Primary Care Clusters 2019

GIG CYMRU NHS WALES

Iechyd Cyhoeddus Cymru

Public Health Wales

FOREWORD

I am pleased to present this Yearbook, which has been prepared for the 4th National Primary Care Conference, 'Clusters Past Present and Future'. This synopsis showcases the wide range of good work being undertaken locally by clusters; delivering a positive impact to patients across Wales.

Providing and connecting people to a wide range of care and support in local communities is essential in meeting the health and wellbeing needs of the people of Wales. Collaborating at community level through the clusters to plan and deliver this care and support is vital to transforming our health and care system and achieve the vision set out in A Healthier Wales.

Taken together, the submissions from each cluster demonstrates how clusters have developed since the National Plan for a Primary Care Services for Wales was published in 2014 and the collective and ongoing commitment to the Primary Care Model for Wales. The impressive examples of work in specific clusters across Wales, together with the enthusiasm and commitment of staff working with and within clusters, is clear in reading this synopsis.

We must now reflect on the progress to date and continue to make further improvements. For my part, I will continue to encourage clusters to evolve and mature to respond to local challenges to improve the health and wellbeing of the population they serve.

Vaughan Gething AM
Minister for Health and Social Services

Aneurin Bevan University Health Board

Foreword

by Siân Millar
Director, Primary Care & Community Services

I am delighted to introduce the Yearbook contribution for ABUHB.

Clinical Futures (CF) has been the consistent ABUHB organisational strategy since 2007, aiming to provide more care closer to home, harnessing the important role of patients and their carers in maintaining independence and improving health. A network of Local General Hospitals has been developed, providing local access to safe hospital services that people use most frequently. A single Specialist and Critical Care Centre is under construction at Llanfrechfa, near Cwmbran, to provide rapid access to the most specialist care when needed. A core component of the CF strategy is to strengthen and develop primary, community and social care services. In order for us to continue to improve the health and well-being of our growing and ageing population, we need to change how we do things. We have developed a place-based model of well-being called Integrated Well-being Networks.

This work is creating the capacity to support and treat more patients in their homes and communities:-

- Helping people to live a healthy and independent life
- Detecting health problems quickly
- Delivering timely, effective local integrated care and support
- Involving people in decisions about local services and their care
- Planning, organising and delivering local integrated care

The Neighbourhood Care Network (NCN) teams (our local terminology for clusters) work at the centre of this significant transformation agenda, engaging a wide range of local partners to understand local priorities and to create appropriate and effective solutions. This requires a population health approach, a detailed understanding of national policy and local strategies and an ability to work across organisational boundaries to maintain focus on collaborative community-focussed solutions.

Representation from primary care, public health, local authorities, hospital services and third sector organisations was established at an early stage of NCN development and investment was made into clinical leadership and management support. A Neighbourhood Care Network Strategic Plan guided the progression of this work from 2013-2018 delivering:-

- 12 clinically led Neighbourhood Care Networks (enabling services to be planned and delivered on population bases 30-50,000).
- A frailty model across Gwent
- Continued emphasis on developing core primary care including a proactive approach to the management of GP sustainability challenges
- Increased emphasis on the interface between primary and community services and the acute sector
- Implementation of new community services including Community Resource Teams and Primary Mental Health Services.

As concerns increased in relation to the sustainability of GP services, the organisation took action to encourage recruitment, support practice mergers and facilitate collaborative working across networks. The implementaion of the New Model of Primary Care has been strongly supported, introducing new roles such as clinical pharmacists, advanced nurse practitioners, physicians associates and physiotherapists into primary care practice. A Primary Care Academy has been introduced, as a Transformation Fund initiative, to provide experience in a primary care setting and encourage recruitment into local services.

An NCN Indicator Dashboard and Comparison Tool guides local analysis and provides regular feedback on the progress against agreed objectives. Each NCN Lead also takes responsibilty for the development of integrated care pathway solutions across service boundaries. NCN leads have been encouraged to undertake personal development and many have completed the Confident Leaders Programme.

The NCN Development Programme 2019

The Integrated Medium Term Plan for ABUHB requires NCNs to accelerate the pace of change from April 2019 to implement the Care Closer to Home agenda. Many aspects of the work being undertaken by the NCNs are testing new ground and require a robust and supportive professional framework to prepare, deliver and evaluate new approaches. The Medical Director requested that an intensive development programme be introduced to support the NCN leads and their teams in order to create mature Neighbourhood Care Network systems to articulate and address local needs. The programme aims to provide the pace and scale of primary care development necessary for the ABUHB integrated care system, through which organisational priorities can be delivered. This will include significant programmes of work, including the Compassionate Communities initiative, arising through the Transformation Programme.

The NCN Development Programme is coordinated by a Steering Group- ensuring the engagement of senior leadership. It is delivered by ABCi through 18, monthly, 1hour diagnostic workshops and informed by a Resource Pack to collate all the relevant policy, strategy and 'how to' guidance. There are plans for a Peer Review programme. This is an action learning approach that tailors learning to real challenges and the application of knowledge to achieve local solutions.

Each NCN has produced a Plan on a Page to illustrate local priorities. This detailed focus allows us to respond to the particular needs of each community and to identify where common solutions can be developed. We are also committed to learn from good practice and look forward to using the Yearbook as a source of ideas for future work.

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Blaenau Gwent East

Cluster Lead **Dr Isolde Shore-Nye** Isolde.Shore-Nye@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

- Blaenau Gwent is the smallest Local Authority in Gwent.
- 2017 Census shows 69,609 total population.
- Blaenau Gwent has an ageing population – 19.5% of the Borough are aged 65 years and over. (Blaenau Gwent Well-being Needs Assessment, 2017).
- Annual Population Survey (June 2016) shows that Blaenau Gwent continues to have significantly above average levels of disability with a total of 31.6% of working age people being defined as disabled (economically active core or work-limiting disabled) compared to 22.8% for Wales.
- These comparatively high levels of disability in Blaenau Gwent leads to a high proportion of people claiming disability-related benefits, with 12.0% of working aged people in Blaenau Gwent claimed EAS or Incapacity Benefit, compared to 8.4% across Wales (May 2016).
- When considering the individual domains for the area, Blaenau Gwent had the highest percentage of LSOAs in the most deprived 10% in Wales, for income (19.1%), education (27.7%), and community safety (23.4%).

The NCN has a Practices based population of 33,604 across five Practices, two of which are Health Board Managed Practices.

Practice	Practice Population	Population >65 years	% age
Abertillery Group Practice	7,476	1,505	20.13
Aberbeeg Medical Practice (Managed)	4,528	844	18.64
Blaina Surgery	6,351	1,232	19.40
Brynmawr Wellbeing Centre (Managed)	10,321	2,048	19.84
Cwm Calon Surgery	4,928	997	20.23
Totals	**33,604**	**6,626**	**19.72**

The NCN has an annual budget allocation of £110,907. Recurring funding is appropriated for Independent Contractor Advisors, a DEWIS Coordinator, HCSW Phlebotomist, NCN Pharmacists, First Contact Physiotherapist service at Ysbyty Aneurin Bevan (YAB) and an annual subscription to the Dementia Roadmap programme.

Dr Isolde Shore-Nye is the NCN / GP Cluster Lead and is a Partner at Cwm Calon Surgery. She has the Clinical Lead for Children's Services, including CAHMs, for the Gwent NCNs / GP Clusters.

