Torfaen South GP Cluster Network Annual Report 2017-18

Our Network:
We are a Network of 7 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.

Our Community:
We serve a population of 45,476 (2017/18 capitation figures) in a predominantly urban area with 99.4% of the population residing in the main town of Cwmbran and surrounding areas. Torfaen has 39,052 households; 20,701 (53.0%) of which are in Cwmbran. The NCN has boundaries with Monmouthshire, Caerphilly and Newport.

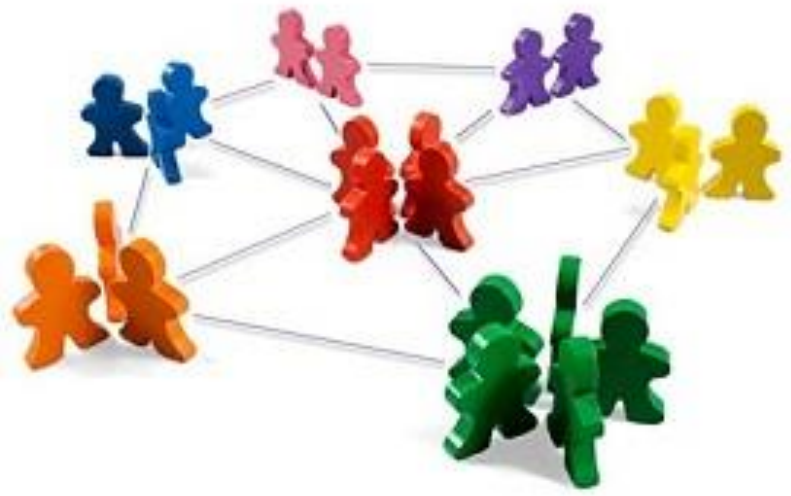
Cwmbran:
Pontnewydd Lower Super Output Area (LSOA) 1, and Upper Cwmbran LSOA 1 are in the 10% of the most deprived LSOAs in Wales. There are higher rates of burglary and criminal damage, violent crime, theft and anti-social behaviour in Cwmbran Central and the percentage of households classed as 'in poverty' is higher than the Wales average. However, a higher proportion of Cwmbran residents are in full-time employment (39.4%) than across Wales (35.6%) with 60.1% in some type of employment, which is higher than the value for Wales (58.2%). The proportion of unemployed residents aged 16-24 in Cwmbran is 1.6% compared to 1.4% in Wales[1]

[1]*The Well-Being of Future Generations (Wales) Act 2015 – Torfaen County Borough Council Well-Being Assessment 2017*

We looked at the needs of our community: • 26.8% of children aged 4 to 5 years old are obese compared with 26.5% across Wales - ranked 3rd highest of the 5 Gwent Boroughs[1] • 12.5% of Cwmbran residents' day-to-day activities are limited due to their health. While lower than the percentage for Torfaen (13.1%), it is higher than the Wales value (11.9%). Across the Cwmbran LSOAs, the rate varies from 7.4% in Two Locks 2 to 19.2% in Llantarnam 3, which also has the highest rate of residents reporting their health as either bad or very bad at 14.7%, being nearly twice the Wales value (7.6%). 13.2% of Cwmbran residents provide unpaid care, similar to Torfaen as a whole and higher than the value for Wales (12.1%). • *[1]The Well-Being of Future Generations (Wales) Act – Torfaen County Borough Council Well-Being Assessment 2017*	**Our agreed priorities for 2017-18 were:** • **Integrated Well-Being Network (IWBN):** To support collaborative working & allowing people to be more engaged in their own care/health and well-being e.g. patient activation • **Social Prescribing:** On-going development & integration of Social Prescriber role • **Tackling Obesity:** To reduce levels of obesity in ante-natal women with a BMI>30 & children in Torfaen • **GP Practice sustainability:** Continue to support GP Practice resilience through NCN funding for training and introduction of alternative support options e.g. social prescribing, practice based pharmacists
What we have achieved: • Supported Public Health team Integrated Well-Being Networks baseline review • Funding for Open Access Physiotherapy triage service • Funding for a Social Prescriber • Funding for GP Practice colleagues to undertake a range of training to reduce demand on Practice staff time • 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, Social Prescribing models,	**Our plans for 2018-19:** • Continue to drive 3 key themes of the Primary Care Plan for Wales: Improved Quality of Care, Sustainability in Primary Care & Care Closer to Home • On-going support to the Direct Access Physiotherapy service • On-going support to the Pharmacist in Practice role • On-going support to the Social Prescriber and independent review • Support the on-going development of Patch Based Working • Continued support to the implementation of the Care Closer to Home strategy

