
# Neighbourhood Care Network Integrated Medium Term Plan 2020-2023

## Caerphilly North

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# Executive Summary

This Integrated Medium Term Plan (IMTP) 2020 to 2023 describes the vision for Caerphilly North Neighbourhood Care Network (NCN), Caerphilly County Borough Services and the Primary and Community Division (ABUHB). This plan seeks to address challenges facing the both the Borough and Division during this time, which include increasing demand from an aging population; significant health inequalities across Gwent; deficits in the current workforce; and the implications of commissioning a new specialist and critical care centre, the Grange University Hospital, in 2021. Care closer to home and sustainability of services remain as the emphasis along with the overarching goal of providing the best possible system of care for the local population and communities.

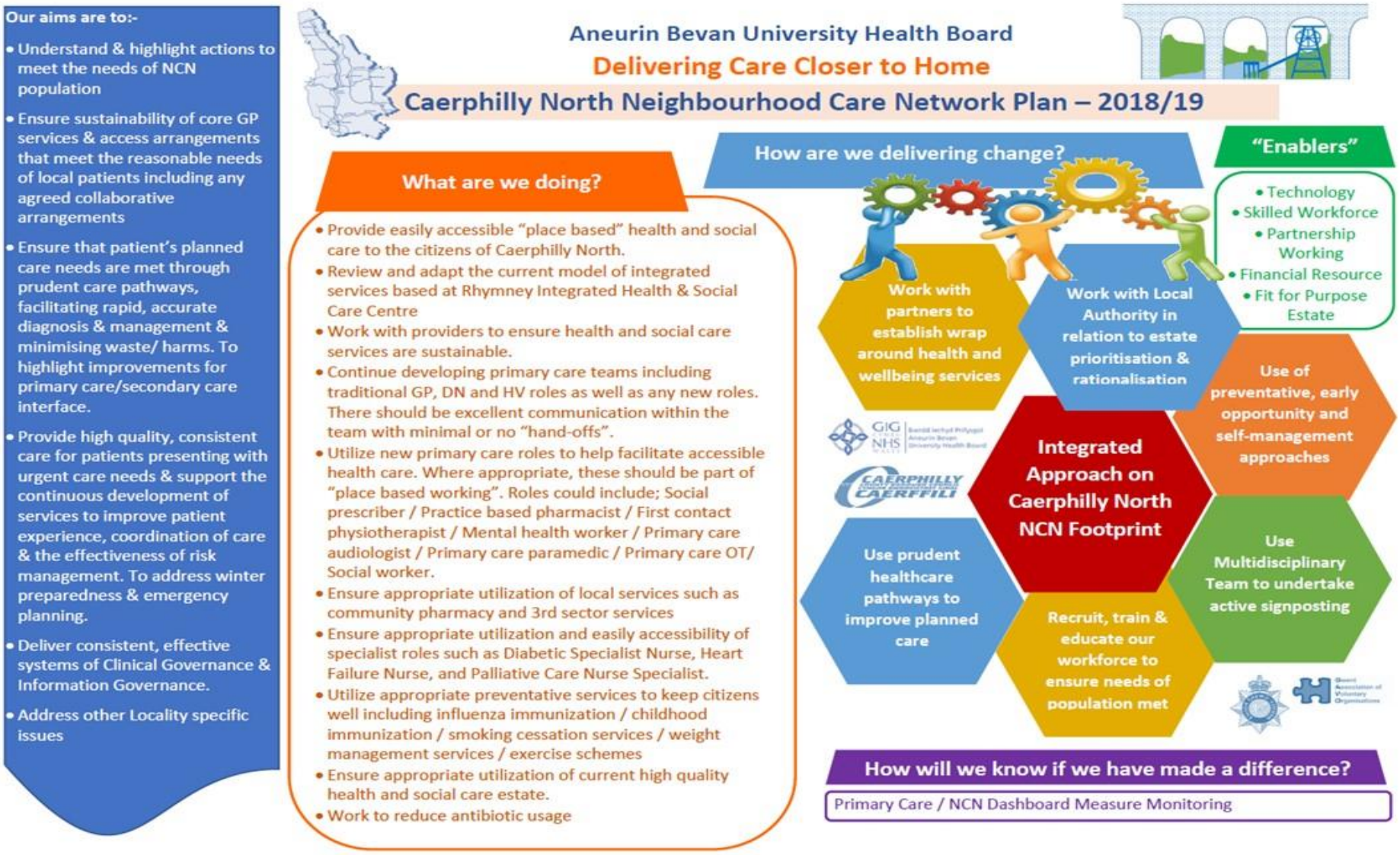
At a national and regional level, there remains continued emphasis on delivering quality health and care services fit for the future and promoting good health and well-being for everyone. Driven by the ambitions in recent documentation including *Healthier Wales.* This plan aims to outline how we will continue to build on strong relationships across statutory and non-statutory agencies, with a growing public facing agenda.

