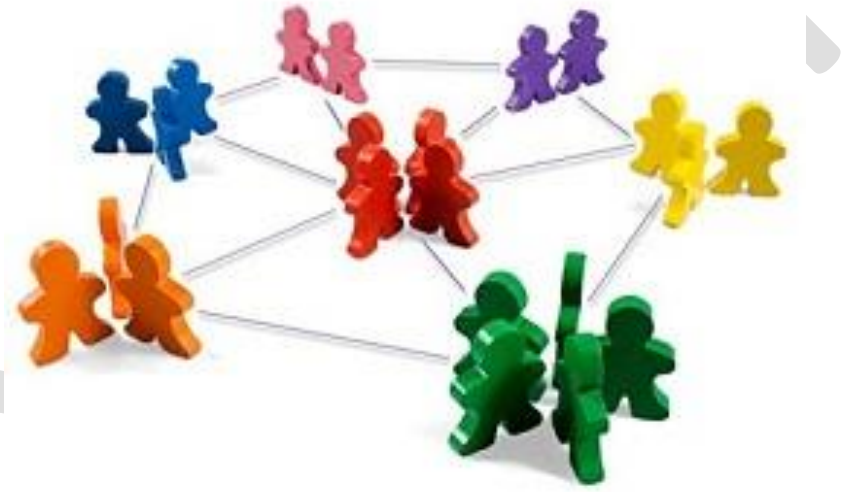
Neighbourhood Care Network Action Plan 2018/19

Newport West 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
1.1 Improving Mental Health and Well Being for Children and Young People	**Years 1,2 & 3**	Ensure people have a greater sense of control over what they need, making decisions about their support as an equal partner	**Action/Measures** • Early intervention and preventing escalation by ensuring the right help is available at the right time, close to home • Collaborative working across partner agencies • Increase in the use of technology to support self-care and management • People and professionals are able to navigate the network and people receive the 'right support, first time' • The wellbeing workforce is able to support the needs and wellbeing outcomes of the population, ensuring a 'core offer' • Implementation of the findings from the PHW IWBN baseline review April 2018 **Progress** • Community Wellbeing work stream established with joint partners • Regular meetings of the CWB held to progress the work plan • Care Closer to Home Project Manager appointed September 2018 to drive the work stream forward • Development of placed based IWBN by NCN • Development of QR boards to support care navigation • Roll out of care navigation training for all frontline staff (commencing October 2018) to ensure consistency of IAA across Newport • Establishment of a local DEWIS work group for Newport • Involvement in the development of the 4 community hubs within Newport to consistently deliver the IWB offer across each NCN. • 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 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,	A

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
			supporting frontline staff and dedicated senior leadership capacity to make change happen in Health, Education and Local Authorities	

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
1.2 Liver disease prevalence and mortality activity and services provision.	**Years 1,2 & 3**	Review of current services undertaken, multi-agency input & support identified, option appraisal developed, business case produced for consideration by ABUHB Exec Team and NCC Cabinet. To facilitate appropriate management of abnormal ALT tests and, thereby, more timely diagnosis of patients with liver disease	**Action:** • **To review the GDAS 10 week pilot** • **Lunch and learn session to review the action plan from 2017 workshop** • **Progress:** Pilot a success, Belle Vue Clinic have recruited a permanent GDAS worker on a part time basis.	G
1.3 Frailty Services –	**Years 1,2 & 3**		**Action:** • **To review workshop from 2017 in lunch and learn session.** **Progress** •	G
1.4 Engagement with wider community stakeholders to improve local planning intelligence, specifically around cultural and language based needs of our communities	**Years 1,2 & 3**	Develop a place based approach to working. Nurture and improve collaboration with partners	**Action:** • **Develop a communication strategy for Newport** **Progress:** • Engagement event scheduled for 3rd November for Newport West residents in regards to Public Engagement Event re DPH Report about Cancer Prevention and Detection	A