Neighbourhood Care Network Annual Report 2017-18

Torfaen South NCN



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

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
1.1 Population Well-Being / Care Closer To Home				
1.1.1 Integrated Well-Being Network (IWBN): Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales and Well-being of Future Generations (Wales) Act IMTP	**Years 1, 2 & 3** Public Health (PH) Social Prescriber NCN Torfaen County Borough Council (TCBC)	Patients benefit from collaborative working allowing people to be more engaged in their own care/health and well-being e.g. patient activation	• **NCN & partners support development of the IWBN linked to established Social Prescribing role** Progress: – NCN and partners supporting growth of the Torfaen Social Prescribing model and importance with development of the IWBN – Accepted as an on-going priority theme by the NCN – Progress reported to NCN Management Team and shared with the wider NCN – Public Health Team in process of completing comprehensive baseline review across each Local Authority area to understand which aspects of the IWBN already exist – completion expected 31.03.18; – 'Care Navigation' training due to be delivered to all GP reception staff during 2018-19 to support appropriate navigation of patients to services that can best meet their need - training to be powered by DEWIS Cymru and NHS 111; – Dedicated DEWIS co-ordinator post created part funded by the 'Transformation' budget & all NCNs - to play an important role in the development and implementation of DEWIS across Gwent, and support/sustain a Gwent wide DEWIS network. – See 1.1.2	
1.1.2 Social Prescribing: On-going development & integration of social prescriber role Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for	**Year 1 with option for years 2 & 3** Torfaen County Borough Council (TCBC)	Patients, carers & families have direct access to a range of information, advice and support through dedicated	• **NCN evaluation of joint funded Social Prescriber assesses impact of role against agreed outcomes** • **Practices, NCN & partner annual review considers demand hot-spots & gaps in service** Progress: – 2016/17 TCBC evaluation shared with NCN found greater	

Wales IMTP	Social Prescriber (SP) NCN Public Health (PH) Primary Care Mental Health Support Service	signposting role in GP Practices	reassurance needed to ensure post holder stability & client confidence - TCBC notified of on-going NCN funding commitment to SP role until 31.03.19 – Emerging links with Primary Care Mental Health Support Service, Community Connectors and British Red Cross – NCN agreed to support independent evaluation of role	
1.2 Tackling Obesity				
1.2.1 To reduce levels of obesity in ante-natal women with a BMI>30 & children in Torfaen Linked to Care Closer to Home Strategy; Primary Care Plan for Wales; Fit for Future Generations: A childhood obesity strategy for Gwent to 2025; Torfaen Public Service Board – Every Child Has The Best Start In Life Torfaen Healthy Outcomes Group IMTP Gwent Obesity Strategy 2015-2025.(	**Years 1, 2 & 3** NCN Adult Weight Management Service (AWMS) Torfaen County Borough Council (TCBC) National Exercise Referral Scheme (NERS) Midwives Public Health (PH) NCN Management Team	Pregnant women & children who are overweight or obese can access schemes designed to support weight loss	• **NCN supports childhood obesity workshop & delivery of work-plan** • **Map currently available services as part of IWBN 'Healthy Living' domain** • **NCN to promote the Adult Weight Management Service & monitor referral rates** Progress: – Child obesity workshop held June 2017, next steps agreed in relation to building effective work-plan around individual & family interventions linked to the Gwent Obesity/Fit for Future Generations 2015-2025 strategy, progress monitored via NCN Management Team – AWMS referral rates monitored by the NCN Management Team and NCN Leads	

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

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
2.1 Sustainability:				
2.1.1 Continue to support GP Practice resilience	**Years 1, 2 & 3** NCN	Patients benefit from standardised	• **NCN team analysis of Practice Development Plans (PDPs) & Sustainability Risk Matrices to identify**	

Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales and Well-being of Future Generations (Wales) Act IMTP	Practices Housing Community Nursing TCBC	processes, collaborative working and stable workforce	**pressure points** • **Consider NCN funding for development of non-clinical roles e.g. Medical Assistance** Progress: – Review of GP Practice sustainability risk matrices (of those available) showed 60% of Practices at low, 20% at medium & 20% at high risk with returns citing deprivation, number of appointments per GP, singlehanded Practice, care home demand, reliance on locums and vacancies as key factors – 57% of Practices reported increasing list sizes – 100% of Practices reported concerns about current & planned housing developments – Dedicated sustainability workshops held to consider acute hub, collaborative working and benefits of urgent care practitioner role etc – NCN/Primary Care funding agreed for non-clinical Practice staff to train in telephone triage, workflow optimisation (medical assistance) and care navigation – Practice DNA rates monitored - ranging from 1% to 6.8% – Practice support provided to neighbouring Practice with capacity issues – On-going NCN commitment for Practice Based Pharmacist – On-going NCN & TCBC commitment to Social Prescriber role	
2.1.2 Continue to support early warning process for Practices anticipating difficulty with recruitment/filling vacancies Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales Healthcare Standard 7.1 IMTP	**Years 1, 2 & 3** Practices Primary Care Team NCN Clinical Team NCN	Continuity of services; Support against potential Practice fragility	• **Practices inform NCN if anticipating difficulty** • **Practices meet with NCN clinical team to discuss action** Progress: – Dedicated sustainability sessions held via workshops, NCN Clinical Leads and NCN meetings to support practices in identifying pressures and solutions	

