Our Network: -

We are a Network with 11 main Practices and 10 branch surgeries.

- There are 3 practices recognised for GP Training
- There are 3 practices recognised for Nurse Training
- There are 4 practices offering placements to Cardiff University Student Doctors
- There are GPWSIs in Women’s Health, Diabetes, Cardiology, Family Planning and Substance Misuse
- The Network has the ABUHB GP Lead Facilitator for MacMillan
- There is 1 LMC Executive Member
- 73% 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 68,874. Our NCN area comprises the former Rhymney Valley District Council patch, covering the towns of Ystrad Mynach, Nelson, Markham, Pengam, Bargoed, New Tredegar, Rhymney and surrounding villages and rural areas. The NCN has boundaries with Blaenau Gwent, Merthyr Tydfil and Powys.

This NCN is the most deprived in Caerphilly Local Authority area and is considered a priority for investment for the Council and for the Welsh Government.

Particular features of our population include:

- Growing older population;
- Income deprivation, low educational attainment and high unemployment
- Low levels of digital inclusion
- Pockets of severe deprivation
### We looked at the needs of our community:

- In terms of mental health North Caerphilly has the 2\textsuperscript{nd} highest prevalence of depression across the 12 NCNs at 9.9\%, behind Blaenau Gwent East at 10.2\%.
- For the North NCN area an average of 31.5\% - 35.8\% of adults smoke daily or occasionally (2010), compared with 24\% for Caerphilly overall, and 25\% in Wales. This NCN area has the highest smoking rate in Gwent.
- This NCN area is above Health Board and all Wales levels; and within the highest 25\% in Wales for levels of Hypertension, Diabetes, Coronary Heart Disease and COPD
- The lifestyle of Caerphilly residents is generally unhealthy with obesity levels being the second worst in Wales at 26\%, compared with the Welsh average of 20\%.

### Our agreed priorities for 2015/16 were:

- 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

### What we have achieved:

- 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
- Launched the Living Well Living Longer National Programme in Caerphilly North NCN
- Provision of Smoking Cessation services
- Have established 9 smoking cessation champions in GP practices
- 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

### Our plans for 2016/17:

- Continue to explore ways to improve access to and use of PCMHSS
- Continue to explore methods of improving access to primary care.
- Use of NCN investment funds
- Work with prescribing support team to meet NCN prescribing budget
- Consider comparative radiology/pathology data and how to achieve consistency and quality across practices
- Work with 3\textsuperscript{rd} sector to develop/promote knowledge of the registry of locally available services /social prescribing
- Improve uptake of flu vaccinations
Strategic Aim 1: To understand the needs of the population served by the Network

