Three Year Cluster Network Action Plan 2017-2020
(Year 2018-2019)

(Caerphilly South) Neighbourhood Care Network

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 Smoking Cessation				
1.1.1 **Smoking:** Achieve/work towards the National Tier 1 target of 5% of smokers make a quit attempt via smoking cessation services ***Improved Quality of Care*** *Supports Caerphilly SIP – Healthier Caerphilly H1, H2, H3, H4* *Supports IMTP* *SCP2/3*	**Years 1,2&3** NCN, PHW, Smoking Cessation Wales, Housing Associations, Communities First, Community Pharmacy	Increased numbers of staff who have access to brief intervention training Increased access for patients to staff trained in brief intervention techniques Patients will be motivated to make a quit attempt and will receive effective treatment to quit smoking	**Actions:** • **Provide Brief Intervention training for staff** • **Ensure all practices have a Smoking Champion to link with SSW** • **Increase Pharmacies providing Level 3 Smoking Cessation** • **Implement Smoking Champions training** • **Encourage young people to access smoking cessation services** Progress: • Brief intervention training for staff continued to be rolled out including for Midwifery Service • 7 out of 7 practices have identified a Smoking Champion • 3 Stop Smoking Wales Clinics held at various venues in the South NCN • 5 Pharmacies offer level 3 Smoking Cessation Services • Promotional campaign materials circulated to third sector and information on pharmacies offering smoking cessation support in the borough. Also information from ASH Wales. • Referral updates reported timely at NCN meetings • Stop Smoking Champions event held on the 9th November 2017 • Total number of smokers referred directly to smoking cessation services in Caerphilly South NCN (Stop Smoking Wales and Level 3 Pharmacy) = **240** at the end of Qtr 3 2017/18	A

1.2 Tackling Obesity				
1.2.1 **Obesity:** Continue to work to tackle obesity and work towards a reduction in the numbers of adults/children who are overweight/obese ***Care Closer to Home*** ***Improved Quality of Care*** *Supports Caerphilly SIP – Healthier Caerphilly H2, H3, H4* *Supports IMTP* *SCP2*	**Years 1,2&3** NCN, PHW, ABUHB Weight Management	Maximise use of existing weight loss services in ABUHB – Adult Weight Management Service, National Exercise Referral Scheme Families will have access to a wide range of children and young people's services, initiatives and projects addressing obesity issues	**Actions:** • **Ensure service users are well informed of weight loss initiatives** • **Support the delivery of the Childhood Obesity work plan** Progress: • Community DSN's receiving patients and planning discharge from secondary care services • Communities' First representation at all NCN meetings. NCN informed of all obesity related programmes and initiatives. • Consideration of the Risk / Future of the Food Wise programme given uncertainty of Communities First Future and impacts. Funding has been considerably reduced within the Legacy programme and it has been necessary to prioritise activities that Communities First will continue with such as Employment, Empowerment & Early Years. • Adult Weight Management Service referral and activity data under development • Directory of available services 'DEWIS' under development and being populated for Caerphilly • Outdoor Active team, National Play Day, holiday schemes for children and young people play schemes delivered by GAVO Play Projects • A consultation is being undertaken for the Play Sufficiency Audit which will inform the CCBC Play Sufficiency Action Plan • Healthy eating policy adopted in all 26 Pop in and Play Groups delivered by GAVO and Homestart • EPP NHS Self-Management courses delivered in all 3 NCN cluster areas - Includes education on weight management, Nutrition (the Eat Well Plate), the benefits of physical activity and remaining active, relaxation and sleep promotion. • There are 6 week courses running in a verity of venues in the borough April, June and September 2018 • 881 referrals across Caerphilly received into NERS for 2017/18 • Focus on Obesity workshop planned for NCN meeting in September 2018	A

