit. This is to meet the needs of the client and agreed care plan. Where possible the service maintains continuity of care. | G |
| 3.3 | Mental Health | | | | | |
| 3.3.1 | To strengthen integration at practice level between Primary Care and the PMHT | Practices, PCMHSS, Third Sector, Statutory Services | 31.03.16 | Reduction in the number of referrals passed between different teams within Mental Health services, and PMHTs Clearer care pathways, including transparent, concise access criteria, | • Team Coordinator regularly updates at every NCN meeting.  
Practice based audit for PCMHSS during 2015/16 revealed general approval for the Service.  
Individual service user feedback indicated satisfaction with it.  
By December 2015: 386 referrals received.  
83.2% were assessed within the WA target of 28 | G |
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<td>will be in place for patients GP’s to make use of the PCMHSS Flowcharts and increase their use of the PCMHSS Practitioners for advice/guidance.</td>
<td>days. Awaiting final data from PMHC</td>
<td></td>
</tr>
<tr>
<td>3.3.2</td>
<td>To ensure that patients are seen by the ‘right person in the right place at the right time’.</td>
<td>Practices, PCMHSS, Third Sector, Statutory Services</td>
<td>31.03.16</td>
<td>The usage of CCBT kiosks are regularly monitored through the gathering of statistical information.</td>
<td>• The kiosks have had mixed success, some are up and running and some aren’t. Collecting data for any evaluation has been proving difficult</td>
<td>A</td>
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<tr>
<td>3.3.3</td>
<td>To increase the uptake of psychological intervention through the ‘Road to Wellbeing’ programme.</td>
<td>Practices, PCMHSS, Third Sector, Statutory Services</td>
<td>31.03.16</td>
<td>300 people to have accessed Stress Control and ACTivate your Life classes in Caerphilly between September 2015 and March 2016.</td>
<td>• From June 2015 to March 2016: 1,981 attendances at the Stress Control sessions across Caerphilly, which were held at Pontllanfraith Groundworks Offices and Caerphilly Library. • From June 2015 to March 2016: 445 attendances at the ACTivate Your Life sessions across Caerphilly, which were held at Gelligaer Surgery and Cross Keys College.</td>
<td>G</td>
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</table>

### 3.4 Pulmonary Rehabilitation Services

<p>| 3.4.1 | NCN to explore the feasibility of providing a Pulmonary Rehabilitation Service in the NCN Network | ABUHB Divisional Colleagues, Thematic Leads | 31.03.16 | There will be a locally available Pulmonary Rehabilitation service provision for Patients within the NCN Network Decreased waiting time from referral Decreased travel for patients | • There is a local service in place but has poor capacity. Query fund expansion via savings from respiratory prescribing • British Lung Foundation in early stages of a Third Sector COPD support course | R |</p>
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<tr>
<td>3.5</td>
<td>Diabetes</td>
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<td>Diabetes Consultant email advice line introduced</td>
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</table>
| 3.5.1 | To improve diabetes services across the NCN for Patients | As above | 31.03.16 | Improved management of patient diabetic service needs across the NCN  
Access to advice from multi-disciplinary team and implementation of the new diabetes work plan leads to improved outcomes for patients  
Improved access to DSNs via email/telephone for initiation of injectable therapy  
Improved access to Consultants for advice  
Improved rapid assessment of patients who need consultation opinion | | |
| 3.6 | COPD | | | | | A |
| 3.6.1 | Improve Inhaler Technique for patients | Community Pharmacy  
NCN | 31.03.16 | Patients using devices appropriately | Primary Care Based Pharmacist to deliver the training  
Pharmacist has undertaken the training  
Pharmacist in process of contacting all practices to agree training dates for identified staff | |
| 3.7 | Osteoarthritis Knee | | | | | G |
| 3.7.1 | Improve management of patients with Osteoarthritis of the Knee (OAK) education sessions -scheduled to take place on a Monday afternoon | NCN Lead  
NCN  
Practices | 31.03.16 | Osteoarthritis of the Knee (OAK) education sessions -scheduled to take place on a Monday afternoon | Pilot established in 2015 and presented to the NCN  
Evaluation findings:  
Sessions well attended;  
Patient reported education and empowerment is | |
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<td>on a weekly basis</td>
<td>significantly higher following attendance; Positive patient experience comments; Patients self referring to physiotherapy; Little or no growth in referrals to orthopaedics from the four NCN areas for the pilot period Pilot period extended by 3 months with review expected June 2016</td>
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<tr>
<td>3.8</td>
<td>Sustainable Care Homes Services</td>
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<tr>
<td>3.8.1</td>
<td>Move toward a more sustainable service for delivery of care for patients in care homes</td>
<td>NCN Lead Practices</td>
<td>31.03.16</td>
<td>Improved care for residential patients</td>
<td>Agreement from LMC that current practice seems inequitable and supportive of change Primary Care currently working on practice boundaries and mapping</td>
<td>A</td>
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### 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