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

- We are implementing a Compassionate Communities programme, led by East NCN Practices.
- Identified GP Clinical Fellows, First Contact Physiotherapists, Practice Pharmacists, and Paramedic led Home Visiting Services for recruitment via Transformation Budgets.
- Established Graduated Care Services (Assessment and Treatment Units, Nurse led Wards, Virtually Home Discharge, District Nurse led weekend Wound Clinic) at YAB.
- Employed an Extended Role Occupational Therapist at Brynmawr Wellbeing Centre and a Physician's Associate at Aberbeeg Medical Practice.
- Implemented Care Navigation and Workflow Optimisation Programmes.
- Established an Intergenerational Action Plan and Work Programme.
- Strengthened preventative services through recruitment to the Information, Assistance and Advice Team based with the Local Authority.
- Community Connectors assigned to each GP Practice on a rota basis.
- Locality Team led the launch of the Period Poverty Programme across Blaenau Gwent.
- Development of an integrated emergency care team (DASH).
- Successfully maintained Primary Care services during inclement weather.
- Appointed a Manager for the Integrated Well-being Network for Blaenau Gwent.

WHAT IS NEXT?

- **Sustainable, quality and safe local services** - Enabling our resident populations to access local services fit for purpose and without the need to travel for them.
- **Improving uptake of preventative services, self-care and advice** – Encouragement of further uptake of My Health Online, greater use of Care Navigation and Signposting, screening services offered by Public Health Wales for cancers and heart disease and continued work towards increased numbers of childhood immunisations and flu immunisations, respectively.
- **Compassionate Communities** – Developing caring communities from the local population upwards to make the best use of networks, assets and resources in the NCN.
- **Graduated Care** - Continued development and measurement of graduated care schemes at YAB. The feasibility of a Therapy Enhanced Enablement Model and a Direct Admissions Service for GPs, respectively, is in the pipeline.
- **Technology** - Automation of processes wherever possible to deliver consistency in collection, analysis and presentation of activity.
- **Partnership Working** - The NCN memberships are multi-organisational and the trust and drive to achieve mutually beneficial objectives are essential to be able to deliver on them.
- **Skilled Workforce** - Our staff are our greatest assets – our IMTP Plans include objectives to enable and upskill our teams to deliver on our stated objectives.
- **Financial Resources** – Financial probity and transparency will continue to be a top priority in the administration of the NCN's allocated budget.
- **Fit for Purpose Estate** - The NCNs in both the East and the West are moving towards a four-hub basis for health and social care provision across Blaenau Gwent. Brynmawr is already up and running. The Project at Tredegar is underway and there is pipeline funding in place for a Hub in Ebbw Vale. The Bridge Centre in Abertillery is a consideration for developing as a fourth hub. Projects for capital bids or improvement grants will be identified on an on-going basis to ensure our estate is maintained in a fit for purpose state.

Gwent Association of Voluntary Organisations

OUR AIMS

- Improve the health and wellbeing of the local population.
- Addressing Health inequalities and working to reduce them.
- Reduce the impact of changes to health and social care.
- Ensuring sustainable Primary care services locally.
- Making sure people are supported to stay well at home.
- Wrap flexible care around the person, providing local 'place-based' care.
- Improving access to specialist care in a timely manner if not available locally.
- Provide access to community pharmacy services according to local need
- Listening to local population and adapting to change.
- Recognising that our population is also our staff; supporting well-being recruitment and retention.

WHAT WE ARE DOING

- Implementing the New Model of Primary Care to meet local needs including additional nursing, physiotherapy, mental health roles to improve access and ensure sustainability of local services.
- Mapping and raising awareness of care and advice available through local services such as community pharmacies, optometry, dental and voluntary sector teams.
- Improving prevention services including influenza immunization, childhood immunisation, smoking cessation, weight management and exercise schemes.
- Improving services to residents in Care Homes through intergenerational befriending and improving medicines management.
- Improving frailty services though a graduated care approach with the Community Resource Team and new Frailty Unit in Ysbty Aneurin Bevan.
- Introducing Compassionate Communities to further develop patient centred goal setting and care planning.

Blaenau Gwent West

Cluster Lead **Dr David Minton** David.Minton@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

- Blaenau Gwent is the smallest Local Authority in Gwent.
- 2015 Census shows 69,544 total population.
- Blaenau Gwent has an ageing population – 19.72% are aged 65 years and over.
- Annual Population Survey (June 2016) shows that Blaenau Gwent continues to have significantly above average levels of disability with a total of 31.6% of working age people being defined as disabled (economically active core or work-limiting disabled) compared to 22.8% for Wales.
- These comparatively high levels of disability in Blaenau Gwent leads to a high proportion of people claiming disability-related benefits, with 12.0% of working aged people in Blaenau Gwent claimed EAS or Incapacity Benefit, compared to 8.4% across Wales (May 2016).
- When considering the individual domains for the area, Blaenau Gwent had the highest percentage of LSOAs in the most deprived 10% in Wales, for income (19.1%), education (27.7%), and community safety (23.4%).

Cyngor Bwrdeistdref Sirol
Blaenau Gwent
County Borough Council

The NCN has a Practices based population of 38,378 across six Practices, one of which is a Health Board Managed Practice.

Practice	Practice Population	Population >65 years	%age
Cwm Health Centre	3,522	706	20.05
Glan Rhyd	8,554	1,747	20.42
Glan Yr Afon	6,746	1,330	19.72
Glyn Ebwy	7,100	1,291	18.18
Pen Y Cae	6,874	1,305	18.98
Tredegar Health Centre	5,582	1,260	22.57
Totals	**38,378**	**7,639**	**19.90**

The NCN has an annual budget allocation of £122,340. Recurring funding is appropriated for Independent Contractor Advisors, a DEWIS Coordinator, a Phlebotomist, Pharmacists, First Contact Physiotherapist service at Ysbyty Aneurin Bevan (YAB) and an annual subscription to the Dementia Roadmap programme.

Dr David Minton is the NCN / GP Cluster Lead. Dr Minton has the Clinical Lead for Surgical Specialties and Gastroenterology and a Lead for Value Based Care within Aneurin Bevan University Health Board.

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

- We are implementing a Compassionate Communities programme, led by West NCN Practices.
- Identified First Contact Physiotherapists, Mental Health Practicioners, Practice Pharmacists, and an Occupational Therapist led Home Visiting Service for recruitment via Transformation Budgets.
- Established Graduated Care Services (Assessment and Treatment Units, Nurse led Wards, Virtually Home Discharge, District Nurse led weekend Wound Clinic) at YAB.
- Undertaken demand and activity audits, piloted Audiology Services in Primary Care in our West NCN Practices, and developing a Fibromyalgia Community support Pathway.
- Implemented Care Navigation and Workflow Optimisation Programmes.
- Established an Intergenerational Action Plan and Work Programme.
- Strengthened preventative services through recruitment to the Information, Assistance and Advice Team based with the Local Authority.
- Community Connectors assigned to each GP Practice on a rota basis.
- Locality Team led the launch of the Period Poverty Programme across Blaenau Gwent.
- Secured funding for the 'Blaenau Gwent on the Move' Partnership initiative.
- Development of an integrated emergency care team (DASH).
- Successfully maintained Primary Care services during inclement weather.
- Appointed a Manager for the Integrated Well-being Network for Blaenau Gwent.

WHAT IS NEXT?

