Newport North Neighbourhood Care Network
Action Plan 2017-2020

2018-19 Progress against the plan

Overview of Newport North Action Plan

	Strategic Aim	NCN Objectives	Aim
1	**To understand and highlight actions to meet the needs of the population served by the Cluster Network**	***Engagement***	*Ensure appropriate NCN communication*
		Improve Community Wellbeing for Newport	*Ensure appropriate NCN communication*
		Improve Mental Health and Wellbeing for Children and Young People	*Identify appropriate models of care*
2	**To ensure the sustainability of core NCN services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements**	***Care Navigation***	*To offer the patient navigation to a direct source of care rather than a GP if appropriate*
		NCN Workforce Planning	*Training and Development of staff. Identifying role and educational deficits for future workforce planning.*
		Direct Access Physiotherapy	*A direct access service pilot that offers specialist and appropriate care*
		Extended Roles	*Crisis Mental Health Support Worker - Explore if the use of extended roles can help sustainability*
		Workflow Optimisation	*To provide an auditable administration tool for staff and to decrease the administrative time required by a GP*
		Extended Care Hub Development	*To provide neighbourhood care for the community*
		Home Visiting Service	*To introduce a home visiting service across Newport*
		Learning Disability Enhanced Service Annual Reviews	*To analyse current reviewing system and communication with Social Services*
		Estates Strategy	*To ensure GP estates are sufficient*
3	**Planned Care – to ensure that patients' needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvement for primary care/secondary care interface.**	***Graduated Care***	*To provide wrap around support in the community, enabling a faster hospital discharge.*
4	**To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management. To address winter preparedness and emergency planning**	***Frailty***	*To provide a greater awareness of the service*
		Cancer diagnosis and survival statistics by Cluster and individual Practice within the NCN	*To increase the screening rate across Newport*
		Winter Preparedness	*To ensure that GP practices and supporting staff have adverse weather plans in place*
5	**GP Contractual Priorities**	***Flu Reporting***	*To vaccinate 2/3 year olds, under 65 years at clinical risk and over 65 years as a priority*
6	**Medicines Management and Pharmacy**	***Pharmacy prescribing updates***	*To monitor the NCN prescribing budget and delivery of the Medicines Management plan*
		Pharmacy input into General Practice	*To offer patients direct access and specialist knowledge closer to home*
7	**Governance**	***Clinical Governance Toolkit***	*To ensure consistency and safety in practices*
		Information Governance	*To comply with GDPR regulations*

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

Link to Strategic Programme for PC/IMTP	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
Informed Public Empowered Citizens' MDT working ***Links to: IMTP SCP1 – Improving Population Health and Well Being: 1.6.8 – Patient Engagement and Partnership***	**1.1 Engagement** with Wider Stakeholders to improve local planning and intelligence	• Ensure the NCN is utilising available resources across the wider NCN partnerships. • Attend two engagement events per year to understand the diversity of issues across the NCN. • Work closely with ABUHB Engagement Team.	Improved integrated working to support locality planning.	• Uptake Data at events	• NCN • ABUHB • Third Sector • Local Authority • Voluntary Services	• Attended Gwent wide multi-agency / Third Sector event in May 2017 to discuss development of Social Prescribing services within Newport and wider Gwent. • Pill engagement event with NCC. • Participating in the Engage for Change events across Newport in conjunction with the ABUHB Engagement Team (Autumn 2018) • Regular contributions to the NCN newsletter and Newport Matters Publication (NCC) • Accompanying the Newport NCN Pharmacy team at the Choose Pharmacy Event to promote Direct Access Physiotherapy	• Ensure active and sustained attendance at key working groups. • Improve opportunities to engage with key reference groups/boards	• To continue to inform the public of changes within community services. • To work with ABUHB Communications team on a communication plan for future changes such as Care Navigation.	**March 2020**	A