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<tr>
<td>4.1</td>
<td>Urgent Access</td>
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<td>4.1.1</td>
<td>Practices to review performance against LMC agreed urgent access figures</td>
<td>GP Practices NCN Lead</td>
<td>31.03.16</td>
<td>Improved patient access to primary care services Practices to engage with project to optimise access in keeping with emerging guidance to be agreed with CHC, Health Board and LMC</td>
<td>Performance reporting discussed at Management Team. Practices undertaken Access LES (see 2.1.1)</td>
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<td>No</td>
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| 4.1.2 | To improve utilisation of available data sources to review activity for the NCN | NCN Lead Network Team GP Practices     | 31.03.16         | Informed understanding of urgent access referrals for NCN patients to secondary care services | • Finalisation and content of the regular NCN Performance Reports has been ongoing throughout 2015/16.  
• Quarterly Performance Reports published for Caerphilly  
• Initial reports have been reviewed by Leads / Members / Support Teams and will provide more appropriate, robust and relevant information during 2016/17  
• Monthly highlights discussed at Management Team meetings with a view to feed down to NCNs | G          |
| 4.1.3 | Appropriate utilisation of WECS Scheme – Eye Health Examination Wales (EHEW) | NCN WECS                               | 31.03.16         | Reduction in avoidable referrals/admissions                             | • Presentation to NCN timescale has slipped due to availability. Planned for delivery by ABUHB Optometrist during 2016.                                                                                             | A          |
| 4.1.4 | Appropriate use of YYF Minor Injuries Unit                                | NCN YYF Minor Injuries Unit            | 31.03.16         | Clarification of MIU services within YYF  
Reduction in avoidable admissions | • Presentation given by ABUHB A&E Consultant at the NCN meeting on 17/03/16 regarding services inclusions and exclusions | G          |

**4.2 Frailty (CRT)**

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| 4.2.1 | Improve appropriate utilisation of the Frailty Service                    | NCN, Practices, CRT Team              | 31.03.16         | Improved access and communication with Fraility and between Frailty and the OOH Service  
Less hand offs between services, and improved communication about the needs of the individual will result in better quality, more timely care | • Engagement with Caerphilly CRT and the NCN has been poor.  
• Capacity issues and period of transition due to change of management.  
• Practices are generally happy with the service provided by the CRT.  
• New CRT Manager has been invited to NCN meetings  
• Meeting held with new CRT Manager and the 3 Caerphilly NCN Leads on the 10.03.16. | A          |
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**Objective**

Increased GP referrals
Reduction in rejection of referrals
Frailty run charts will show improvements.

**Key Partners**

**For Completion by**

**Outcome**

Feedback from GP Practices, Health Visitors, District/Community Nurses will demonstrate improved communications
Patients will receive seamless service transition between primary care and social services

**Progress to Date**

- Regular attendance at NCN meetings by representative of Social Services.
- Regular Feedback and reports received from Practice Based Social Worker based at Risca Surgery.
- Social Services has received additional funding from the Intermediate Care Fund to develop, promote and evaluate the role of the Community Connector. There are presently 3 posts covering the NCN geographical areas of Caerphilly. The project is a preventative and inclusive service to redress the need for Statutory Intervention, to meet the needs of service users, AT THE RIGHT PLACE, AT THE RIGHT TIME.

**4.3 Social Services**

4.3.1 To improve communication between Health Services and Social Services

**Key Partners**

- NCN Lead Network Team
- Caerphilly Integrated Partnership

**For Completion by**

31.03.16

**Outcome**

Feedback from GP Practices, Health Visitors, District/Community Nurses will demonstrate improved communications
Patients will receive seamless service transition between primary care and social services

**Progress to Date**

- Regular attendance at NCN meetings by representative of Social Services.
- Regular Feedback and reports received from Practice Based Social Worker based at Risca Surgery.
- Social Services has received additional funding from the Intermediate Care Fund to develop, promote and evaluate the role of the Community Connector. There are presently 3 posts covering the NCN geographical areas of Caerphilly. The project is a preventative and inclusive service to redress the need for Statutory Intervention, to meet the needs of service users, AT THE RIGHT PLACE, AT THE RIGHT TIME.
### Strategic Aim 5: Improving the delivery of end of life care (National Priority – to be discussed locally)

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| 5.1 | Review the delivery of End of Life Care using the Individual Case Review Audit | NCN Leads, Practices, NCN Support Teams | 31.3.16           | Better care received by individuals at EoL.                                                      | • Dedicated EOLC NCN session held on 21/01/216 with learning points from audits shared and discussed.  
• EOLC Audit Summary Report produced and circulated to NCN by 31/05/16  
• Paper presented to relevant Boards within ABUHB outlining what needs to happen system wide, including 10 lessons in improving patient care. The paper also demonstrates to GP Practices that their work has had an impact.  
• Actions arising from the Audit will be collated and discussed by the NCN for consideration and possible adoption as an element of potential NCN EOLC Standards development | G          |