- **Sustainable, quality and safe local services** - Enabling our resident populations to access local services fit for purpose and without the need to travel for them.
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- **Compassionate Communities** – Developing caring communities from the local population upwards to make the best use of networks, assets and resources in the NCN.
- **Graduated Care** - Continued development and measurement of graduated care schemes at YAB. The feasibility of a Therapy Enhanced Enablement Model and a Direct Admissions Service for GPs, respectively, is in the pipeline.
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WHAT WE ARE DOING

- Implementing the New Model of Primary Care to meet local needs including additional nursing, physiotherapy, mental health roles to improve access and ensure sustainability of local services.
- Mapping and raising awareness of care and advice available through local services such as community pharmacies, optometry, dental and voluntary sector teams.
- Improving prevention services including influenza immunization, childhood immunisation, smoking cessation, weight management and exercise schemes.
- Improving services to residents in Care Homes through intergenerational befriending and improving medicines management.
- Improving frailty services though a graduated care approach with the Community Resource Team and new Frailty Unit in Ysbyty Aneurin Bevan.
- Introducing Compassionate Communities to further develop patient centred goal setting and care planning.

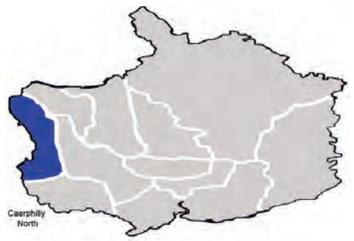
Caerphilly North

Cluster Lead **Heather Griffiths** Heather.Griffiths4@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

Caerphilly North NCN Cluster serves a cluster population of 64,850. There are 9 practices within the area, namely Bryntirion Surgery, Meddygfa Gelligaer, Markham Medical Centre, Nelson Surgery, Oakfield Surgery, Pengam Health Centre, The Lawn Medical Practice, South Street Surgery, Meddygfa Cwm Rhymni

Dr Heather Griffiths is the NCN Lead for Caerphilly North and her areas of responsibility are Diabetes, Endocrinology and Neurology. Heather has been a GP at Oakfield St Surgery in Ystrad Mynach for the last 24 years and has been an NCN Lead for Caerphilly North NCN for six years.



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

The three Caerphilly NCN clusters held a joint event in November 2018 in association with third sector colleagues and this proved very positive with a large number of partner services being represented. The event provided a good understanding of the 'compassionate communities' agenda and how by working collaboratively this can be achieved within Caerphilly. The event was attended by all 23 GP practices and provided them with a better understanding of the volunteer services available locally.

First Contact Physiotherapy

Direct access to assessment by an experienced Band 7 physiotherapist within the GP practice setting for patients who have a concern regarding a musculoskeletal problem and its management. Early feedback at NCN meetings has been extremely positive with the only negative aspect being the need to further expand the service with additional sessions.

Period Dignity

Initiative developed in response to the emerging evidence that accessing sanitary products can be costly and difficult. Caerphilly wide project being implemented providing Red Boxes' of free sanitary products not only in schools but also in other public venues for other women and young girls to benefit from the initiative.

Primary Care Paediatric Toileting/Constipation Pathway

Pathway developed for children aged 0-5 years who have delayed continence or are constipated. The NCN supported the Flying Start service to develop pathway, raise awareness, identify suitable clinic venues and funded the ERIC training for local staff to deliver service.

County Lines

Gwent Police gave an informative and eye opening presentation on 'County Lines' which is criminal exploitation where gangs/ organised crime networks exploit children and vulnerable people to sell drugs. Individuals are made to travel across counties, using dedicated mobile phone 'lines' to supply drugs. It was agreed that a multi-agency response working closely with the NCN / services/organisations to be vigilant and aware and sharing information on the issue will positively assist the police in tackling this issue.

Care Navigation

GP practice staff across the NCN have received training in the delivery of Care Navigation enabling them to signpost patients to relevant services and improve access to relevant GP appointments. It allows front line staff to provide patients with more information about local health and wellbeing services, both within and outside of primary care, in a safe, effective way. It is about offering patients choice and help to access the most appropriate service first which is not always the GP. It means that patients to find it easier to get a GP appointment when they need one.

WHAT WE ARE DOING

- Provide easily accessible 'place based' health and social care to the citizens of Caerphilly North.
- Review and adapt the current model of integrated services based at Rhymney Integrated Health & Social Care Centre.
- Work with providers to ensure health and social care services are sustainable.
- Continue developing primary care teams including traditional GP, DN and HV roles as well as any new roles. There should be excellent communication within the team with minimal or no 'hand-offs'.
- Utilise new primary care roles to help facilitate accessible health care. Where appropriate, these should be part of 'place based working'. Roles could include; Social prescriber, Practice based pharmacist, First contact physiotherapist, Mental health worker, Primary care audiologist, Primary care paramedic, Primary care OT, Social worker.
- Ensure appropriate utilisation of local services such as community pharmacy and third sector services.
- Ensure appropriate utilisation and easy accessibility of specialist roles such as; Diabetic specialist nurse, Heart failure nurse and Palliative care nurse specialist.
- Utilise appropriate preventative services to keep citizens well including; influenza immunisation, smoking cessation services, weight management services, exercise schemes.
- Ensure appropriate utilisation of current high quality health and social care estate.
- Work to reduce antibiotic usage.

Caerphilly East

Cluster Lead **Stuart Thomas** Stuart.Thomas6@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

Caerphilly East NCN Cluster serves a cluster population of 65,800. There are 7 practices within the area:

- Avicenna Medical Centre
- North Celynen Practice
- Pontllanfraith Health Centre
- Risca Surgery
- St Luke's Surgery
- Sunnybank Health Centre
- Wellspring Medical Centre

Stuart has been a GP Partner at Wellspring Medical Centre in Risca for the last 33 years and started his role as the NCN Lead for Caerphilly East NCN 3 years ago. His areas of responsibility are Respiratory, Allergy and Haematology. He feels these are challenging but exciting times for Primary Care with great opportunity to develop and improve the local service provision.

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

The three Caerphilly NCN clusters held a joint event in November 2018 in association with third sector colleagues and this proved very positive with a large number of partner services being represented. The event provided a good understanding of the 'compassionate communities' agenda and how by working collaboratively this can be achieved within Caerphilly. The event was attended by all 23 GP practices and provided them with a better understanding of the volunteer services available locally.

First Contact Physiotherapy

Direct access to assessment by an experienced Band 7 physiotherapist within the GP practice setting for patients who have a concern regarding a musculoskeletal problem and its management. Early feedback at NCN meetings has been extremely positive with the only negative aspect being the need to further expand the service with additional sessions.

Period Dignity

Initiative developed in response to the emerging evidence that accessing sanitary products can be costly and difficult. Caerphilly wide project being implemented providing Red Boxes of free sanitary products not only in schools but also in other public venues for other women and young girls to benefit from the initiative.

Primary Care Paediatric Toileting/Constipation Pathway

A pathway for children aged between 0-5 years who have delayed continence or are constipated has been developed. The NCN supported the Flying Start service to develop pathway, raise awareness, identify suitable clinic venues and funded the ERIC training for local staff to deliver the service.

County Lines

Gwent Police gave an informative and eye opening presentation on 'County Lines' which is criminal exploitation where gangs/ organised crime networks exploit children and vulnerable people to sell drugs. Individuals are made to travel across counties, using dedicated mobile phone 'lines' to supply drugs. It was agreed that a multi-agency response working closely with the NCN / services/ organisations to be vigilant and aware and sharing information on the issue will positively assist the police in tackling this issue.

Care Navigation

GP practice staff across the NCN have received training in the delivery of Care Navigation enabling them to signpost patients to relevant services and improve access to relevant GP appointments. It allows front line staff to provide patients with more information about local health and wellbeing services, both within and outside of primary care, in a safe, effective way. It is about offering patients choice and help to access the most appropriate service first which is not always the GP. It means that patients to find it easier to get a GP appointment when they need one.