The Caerphilly North locality has long standing high levels of depravation and associated health and social care needs. The aforementioned issues inevitably create a lot of pressure on Primary and Social Care services. Sustainability of services within the NCN is the key factor for the aim of recruiting to our wider healthcare team, along with upskilling existing staff. To provide this prudent healthcare model, various funding routes will need to be explored to achieve these goals.

We also aim to expand on the good work already being undertaken within Caerphilly North in the development of place based care models and hubs incorporating the medical element and the social wrap around services required to support sustainable services for the local population.

We aim to work closely with Public Health Wales, local services and voluntary sector organisations to develop an integrated wellbeing network and build resilient communities through partnership working with affiliated services across the NCN footprint.

## Plan on a Page



# 1 Introduction to the 2020-2023 Plan

Our Primary and Community Care Division's Integrated Medium Term Plan sets out the ambition to create a new system of primary care and community services which, in partnership with local government and the independent / third sectors, strives to improve wellbeing across Gwent.

It describes a place based model of care whereby, through our 12 Neighbourhood Care Networks, people access the care they need in their own resilient community and homes wherever appropriate and avoid any unnecessary harm, be it from injury at home, medication errors, and unnecessary admissions to hospital or from delayed diagnosis or access to treatment. In our vision, services are designed to provide more co-ordinated care, with fewer handoffs and reduced complexity.

This plan describes the steps which the Caerphilly North Neighbourhood Care Network will take over the next three years to take us closer to achieving our vision.

It sets our key priorities, milestones and implementation plans, and analyses the challenges, opportunities and risks associated with delivery.

Our NCN plan will also describe what it will take to deliver these actions, in terms of workforce configuration and financial implications.

This plan will be the cornerstone of our NCN business, enabling us to be clear and purposeful in our actions and to hold ourselves accountable for delivering our priorities, for the benefit of the communities we serve.

Our ambition is to improve the population health and wellbeing of our local population, supporting people to stay well, lead healthy, independent lifestyles and reduce inequalities, utilising an asset based community development approach.

Transformation of services will be required, changing the ways of working within services which have been working in particular format for many years.

However, standing still is not an option because:

- **Demand for healthcare is growing and will continue to grow;** we have an aging population, with patients living longer and with more complex needs, which intensifies the challenges faced by the NHS
- **Our population is characterised by pockets of health inequalities, linked to socio-economic deprivation;**

- **Primary and community services sustainability;**
- **Implications of the opening of the Grange hospital within our whole system service model;**
- **Our estate is not totally fit to provide primary care services for now and the future**

With such challenges come opportunities, and we have been extremely lucky in Caerphilly North NCN to have received funding to enable us to test components of the new model including;

- Appointment of two Practice Based Pharmacists (2.4WTE), covering practices within Caerphilly North NCN
- Establishment of a First Contact Physiotherapy Service
- Establishment of a Community Phlebotomy Service utilising primary care cluster funding

During 2020-2023, we have more exciting opportunities ahead including;

- Further development in the utilisation of the Rhymney Integrated Health & Social Care Centre
- Reorganisation of the District Nursing Team in line with CNO District Nurses Principles
- Implementation of graduated care
- Establishment of a hub and spoke place based care model across the NCN footprint
- Implementation of Compassionate Communities in Caerphilly North

Our main challenge as an NCN will be to first embed and then sustain these changes so that they become business as usual, whilst also managing the day to day service pressures.

The complex systems described above will take time to implement and change not only practice, but culture. In order for these systems to be embedded, engagement of multiple stakeholders is vitally important and the resulting interventions evaluated in order to assess their value. We regularly maintain good representation from all partner services and organisations at our NCN meetings where we continue to uphold strong working relationships with a good ethos for partnership working.