1.3 Public Health				
1.3.1 **Influenza:** Increase update of uptake of immunisations within Caerphilly South NCN ***Improved Quality of Care*** *Supports Caerphilly SIP – Healthier Caerphilly H3* *Supports IMTP* *SCP2*	**Years 1,2&3** NCN, PHW, District Nursing	Decrease in hospital admissions Decrease in morbidity	**Actions:** • **Implement the Caerphilly NCN Flu Plan for 2017/18** • **Target improvent on uptake figures from previous year** Progress: 2017/18 • **69.8 %** acheived as at 06.03.18 for immunisation against influenza for 65yrs and older (@30.03.17=69.1%) • **53.0%** acheived as at 06.03.18 for immunisation against influenza for 6months to 64yrs (@30.03.17=50.6%) • **54.6%** achieved as at 06.03.18 for immunisation against influenza for children 2-3 years (@30.03.17=47.7%) • By end of January 2018 **1,425** Housebound patients and Carers in Caerphilly Borough were offered flu vaccinations with **944** completed by District Nurses Progress: 2018/19 • The July Caerphilly East NCN Cluster meetings have a subject focus "Winter Planning" and a key component of this is flu vaccinations. Clusters have reviewed and discussed what went well and not so well in previous vaccination programme periods. New and alternative ideas have been suggested and these will be shared across the Caerphilly borough. • Throughout the programme period weekly reports of age 2-3 uptake by individual practices to be shared with ABUHB Health Visiting to highlight and address areas of lower compliance.	A
1.3.2 **Childhood Imms:** Maintain working towards the National Tier 1 targets ***Improved Quality of Care*** *Supports Caerphilly SIP – Healthier Caerphilly H3* *Supports IMTP* *SCP2*	**31.03.19** NCN, GP Practices	Improve uptake of Childhood Immunisations	**Action:** • **Monitor progress of uptake Childhood Immunisations across the NCN – sharing good practice** Progress:2017/18 • **97.4%** achieved from Oct 2016-Sept 2017 for Childhood Immunisations in Caerphilly South NCN • Support practices whose nurses are taking over the immunisation role from HVs • Monthly data received regarding Childhood imms uptake rates from core performance team.	A

1.4 Screening				
1.4.1 **Cervical Screening:** Aim to increase for an uptake target of 80% ***Improved Quality of Care*** *Supports Caerphilly SIP – Healthier Caerphilly H2* *Supports IMTP* *SCP2*	**31.03.19** NCN Lead, GP Practices	Earlier detection of cervical cancer with improved chance of survival	**Action:** • **Monitor progress of uptake Cervical Screening across the NCN – sharing good practice** Progress: • Practices self report quarterly presented at NCN meetings to form feedback shared in NCN meeting. • March 2017 reporting 3 practices of 7 achieiving the 80% target with 4 practices improving and working towards the 80% target. • January 2018 reporting 5 practices of 7 achieving the 80% target with the remaining 2 practice in the high 70s% and working towards hitting the target by year end. • Screening for Life training promoted to the third sector including train the trainer. Information on the screening mobile service availability and access disseminated through networks and community fora.	A

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 Access				
2.1.1 To identify gaps in services & access deficit in Primary Care ***Care Closer to Home*** ***Sustainability*** ***Improved Quality of Care*** *Supports IMTP* *SCP3*	**Years 1,2&3** NCN, Practices	Support the use of technology to improve patient access to primary care services through: - MHOL - Text messaging - Use of mobile technology by GPs & Nurses - Utilisation of DEWIS	**Action:** • **Continue to promote the use of MHOL and monitor progress** • **Share best practice regarding MHOL uptake** • **Liaise with the DEWIS Coordinator to improve webpages and uptake across Caerphilly** Progress: • 100% uptake from practices of My Health Online in Caerphilly South NCN • 100% of practices using for Appointments and Prescribing	A