WHAT WE ARE DOING

- Provide easily accessible 'place based' health and social care to the citizens of Caerphilly North.
- Work with providers to ensure health and social card services are sustainable.
- Continue developing primary care teams including traditional GP, DN and HV roles as well as any new roles. There should be excellent communication within the team with minimal or no 'hand-offs'.
- Utilise new primary care roles to help facilitate accessible health care. Where appropriate, these should be part of 'place based working'. Roles could include; Social prescriber, Practice based pharmacist, First contact physiotherapist, Mental health worker, Primary care audiologist, Primary care paramedic, Primary care OT, Social worker.
- Ensure appropriate utilisation of local services such as community pharmacy and third sector services.
- Ensure appropriate utilisation and easy accessibility of specialist roles such as; Diabetic specialist nurse, Heart failure nurse and Palliative care nurse specialist.
- Utilise appropriate preventative services to keep citizens well including; influenza immunisation, smoking cessation services, weight management services, exercise schemes.
- Ensure appropriate utilisation of current high quality health and social care estate.
- Waste Management - Reduce medicines waste and safety concerns relating to repeat prescribing systems.
- Use data/evidence to inform decision making.
- Use IT/technology to enhance/improve service delivery.

Caerphilly South

Cluster Lead **Dr Alun Edwards** Alun.Edwards@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

Caerphilly South NCN Cluster serves a cluster population of 56,500. There are 7 practices within the area:

- Courthouse Medical Centre
- Lansbury Surgery
- Tonyfelin Medical Centre
- Aber Medical Centre
- Nantgarw Road Medical Centre
- Village Surgery
- Ty Bryn Surgery

Dr Alun Edwards is the NCN Lead for Caerphilly South and areas of responsibility are Cardiology, Stroke and the NCN web pages. Alun has been a GP in Ty Bryn Surgery Trethomas since 2001 and is a GP trainer. He has previously been an independent medical adviser within Caerphilly and was a Clinical Champion for Cardiology in Aneurin Bevan University Health Board.

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

The three Caerphilly NCN clusters held a joint event in November 2018 in association with third sector colleagues and this proved very positive with a large number of partner services being represented. The event provided a good understanding of the 'compassionate communities' agenda and how by working collaboratively this can be achieved within Caerphilly. The event was attended by all 23 GP practices and provided them with a better understanding of the volunteer services available locally.

First Contact Physiotherapy

Direct access to assessment by an experienced Band 7 physiotherapist within the GP practice setting for patients who have a concern regarding a musculoskeletal problem and its management. Early feedback at NCN meetings has been extremely positive with the only negative aspect being the need to further expand the service with additional sessions.

Period Dignity

Initiative developed in response to the emerging evidence that accessing sanitary products can be costly and difficult. Caerphilly wide project being implemented providing Red Boxes' of free sanitary products not only in schools but also in other public venues for other women and young girls to benefit from the initiative.

Primary Care Paediatric Toileting/Constipation Pathway

A pathway for children aged between 0-5 years who have delayed continence or are constipated has been developed. The NCN supported the Flying Start service to develop pathway, raise awareness, identify suitable clinic venues and funded the ERIC training for local staff to deliver the service.

Staying Healthy At Home

Provides a casework service that links with GP surgeries to reach people who are socially inactive/isolated and to assist with sustainable independent living. Links are made to appropriate services including the Rapid Response Adaptation Programme who provide clients with income maximisation, grants, referrals to other local organisations and groups and a Healthy Home Check for additional works/services to sustain independent living.

Complex Wound Care Service

NCN funding ensures that the service continues to increase the numbers of complex wounds being actively managed within the primary care setting in the Caerphilly South NCN area and reduces secondary care appointments.

Care Navigation

GP practice staff across the NCN have received training in the delivery of Care Navigation enabling them to signpost patients to relevant services and improve access to relevant GP appointments. It allows front line staff to provide patients with more information about local health and wellbeing services, both within and outside of primary care, in a safe, effective way. It is about offering patients choice and help to access the most appropriate service first which is not always the GP. It means that patients to find it easier to get a GP appointment when they need one.

Dermatoscopy

In an attempt to improve the quality of referrals to secondary care dermatology, the NCN purchased dermatoscopes for use in practice and facilitated training.

WHAT WE ARE DOING

- Provide easily accessible 'place based' health and social care to the citizens of Caerphilly North.
- Work with providers to ensure health and social card services are sustainable.
- Continue developing primary care teams including traditional GP, DN and HV roles as well as any new roles. There should be excellent communication within the team with minimal or no 'hand-offs'.
- Utilise new primary care roles to help facilitate accessible health care. Where appropriate, these should be part of 'place based working'. Roles could include; Social prescriber, Practice based pharmacist, First contact physiotherapist, Mental health worker, Primary care audiologist, Primary care paramedic, Primary care OT, Social worker.
- Ensure appropriate utilisation of local services such as community pharmacy and third sector services.
- Ensure appropriate utilisation and easy accessibility of specialist roles such as; Diabetic specialist nurse, Heart failure nurse and Palliative care nurse specialist.
- Utilise appropriate preventative services to keep citizens well including; influenza immunisation, smoking cessation services, weight management services, exercise schemes.
- Ensure appropriate utilisation of current high quality health and social care estate.
- Support Llanbradach development.
- Support Aber Valley development.
- Use data/evidence to inform decision making.
- Use IT/technology to enhance/improve service delivery.

Monmouthshire North

Cluster Lead **Dr Brian Harries** Brian.Harries@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

As a first step in a three year development programme in response the Welsh Governments: Setting the Direction, aligned to the Quality and Outcomes Framework (QOF), 12 Neighbourhood Care Networks (NCNs) were formed across Aneurin Bevan University Health Board aimed at responding to needs of local populations of around 35 to 50,000.

Monmouthshire North NCN is supported by a Clinical Lead (GP), a Network Manager and Support Officer and holds a relatively small budget, which means the NCN can test new services based on identified need. The NCN lead also plays a key role in ensuring that existing clinical pathways to general surgery services in secondary care, are seamless and efficient. The NCN has representation from GP Practices, integrated health and social care teams, primary mental health/ adult and older adult mental health, third sector, housing, weight management, Monmouthshire County Council, public health, carers, child and family services etc.

Monmouthshire North NCN is a network of 8 GP Practices, 2 branch surgeries, and two Integrated Health and Social Care teams working alongside third sector colleagues to serve a population of around 52,000 people living in Monmouth, Abergavenny, Usk & surrounding areas. 43.7% in rural and semi-rural areas. As the North NCN boarders with Powys, England, Torfaen and Newport we face the challenge of cross border service provision ensuring that services work seamlessly for the benefit of the patient. Wages on offer are some 10% below UK average, only marginally above the average for Wales. Some 34% of our working population commute out of the county to earn a living. Monmouthshire North has two Secure Estates – one of which is to become a centre of excellence for older prisoner care. This signifies potential increase on demand for services. Recent addition of responsibilities for resettlement from HMP Usk (since 1/4/19) impacts on services.

The 8 GP practices operating in the Monmouthshire North (NCN) Cluster area:

- Castle Gate Surgery
- Dixton Road Surgery
- Hereford Road Surgery
- Old Station Surgery
- Medical Centre Usk
- The Surgery (Usk)
- Tudor Gate Surgery
- Wye Valley Practice

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Safeguarding Forum

Dr Rowena Christmas, GP at Wye Valley Practice and NCN member received Monmouthshire North NCN funding to establish a Safeguarding Forum aimed at promoting cross-practice working, improving resilience and creating efficiencies. National Safeguarding Leads Dr Aideen Naughton and Dr Nigel Farr are following the progress of this pilot group. Best practice is promoted through group discussion creating an environment for GPs to share ideas and concerns. Examples of best practice include child case reviews of those children who did not attend same day booked appointments. This was considered a marker for vulnerability. Practices are also reviewing non-attendance for immunisations, chronic disease reviews e.g. asthma or epilepsy, as part of the safeguarding work.

