Torfaen North GP Cluster Network Annual Report 2017-18

Our Network:
We are a Network of 6 main GP Practices and 5 branch surgeries. There are 3 'Patch Based' Teams (2 North/1 Central) 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.

Our Community:
We serve a population of 49,116 (2017/18 capitation figures) in a predominantly urban area with approximately 84% of the population residing in Blaenavon, Pontypool and surrounding areas. Torfaen has 39,052 households – 2,592 (6.9%) of which are in Blaenavon. The NCN has boundaries with Monmouthshire, Blaenau Gwent and Caerphilly.

Blaenavon:
Three quarters of residents are reported as having good or very good health. There are higher levels of full-time employed people with nearly a fifth of those employed in manufacturing. There are however, a higher proportion of low birth-weight babies, people with limiting long-term illness and lower life expectancy. Approximately half of all households are in poverty.[1]

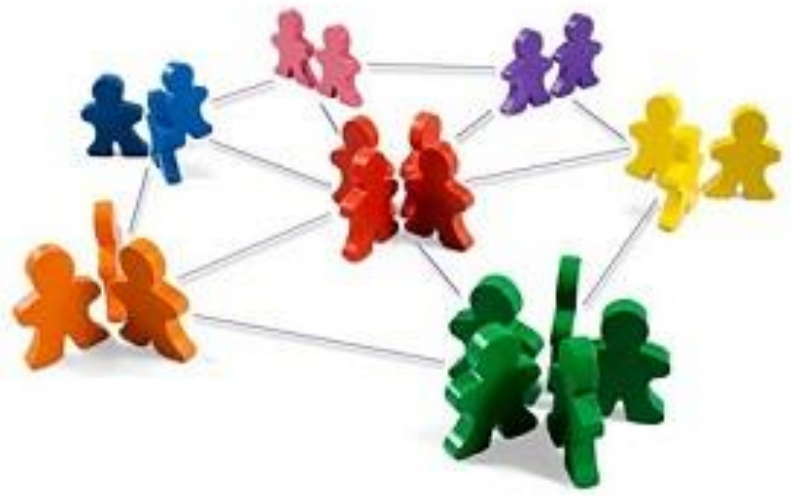
Pontypool:
15,759 (40.4%) households are in Pontypool. There are a lower number of low birth-weight babies and significantly lower all cause death rate in Pontypool East. Pontypool East and South have lower overall rates of crime and anti-social behaviour, except burglary. There is a lower take-up of children's immunisations in Pontypool West[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:	**Our agreed priorities for 2017-18 were:**
• 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] • Diabetes – 6.4% recorded prevalence making the NCN above Health Board and all Wales levels; and within highest 25% in Wales; • Just over 50% of the resident population in Torfaen North NCN live within the Most or Next Most deprived areas in Wales • [1]*The Well-Being of Future Generations (Wales) Act – Torfaen County Borough Council Well-Being Assessment 2017*	• **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:	**Our plans for 2018-19:**
• 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, proposal for a parental resilience education programme linked to health visitor & flying start teams.	• 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 & 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 North 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 – See 1.1.2 - PH team are in the process of completing baseline review report for each local authority area by end of March 2018 to present and gain agreement from leadership group in April.	
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 Wales IMTP	**Year 1 with option for years 2 & 3** Torfaen County Borough Council (TCBC) Social Prescriber (SP) NCN Public Health (PH) Primary Care Mental Health Support Service	Patients, carers & families have direct access to a range of information, advice and support through dedicated signposting role in GP Practices	• **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 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 Strategy/Fit for Future Generations 2015-2025, progress to be monitored via NCN Management Team – PH team are in the process of completing baseline review report for each local authority area by end of March 2018 to present and gain agreement from leadership group in April. – AWMS referral rates monitored by the NCN Management Team and NCN Leads – PH rep supports obesity in children service – New aqua-natal service planned with midwifery team	