			• All practices providing text messaging services to patients for appointment, flu vacs reminders • Partner services providing patient information for waiting room electronic information screens • DEWIS Co-ordinator attend the July NCN Cluster meeting to give status update report and discuss any issues. • Update at NCN Management Team • Caerphilly DEWIS co-ordinator currently cross referencing, checking and uploading Caerphilly related information. • Currently working with community connectors to where appropriate upload information. • Caerphilly co-ordinator to attend future NCN meetings to discuss progress and any issues raised	
2.1.2 Implement Social Prescribing model with the NCN ***Care Closer to Home*** ***Improved Quality of Care*** *Supports IMTP* *SCP3*	**31.03.19** GP Practices, NCN Membership, Allied local services	Patients are encouraged to self-refer to local community services where they do not need to see a GP first	**Action:** • **Implement the West Wakefield model of Active Signposting across all GP practices within the NCN** Progress: • The first of the 3 training sessions is scheduled for 5th September with following up sessions in Oct and Dec 2018. • All practices have expressed intention to uptake this training opportunity. • Scoping of who potentially would be required to be there in terms of a signposted service underway**.** • Planning to increase the capacity and enhance the role of Community Connectors across Caerphilly NCNs in partnership with Social Services	A
2.2 Sustainability				
2.2.1 Continue to support GP Practice Resilience ***Sustainability*** *Supports IMTP* *SCP3/7*	**Years 1,2&3** NCN Team, Primary Care Team, PCOST	Patients benefit from stability of Primary Care workforce	**Action:** • **Network team to analyse practice PDPs and Sustainability Risk Matrices to identify issues** • **Explore options of collaborative working among practices** Progress:	A

			• Following the NCN meeting on the 6th of July 2017 all practices within the NCN stated that there were currently no immediate pressures • Sustainability Meeting 2 for all practices within Caerphilly South NCN held on 21/02/18	
2.2.2 To promote and raise awareness of the Local Oral Health Action Plan (LOHAP)	**31.03.19** 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: • Dental Advisor appointed across all NCNs • Dental Advisor attended the NCN meeting on the 07/09/17 and provided an update on services and special care dentistry pathways • LOHAP circulated to NCN members for information • LOHAP up-date expected July 2017 • Welsh Government issued a 5 year National Oral Health Plan in 2013. • Health Boards were asked to develop an annual Local Oral Health Action Plan during this period, which identified need and addressed key dental issues, in line with the NOHP. • As the NOHP has come to an end, the HB has not developed a LOHAP but is waiting for guidance from WG on next steps. • The NOHP (2013/18) focused on service delivery but the new 'Prosperity for All' oral health and dentistry response is going to be focusing on prevention, and cluster working. • Awaiting update from Senior Primary care Manager for Dental	A
2.3 Workforce				
2.3.1 Social Prescribing utilising Community Connectors/Social Workers ***Care Closer to Home*** ***Improved Quality of Care*** *Supports IMTP* *SCP2/3/4*	**31.03.19** NCN Lead Social Services Identified practices	Better GP Access Avoid social isolation for people within the NCN are A greater focus on achieving people's well-being outcomes through holistic integrated service provision	**Action:** • **Employ a further 6 Community Connectors via Social Services to work closely with GP practices across Caerphilly East NCN** • **Monitor progress and impact on access to local service** Progress:	R