Care Navigation/Active Sign-Posting

Aimed at building community resilience and sustainable GP Practices across North and South Monmouthshire NCNs came together to jointly fund evidence based training for GPs, Practice Managers and reception staff to explore proven methods of discussing patient's needs when they make contact with surgeries. These methods allow for alternative care options to be considered by patients suffering from low level mental health, dental, ophthalmological problems.

The Dementia Roadmap Wales (on-line resource)

A concept initiated in South Monmouthshire to provide high quality information about the dementia journey alongside local information about services, support groups and care pathways to support people to live well with dementia. NCN funding continues to support this.

Practice-based Clinical Pharmacists (PBPs)

Monmouthshire NCNs took the decision to fund PBPs in 2015 to release GP time to support patients with more complex needs.

An example of success is the total number of prescription queries managed by the pharmacists: A total of 334, saving an estimated 188 hours of GP time.

All Wales Obesity Pathway

A full time **Community Dietician** appointed from NCN Monies to assist the existing Adult Weight Management Service. Since starting in 1st April 2016, progress has been made in the following areas:

- Steady Increase in referrals first 4 months
- Monnow Vale clinic established
- Antenatal clinics Nevill Hall Hospital
- Mapping of agencies interested in delivering Food-wise Scheme

WHY WE ARE GREAT!

As an NCN we work together to make best use of available resources in establishing wrap around health and wellbeing services, making best use of health and social care estate, and supporting the use of preventative, early self-management approaches. NCN consider that the only valuable way to deliver change is by first gaining an understanding of local needs and then working jointly to developing effective solutions. Reviewing health and wellbeing outcomes regularly and learning from feedback from patients, carers and staff.

We embrace as Monmouthshire North NCN the importance of our residents living as independent lives as possible. Maximising people's individual contributions, and developing community spaces where people can **come together to develop friendships** and share experiences and support. NCN is driving the development of both **well-being** centres in North Monmouthshire.

WHAT'S NEXT

2019 has brought a new approach with a shift in the way NCN meetings are conducted with the first part now dedicated to a themed workshop style with NCN level discussions taking place to agree priorities, address concerns/ gaps and consider budget spend options, plus other themes such as:

- Regularly reviewing local needs to identify priorities and develop effective solutions.
- Developing primary care teams using the Primary Care Model for Wales built around traditional GP, District Nurse and Health Visitor roles.
- Introducing new primary care roles to provide easier access to local services. Current examples include social prescribers, practice based pharmacists, physiotherapists, mental health workers, primary care audiologists, paramedics, occupational therapists and social workers.
- Increasing access to specialist roles in the community including Diabetic Specialist Nurse, Heart Failure Nurse, and Palliative Care Nurse Specialist.
- Working to increase uptake of preventative services to keep citizens well including influenza immunization / childhood immunization / smoking cessation services / weight management services / exercise schemes.
- Developing clinical pathways to improve patient experience and service quality.
- Building a strong social navigation system to support community engagement.
- Finding and championing local community initiatives.

Key NCN themes for 2019-20

Themed workshops for discussion/ collaboration and planning (all partners actively involved), NCN 3-5 year planning for resilience, sustainability & workforce development, population growth joint working with housing colleagues to ensure local plans reflect potential impact on Health and Social Care Services, building strong ties with third sector and secondary care colleagues, 'one front door' approach and information in key towns/ focused on need, improving health & wellbeing, local access to IAA, raising awareness of the work of the NCN and learning from service users, supporting clinical futures (driving care closer to home), empowering staff, finding local solutions, on-going support for a 'Social Navigation' model linked to well-being centres helping local people find local non-medical solutions where possible.

Monmouthshire South

Cluster Lead **Dr Annabelle Holtham** Annabelle.Holtam@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

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Monmouthshire South NCN is a network of 5 GP Practices, 4 branch surgeries, and 2 Integrated Health, Social Care and Well-Being Centres that house Community Nursing and Social Service teams working alongside third sector colleagues to serve a population of Chepstow, Caldicot and surrounding areas. With a population of 46,229 - **44%** in a predominantly rural area with approximately a quarter of the population residing in the two main towns of Chepstow and Caldicot. As South Monmouthshire NCN borders with England and Newport we face the challenge of cross border service provision, ensuring that services work seamlessly for the benefit of the patient. Monmouthshire is perceived as affluent, which can sometimes mask differences within and between communities. The wages on offer are some 10% below UK average and only marginally above the average for Wales. Some 34% of our working population commute out of the county to earn a living.

The 5 GP practices operating in the Monmouthshire South (NCN) Cluster area:

- Gray Hill Surgery
- Mount Pleasant Practice
- Town Gate Practice
- Vauxhall Surgery
- Wyedean Practic

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Pulmonary Rehabilitation (PR) Pilot Programme

People in poor respiratory health living in South Monmouthshire were expected to travel to Newport Stadium if they wanted to take part in PR. The NCN stepped in and agreed £7,500 funding to support a PR Pilot to run in Chepstow. The pilot, in partnership with Monmouthshire County Council National Exercise Referral Scheme (NERS) allowed participants the opportunity for gentle exercise, education about their condition, and to meet other people in a similar situation. The programme has also given people the **confidence to go on and engage in activities** after the PR programme has ended via the NERS.

Care Navigation/Active Sign-Posting

Aimed at building community resilience and sustainable GP Practices across North and South Monmouthshire NCNs came together to jointly fund evidence based training for GPs, Practice Managers and reception staff to explore proven methods of discussing patient's needs when they make contact with surgeries. These methods allow for alternative care options to be considered by patients suffering from low level mental health, dental, ophthalmological problems.

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Childhood Constipation Pilot

Monmouthshire South NCN initiated a pilot to increase support for children aged 1-12 suffering from constipation and recurrent abdominal pain. This created links between ABUHB pediatricians, South GPs and a local Nursery Nurse qualified to offer advice to children and their families on diet, exercise, fluids and variable dosing of laxative medication for up to 3 months. The successful pilot ran for 6 months to test the need for a service and has now been rolled-out across the whole Health Board.

WHY WE ARE GREAT!

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monmouthshire
sir fynwy

WHAT'S NEXT

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Newport East

Cluster Lead **William Beer** William.Beer@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

In Newport, there are three NCNs serving a population of approximately 147,700 people. It is a city of two halves, where the most affluent meet the most deprived. There are over 48 different languages spoken here amongst 20 different communities. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

Newport East NCN team:
Will Beer, Sara Garland, Leah McDonald, Nicola Cunningham, Kate Hopkins, Lowri Ashworth and Daniel Kendall at Victoria House Newport.

There are seven GP practices which operate in the Newport East Cluster area:

- Beechwood Primary Care Centre
- Llliswerry Medical Centre
- Park Surgery (Newport)
- Ringland Health Centre
- The Rugby Surgery
- Underwood Health Centre

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Ringland Community Campus

We have been working with the Health Board's Planning Department to design a new Health & Well-being Centre. This is part of a wider regeneration plan to create a 'community campus' is the Ringland area of Newport East. The community campus will be created through three significant capital schemes which will co-locate a range of neighbourhood services including Flying Start, Families First, Work & Skills Team, Careers Advice, Department for Work & Pensions, Housing Support, Citizens Advice Bureau. These facilities will also offer other preventative services such as smoking cessation, drug and alcohol services, weight management and psychoeducation classes.