Crucially, we must take our citizens on the journey with us, so that they are continuously co-designing the model and truly own and feel responsible for not only their community but for their own health and well-being.

It is clear that no one organisation can tackle the scale of the challenges nor deliver the scale of ambition described above; the remainder of this plan describes how the Caerphilly North NCN will work together to deliver place based care to the citizens of Caerphilly County Borough.

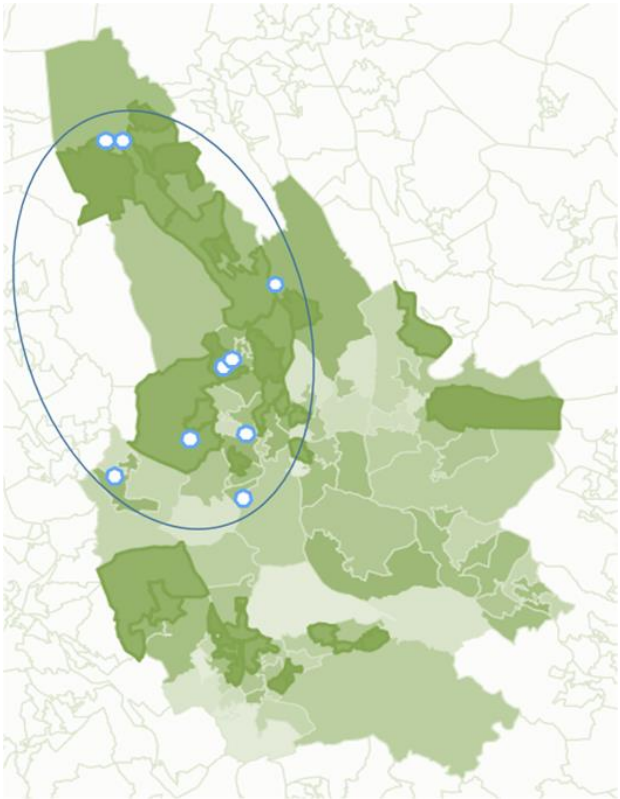
# 2 Overview of the Neighbourhood Care Networks

## 2.1 Profile of the Neighbourhood Care Network

Caerphilly Borough is divided into 3 NCN cluster areas, namely Caerphilly East, Caerphilly North and Caerphilly South.

Much of the following profile is extracted from the Caerphilly County Borough Area Assessment of Local Well-being dated March 2017. More detailed information is available at the following link – *athttp://your.caerphilly.gov.uk/publicservicesboard/sites/your.caerphilly.gov.uk.publicservicesboard/files/AssessmentofLocalWellbeing2017.pdf*

Caerphilly North NCN consists of the electoral wards of Twyn Carno, Moriah, Darren Valley, New Tredegar, Pontlottyn, Bargoed, Aberbargoed, Gilfach, St Catwg, Nelson, Ystrad Mynach, Hengoed and Maesycwmmer.



The NCN has good road and rail transport links with some areas having easy access to the A470 and Heads of the Valleys and some areas are only a short distance from Merthyr Tydfil which brings opportunity for work and social links.

There are high areas of deprivation within Caerphilly North NCN and the map opposite shading indicates levels of deprivation (the darker the shade the greater the deprivation). The areas within Caerphilly North indicated as having higher levels of deprivation include areas within Twyn Carno, Moriah, Darren Valley, New Tredegar, Bargoed, Aberbargoed and Hengoed.

The cluster has 9 GP practices with some of these having branch surgeries also. The main practice is indicated with blue dot on map.

There are 24 primary schools (20 English, 4 Welsh), 4 English medium comprehensive schools and the Ystrad Mynach campus of Coleg y Cymoedd.

The proportion of the population aged 65 years and over was 16.6% for the community area as a whole, slightly higher than the county borough average of 16.5% and lower than the Wales average of 18.3%. The proportion ranged from 12.2% in Hengoed ward to 21.5% in Gilfach ward.

The proportion of males aged 16-74 years who were long-term sick or disabled was higher in 12 out of 13 wards than the Wales average of 6.5% and higher than the county borough average of 8.6% in eight out of thirteen wards in the community area –The proportion ranged from (5.2%) in Ystrad Mynach ward to (16.2%) in Twyn Carno ward, with an average for the community area as a whole of 10.5%.