		Increased capacity for GP's where people can access the right person, with the right skills and at the right time.	• Head of Service for ABUHB and Social Services to meet to agree model, costings and sign-off of additional posts	
2.3.2 Maintain and provide continuous support for the Primary Care Based Pharmacists time from NCN funding to integrate with NCN and Partners ***Care Closer to Home*** ***Improved Quality of Care*** *Supports IMTP* *SCP3*	**Years 1,2&3** NCN Lead Pharmacy NCN Practices	Patients have local access to and benefit from evidence based interventions; Patients benefit from reduced waiting times from increased GP capacity	**Action:** • **Maintain the current capacity of Primary Care Based Pharmacist time for Caerphilly South** • **Integration of Pharmacist to be monitored** • **Maximise Practice Based Pharmacists working** Progress: • NCN funding agreed to continue support roles for 2017/18 • NCN agreed to re-appoint to vacant post to maintain current Primary Care Pharmacist capacity within Caerphilly South – Pharmacist appointed and working in the NCN • Pharmacists regularly attend the NCN meetings and have presented on their work programme and shared good practice across the NCN Work undertaken during 2017/18: • Practice based medication reviews = 1,413 • House bound medication reviews = 64 • Nursing home reviews = 104 • Prescription queries and re-authorisations = 625 • Discharge summaries = 40 Other work includes: • Finding suitable patients and setting them up on to batch repeats • Auditing Lithium patients as per request from Alison Shaw. • DOAC audit and review clinics including maintaining a register of patients • DMARDs bloods audit • Audit and review of Sodium Valproate in women of childbearing age • Audit of methotrexate injections • Increased Yellow Card reporting	A

2.3.3 Re-alignment of GP Practices and District Nursing	**31.03.19** District Nursing, NCN Leads, Asst Head of Service	Improved communication and working relationships creating a more streamlined service provision	**Action:** • **Scoping exercise to determine feasibility of DNs being practice aligned as opposed to working geographically** Progress: • Senior Nurse for Caerphilly and Asst Head of Service to have planned to review and feed back to NCN Management Team	R
2.3.4 Improved access to Physiotherapy across Primary Care within the NCN (Pilot) ***Care Closer to Home*** ***Improved Quality of Care*** *Supports IMTP* *SCP3*	**31.03.20** Physiotherapy Directorate, NCN Leads, NCN Membership	Patients have improved access to physiotherapy services with reduced waiting times	**Action:** • **Employ a Band 7 Physiotherapist utilising NCN funding** • **Monitor progress and impact on local GPs and Physiotherapy Service** Progress: • Agreement to progress with the Band 7 physiotherapist option given by NCN clusters. • Recruitment is in progress with the aim to have a physiotherapy presence in practice by end of October 2018. • The therapists will be aligned to practices on a list size equitable share and will be able to undertake initial assessment, give advice, refer for diagnostics, refer to secondary care etc. • Physios will not give injectable therapies where an enhanced service exists within the practice to administer this.	A
2.4 Care Closer to Home				
2.4.1 Ensure NCNs full participation in the Care Closer to Home Strategy	**Years 1,2&3** NCN Team, IP Membership	Agreed vision and action plan for delivering prudent healthcare across ABUHB	**Action:** • **Ensure strong links with Clinical Futures and the Care Closer to Home strategy and delivery framework** Progress: • Phase 2 workshop for Care Closer to Home held on 02/08/2018 to agree delivery framework • Awaiting outcomes from the meeting and Action Plan	A

2.5 Community Engagement				
2.5.1 NCN to work collaboratively with Youth organisations/services in Caerphilly Borough to take forward the agenda for young people and improve understanding of health services and provide prudent signposting to 11-25 year olds	**Year 1**	Young people in Caerphilly have a better understanding of what services and support is available to them	**Actions:** • **Encouraging young people in the "at risk" group to have their flu vaccinations** • **Signposting to local smoking cessation support services, with selected youth workers willing to be trained as Smoking Champions** • **Signposting young people with low level mental health and wellbeing issues to local wellbeing services** • **Supporting Young Carers** Progress: • Meeting held with SYDIC a Youth Drop-in Centre in Senghenydd in August 2018 • Exploring opportunities to promote access to services via current android and ios technology utilising QR Information pods	A
2.6 Training & Development:				
2.6.1 **Training & Development:** To support relevant education and development opportunities across the NCN where appropriate ***Improved Quality of Care Sustainability*** *Supports IMTP* *SCP2/5/7*	**Year 1**	Sharing education sessions across practices providing up to date enhanced skills to provide better patient care Utilise the NCN Training Plan from NCN slippage monies	**Action:** • **Facilitate training opportunities:** Examples: - Workflow Optimisation - Care Navigation - Signposting for Reception Staff planned to commence for all practices on 05/09/2018 - Diploma in Therapeutics for Practice Based Pharmacist	A