Link to Strategic Programme for PC/IMTP	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
						and Care Navigation • Attendance at the PHW Knowledge Exchange in the Parkway Hotel July 2018 • Newport Health and Wellbeing Campus engagement commenced on 7 September 2018 • Cancer and Prevention Screening event November 2018 • Wider stakeholders from Carers and GAVO invited to NCN meetings to inform and share information				
Empowered Citizens' MDT working Community Services Direct access People with Complex Care ***Links to: IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being IMTP SCP7 – Service Sustainability***	**1.2 Improving Mental Health and Well Being for Children and Young People**	• Newport agreed as a pilot area for the collaborative PCMHSS model to strengthen integration, reduce duplication across agencies for referrals, assessments and interventions. • Select as a National Clinical Priority area within the GMS Contract for 2017/18. • Compare number of referrals made into new SPA model with previous PCMHSS model	To develop and agree a local Improvement Plan for Mental Health Early Intervention in Newport.	• CAMHS Referral data	• CAMHS • GP Practices • NCN • Patients • Schools	• NCN lunch and learn session held on 19th July 2018 to review progress against the action plan. • Work is progressing at pace to develop a transformational model for service provision based on the 'iceberg' model, building on the 'single point of access' model in Newport with	•	•		

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		• Review number of instances PCMHSS Practitioners provide consultation to frontline staff from other agencies and types of consultation (e.g. signposting consultation to ensure CYP accesses the most appropriate support) • Raise awareness of other mental health resources available within the community • Practices to complete the learning requirements outlined within the Mental Health DES and NCP				Education included, providing mental health 'in reach' to schools, perinatal mental health provision for infants and parents, community-embedded, family-based early interventions for vulnerable families, community Psychology, supporting frontline staff and dedicated senior leadership capacity to make change happen in Health, Education and Local Authorities				

Strategic Aim 2: To ensure the sustainability of core NCN services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements

Link to Strategic Programme for PC/IMTP	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
Support for Self-Care ***Community Services*** ***Empowered citizens*** ***Direct access*** ***MDT working*** ***First point of contact*** ***Links to:*** ***IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being*** ***IMTP SCP7 – Service Sustainability***	**2.1 Care Navigation**	• Develop a person centred information, advise and approach across all front doors within Newport • Increase opportunity to access the right help at the right time, preventing escalation	Ensure people have equitable access to sustainable services across the NCN and that the most appropriate source of care is available	• Data measures captures within the system of the number of patients that were navigated to alternative services. • If there is an increase upon the services that are being navigated to.	• GP Practices • Pharmacy • Physio • MH team • Community Connectors	• Care Navigation SLA signed. • Newport training dates and workshops 1&2 completed, workshop 3 arranged for Jan 2019. • 6 priorities identified by NCN. • Communication plan being developed to support the roll out to all citizens in Newport	• Workshop 3 scheduled for the 8th Jan 2019. • To work with Vision/EMIS/MircoTest in the development of the computer templates. • Liaise with the Communication team to ensure the most appropriate communication is cascaded.	•	**Jan 19**	G
Community Services ***MDT Working*** ***MDT working*** ***Links to:*** ***IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being*** ***IMTP SCP7 – Service Sustainability***	**2.2 NCN Workforce Planning, Training and Development** To ensure staff have the sufficient skills and support to meet current and future working to meet the needs of the population & it's changing demographic	• NCN to pilot/support extended roles in GP practices • Support alignment of DN Staffing Principles • New NCN management structure bedded in	• To scope current skills, identify gaps and provide training where needed. • To ensure that NCN community are informed, equipped and prepared	• TNA • Skills matric • Population demographics/disease prevalence capture • Evaluation of extended roles	• Education Department • ABUHB • Ward nurses • DN's • CRT • Therapies • Pharmacy • QPS • HR • COTE • GP Practices	• Acuity assessments have been undertaken but need to analysed • TNA have commenced during Dec 18 and need completion by Jan 19 • Initial skills matrix completed for review with HR	• Training needs analysis being competed for nurses. • Ward acuity assessments being undertaken by Jan 19 to inform case mix and TNA. • Future HB skill mix/staffing/training options against strategic direction of Clinical Futures to be produced • Buurtzorg pilot to continue to be rolled out & impact of carefully captured	• Due an interim evaluation of Direct Access Physio Jan 19 • Commenced Primary Care Workforce plan • Trialling Ambulatory CFU as part of winter planning • Graduated care workshop planned • Representation at accommodation groups for the future plans of STW	**Feb 19**	A