### Strategic Aim 6: Targeting the prevention and early detection of cancers (National Priority)

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| 6.1 | Review the care of all patients newly diagnosed between 1 January 2015 to 31 December 2015 with lung, gastrointestinal and ovarian cancer | NCN, NCN Leads, Practices               | 31.03.16          | All lung, gastrointestinal and ovarian cancer patients will have their referral information reviewed and o/p appointments / results followed up | • Dedicated Cancer NCN session held on 09/12/15 with learning points from audits shared and discussed.  
• Cancer Audit Summary Report produced and circulated to NCN by 31/05/16  
• Paper presented to relevant Boards within ABUHB outlining what needs to happen system wide, including 10 lessons in improving patient care. The paper also demonstrates to GP Practices that their work has had an impact.  
• All practices participated in the Bowel Screening Non-responders Pilot Project  
• Actions arising from the Audit will be collated and discussed by the NCN for consideration and possible adoption as an element of potential NCN EOLC Standards development | G          |
## Strategic Aim 7: Minimising the risk of poly-pharmacy (National Priority – to be discussed locally and also Medicines Management)

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| 7.1 | Poly-pharmacy | NCN, NCN Leads, Practices | 31.03.16 | Identify patients at high risk or harm of either over or under medicating. | • Dedicated Poly-pharmacy NCN session held on 17/03/2016 with learning points from audits shared and discussed.  
• Poly-pharmacy Audit Summary Report produced and circulated to NCN by 31/05/16  
• Paper presented to relevant Boards within ABUHB outlining what needs to happen system wide, including 10 lessons in improving patient care. The paper also demonstrates to GP Practices that their work has had an impact.  
• Actions arising from the Audit will be collated and discussed by the NCN for consideration and possible adoption as an element of potential NCN EOLC Standards development | G |

### 7.2 Medicines Management

| 7.2.1 | Appointment of Primary Care Pharmacists to assist the delivery of safe and cost effective prescribing to the NCN population | NCN Lead, Practices | 31.03.16 | See 2.2.6 | • See 2.2.5 | G |
| 7.2.2 | To monitor the NCN prescribing budget and delivery of the Medicines Management Plan | NCN Lead, Prescribing Lead GP Practices | 31.03.16 | Efficient use of resources leads to re-investment & more appropriate care | • Primary Care Pharmacy Team member regularly attends NCN meetings to update practices on prescribing information and budget performance.  
• Budgets scrutinised on practice by practice basis at NCN meetings.  
• Individual NCN performance benchmarked against all other NCNs. | G |
| 7.2.3 | To review the variation in prescribing | NCN Lead, GP Practices | 31.03.16 | Patients and professionals have access to a named Pharmacist in Primary | • Primary Care Based Pharmacists appointed through utilisation of NCN funding.  
• Primary Care Pharmacy Team member | G |
### Strategic Aim 8: Delivery consistent, effective systems of Clinical Governance

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<td>8.1</td>
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| 8.1.1 | To fully implement the Clinical Governance Toolkit | NCN, Primary Care & Network Division, GP Practices | 31.03.16 | Consistency and safety in Practice and NCN wide primary care services | • Practices reminded at NCN meetings to undertake the toolkit for 2015/16  
• All 7 practices submitted their CGPSAT forms  
• 2 practices shared their forms via PHW  
• Practices regularly attend CPD sessions facilitated by ABUHB | G |
## Strategic Aim 9: Agreed Locality Priority Issues

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| 9.1 | To Improve communication and utilisation of Mental Health / Mental Wellbeing services in the Locality | NCN, NCN Lead, Practices, PCMHSS, ABUHB Divisional Colleagues | 31.03.15 | Better referrals and access to services in appropriate timescales | • Regular feedback provided by PCMHSS Team Leader at NCN Meetings  
• 83.2% were assessed within the WA target of 28 days | G |
| 9.2 | Establishment of an NCN Web based solution that provides information for local, available services for Dementia patients. | PC & ND Phil Diamond - (Dementia Friendly Community Lead) | 31.03.16 | Patients and their families / carers can access up to date information on services available to them relating to dementia support. | • NCN funding agreed to support development of a Dementia Roadmap – online support resource for people with dementia and their carers and families  
• The Dementia Roadmap due for launch at the end of March 2016  
• Promoted via NCN and Carers Newsletters, Housing Associations etc  
• Evaluation expected at 6 months | G |
| 9.3 | Increase awareness of dementia friendly communities | ABUHB, OAMH, Social Services, LA, NCN, GP Practices | 31.03.16 | Patients are supported in their communities | • Over 50 staff trained in Dementia Awareness across Caerphilly during 2015/16  
• Practices are in the process of signing up as Dementia Friendly Practices | G |
| 9.4 | To improve utilisation of available data sources to review activity for the NCN | NCN Lead, NM, NSO Practices | 31.03.16 | Informed understanding of recorded activity for NCN patients accessing Primary and Secondary Care services | • Monitoring template has been produced and is regularly discussed at Management Team meetings  
• Relevant actions from Management Team disseminated to NCN membership | G |