2.7 Estates				
2.7.1 **Estates:** Llanbradach Development ***Care Closer to Home Sustainability*** *Supports IMTP SCP3/7*	**Years 1,2&3** NCN, Primary Care Estates, Asst Head of Services	Building of High quality facilities available to best meet patient need commenced	**Action:** • **To ensure NCN members are made aware of progress of all relevant issues regarding the Llanbradach Development** Progress: • Room Data Sheets – Following review meeting on 22nd June 2018 these are requiring further amendment by Apollo prior to sign off • Initial bat emergent survey undertaken in June 2018 and confirmed Greater Horseshoe Bats – follow up survey scheduled end of July • Solicitors confirmed that the new calculations for Land Transfer Tax in line with the estimated Stamp Duty Land Tax. • Minimum Sale Guarantee - Aber Medical Centre not taking up this option at present but will liaise with Health Board if decision changed. • 4 tenders received - tender analysis in process	G
2.7.2 **Estates:** Aber Valley ***Care Closer to Home Sustainability*** *Supports IMTP SCP3/7*	**Years 1,2&3** NCN, Primary Care Estates, Asst Head of Services	High quality facilities available to best meet patient need Annual practice reviews and CHC statutory visit reports demonstrated facilities are to required standard. Patients are able to local access services in high quality premises	**Action:** • **To ensure NCN members are made aware of progress of all relevant issues regarding a potential Aber Valley Development** Progress: • Remains a priority area for Caerphilly Borough for service model development. • Scoping workshop held end of April 2018 with good attendance from variety of stakeholders and local residents. • Good links established with local community. • Project Group in process of being established with a date for inaugural meeting in September 2018. • Working with Local Authority to undertake detailed asset mapping of area.	G

Strategic Aim 3: Planned Care- to ensure that patients needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and 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 **Service Development** - working towards developing an integrated health and social care provision across acute and community services ***Care Closer to Home*** ***Improved Quality of Care*** *Supports IMTP* *SCP2/3/10*	**Years 1,2&3** NCN Lead, Caerphilly Locality Team	Improved links and communication with Secondary Care Leads	**Action:** • **NCN Leads to work collaboratively with Secondary Care /CRT consultants.** • **Secondary Care/CRT Consultants to become core members of the local Caerphilly Management Team meeting** • **NCN Leads to be engaged in the development and implementation of a graduated care model within Caerphilly borough.** Progress: • NCN Leads disseminated to their respective NCN • Seconday Care/CRT Consultants to invited to Managent Team meetings	A
3.2 Complex Wound Management Service				
3.2.1 Continue to support the Complex Wound Management Service in Caerphilly South NCN ***Care Closer to Home*** ***Improved Quality of Care*** *Supports IMTP* *SCP2/3/10*	**31.03.19** NCN Lead and Support NRMC	Release practice nurse time across Caerphilly South NCN practices Reduced waiting times for patients for TVN	**Action:** • **Continue to support the Complex Wound Management Service in Caerphilly South NCN via NCN funding for 2018/19** • **Monitor Progress with regular update reports** Progress: • NCN agreed continued recurrent funding for the service • Regular reporting received from the service • Patients now being referred to the service from all practices within Caerphilly South NCN • 6 monthly report for 2018/19 due in September 2018	A