Link to Strategic Programme for PC/IMTP	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
			for any changes in community care that may arise			• NCN Workforce themed meeting held • Practice Manager's forum being used as means to build upon and support planning • Extended roles have been commenced in a number of GP practices	• Public World sessions with Brendan Martin to be held • Educational training requirements of GP practices that need to be brokered with universities to be collated/shared buy NCN • To develop a workforce plan in conjunction with Workforce & OD • Promote greater integrated working • Preparedness for the Grange opening and the change in services/resources/locations			
Support for Self-Care ***Community Services*** ***Empowered citizens*** ***Direct access*** ***MDT working*** ***First point of contact*** ***Links to:*** ***IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being*** ***IMTP SCP7 – Service Sustainability***	**2.3 Direct Access Physiotherapy** To offer the public an appointment with an experienced physiotherapist who can offer help and guidance with any muscular issues	• Investigate the added value of having a band 7 Physio post in Newport to provide clinical imaging requests, IPS and injection therapists. • Determine if there can be 1 physiotherapist dedicated to each NCN within Newport based following the pilot.	• An open access physiotherapy resource where advice and guidance can be offered for Newport residents	• Monthly KPI • Number of GP appointments given for such conditions	• Physiotherapy team • GP Practices • NCN • Patients	• 12 month pilot established on 11 June 2018 • SLA and KPI's drafted •	• 6 monthly review scheduled for Jan 2019 • To ascertain how the service will be managed and whether a band 7 Physio would be more appropriate. • To investigate if an additional band 6 Physiotherapist can be appointed to cope with the forthcoming demand created by Care Navigation.	• Ongoing pilot analysis on a monthly basis.	**Jun 19**	A
Urgent Care ***Support for Self-Care***	**2.4 Winter preparedness and emergency planning.**	• Encourage all residents to be up to date with their immunisations.	• Clarity for processes followed for NCN footprint	• OOH data following an adverse	• GP practices • Primary Care Team	• NCN workshop held in July 2018 to	• To include all relevant information into the divisional winter plan.	• All practices have an adverse weather plan in place.	Jan 19	G

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Community Services Direct access MDT working ***Links to: IMTP SCP2 – Deli Integrated Systen Care and Well Be IMTP SCP7 – Service Sustainability***	• In the event of adverse weather or an emergency event that there are contingency plans in place to be able to cope with the minimum of stress to both patients and staff.	• All practices have an up to date winter plan • NCN partners to be involved in wider winter contingency planning. • Work with the DN team to update My Winter Plan with patients • Ensure that all patients with a ACP are reviewed regularly and that the relevant staff are aware of any changes	services in the event of adverse weather and emergency situations.	weather incidence • Hospital Admissions via A&E rather than MAU	• To maintain corresponde nce with the Emergency Planning team • NCC • DN team • Estates team	develop a joint contingency plan with partners • Lunch & Learn session facilitated by Wendy Warren was held to discuss and support the development of contingency plans with GP practices. • Practices provided contact details and direct numbers for inclement weather conditions. • Practices advised on their plan for mobile text usage during inclement weather conditions • DN teams completing My Winter Plan with housebound patients whilst administering their flu jab. • Practices contacted to	• To ensure that a contact name and direct name is received from all practices in cases of adverse weather. • To ensure that practices are supplied with a direct number for Primary Care during these times • Escalate any concerns regarding highways to NCC. • Ensure that the DN team have identified those patients that require daily assistance from the team in order to prioritise patients. • NCN discussion to share ideas & good practice • Patient/NHS staff immunisation levels monitored • Ensure patients have adequate supplies of medications – advertising & reminders • Utilisation of Third Sector schemes e.g. housing	• Practices have supplied their contact name and direct number data.		

Link to Strategic Programme for PC/IMTP	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
						query the review process of patients with an ACP				
Urgent Care Community Services Direct access MDT working Empowered Citizens First point of contact Support for Self-Care ***Links to: IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being IMTP SCP7 – Service Sustainability***	**2.5 Extended Care Roles-** ***Crisis Mental Health Support Worker*** To explore where roles extended can be utilised in order to meet the demands of an ever growing population and offer care closer to home. Release capacity in general practice to support longer consultations in surgery for managing complex patients	• To investigate how extended roles within general practice can impact on the services offered in the most effective and safe manner. • To liaise with the Primary Care Mental Health team in order to identify suitable banding/role to provide this service.	• Develop a multi-disciplinary approach to enable more efficient, effective, and well-co-ordinated services • Ensure a sustainable workforce through creation of new roles and greater skill mix • Shift from secondary to primary care: Ensuring people are able to access support close to home • Support the development of a sustainable model to fit the roles purpose.	• Capture the numbers of appointments that would be classed as a 'crisis mental health need 'that the GPs see following the launch of the pilot.	• NCN • PCMHT • GP Practices • Patients	• The concept of the addition of a Mental Health Support Worker being considered. • Care Closer to Home project manager appointed September 2018 to drive work stream forward. • Interviews held in Dec 18. 0.5wte recruited to, awaiting confirmation of the remaining 0.5wte.	• To implement the service within the North NCN practices. • Determine a • Location/booking system	• Continuing to liaise with Luke Jones in the recruitment of the 0.5wte and possible start date	March 19	A
MDT Working ***Links to: IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being***	**2.6 Workflow Optimisation** To allow practices the opportunity to adopt an auditable time saving administration system	• Explore different models of workflow optimisation in order to implement an administrative system that not only saves time	• To reduce the time required by a GP in relation to reading/coding of the correspondence and to ensure a slick auditable	• Data captured within the system • Duration of time that the GP has to spend on admin	• HERE (System provider) • GP Practices • NCN	• Several practices within the North NCN are utilising the system.	• To measure if the numbers of letters that a GP has previously read and read coded reduces. •		**Sept 18**	G