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| 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 has not been available.  
- Brief intervention training for staff – 42 staff across Caerphilly have been trained during 2015/16 with future training planned for 2016/17  
- 9 out of 11 practices currently have a Smoking Champion.  
- 3 Stop Smoking Wales Clinics held at various venues in the North NCN.  
Progress of Level 3 Smoking Cessation Pharmacies:  
**2014/15**  
3 Pharmacies offer level 3 Smoking Cessation Services  
**2015/16**  
7 Pharmacies offer level 3 Smoking Cessation Services | A |
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<tr>
<td>1.2</td>
<td>Obesity</td>
<td>NCN, Social Services/Communities First, Adult Weight Management Service, PHW, GAVO</td>
<td>31.03.16</td>
<td>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</td>
<td>• 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 28\th April 2016. Further Workshop planned. • X-POD - 63 Referrals made from practices - 46 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 biemg developed with MECC/PHW</td>
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<td>1.3</td>
<td>Bowel Screening</td>
<td>NCN, PHW, National Screening Services, GP Practices</td>
<td>31.03.16</td>
<td>Earlier detection of bowel cancer with improved chance of survival</td>
<td>• NCN funding agreed. • Lists provided by Bowel Screening Wales via PHW • 1455 patients identified (over 2 cohorts of lists). • 1222 contacts made. • Evaluation to be undertaken by PHW / SSW to show impact against national target of 60% target.</td>
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<td>1.4</td>
<td>Public Engagement</td>
<td>Network Team NCN, GP Practices, Communities First</td>
<td>On-going</td>
<td>Formal and informal consultation opportunities for all residents to influence the development and improvement of all services (including integrated services)</td>
<td>• 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</td>
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|    | Strategy and seeking / collecting information on service provision and change from the wider Gwent resident population. | GAVO                                                                          |                   | across ABUHB.                                | NCNs.  
|    |                                                                           |                                                                               |                   |                                              | • NCN Leads and Network Manager attending an ABUHB Engagement & Listening event at Asda Caerphilly on 06/05/16. |            |
| 1.5 | **Influenza**                                                            |                                                                               |                   |                                              |                                                                                                     | A          |
| 1.5.1 | Achieve the national target of 75% for immunisation against influenza     | GP Practices, NCN, Contractor Services, DNs                                  | 31.03.16          | Decrease in hospital admissions, Decrease in morbidity | Progress 2015/16:  
|    |                                                                           |                                                                               |                   |                                              | • 66.9% achieved as at 07.03.16 for immunisation against influenza for 65yrs and older          |            |
|    |                                                                           |                                                                               |                   |                                              | • 48.7% 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 Management Team 2nd June 16. |            |
| 1.6 | **NCN Management Team**                                                   |                                                                               |                   |                                              |                                                                                                     | G          |
| 1.6.1 | Establish a Management Team Structure for Caerphilly East NCN             | NCN Lead, NCN Partnership Teams, Network team                                | 31.03.16          | Improved guidance, coordination 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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| 2.1.1| 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 26/05/16.  
  • Workshop planned for practices.  
  • Dedicated session held at NCN meeting on the 24/03/16 for practice taking up the Access LES  
  • Uptake of the Access LES:  
    - Gelligaer Surgery  
    - Meddygfa Cwm Rhymni  
    - Oakfield St Surgery                                                                                           | A                                                     |
| 2.1.2| 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 North NCN.  
  • 64% of practices using for Appointments  
  • 64% of practices using for Prescribing  
  • 92% of all ABUHB practices using elements of MHOL.                                                                 | G                                                     |
| 2.2  | Workforce                                     |                       |                  |                                                                                                                                           |                                                                                                       |            |
| 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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| 2.2.2 | Long term viability and sustainability of Caerphilly north NCN practices                        | NCN practices and ABUHB   | 31.03.16         | Maintained availability of local primary care GP service provision       | • Meeting held with Clinical Director to discuss issues  
• Various federation options being explored  
• Care Closer to Home presentation planned for 26/05/16                                                                                                 | G          |
| 2.2.3 | Diversify the range of allied professional supporting GPs in practices through training etc    | Practices ABUHB           | 31.03.16         | Improved access to a more diverse range of allied specialties within surgeries, i.e HCAs, NPs, minor illness trained Nurses, Pharmacists, Social Workers etc | • Variety of training/development opportunities have been supported by NCN funding for 2015/16 (see below).                                                                                               | G          |
| 2.2.4 | 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          |
| 2.2.5 | 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          |
| 2.2.6 | Provide Practice Based Social                                                                  | NCN Lead                  | 31.03.16         | Better GP Access  
A greater focus on  | • Three social workers appointed across Caerphilly, (1 in Caerphilly East NCN based at Risca Surgery). Feedback to date extremely positive.                                                                 | G          |
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|    | Workers (Pilot) | Social Services Identified practices | | achieving people’s well-being outcomes through holistic integrated assessment and co-productive solutions | - Funding allocated as non-recurrent for 2015-16.  
- Receiving regular 3 monthly update review reports outlining activity and savings. | |
|    |          |              |                  | Increased capacity for GP's where people can access the right person, with the right skills and at the right time. | |
|    |          |              |                  | Increased patient safety and the promotion of carer’s needs | |
|    |          |              |                  | Avoidance of admissions to hospital through community support via Frailty, increased care at home, innovative co-productive solutions or access to step up beds | |
| 2.2.7 | Recruit Primary Care Based Pharmacists from NCN funding to integrated with NCN and Partners (Also see 7.2.1) | NCN Lead Pharmacy NCN Practices | 31.03.16 | Patients have local access to and benefit from evidence based interventions; Patients benefit from reduced waiting times from increased GP capacity | - NCN funding agreed to support the role.  
- 1.88 WTE Pharmacists (3 individuals) appointed to Caerphilly North NCN commenced in roles in September, November & December 2015  
- 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 | G |
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|    | 2.2.8     | Increase access to Primary Care Community Phlebotomy Service | NCN Community Nursing | 31.03.16 | Increased capacity and access to Primary Care phlebotomy services | • £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.  
• 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 months and 12 months. |