Sustainability

We continue to focus on workforce sustainability with meetings and workshops held to discuss possible solutions. A number of GPs are now employing extended roles including clinical pharmacist, physiotherapist and mental health practitioner. Transformation funding is being used in Newport East to incentivise greater skill mix which has resulted in a number of posts being appointed on a fixed term basis

Partnership Working

The Newport Older Person's Pathway is a partnership project with Newport City Council and Age Cymru. This programme identifies people who benefit from additional preventative support and services. An Age Cymru Care Facilitator produces a Stay Well Plan that supports the individual to maintain their health, wellbeing and independence into old age.

Care Navigation

Care navigation is a tried and tested model to ensure patients are directed to the right professional, in the right place, at the right time. Care navigation is about provide greater choices and access. Work has been undertaken across the Newport NCNs to develop pathways into appropriate sources of support include Choose Pharmacy, Welsh Eye Care Scheme, Direct Access Physiotherapy, Road to Well-being and the Social Services First Contact IAA Team. Training has been commissioned for existing reception and clerical staff to play a greater role in the navigation of patients. A promotional video, posters and leaflets have been produced to raise awareness amongst patients about this new way of working.

Schemes to reduce administrative workload for GPs

Newport NCNs continue to support the Practice Managers Forum and provided funding for Practice Managers to complete the AMSPAR diploma. Other schemes have been introduced to promote efficiency within general practice including workflow optimisation and provision of digital dictation software.

Direct Access Physiotherapy Service

Newport NCNs have pooled cluster funding to launch a new service for patients with musculoskeletal problems. Based at St Woolos Hospital in the centre of Newport, drop in services are available from Monday to Friday between 9am and 11.30am. The service is proving popular with patients who are able to have an earlier assessment without the need for GP appointment. Patients are given self-help advice or referred on for physiotherapy treatment or to the Multi-professional Triage and Treatment Team if necessary.

Multi-Agency model of Mental Health Support for Children and Young People

The Primary Care Mental Health Support Service is developing a new model of care for children and young people with mild to moderate mental health difficulties. All referrals from GPs and schools are now sent through a single point of access which operates a 'no bounce' policy. Primary care mental health practitioners are now working alongside Families First to review referrals in a weekly multi-agency joint allocation meeting.

Neighbourhood Nursing Pilot

We are testing a different approach to District Nursing to provide person-centred, co-ordinated and prevention focused care that enables people to self-manage their conditions, through formal and informal networks, with the support of a self-managed neighbourhood nursing team. This reflects international models which have proven to be effective.

The District Nursing team have introduced new care processes and additional posts to provide the capacity for change and create a richer skill mix with better utilisation of health care support workers within their scope of practice alongside creating areas of expertise within the RN team. They have received Care Aims training which is focussed on what matters to the person, enables staff to manage clinical risk more effectively, and has been proven to provide a clear evidence-based framework for decision-making. This has already had a significant impact on how they manage referrals and individual patient needs. The teams will be spending time with the Social Service First Contact Team to explore how they have changed their approach and ways of working following implementation of the SSWBA. This approach is anticipated to develop a more consistent approach to care planning to meet medical, long-term conditions and personal and social care needs.

Planning Workshops and Events

Newport NCNs have held a series of joint planning workshops and events on a range of priority areas including liver pathway, integration of frailty services, flu vaccination, emergency planning and winter preparedness.

Newport North

Cluster Lead **Dr Graeme Yule** Graeme.Yule@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

There are three NCNs in Newport, together serving a population of approximately 147,700 people. It is a city of two halves, where the most affluent meet the most deprived.

Newport has the second highest proportion of population from a BME background in Wales and is an asylum **seeker dispersal area.**

There are six GP practices which operate in the Newport North Cluster area:

- Westfield Medical Centre
- Isca Medical Centre
- Malpas Brook Health Centre
- Richmond Clinic
- St Julians Medical Centre
- The Rogerstone Practice

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Crisis Mental Health Worker

Dr. Graeme Yule is leading Newport North NCN in a 2 year pilot of a Crisis Mental Health Worker (CMHW) to be based within St Julians Medical Centre. The aim of the pilot is to provide the most appropriate care to patients that are in need of a CMHW

Partnership Working

The Newport Older Person's Pathway is a partnership project with Newport City Council and Age Cymru. This programme uses a risk stratification tool to identify people who benefit from additional preventative support and services. These people are visited at home by an Age Cymru Care Facilitator who will work together to produce a Stay Well Plan. This focusses on all aspects of their life to help them maintain their health, wellbeing and independence into old age.

Care Navigation

Care navigation is a tried and tested model to ensure patients are directed to the right professional, in the right place, at the right time. The Newport NCNs have developed pathways into appropriate sources of support include Choose Pharmacy, Welsh Eye Care Scheme, Direct Access Physiotherapy, Road to Well-being and the Social Services First Contact IAA Team.

Training has been commissioned for clerical staff to play a greater role in the navigation of patients. A promotional video, posters and leaflets have been produced to raise awareness amongst patients about this new way of working.

Multi-Agency model of Mental Health Support for Children and Young People

Newport NCNs have been working with the Primary Care Mental Health Support Service to develop a new model of care for children and young people with mild to moderate mental health difficulties. All referrals from GPs and schools are now sent through a single point of access which operates a 'no bounce' policy. Primary care mental health practitioners are now working alongside Families First to review referrals in a weekly multi-agency joint allocation meeting.

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Practice Based Pharmacists

We have expanded the capacity of the pharmacist provision within the cluster. Pharmacists deal with medication queries, medicines optimisation for patients with long terms conditions, medication reviews and clinical audits of prescribing.

The clinical pharmacist employed to provide this service has recently completed an Interdependent Prescribing qualification and has received specialist training in addiction and behaviour change. The Community Pharmacy will be able to remotely update the GP record and access specialist advice from the Gwent Specialist Substance Misuse Service and the Specialist Pain Management Service.

Schemes to reduce administrative workload for GPs

Newport NCNs continue to support a Practice Managers Forum and provided funding for Practice Managers to complete the AMSPAR diploma. Other schemes have been introduced to promote efficiency within general practice including workflow optimisation and provision of digital dictation software

WHAT WE ARE DOING

- Developing a person centred information, advice and approach across all 'front doors' within Newport.
- Increasing opportunity for local people to access the right help for physical, psychological and sociological needs at the right time, addressing urgent needs and preventing escalation.
- Exploring where health and social care skill mix can be utilised to meet the demands of an ever growing population and offer care closer to home.
- Offering the public an appointment with an experienced physiotherapist who can offer help and guidance with muscular issues.
- Offering the public an appointment with an experienced mental health practitioner who can offer help and guidance with mental health issues.
- Building medicines management expertise in general practice, through practice-based pharmacist roles.
- Working with integrated teams to identify ways of improving the management of long term chronic conditions, complex and palliative care needs.
- Working with integrated teams and local people to increase health and well-being, including screening and vaccine uptake.
- Working with NCN partners to improve people's access to services that support language and cultural needs.
- Ensuring staff have the sufficient skills and support to meet current and future working to meet the needs of the population & its changing demographic.
- Ensuring that, in the event of adverse weather or an emergency event, plans are in place to be able to cope with the minimum of stress to both patients and staff.

Newport West

Cluster Lead **Susan Thomas** Susan.Thomas30@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

There are three NCNs in Newport, together serving a population of approximately 147,700 people. It is a city of two halves, where the most affluent meet the most deprived.