Link to Strategic Programme for PC/IMTP	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
IMTP SCP7 – Service Sustainability		but is also auditable.	process can be created	task analysed.						
Community Services Direct access MDT working Empowered Citizens ***Links to: IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being IMTP SCP7 – Service Sustainability***	**2.7 Extended Care Hub development** As part of the 'Newport Vision', Care Closer To Home and Clinical Futures initiatives.	• Support the Scoping document and position statement for the Newport Vision to be produced. • Work collaboratively with Community hospitals in relation to Care Closer to Home strategy • Ensure strong links with Clinical Futures & CCTH strategy and delivery framework. •	• Agreed vision and business cases for the individual elements of the Extended Care Hub proposal for submission to the ABUHB Executive and NCC Cabinet for review and approval	•	• NCN • NCC • ABUHB • Patients	•	•	•		A
Urgent Care Community Services Direct access MDT working ***First point of contact People with complex care needs*** ***Links to: IMTP SCP2 – Delivering an Integrated***	**2.9 Home Visiting Service** To ascertain if the introduction of a home visiting service utilising appropriately qualified extended roles could save GPs time which could be utilised elsewhere**.**	• Reduce the volume of home visits. Triaging the need for GP appointments would also help to • Admissions from primary care. More time would enable a more detailed assessment. Home visits are typically longer (typically 20 minutes) • Reduce waiting times for home visits: visits can take place earlier in the day following triage, compared with	• Support the development of a sustainable model of primary care service delivery by enhancing the provision of home visits to patients registered with the 18 practices across Newport.	• numbers of home visits required by a GP • Capture the levels of patients being admitted to hospital within the pilot period	• NCN • Nursing Teams • DN Teams • GP Practices • Patients • WAST •	• NCN • Nursing Teams • DN Teams • GP Practices • Patients • WAST •	• Receive analysis from Newport West and Newport East Home Visiting pilots.	•		A

Link to Strategic Programme for PC/IMTP	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
System of Health, Care and Well Being IMTP SCP7 – Service Sustainability		afternoon reviews which may lead to deterioration of a patient's condition • Improve patient flow into the hospital by admitting Patients steadily throughout the day, rather than the usual pattern of sudden spikes in afternoon or evening conveyances. •								
People with Complex Care ***Community Services*** ***Links to: IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being***	**2.8 Learning Disability Enhanced Service Annual Reviews** To review the number of LD reviews being undertaken and the ability to update social services	• To review with Practice Managers the quality/accuracy of information received regarding the annual reviews in partnership with Social Services colleagues.	• Reconciliation of Learning Disability residents across Local Authority and Primary Care services in Newport.	• GP data	• GP Practices • Social Services • LD • NCN • Patients	•	•	•		A

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

Link to Strategic Programme for PC	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
People with Complex Care Support for self-care Community services Informed public MDT Working Empowered citizens Direct Access ***Links to: IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being IMTP SCP7 – Service Sustainability and Regional Collaboration***	**3.1 Graduated Care** To develop the roll out of graduated care within Newport Locality	• The remodelling of the short term intervention/intermediate care pathway to ensure person centred wrap around support to increase independence and enable people with complex needs to be supported in the community, facilitating hospital discharge and reducing readmissions	• A multi-disciplinary approach to hospital discharge, remodelling of the re-ablement care provision and MDT approach to step up step down beds.	• Pan Gwent KPI's agreed with Information department • Complaints/ accolades • Frailty dashboard	• Local Authority • NCC • WAST • Nursing teams • CRT • Estates • DN Teams • STW staff • COTE • Information • GP Practices • Public	• Established a St Woolos hospital clinical site forum to take the work stream forward. Home First was established in the Royal Gwent on the 1st Nov 2018. • Holly ward is on target to open for winter pressures on 17th Dec. • Holly ward to incorporate an ambulatory community frailty unit (ACFU) from Jan 2019. • Proposal to accommodation committee for the future of the ACFU following winter pressures. • District Nursing are also exploring how the service can link with ACFU. • Joint MDT ward rounds in EFU to monitor the number of patients that can be pulled. • Awaiting the approval of designated Reablement & Complex care wards in STW.	• Graduated care workshop to determine timescales/protocols and any staffing considerations to provide graduated care	• Resignation of wards approved	March 2020	A