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<th>2.3 Estates</th>
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|    | 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 | • 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. |
|    | 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 planned for the NCN meeting on the 26/05/16 |
### 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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<tr>
<td>3.1</td>
<td>Living Well Living Longer</td>
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| 3.1.1 | Introduce the Living Well, Living Longer Programme across the NCN | Practices Community Division District Nursing Team Lead | 31.03.16 | Patients have improved access to both DN Team services and to newly established Community Phlebotomy Team services. See 2.2.6 | • LWLL Programme underway in Caerphilly North NCN – Dec 2015.  
• By the end of Jan 2016, 150 citizens seen across 28 sessions at RIHSCC, Rhymney Library and St David’s Community Centre.  
• 22% identified as at ‘increased risk’  
• 19 citizens successfully referred to Stop Smoking Wales.  
• Awaiting final report from LWLL | G |
| 3.2 | District Nursing | | | | | |
| 3.2.1 | To maximise the effectiveness of the District Nursing (DN) workforce by appointing Community Phlebotomists. | 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. | • Phlebotomists newly appointed. Will need to assess effectiveness once the first months data is received (see 2.2.8).  
• 24hr – 7 day service implemented. | G |
| 3.3 | Health Visiting | | | | | |
| 3.3.1 | 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 | G |
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<td>Practices, PCMHSS, Third Sector, Statutory Services</td>
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<td>possible the service maintains continuity of care.</td>
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<td>3.4</td>
<td><strong>Mental Health</strong></td>
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| 3.4.1 | 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, 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. | • 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 days. Awaiting final data from PMHC | G          |
| 3.4.2 | To ensure that patients are seen by the 'right person in the right place at the right time'. | Practices, PCMHSS, Third Sector, Statutory Services | 31.03.16         | The usage of CCBT kiosks are regularly monitored through the gathering of statistical information.                                                                                                          | • The kiosks have had mixed success, some are up and running and some aren’t. Collecting data for any evaluation has been proving difficult | A          |
| 3.4.3 | To increase the uptake of psychological intervention through the 'Road to Wellbeing' programme. | Practices, PCMHSS, Third Sector, Statutory Services | 31.03.16         | 300 people to have accessed Stress Control and ACTivat Your Life classes in Caerphilly between September 2015 and March 2016.                                                                          | • 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 ACTivat Your Life sessions across Caerphilly, which were held at Gelligaer Surgery and Cross Keys College. | G          |
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| 3.4.4 | Evaluate the effectiveness of LEAP and feedback experiences and outcomes to NCN | Leap team members                 | 31.03.16         | Signposted care by the most appropriate person                                           | • Received 420 referrals by November 2015.  
• Feedback meeting arranged with Bev Nash to discuss progress, feedback and evaluate.  
• Practices stated that LEAP is working very well. |
| 3.5   | **Pulmonary Rehabilitation Services**                                      |                                   |                  |                                                                                                                                             |                                                                                                                                                                                                                  | G        |
| 3.5.1 | 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 |
| 3.6   | **Diabetes**                                                               |                                   |                  |                                                                                                                                             |                                                                                                                                                                                                                  | R        |
| 3.6.1 | 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 | • Diabetes Consultant email advice line introduced.  
• Diabetes Consultant/DSN telephone advice line introduced  
• Community Primary Care DSN’s receiving patients and planning discharge from secondary care services.  
• The Local Development Plan for Diabetes 2016/17 is being produced with the Integrated Model embedded within it. |
### 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>
<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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#### 3.7 COPD

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<td>3.7</td>
<td>COPD</td>
<td>Community Pharmacy, NCN</td>
<td>31.03.16</td>
<td>Patients using devices appropriately</td>
<td>• 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</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 |
| 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 Dawn Saville during 2016. |
| 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 delivery by ABUHB A&E Consultant planned for NCN meeting on 26/05/16. |
| 4.2 | Frailty (CRT) | NCN, Practices, CRT Team | 31.03.16 | Improved access and communication with Frailty 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. |
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<td>Increased GP referrals</td>
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<td>Reduction in rejection of referrals</td>
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<td>Frailty run charts will show improvements</td>
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### 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

**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 Gelligaer 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.

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### 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 04/02/16 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 | G |
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|    | 6.1       | 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 03/12/15 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 |

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

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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 24/03/16 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 |

**Strategic Aim 7: Minimising the risk of poly-pharmacy (National Priority – to be discussed locally and also Medicines Management)**
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**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 |

<p>| 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 &amp; 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. |</p>
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| 7.2.3 | To review the variation in prescribing compared to national guidance in relation to Diabetes and Respiratory and deliver the NCN savings target for these work streams within the three year plan | NCN Lead, GP Practices, Pharmacy | 31.03.16 | Patients and professionals have access to a named Pharmacist in Primary Care  
Efficient use of resources that can be re-invested more appropriately into patient care  
Minimise avoidable harm from the adverse effects of inhaled steroids  
Undertaking the minimum appropriate intervention to ensure prudent prescribing aligned with NICE Guidance. | • Primary Care Based Pharmacists appointed through utilisation of NCN funding.  
• Primary Care Pharmacy Team member presented information for general discussion at NCN meetings regularly.  
• Data presented to NCN regularly by Primary Care Pharmacy Team member and prescribing switch options highlighted.  
• Efficiencies and practice performance openly discussed at all NCN meetings. |
| 7.2.4 | To provide consistency in medicines reviews in both Practice and home visit settings. | NCN Leads, Practices | On-going | Patients will have a consistent medicines review in Practice or at home. | • Primary Care Based Pharmacist is regularly undertaking medicine reviews across all practices within the NCN |
### Strategic Aim 8– Delivery consistent, effective systems of Clinical Governance

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| 8.1 | Clinical Governance | 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.  
• 9 out 11 practices submitted their CGPSAT forms.  
• 7 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  
• Awaiting final data from PCMHSS | 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 |
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| 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 |