There are over 48 different languages spoken within the Newport West's population of approximately 50,000 people. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

The representation across the three NCNs encompasses 17 GP surgeries, 3 branch surgeries, District Nursing Teams, Health Visiting, Housing, Third Sector colleagues, Child and Family Services, GAVO, Community Resource team and Local Government. Each NCN meets bi-monthly to consider how they can make a difference to their local communities by supporting local health and social care initiatives and pump priming local pilot schemes which **attempt to improve local services.**

There are five GP practices which operate in the Newport West Cluster area:

- Bellevue Surgery
- Bryngwyn
- St David's Clinic
- St Brides Medical Centre
- St Paul's Clinic

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Multi Disciplinary Team Virtual Ward

The MDTVW is a place-based, multi disciplinary approach comprising a range of professionals and agencies. The team reviews the care of those most 'at risk'

- People brought to the MDT VW often have complex, inter-related, bio-psycho-social needs that a single professional or agency is unable to meet.
- The MDTVW provides a focused forum for multi-disciplinary/multi-sector care-planning.
- This meets the essence of Care Closer to Home, in using community-focused resources to support needs that might otherwise lead to hospital admission.
- The key concept is underpinned by prevention and early intervention approaches.

All five practices within Newport West have adopted the MDTVW approach and have weekly MDT meetings.

- "Although unsure initially of how the MDTs would work, I can't see how we could work without them now'" = Senior Nurse CRT
- "It's good to get a whole team on board" = GP
- "It gets us away from the medical model" = District Nurse
- "I probably would otherwise have admitted her (the patient)" = GP
- "Sitting together with health professionals and hearing different ideas is really helpful" = Older Persons' Pathway team member

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Partnership Working

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Planning Workshops and Events

Newport NCNs have held a series of joint planning workshops and events on a range of priority areas including liver pathway, integration of frailty services, flu vaccination, emergency planning and winter preparedness.

Practice Based Pharmacists

Newport West NCN has expanded the capacity of the pharmacist provision within the cluster. These pharmacists are able to deal with medication queries, medicines optimisation for patients with long terms conditions, medication reviews and clinical audits of prescribing in areas directed by the GP. They record and access specialist advice from the Gwent Specialist Substance Misuse Service and the Specialist Pain Management Service.

Population Needs and the Planning Cycle

- Newport West NCN is working in partnership with the Integrated Wellbeing Network Lead, to gain a robust understanding of the health and well-being needs of the population and the local support, assets and resources available.
- The Population Segmentation and Risk Stratification methodology will be utilised as soon as possible, to fully understand the breadth of health needs and service responses, including risk and prioritisation.
- The Primary Care Needs Assessment tool will be used to complement on-going needs assessment of the Newport West population.

These will form the basis of the NCN Plan and IMTP, to enable the health and well-being needs of the population to be met in an organised, fashion, by all NCN partners. This will also form the basis for monitoring and evaluation of qualitative and quantitative outcomes.

Care Navigation

Care navigation is a tried and tested model to ensure patients are directed to the right professional, in the right place, at the right time. Care navigation is about provide greater choices and access.

We have developed pathways into appropriate sources of support include Choose Pharmacy, Welsh Eye Care Scheme, Direct Access Physiotherapy, Road to Well-being and the Social Services First Contact IAA Team. Training has been commissioned for existing reception and clerical staff to play a greater role in the navigation of patients. A promotional video, posters and leaflets have been produced to raise awareness amongst patients about this new way of working.

WHAT WE ARE DOING

- Increasing opportunities for local people to access the right help for physical, psychological and sociological needs at the right time
- Exploring new models of intermediate care working, through developing and testing a bespoke MDT Virtual Ward approach with NCN partners
- Exploring where health and social care skill mix can be utilised to meet the demands of an ever growing population and offer care closer to home.
- Working with NCN partners and local communities to;
  - increase the uptake of breast, cervical and bowel cancer screening.
  - understand perspectives and increase the uptake of childhood flu vaccination.
  - identify ways of improving the management of diabetes.
  - identify ways of improving support for mental health concerns.
- Working with NCN partners to improve people's access to services that support language and cultural needs.
- Developing flexible primary care services for local people, including physiotherapy for help and guidance with muscular issues and practice-based pharmacist roles for building medicines management expertise in general practice.
- Developing a person centred information, advice and support approach across all 'front doors' within Newport
- Ensuring staff have the sufficient skills to meet the current and future needs of the population, including through the Primary Care Academy and MDT learning in Care Aims methodology, as examples.
- Ensuring that, in adverse weather or emergency event, plans are in place to be able to cope with the minimum of stress to patients and staff.

Torfaen North

Cluster Lead **Eryl Smeethe** Eryl.Smeethe@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

Torfaen North is a Network of 6 main GP Practices and 5 branch surgeries. There are 2 'Patch Based' Teams (2 North) covering the North, developed in response to the Social Services & Well-Being (Wales) Act, based on the principles of Asset Based Community Development (ABCD), and co-production. Torfaen North has 11 community pharmacies, 5 dental practices and 4 optometrists.

The NCN serves a population of 49,650 (2019/20 capitation figures) in a predominantly urban area with approximately 84% of the population residing in Blaenavon, Pontypool and surrounding areas. The NCN has boundaries with Monmouthshire, Blaenau Gwent and Caerphilly.

There are six GP practices which operate in the Torfaen North Cluster area:

- Blaenavon Medical Practice
- Churchwood Surgery
- Panteg Health Centre
- The Mount Surgery
- Abersychan Surgery
- Trosnant Lodge Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

Torfaen North NCN has worked across Gwent wide schemes and programmes along with local initiatives to benefit the population of Torfaen.

Supporting sustainability in Torfaen North

Using the 10 Key Impact Actions we are beginning to address how best to ease workload pressures in the NCN. Progress so far includes:

1. Active signposting – Adopting the Integrated Wellbeing Network (IWN) model we have begun to link existing mapping in the area from Public Health and Torfaen County Borough Council. This signposting helps patients access the right service at the right time, aids collaborative working, makes more appropriate use of available services and reduces demand on clinical services in primary care.

2. Develop the team/Personal productivity – Practices participated in Medical Assistant/Workflow Optimisation to free GP time and provide opportunity of enhanced roles for existing staff. Reception Care Navigation will make it easier for patients and carers to access the most appropriate services.

3. Social Prescriber – A practice-based role that is jointly funded by the NCN and the Local Authority. The post aims to increase the reach and speed of connectivity between Primary Care and Community Wellbeing Services, which mitigate the causes of ill health and improve mental wellbeing.

4. Support self care and management – Target patients who cannot attend an annual asthma review in surgery hours, we will be participating in the Community Pharmacy Respiratory Medicines Adherence Service LES. Objectives include improved patient outcomes, reduced medicines waste and promotion of prudent prescribing.

5. Direct Access Physiotherapy Service - The 'drop in' clinic provides assessment of patients presenting with a musculoskeletal problem. The service operates weekday mornings at County Hospital since April 2017.

6. NCN Practice-based Clinical Pharmacists –Aims to improve patient care and assist with freeing up GP time. The Clinical Pharmacists are able to review regular prescription medicine , provide expert advice to GPs, prescribe medicines to patients and support the better management of chronic conditions such as respiratory and diabetes illnesses. This work is continued and supported at care homes and home visits.

7. Extended roles – The NCN has reviewed and looked at working collaboratively with employing varied extended roles, linking with the transformational work to support practices sustainability.

8. PCC – Practices have engaged with PCC to support collaborative working and sustainability.

9. Practice Managers Forum - Has been successful to assist practices to work more collaboratively on projects such as MHOL, share policies and processes which gave a more equitable services to the population of Torfaen North.

10. Training - NCN monies have been made available to support Practices with clinical and non-clinical training to improve knowledge, skills and access to training courses.

NCN meetings raised awareness of Making Every Contact Count, Advanced care Planning, Integrated Autism Service, Flu planning, Health Visiting data, Ask My GP pilot, Emerging Model of Primary Care, 10 High impact changes in Primary Care, Third Sector schemes, Community Connectors and Social Prescribing models.