The proportion of females aged 16-74 years who were long-term sick or disabled was higher than the county borough average of 7.8% in nine of the thirteen wards in the community area. Only 3 wards, Nelson, Ystrad Mynach and Maesycwmmer were level with the Wales average of 6.0%. The proportion ranged from (6.0%) in Nelson, Ystrad Mynach and Maesycwmmer wards to (11.9%) in Twyn Carno ward, with an average for the community area as a whole of 9.5%.

## 2.2 Vision Statement

Welsh Government's vision is stated as 'to achieve the best possible health and well-being for all people in Wales, whatever their circumstances, or wherever they live'.

The Neighbourhood Care Networks vision for primary and community care services is summarised as 'delivering services in the community by primary and community care delivery units providing excellence in core primary care and a range of locally determined enhanced and extended community services. These will ensure that the population served will receive appropriate individualised care to promote as long and healthy a life as possible.'

**What will be different?**

- Care, when safe and appropriate, will be managed at a community level through the establishment of integrated primary care delivery units, that extend beyond existing primary and community care teams and include social care and other key partners.
- Teams will integrate both horizontally and vertically throughout the health board to deliver effective care to patients and reduce gaps and duplication in care.
- Patients will be central to all care planning and delivery and co-producers, through informed decision making.
- Resources, both staffing and financial, required to deliver the care will follow the patient.
- Services will be developed to reflect the unique needs of local communities.

**How will this be different for patients?**

- People in communities will be supported to look after their own health and well-being, through local ownership of public health issues to reduce their risk of developing chronic conditions.
- People with a chronic condition will be supported to manage their own condition, recognising when changes necessitate professional support and having access to this in a timely manner.
- People requiring an increasing range of services from their primary care teams in a general practice setting.
- People will be cared for and supported to remain at home, when care can be safely provided, thus reducing hospital admissions.
- People will only be in a hospital, or other institutional care setting, for the minimum period of time and only when they cannot be cared for at home.

**How will this be different for the Health Board and key partners?**

- The focus will be to ensure as many patients as possible are managed at home when safe to do so.
- There will be vertical and horizontal integration of all health and social care professionals to ensure that services are delivered to meet the needs of patients, to enable them to remain at home.
- Evidence based integrated care pathways underpin all service delivery; these will include interventions provided by health, social care and third sector staff.
- The Primary Care Delivery Units will ensure that patients are in a hospital for the minimum time.
- The organisation supports the shift of resources (whether staff or finances to support the provision of more care in a primary/community setting.

In considering the vision set locally and the National direction communicated through 'Together for Health and Sustainable Social Services: Delivering Local Integrated Care', there appears to be correlation between the two. Following publication of the document, this vision will be revised to ensure congruence with the policy direction. The Neighbourhood Care Networks have considered how this vision will translate into service delivery through a series of workshops. This has resulted in the following strategic themes being identified:

- Helping people to live a healthy and independent life.
- Detecting health problems quickly
- Delivering timely, effective local integrated care and support
- Involving people in decisions about local services and their care
- Planning, organising and delivering local integrated care

These will be used as the basis for implementing Annual Neighbourhood Care Network Delivery Plans and Caerphilly North will ensure alignment to 'The Caerphilly We Want 2018-2023' Well Being Plan which sets out what the Caerphilly Public Services Board will deliver in collaboration with the statutory, private and third sectors together with local communities. The wellbeing plan aims to achieve long-term improvements and has 4 high level objectives, namely –

- Positive Change - A shared commitment to improving the way we work together
- Positive Start - Giving our future generations the best start in life
- Positive People - Empowering and enabling all our residents to achieve their own potential
- Positive Places - Enabling our communities to be resilient and sustainable

## 2.3 Neighbourhood Care Network Governance

The NCN itself is a collaborative network, led by an NCN Lead but featuring a wide range of individuals from different disciplines and agencies who deliver care within the local area. The group are required to meet on a monthly basis to share information and discuss / plan local developments. This section outlines these arrangements.