3.3 Mental Health				
3.3.1 To strengthen integration at practice level between Primary Care and the PMHT ***Care Closer to Home*** ***Improved Quality of Care*** *Supports Caerphilly SIP – Healthier Caerphilly H1, H2, H4, H5* *Supports IMTP* *SCP3/8*	**31.03.17** Practices, PCMHSS, Third Sector, Statutory Services	Reduction in the number of referrals passed between different teams within Mental Health services, and PMHTs Clearer care pathways, including transparent, concise access criteria, will be in place for patients GP's to make use of the PCMHSS Flowcharts and increase their use of the PCMHSS Practitioners for advice/guidance. Increased uptake of psychological intervention through patient education	**Action:** • **Ensure local links are well maintained** • **Continue improved uptake of patient education opportunities** Progress: • Team Coordinator regularly updates at every NCN meeting. • Individual service user feedback indicated satisfaction with the service • Collation of average referral data and interventions • A number of practices are Direct Booking for PCMH Assessments and it is reported that the national targets for assessments is being achieved • There is now in place a Third Sector Mental Health Consortium contracted to provide mental health support across Caerphilly Borough (part of a Gwent service) • Caerphilly South NCN chose National Clinical Priority C- Improved Mental Health & Well Being • Workshop: A Co-ordinated multi-agency provision for CYP with mental health, behavioural and emotional wellbeing needs was held on the 15/02/18 • Outcomes: Aspiration to implement a multi-agency referral process - Develop an understanding of the right, integrated service model for families and implement this using new resource for transformation and integration - Focus on development and training - Massive cultural change - Focus on communication and developing a common language - Permission at the senior levels of health, Social Care, Education needed - A model that ensures that families' needs are considered holistically (the needs of adults as well as children) and that families are 'held' across their journey - A model that ensures that returning to the support system is OK / an achievement rather than failure	A

3.4 Pulmonary Rehab				
3.4.1 Utilisation of the Pulmonary Rehabilitation Service in the NCN Network ***Care Closer to Home*** ***Improved Quality of Care*** *Supports Caerphilly SIP – Healthier Caerphilly H3, H4* *Supports IMTP* *SCP1/3/10*	**Years 1,2&3**	There will be a locally available Pulmonary Rehabilitation service provision for Patients within the NCN Network Decreased waiting time from referral Decreased travel for patients	**Action:** • **Practices refer to the Pulmonary Rehabilitation Service in Caerphilly** • **Signpost patients to the Breathe Easy Groups** Progress: • Evidence shows that access to a Pulmonary Rehabilitation programme can reduce hospital admissions, therefore a full business case was developed & accepted by ABUHB outlining an increasing in the number of programmes across all NCN areas, to align capacity with demand – roll out expected during 2017/18 • Service being run out of Caerphilly YMCA (New Centre). Rolled out during 2017/18 - • British Lung Foundation in early stages of a Third Sector COPD support course	A
3.5 Medicines Management				
3.5.1 **Medicines Management** To monitor the NCN prescribing budget and delivery of the Medicines Management Plan ***Improved Quality of Care*** *Supports IMTP* *SCP3/4/7*	**Years 1,2&3** ABUHB Pharmacy, GP Practices	Efficient use of resources leads to re-investment & more appropriate care	**Action:** • **To scrutinise prescribing budgets on Practice by Practice basis at all NCN meetings** • **To monitor NCN performance against all other NCNs** Progress: • Primary Care Pharmacy Team member attends NCN meetings to update practices on prescribing information and budget performance. • Budgets scrutinised on practice by practice basis at NCN meetings • Individual NCN performance benchmarked against all other NCNs • Efficiencies and practice performance openly discussed at all NCN meetings.	A
3.5.2 **Waste Management**	**Year 1 & 2** ABUHB Pharmacy, GP Practices	Prevention of fragmentation, repetition and erosion of potential benefits	**Action:** • **Evaluate progress of the established Batch Prescribing Model and establish learning and best practice**	A

Reduce medicines waste and safety concerns relating to repeat prescribing systems			Progress: • All practices agreed to undertaking Repeat Batch prescribing • Outcomes and final figures due in May/June 2018	