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

Link to Strategic Programme for PC	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
First Point of Contact Direct Access People with Complex Care Needs Support for Self-Care Direct Access ***Links to:*** ***IMTP SCP5 – Urgent and Emergency Care.*** ***IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being*** ***IMTP SCP7 – Service Sustainability and Regional Collaboration***	**4.1 Frailty** To develop clearer and more accessible links with the Frailty Team	• Frailty forum to provide a of shared understanding • Improve GP access • Decrease inappropriate referrals • Pilot Ambulatory frailty from Dec 18 to March 19 at St Woolos.	• To provide a greater awareness of the service which will result in an increased number of referrals from GPs • Ensure that appropriate referrals are received	• The number of referrals received via GPs.	• CRT/Frailty Teams • GPs • NCN • First Point of Contact • Public	• GPs invited to visit Frailty to gain an understanding of cross working between the teams. • Pathway under development; anticipating that this will be in place in time for winter pressures. • Service hours have previously been extended but a further extension is being discussed (resource dependent) • SPA have been advised to transfer calls for advice only to teams and where a professional or clinical conversation needs to be held. All agreed/requested referrals will require capture and recording via SPA. Service currently undertaking review of front access models, would be useful to further understand nature and borough demand for calls and any opportunities to improve service education. • Potential for 'e' communication around WCCG (e-referral) development and interface with WCCIS. Captured requirements to be fed through ABUHB WCCIS Steering Group.	• Frailty Forum to be convened	• First Frailty Forum meeting scheduled for 10th Jan 2019.	March 2020	A

Link to Strategic Programme for PC	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
Urgent Care Support for self-care Community Services Empowered Citizens ***Links to: IMTP SCP1 – Improving Population Health and Well Being IMTP SCP2 – Delivering an Integrated System of Health, Care and Well Being***	**4.2 Cancer diagnosis and survival statistics by Cluster and individual Practice within the NCN** To improve screening uptakes in particular with ethnic minorities.	• Baseline intelligence to underpin and support NCN National Priority Area review. • local NCN wide data for cancer diagnosis and survival • Available services pathways to access. •	• Increase in key screening across the Borough	• The number of patients presenting to the GP/secondary care with earlier staged cancer • PHW screening uptake info	• NCN Leads • GP Practices • PHW • Public	• An Early Detection and Prevention of Cancer screening event was held in November 2018 – but was not well attended, despite indications re uptake	• Identify approaches to improve uptake of breast/bowel/AAA screening • Identify means to improve the communication/uptake with ethnic minorities • Explore options to replicate such as GP led Diabetes education event that was widely attended with GP practices in NCN re screening • Review and critique current practice in regards to recognition and referral of cancer, with particular reference to NICE suspected cancer referral guidance, at risk groups, and potential barriers to prompt referral.	• Investigating the purchase of Dermascope (skin cancer detection tool)		A

Strategic Aim 5: GP Contractual Priorities

Link to Strategic Programme for PC	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
Empowered Citizens Support for Self-care People with complex Care needs MDT Working ***Links to: IMTP SCP1 – Improving Population Health and Well Being IMTP SCP2 – Delivering an Integrated System of Health, SCP5 – Urgent and Emergency Care. Care and Well Being Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales and Future Generations Act***	**5.1 Flu Reporting.** To work with integrated teams in order to identify ways of improving the management of long term chronic conditions. Increase vaccine uptake.	• Review of current services and activities to be held. • Offer District Nursing teams funding to assist in the delivery of vaccines to housebound patients	• To develop NCN resilience for winter preparedness and emergency planning	• Reports generated by IVOR • Numbers of admission throughout the winter period	• GP Practices • DN teams • Health Visiting teams • Community Connectors • Voluntary Sector • Pharmacy • Schools • CRT Team • Public	• The data submitted to IVOR is reviewed on a regular basis and support being offered to the practices. • Practices advised of any available vaccines within Gwent • Practice Manager Forum – sharing good practice, review and implemented flu vaccine plan.	• Collaborate with local authority and school nursing leads to establish a robust roll out plan for children in years 1 to 6. • Highlight lessons learned from previous years. Implement change to improve the service. • Through integrated working with District Nurses/CRT/Home visiting look to explore the Stay Well plans with patients in order to identify ways of improving/maintaining patient's health, helping them to live longer whilst remaining in their own home.	• Lessons learnt from 2018.		