### *2.3.1 Membership*

| Name | Role | Organisation / Designation |
|---|---|---|
| Dr Heather Griffiths | NCN Lead | GP Partner, Oakfield St Surgery |
| GP Practice representation from all 7 Caerphilly North practices | GP & Practice Manager | Bryntirion Surgery, The Lawn Medical Practice, Markham Medical Centre, Meddygfa Cwm Rhymni, Meddygfa Gelligaer, Nelson Surgery, Oakfield St Surgery, Pengam Health Centre, South St Surgery |
| | Team Leader | District Nursing |
| | Team Leader | Health Visiting |
| | Service Manager | LA-Social Services |
| | Principal Public Health Specialist | Public Health Wales |
| | Health Social Care & Wellbeing Coordinator | GAVO |
| | Community Connectors | Local Authority |
| | Medicines Management Pharmacist | Pharmacy |
| | Team Leader | Primary Care Mental Health |
| | Manager | CRT |

### *2.3.2 NCN Leadership and Support Teams*

Within Caerphilly the NCNs have a support structure consisting of a NCN Lead and members of the Caerphilly Locality Team. These individuals will ensure that NCN governance is maintained, collaboration is supported and will provide a link between the NCN and the mechanics of the Health Board in order to assist in the delivery of identified objectives.

| Name | Role in Borough/NCN |
|---|---|
| Alison Gough | Head of Service |
| Eira Turner | Assistant Head of Service |
| Dr Heather Griffiths | NCN Lead |
| Jonathan Lewis | Network & Community Services Manager |
| Stella Montgomery | Network & Community Support Officer |
| Deborah Harrington | Primary Care Contracting Manager |
| Angela Dawn Williams | Primary Care Service Development Manager |

### *2.3.2 Frequency of Meetings*

The Caerphilly North NCN holds six cluster meetings per year on a bi-monthly basis. In line with the Quality Outcomes Framework (QOF), GMS colleagues are required to attend 5 of the 6 meetings in order to fulfil the QOF.

### *2.3.3 Secretariat Support*

The Network Support Officer (Stella Montgomery) co-ordinates the agenda for each of the three Caerphilly cluster areas and items for inclusion on the agenda can be sent to her for discussion and agreement with the NCN cluster lead. The Locality Personal Assistant (Samantha Davies) provides secretariat support for cluster meeting for the North.

### *2.3.4 Quorum*

To be quorate, the NCN would need to have two thirds of the membership by profession, either primary membership or nominated deputies, as per the list of members at 2.3.1 above. Where voting is necessary it will be along the lines of a vote per professional entity. Where no majority is achieved, the Chair will have the casting vote.

### *2.3.5 Communication*

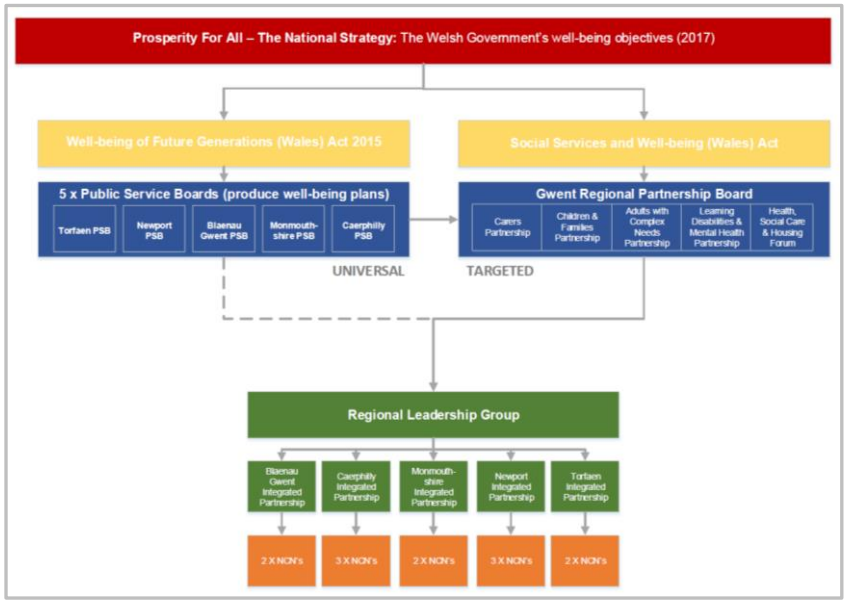
The NCN leads work one day per week with the locality team and use this time to best effect to progress meeting planning and implementation of NCN plans and objectives. To supplement this the team is in email correspondence throughout the week with all NCN partners as required to share relevant correspondence and to facilitate local

resolution of queries linked to the plan actions. The Locality Team has recently developed a Caerphilly Borough Newsletter which will be issued on a regular basis and the Gwent wide NCN intranet pages are led by the Caerphilly North NCN Lead.