2.1.3 To promote and raise awareness of the Local Oral Health Action Plan (LOHAP) Linked to Care Closer to Home Strategy IMTP	**Year 1** NCN Team	Raised awareness of the existence of the LOHAP for the wider NCN membership	• **Publicise LOHAP across NCNs** • **Circulate information complementing the programme e.g. materials from MEND promoting healthy diet** Progress: – LOHAP situation reported to the NCN and circulated to NCN members for information – NCN Dental Advisor up-date re provision of multi-disciplinary dementia training primarily for professionals, to improve knowledge and current research.	
2.1.4 Ensure NCN participation in Care Closer to Home Strategy	**Years 1,2 & 3**	Agreed vision and action plan for delivering prudent healthcare across ABUHB	• **Ensure strong links with Clinical Futures and the Care Closer to Home strategy and delivery framework** Progress: – Two Care Closer to Home, multi-disciplinary/agency workshops undertaken in Torfaen to support next phase planning.	
2.2 Workforce				
2.2.1 To support the integration of & work-streams relating to the Practice Based Pharmacist role Linked to Care Closer to Home Strategy Healthcare Standard 3.1/7.1 IMTP	**Years 1,2 & 3** NCN Pharmacy Directorate Practices Practice Based Pharmacist(s)	Patients have local access to, and benefit from evidence based interventions; Patients benefit from reduced waiting times; Increased GP capacity	• **Pharmacist presents to the NCN impact of role against expected outcomes** • **Quarterly report to be shared with Community Nursing Leads** Progress: – On-going commitment to NCN funded Pharmacist agreed at NCN meeting with regular performance reports reviewed by Clinical Leads and shared with NCN partners – Data reports confirm efficiencies against intended outcomes	
2.2.2 To support delivery of the Direct Access Physiotherapy (DAP) triage service Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales IMTP	**Year 1 with option for 2 & 3** NCN Physiotherapy	Patients benefit from open access specialist advice closer to home	• **NCN monitoring of impact of DAP against agreed outcomes** Progress: – Joint funded across Torfaen North and South NCNs – Open Access Clinics run from County Hospital, Pontypool and offers a drop-in triage service for people with musculoskeletal problems;	

			– Between April 2017 and February 2018, 1,562 patients were assessed, 42% discharged to self-manage, 41% placed on a routine waiting list and 15% assessed as urgent; – 0.9% of patients were referred back to GP for onward referral and total utilisation for this period was 56%	
2.2.3 Social Prescribing			• See 1.1.2	

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.

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
3.1 Secondary Care:				
3.1.1 To review quality of Secondary Care referrals Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales IMTP	**Year 1** Practices NCN Lead NCN ABUHB	Patients benefit from improved communication and streamlined processes	• **Practices to undertake referral quality review of specific secondary care specialty & share with the NCN** Progress: – NCN meeting to identify review period - suspended due to on-going Practice pressures and sustainability concerns	

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.

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
4.1 Urgent Care : CND 009W				

4.1.1 To develop NCN resilience for winter preparedness and emergency planning
 	
Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales
	Year 1
	Practices
	NCN
	Community Teams
	NCN partners
		Patients benefit from clarity for processes followed in the event of adverse weather and emergency	• **To implement a range of methods to increase flu immunisation up-take including:**
			  • **NCN discussion to share ideas & good practice**
			  • **Patient/NHS staff immunisation levels monitored**
			  • **Ensure patients have adequate supplies of medications – advertising & reminders**	

IMTP		situations	• **Utilisation of Third Sector schemes e.g. housing** • **Suspension of chronic disease clinics during emergency periods to release GP & Nurse time** Progress: – Achieved – Practice Manager Forum – shared good practice, review and implemented flu vaccine plan	
4.1.2 To increase the use of Adastra Special Notes (SPN) Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales IMTP	**Years 1,2** Practices NCN	Patients with complex health & social care problems receive holistic support from informed professionals	• **Source data to undertake baseline comparison to demonstrate increased use of Special Notes to OOH by Practices** Progress: – Data requested to inform baseline	

Strategic Aim 5: Improving the delivery of cancer, liver disease & COPD.