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 Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales and Well-being of Future Generations (Wales) Act	**Years 1, 2 & 3** NCN Practices Housing Community Nursing TCBC	Patients benefit from standardised processes, collaborative working and stable workforce	• **NCN team analysis of Practice Development Plans (PDPs) & Sustainability Risk Matrices to identify pressure points** • **Explore options of collaborative working among practices e.g. Acute Hub, Care Home and Home Visit service**	

IMTP			• **Consider NCN funding for development of non-clinical roles e.g. Medical Assistance** • **Form a sustainability focus group to plan for a sustainable future and investigate ideas to address current issues** Progress: – Review of GP Practice sustainability risk matrices showed 17% of Practices at low, 50% at medium & 20% at high risk – all returns identified care home demand, deprivation, vacancies, use of locums & workforce issues as key factors – 67% of Practices reported increasing list sizes – 100% of Practices reported concerns with current & planned housing developments – 67% of Practices cited difficulties with sustaining branch surgeries – 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	**Year 1** NCN Team	Raised awareness of the existence of	• **Publicise LOHAP across NCNs** • **Circulate information complementing the programme**	

Health Action Plan (LOHAP) Linked to Care Closer to Home Strategy IMTP		the LOHAP for the wider NCN membership	**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	**Action:** • **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	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 – NCN funding agreed to support additional pharmacist hours for COPD work to address National Prescribing Indicators and Improving the Delivery of COPD (see 5.2). COPD patients receiving high dose inhaled corticosteroid therapy reviewed in pharmacist-led clinics.	
2.2.2 To support delivery of the Direct Access Physiotherapy (DAP) triage service	**Year 1 with option for years 2 & 3** NCN	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	

Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales IMTP	Physiotherapy		– 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 build on 2016/17 MSU Nursing Home pilot Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for Wales IMTP	**Years 1 & 2** District Nurses Nursing Homes Practices NCN Clinical Lead NCN Team NCN ABUHB	Patients benefit from prudent healthcare principles and improved practise through implementation of agreed protocol	• **To promote best practice to reduce contaminated MSU samples & evaluate** • **Further roll-out of RCGP quick reference guide to remaining Nursing Homes & DN teams** Progress: – Pilot in single Nursing Home identified areas for improvement re reducing the number of contaminated samples – baseline data captured & educational leaflet developed – NCN agreement to further reduce contamination through sharing of best practice – NCN Lead and District Nurse team leader working together to develop leaflets and guidance for promotion of best practice	
3.1.2 To reduce levels & impact of Clostridium Difficile (C-Diff) infection Linked to Care Closer to Home Strategy, Clinical Futures, Primary Care Plan for	**Years 1, 2** Practices NCN Lead Practice Based Pharmacist	Patients benefit from reflection & informed decision making	• **NCN Management Team monitors community acquired C-Diff infection rates** • **NCN prescribing advisor to review antibiotic prescribing levels linked to incidence & monitor to see if incidence decreases**	

Wales, Prudent Healthcare IMTP			• **NCN Lead undertakes case reports review to see if incidence and any related admissions were avoidable** Progress: – NCN hot-spots identified, evidence of high antibiotic prescribing across patch – Completed QOF antibiotic audits submitted for local analysis – Antibiotic education session booked for April 2018 CPD session – NCN Lead attends Infection Prevention Committee meetings	

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
IMTP
	Years 1, 2 & 3
	Practices
	NCN
	Community Teams
	NCN partners
		Patients benefit from clarity around processes followed by services in the event of adverse weather and emergency situations	• **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**
			  • **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	

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 September 21st 2017 NCN meeting and submit data** • **To re audit and discuss learning in NCN meeting November 23rd 2017 – submit data prior to meeting** • **To discuss learning in NCN meeting January 18th 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 cluster 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 September 21st 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 – Linked to 2.2.1 – 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	**Years 1,2 & 3**	Reviews completed	• **Practices contribute to dedicated peer review sessions at two NCN meetings (6 months & 12 months) for**	

Governance & Peer Review of inactive QOF indicators	Practices NCN		**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	• **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	