Strategic Aim 6: Medicines Management and Pharmacy.

Link to Strategic Programme for PC	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
MDT Working Community services ***Links to: IMTP SCP7 – Service Sustainability, Healthcare Standards 2.6***	**6.1 Medicines Management** To monitor the NCN prescribing budget and delivery of the Medicines Management plan	• Quarterly update to practices by Pharmacy in regards to their performance in the national prescribing indicators. • NCN will receive a financial reimbursement under the ABUHB CEPP (incentive scheme) if the whole NCN comes under budget	• Efficient use of resources that can be re-invested more appropriatel y into patient care	• Performance management and analysis of the NCN prescribing budget • Prescribing Out turn. • Finance report to MMOG in terms of CEPP reimbursement	• Pharmacy • GP Practices • Patients • Finance	• Regular updates provided by Lead Pharmacist at NCN meetings • Support any outlier results • Regular updates with Newport Pharmacy technicians based within the locality office. • Community pharmacists attend NCN meetings on a rota basis to	• To determine if the current process should continue in the current format at NCN meetings. • Quarterly financial reports to be received in terms of CEPP. • To scrutinise prescribing budgets on Practice by Practice basis at all NCN meetings; • To monitor NCN performance against all other NCNs			
Direct Access Community Services MDT Working Informed Public People with Complex care needs Empowered Citizens ***Links to: IMTP SCP7 – Service Sustainability, Care Closer to Home Strategy, Clinical Futures***	**6.2 Pharmacy input into General Practice.** Ensuring that there is the correct skill mix for patients. Optimising the practice team/expert knowledge in medicine safety	• Regular updates provided by practice based pharmacists at NCN meetings • Practice based pharmacist funded by the NCN and share best practice across the NCN	Patients benefit from open access specialist advice closer to home	• Quantify the number of medication reviews and other interventions.	• Pharmacy • NCN • GP Practices • Finance • Patients	• NCN Practice based Pharmacists appointed by the NCN with support offered across the NCN • Practices have appointed practice based pharmacists based upon the success of the NCN funded posts. • The NCN pharmacists report to the Newport Medicines Management team and provide an update on their current work plan. • Quarterly snapshot of pharmacist activity.	• Explore the Pharmacy audit system provided by HERE to the time efficiency of a practice based pharmacist. (Workflow Opt provider)			

Strategic Aim 7: Governance

Link to Strategic Programme for PC	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
Community Services ***Links to: IMTP Enabler 3.16 - Governance***	**7.1 Clinical Governance Toolkit.**	• Encourage practices to undertake and complete the toolkit.	Consistency & safety in Practices and NCN wide Primary Care services	• Annually by GP Practices	• GP Practices • WG	• Practices reminded by email and at NCN meetings to undertake the toolkit before Q4	•			
Informed Public Community services Direct Access First point of contact ***Links to: IMTP Enabler 3.16 - Governance***	**7.2 Information Governance.** To ensure that the NCN is compliant with the IG legislation in terms of patient data	• Information Governance toolkit completed and learning outcomes identified • Practices to appoint a Data Protection Officer by 25th May 2018 • Practices to ensure that policies are GDPR compliant and that the correct measures are in place when collecting personal information. • Practices to refrain from	• To be compliant with the required GDPR processes and to avoid breaching regulations	• Annually by GP Practices	• WG • GP Practices • IG Team	• Newport wide GDPR seminar arranged to support all GP practices • GDPR information circulated to NCN membership when necessary. • Newport NCN to be represented by Welsh Government in terms of a GDPR Data Protection Officer.	• Attend regular Information Governance meetings and fee back any changes.			

Link to Strategic Programme for PC	Objective	Action 18/19	Outcome	Measures	Leads & Key Partners	Progress to date 18/19	Action 19/20	Working Progress	Completion By:	RAG Rating
		using fax machines								