Local Initiatives

Obesity - As one of the NCNs priorities Torfaen North has linked with "Fit for Future Generations" and "Every Child Has The Best Start In Life". The NCN planned how to deliver more effective weight management services for children, young people and families in Torfaen and supported delivery of the Gwent Childhood Obesity Strategy workshop for professionals. Foodwise in Pregnancy was a 6 week programme piloted in Torfaen to help pregnant women to learn more about achieving a healthy weight gain in pregnancy, keeping active and get support/ideas to change eating habits. Aqua natal classes have been funded to support obesity in pregnancy. Wild Tots is an initiative that has been funded to activate parents and children to play, explore and discover the outdoors.

Blaenavon Resource Centre - an integrated approach alongside Local Authority and Third Sector partners to support full utilization of the Resource Centre in Blaenavon. Citizens to have local access to services including Citizens advice, Veterans Service, Gwalia etc.

Parental Resilience Project - a course offering parents the skills and confidence with which to decide when they need to see their GP and when the can safely manage their child's illness with the help of first aid, the pharmacist and over the counter remedies. This project linked to Health Visiting & Flying Start teams.

QR Info Pods - Torfaen NCNs have transformed how patients access information by introducing QR Info Pods. Noticeboards have been upgraded to pods, which have QR codes linked to information on NHS Services, self-help guides, local services and other useful information. Users simply use any device's digital camera to scan the QR code, before being directed to websites or documents linked with the code.

Wound Care - Practice Nurses supported to develop skills in wound management by District Nurses and Tissue Viability Nurses.

MSU Quality Improvement programme - to reduce microbiology culture and sensitivity (MC&S) testing of urine samples in 1 Nursing Home and 1 District Nursing Team within 8 months. Work has continued with the lead district nurse to roll out across the borough.

Gwent Wide Schemes

Smoking Cessation, Choose Pharmacy Services, Bowel Screening, Primary Care Careers, Dementia roadmap, Seasonal flu, Phlebotomy Service.

AIMS

- Improve the health and well-being of the local population.
- Improve and support sustainability of our GP practises and supporting services.
- Support people to stay well, lead healthier lifestyles and live independently.
- Expand on our CRT unit support within the community, working collaboratively.
- Specifically work with our Carers on Community based projects.
- Reduce health inequalities.
- Deliver the Clinical Futures Strategy in primary and community care.
- Care closer to home.
- Provide more easily accessible, joined up 'place based' health and social care in community settings.
- Work towards national Prescribing indicator targets. Address any earlier prescribing practice and remain below set budgets.
- Ensure that services have the flexibility to meet individual needs.
- Improve access to specialist expertise.
- Provide positive experience for patients and carers.
- Ensure a supportive working environment and career development opportunities for our staff.

Torfaen South

Cluster Lead **Dr Amanda Head** Amanda.Head@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

Torfaen South is a Network of 6 main GP Practices and 1 branch surgery. There are 3 'Patch Based' Teams (2 South/1 Central) developed in response to the Social Services & Well-Being (Wales) Act, based on the principles of Asset Based Community Development (ABCD), and co-production.

Torfaen South has 10 community pharmacies, 8 dental practices and 7 optometrists.

The NCN serves a population of 46,589 (2019/20 capitation figures) in a predominantly urban area with 99.4% of the population residing in the main town of Cwmbran and surrounding areas. The NCN has boundaries with Monmouthshire, Caerphilly and Newport.

There are seven GP practices which operate in the Torfaen South Cluster:

- Clark Avenue Surgery
- Cwmbran Village Surgery
- Fairwater Medical Centre
- Greenmeadow Surgery
- Llanyravon Surgery
- New Chapel Street Surgery
- Oak Street Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

Throughout the years Torfaen South have worked across Gwent wide schemes and programmes along with local initiatives to benefit the population of Torfaen.

Supporting sustainability in Torfaen South

Using the 10 Key Impact Actions we are beginning to address how best to ease workload pressures in the NCN. Progress so far includes:

1. Active signposting – Adopting the Integrated Wellbeing Network (IWN) model we have begun to link existing mapping in the area from Public Health and Torfaen County Borough Council. This signposting helps patients access the right service at the right time, aids collaborative working, makes more appropriate use of available services and reduces demand on clinical services in primary care.

2. Develop the team/Personal productivity – Practices participated in Medical Assistant/Workflow Optimisation to free GP time and provide opportunity of enhanced roles for existing staff. Reception Care Navigation will make it easier for patients and carers to access the most appropriate services

3. Social Prescriber – A practice-based role that is jointly funded by the NCN and the Local Authority. The post aims to increase the reach and speed of connectivity between Primary Care and Community Wellbeing Services, which mitigate the causes of ill health and improve mental wellbeing.

4. Support self-care and management – To target patients who cannot attend an annual asthma review in surgery hours, we will be participating in the Community Pharmacy Respiratory Medicines Adherence Service LES. Objectives include improved patient outcomes, reduced medicines waste and promotion of prudent prescribing.

5. Direct Access Physiotherapy Service - The 'drop in' clinic provides assessment of patients presenting with a musculoskeletal problem. The service operates weekday mornings at County Hospital since April 2017.

6. NCN Practice-based Clinical Pharmacists – Aims to improve patient care and assist with freeing up GP time. The Clinical Pharmacists are able to review regular prescription medicines , provide expert advice to GPs, prescribe medicines to patients and support the better management of chronic conditions such as respiratory and diabetes illnesses. This work is continued and supported at care homes and home visits.

7. Extended roles – The NCN has reviewed and looked at working collaboratively with employing varied extended roles, linking with the transformational work to support practices sustainability.

8. Practice Managers Forum – Has been successful to assist practices to work more collaboratively on projects such as MHOL, share policies and processes which gave a more equitable services to the population of Torfaen North.

9. Training - NCN monies have been made available to support Practices with clinical and non-clinical training to improve knowledge, skills and access to training courses.

10. NCN meetings - raise awareness of Making Every Contact Count, Advanced care planning, Integrated Autism Service, Flu planning, Health Visiting data, Ask My GP pilot, Emerging Model of Primary Care, 10 High impact changes in Primary Care, Third Sector schemes, Community Connectors, Social Prescribing models, proposal for a parental resilience education programme linked to health visitor & flying start teams.

Local Initiatives

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Wound Care - Practice Nurses supported to develop skills in wound management by District Nurses and Tissue Viability Nurses.

Primary Care Careers - Torfaen South NCN Lead led, supported and contributed to the development of a primary care career DVD to encourage young people to consider a career in Primary Care. The DVD was part of a programme being undertaken with partners in Education to engage and excite young people, so that they consider the numerous opportunities that Primary Care provides. The DVD was shown to Sixth Form students in all of the schools and colleges in Gwent.

NCNs across Gwent also supported 43 Gwent students wishing to study a medical degree. Students received training regarding the application process, ongoing mentoring, resources for school libraries (Health & Social Care) and interview support.

Gwent wide schemes:

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- Care closer to home.
- Provide more easily accessible "place based" health and social care or Provide more joined up services in community settings.
- Ensure that services have the flexibility to meet individual needs.
- Improve access to specialist expertise.
- Provide a positive experience for patients and carers.
- Ensure a supportive working environment and career development opportunities for our staff.

Canolfan Datblygu ac Arloesi Gofal Sylfaenol a Chymunedol
Datblygu Gofal Sylfaenol yng Nghymru

Primary and Community Care Development and Innovation Hub
Developing Primary Care in Wales

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GIG CYMRU NHS WALES

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