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
5.1 Liver Disease: CND 012W				
5.1.1 To reduce the number of repeat liver function tests following an abnormal ALT, to increase appropriate testing following an abnormal ALT and increase appropriate referrals to hepatology for patients with abnormal ALT indicative of hepatic fibrosis IMTP	**31st March 2018** Practices NCN	To facilitate appropriate management of abnormal ALT tests and, thereby, more timely diagnosis of patients with liver disease	• **Complete baseline audit by October 5th 2017 NCN meeting and submit data** • **To re audit and discuss learning in NCN meeting December 7th 2017 – submit data prior to meeting** • **To discuss learning in NCN meeting February 1st 2018** • **Collated results to be discussed by the NCN & included in the NCN Annual Report** Progress: – Dedicated NCN meeting for GP Practice presentation of individual case studies and learning points – Quarter 4: Welsh Government relaxation of QOF	

5.2 Chronic Obstructive Pulmonary Disease (COPD): CND 012W				
5.2.1 Higher percentage of accurate coding and recording of COPD consultations, and more appropriate prescribing and referrals, with the improvements being measured by the practice and shared with the NCN IMTP	**31st March 2018** Practices NCN	Patients benefit from improved processes and quality of care	• **To undertake baseline audit - outcome to inform peer review session at October 5st 2017 NCN meeting** • **Findings to be referenced in annual NCN end of year review** Progress: – Dedicated NCN meeting for GP Practice presentation of individual case studies and learning points – Quarter 4: Welsh Government relaxation of QOF	
5.3 Cancer: CND 012W				
5.3.1 To complete Module 2 of the Macmillan Cancer Toolkit for General Practice in Wales IMTP	**31st March 2018** Practices NCN	Patients benefit from prompt recognition and early referral	• **To complete the toolkit (Module 2)** • **Review current data regarding cancer presentation, referral and incidence for your practice (and NCN).** • **Review and critique current practice regarding recognition and referral of cancer, with particular reference to NICE suspected cancer referral guidance, at risk groups, and potential barriers to prompt referral.** • **Agree and carry out three actions/tests of change to enhance patient care, using quality improvement methods** Progress: – Dedicated NCN meeting for GP Practice presentation of individual case studies and learning points – Quarter 4: Welsh Government relaxation of QOF	

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority.

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
N/A				

Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and Information Governance. To include actions arising out of peer review Quality and Outcomes Framework (when undertaken).

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
7.1 GPSAT & Dormant Indicators: CND 011W				
7.1.1 To fully implement the Clinical Governance Toolkit Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales IMTP All SCPs	**31st March 2018** Practices NCN	Consistency & safety in Practices and NCN wide Primary Care services	• **Practices up-date the Clinical Governance Practice Self-Assessment Toolkit** • **Practices complete Information Governance Self-Assessment Toolkit** • **Practices utilise learning/outcomes in peer review at NCN meeting** Progress: – Practices informed that despite QoF relaxation for 2017/18, the toolkit can still be completed for Clinical Governance and contractual compliance.	
7.1.2 Clinical & Information Governance & Peer Review of inactive QOF indicators	**Years 1,2 & 3** Practices NCN	Reviews completed	• **Practices contribute to dedicated peer review sessions at two NCN meetings (6 months & 12 months) for inactive QOF indicators** • **Outcome of inactive QOF peer review completed and shared with ABUHB** • **Actions resulting from analysis reflected in PDPs to consider if issues need to be discussed at NCN meetings** Progress: – Practices informed that despite QoF relaxation for 2017/18, the toolkit can still be completed for Clinical Governance and contractual compliance.	

Strategic Aim 8: Other Locality issues

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
8.1 Medicines Management				
8.1.1 To monitor the NCN prescribing budget and delivery of the Medicines Management plan Healthcare Standard 2.6 IMTP	**Years 1, 2 & 3** Prescribing Advisors Practices NCN	Efficient use of resources that can be re-invested more appropriately into patient care	**Action:** • **To scrutinise prescribing budgets on Practice by Practice basis at all NCN meetings;** • **To monitor NCN performance against all other NCNs** Progress: - NCN Prescribing Advisor & Pharmacy Technician regular GP Practice visits to identify & support prescribing efficiencies - Prescribing dedicated session at each NCN meeting allowing for NCN/ABUHB benchmarking & comparison - Prescribing Leads meetings reinstated	