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
			• Accompanying the Newport NCN Pharmacy team at the Choose Pharmacy Event to promote Direct Access Physiotherapy and Care Navigation • Attendance at the PHW Knowledge Exchange in the Parkway Hotel July 2018 •	

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

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
2.1 Access				
2.1.2 Direct Access Physiotherapy	**Years 1,2 & 3**	To provide a sustainable direct access physiotherapy resource within a community setting	• Investigate the added value of having a band 7 Physio post in Newport to provide clinical imaging requests, IPS and injection therapists. • Develop triage process to avoid creating a demand on the service. • Consider developing a complete MSK direct access for Newport in the future. • Information dissemination opportunities for NERS, community and NCC walking and organised groups, Leisure Centre opportunities **Progress:** • Pilot project established on 11 June 2018 • SLA and KPI's drafted • Project team established to monitor progress	A
2.1 Care Navigation	Years 2&3	Ensure people have equitable access to sustainable services across the NCN	**Action/Measures:** • Develop a person centred IAA approach across all front doors within Newport • Increase opportunity to access the right help at the right time, preventing escalation **Progress:** • Care Navigation SLA signed.	

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
			• Newport training dates and workshops 1&2 arranged • Communication plan being developed to support the roll out to all citizens in Newport	
2.2 Develop NCN resilience for **winter preparedness** and **emergency planning.**	**Years 1,2 & 3**	Clarity for processes followed by services in the event of adverse weather and emergency situations	**Action/Measures:** • Encourage all residents to be up to date with their immunisations. • All practices have an up to date winter plan • NCN partners to be involved in wider winter contingency planning. **Progress:** • NCN workshop held in July 2018 to develop a joint contingency plan with partners Sessions being arranged on an NCN basis to support the development of contingency plans with GP practices.	A
2.3 Extended Care	**Years 1,2 & 3**	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 demand management by ensuring the most	**Action/Measures:** • Agreement of the elements to develop • Agreement of resource to support development and implementation of pilots • Establish mechanism to obtain robust demand data from GP practices • define the required model for each element, including workforce requirements, operational requirements, triage arrangements, service hours, roles and Responsibilities, Clinical governance, Management Structures, Training & Professional Development requirements, Funding requirements, Development of detailed workforce plan. • Continual evaluation of pilots • Agree governance and reporting structure **Progress:** • Direct Access Physiotherapy pilot commenced 11 June 2018. Project team established and outcomes being monitored. • Home visiting services in Beechwood and St Davids practices being audited	A

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
		appropriate and timely response	• Mental Health Support Worker and DAP being employed within Ringland • Care Closer to Home project manager appointed September 2018 to drive work stream forward. Programme structure being developed.	
2.4 Social Prescribing	**Years 1,2 & 3**	Development of a comprehensive network of non-medical information, advice, guidance to build resilient communities	**Action:** • To create a plan for the implementation of Patient Navigation training within Newport due to commence Oct 2018. • Support practices during the launch of DEWIS (June 2018) **Progress:** •	A
2.5 Primary Care Mental Health Support Services f	**Years 1,2 & 3**	Establishment of a coherent, transparent and fully staffed PCMHSS across Newport.	**Action:** • **Support the implementation of ICEBURG model at lunch and learn session.** • **Follow and support the implementation of a Mental Health Crisis Support Worker within the North NCN** **Progress:** •	A
2.6 Integrated Services.	**Years 1,2 & 3**	Development of an integrated wellbeing network to create a holistic approach to community services	**Action:** • **Progress the integration of services through the Newport Vision** • **Support the Newport Vision through the recruitment of a Project Lead Officer** **Progress:** •	A