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				
4.1.1 To develop NCN resilience for winter preparedness and emergency planning	**Years 1,2&3** NCN, Caerphilly Locality Team	Patients provided with clarity of process followed by services in the event of adverse weather and emergency situations	**Action:** • **Flu Immunisations** • **Practice adverse weather plans (business continuity)** • **Prioritisation of clinics** • **Patient interface issues (access, travel, etc)** Progress: • July Caerphilly East NCN Cluster Meetings: NCN Leads have facilitated a session to reiterate the necessity for all services collectively have a part to play to ensure effective service delivery through maintained planning to cope during times where demand and capacity can be an issue and also in times of inclement weather to ensure business continuity. A reflection of what has gone well in previous years and what posed an issue for local teams was briefly discussed. Partners at the meeting contributed with potential ideas to be explored to support the 2018/19 period. • CRT undertaking a pilot intake model for Reablement. Pilot to be undertaken during July/Aug 2018, using ward 2.1 at YYF. The aim of the pilot is to improve the flow within YYF.	A

4.1.2 **Frailty:** To monitor CRT referral rates, pressures, trends & address as required	**Years 1,2&3** NCN, CRT, Caerphilly Locality Team	Improved access and communication with Frailty and between Frailty and the OOH Service Less hand offs between services, and improved communication about the needs of the individual will result in better quality, more timely care Increased GP referrals Reduction in rejection of referrals	**Action:** • **Discuss at NCN with partners to address issues e.g. communication between Practices and frailty teams** • **Included in ISPB performance reporting** • **Quarterly NCN performance tracking of CRT referrals** Progress: • Capacity issues improved • Reported increase in referrals from GPs & secondary care to the whole Frailty team • Staff from the CRT are regularly attending the NCN meetings and Management meetings and using these opportunities to update the GP and partners with any changes in the CRT. • The last year has seen an increase in the CRT staffing numbers with the Community Physios being moved from a hospital setting to the community. They brought with them a large waiting list of patients but work has been undertaken and although there is still a waiting list this has been reduced significantly (currently around 34, with an average waiting time of 3 weeks. This is down from 80 and a waiting time of several months). • Falls Assessments waiting list has reduced significantly over the year. • Although 'pull' is an important function of the CRT, moving forward the CRT want to do more work at the preventative end in trying to avoid hospital admission. • Developing 'pathways' within CRT to try to facilitate easier access into the service • Frailty medics and nursing staff are visiting the GP surgeries to update them on Frailty and also try to address any issues the GPs are having in trying to access our service	A

Strategic Aim 5: Improving the delivery of dementia; mental health and wellbeing; cancer; liver disease, COPD, (delete as appropriate).

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
N/A for 2018/19				

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				
7.1.1 To fully implement the Clinical Governance Toolkit ***Sustainability*** ***Improved Quality of Care*** *Supports IMTP* *All SCPs*	**31.03.18** NCN, Primary Care & Network Division, GP Practices	Consistency and safety in Practice and NCN wide primary care services	**Action:** • **All practices to complete the Toolkit within agreed timescale** • **Monitor progress via QPS reporting** Progress: • 100% of practices completed the toolkit for 2017/18 • Deadline for completion has been extended to the end of April 2019	A

Strategic Aim 8: Other Locality issues

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
8.1 **NCN Funding:** Appropriate use of surplus NCN funding allocation for 2018/19	**31.03.19**	Utilisation of slippage monies from the annual budget after all recurrent funding has been allocated	**Action:** • **Consideration for funding towards:** - **Considering various training and development which would be beneficial to the NCN** - **Other spending options are yet to be discussed and agreed** Progress: • Decision on allocation of slippage monies to be agreed at NCN meeting • NCN Lead to produce Spend Plan for 2018/19 • Care Navigation licenses to be provided via NCN funds for 2017/18. • Consider NCN funding for QR Info Pods for community services • Roll out of POWeR to be re-considered for 2018/19	A