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
2.7 Extended Care Hub development as part of the **'Newport Vision'**, **Care Closer To Home and Clinical Futures** initiatives.	**Years 1,2 & 3**	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.	**Action:** • **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.** **Progress:** •	A
2.8 Workflow Optimisation	**Years 1,2 & 3**	Option appraisal and recommendations on a preferred workflow optimisation model for NCN use, and procurement of chosen option.	**Action/Measures** • **Explore different models of workflow optimisation** • **Produce option appraisal with recommendations** • **Roll out to all GP Practices** **Progress** • GP Practices received HERE training in March 2018. • Uptake in Newport has been poor as most practices had already developed an in-house method for workflow • Bryngwyn Surgery in Newport West NCN has participated. • HERE attending practice managers forum on 4 October 2018 to promote advantages of the system to increase uptake. •	A
2.9 Home Visiting Service.	**Years 2 & 3**	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.	**Action/Measures:** • **Reduce the volume of home visits. Triaging the need for GP appointments would also help to screen out unnecessary or inappropriate requests for urgent surgery appointments.** • **Release capacity in general practice to support longer consultations in surgery for managing complex patients. Increased capacity, typically 1-2 additional appointment slots per day, due to the absence of the need for home visits.** • **Reduce avoidable A&E admissions and attendances** • **Reduce the number of 999 calls because there had been no recent clinical review or the deterioration of a patient's condition.**	A

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG
			• **Limiting time for home visits may be adding to an already high rate of emergency 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 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**. •	
2.1.1 f **Neighbourhood Hubs**.	**Years 1,2 & 3**	Provision of integrated services by local NCN partner agencies and stakeholders.	**Action:** • **To support the 5 areas proposed for the hubs across Newport– Gaer, Ringland, Pill, Maesglas and Bettws as progress is actioned.** **Progress:** Ongoing discussions	A
2.1.2 Learning Disability Enhanced Service Annual Reviews .	**Years 1,2 & 3**	Reconciliation of Learning Disability residents across Local Authority and Primary Care services in Newport.	**Action:** • **To review with Practice Managers the quality/accuracy of information received regarding the annual reviews in partnership with Social Services colleagues.**	A
2.2 Estates				
2.2.1 Accommodation requirements.	**Years 1,2 & 3**	NCN member estates are fit for purpose in the delivery of the NCN agenda.	**Action:** • **To review and establish if buildings are fit for purpose.** • **Ongoing monitoring of general Practice estates through PDPs.**	A

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		RAG Rating
3.1				
3.1.1 Graduated Care		.	• **Action:**	A

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

Strategic Aim 4: Medicines Management and Pharmacy.

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
4.1 Medicines Management	**Years 1,2 & 3**	Performance management and analysis of the NCN prescribing budget.	**Action/Measures:** • **Regular updates provided by Lead Pharmacist at NCN meetings** • **Support any outlier results** **Progress:** • Regular updates with Newport Pharmacy technicians based within the locality office. • Community pharmacists attend NCN meetings on a rota basis to support the discussions.	
4.2 Pharmacy input into General Practice	**Years 1,2 & 3**	Provide the most effective and cost efficient treatments for patients	**Action/measures:** • **Regular updates provided by practice based pharmacists at NCN meetings** • **Practice based pharmacist shares best practice across the NCN** **Progress** • NCN Pharmacists appointed by the NCN for Newport East with support offered across the NCN	

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
			Practices have appointed practice based pharmacists based upon the success of the NCN funded posts.	

Strategic Aim 5: Governance

Objective	For completion by:-	Outcome	Action, Progress to date & Measures	RAG Rating
5.1 Clinical Governance Toolkit	Annually by GP Practices	Clinical Governance toolkit to be completed and learning outcomes identified and discussed with peers	**Action/Measures:** • **Encourage practices to undertake and complete the toolkit.** Progress: • Practices reminded by email and at NCN meetings to undertake the toolkit before Q4	G
5.2 Information Governance	Annually by GP Practices	Information Governance toolkit completed and learning outcomes identified	**Action/Measures:** • **Monitoring of NCN GDPR activities** **Progress:** • Newport wide GDPR seminar arranged to support all GP practices • GDPR information circulated to NCN membership when necessary.	G