The governance arrangements ensure that good communication exists between clusters across Gwent via the NCN Leads monthly meeting and also via Caerphilly Integrated Partnership Board and NCN management team meetings.

### *2.3.6 Reporting Framework*

The NCNs form part of a wider reporting framework, as described opposite.

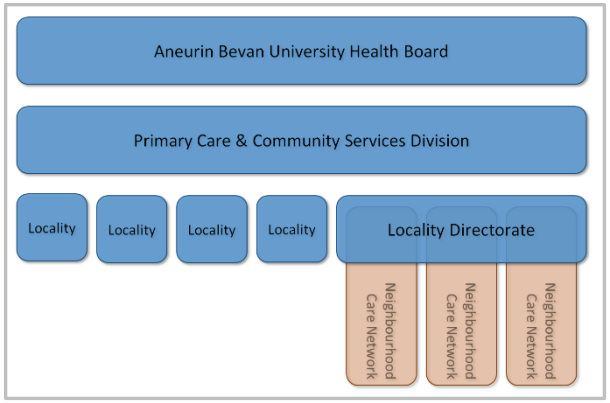



The NCNs are a key component of the Integrated Services Partnership Boards (ISPBs) in each of Gwent's five boroughs, which report to the Regional Leadership Group and onwards to the Public Service Boards and Gwent Regional Partnership Board.

The NCNs are an operational arm of this framework, and as such have the responsibility of implementing national and regional strategy through local actions. However, the NCNs are also crucial in prioritising the implementation of these strategies depending on local circumstances.

Where need is identified that is not currently being addressed, NCN plans must seek to address these issues and, via the ISPBs, influence regional planning as required.

### *2.3.7 Organisational Alignment within Aneurin Bevan University Health Board*




Although the NCNs consist of representatives from a wide range of services, both within and outside Aneurin Bevan University Health Board, the NCN function is organisationally aligned to the Primary Care & Community Services Division of the Health.

This alignment ensures that the resources of the Division can be utilised to support the NCN function as a whole (including support for consistent governance between NCNs) and support individual NCNs with planning and implementation of prioritised developments, as and when required. The NCN Leadership & Support Teams, described earlier, provide the key link between NCNs and the wider Health Board.

# 3 Planning Context

## 3.1 A Healthier Wales

Integration across Health and Social Care is the driving force for reform and service modernisation, set out in both the *Parliamentary Review of Health and Social Care* (January 2018) and Welsh Government's long term plan, *'A Healthier Wales'*. These documents describe four interlocking aims – described together as the Quadruple Aim – which create a shared commitment to how the system will develop and prioritise change over the coming years. These aims consist of:

- Improved population health and wellbeing;
- Better quality and more accessible health and social care services;
- Higher value health and social care; and;
- A motivated and sustainable health and social care workforce

The context in which these aims will be delivered is through regional planning of health and social care services, for people with a care and support need. This is done via the Regional Partnership Board, and the publication of an 'Area Plan' detailing the agreed 'partnership activity'.

As such the NCN IMTPs are developed within the context of the agreed regional partnership planning framework (the Area Plan) and in alignment with five Wellbeing Plans, published in May 2018, by Public Service Boards.

## 3.2 Clinical Futures Strategy

Within the Health Board, the need for clinical modernisation has been recognised in the context of the delivery of the new model of primary and community care. The *Clinical Futures Strategy* sets out the strategic direction for modernising clinical services and forms part of the Health Boards response to delivering *'A Healthier Wales'*. Clinical Futures is a clinically owned and led programme that seeks to rebalance the provision of care in Gwent. The programme aims to:


- Improve citizen well-being and patient outcomes (including patient experience) for people of all ages, by designing and delivering new models of care for the population of Aneurin Bevan University Health Board across the whole health and wellbeing system. The models are designed with a focus of prevention, delivering care close to home where ever possible, routine care and specialist and emergency care in the most appropriate care setting.
- Improve the efficiency and sustainability of service provision from 2018 – 2022 by ensuring that service development, model of care design and implementation is patient-centred, transformative, evidence based and economically viable.
- Ensure that care quality and safety is of the highest importance during a period of transition to different delivery models, that any changes are well planned.
- Improve staff satisfaction, recruitment and retention through the enhancement of patient and citizen focussed services.

The design principles of Clinical Futures are:-

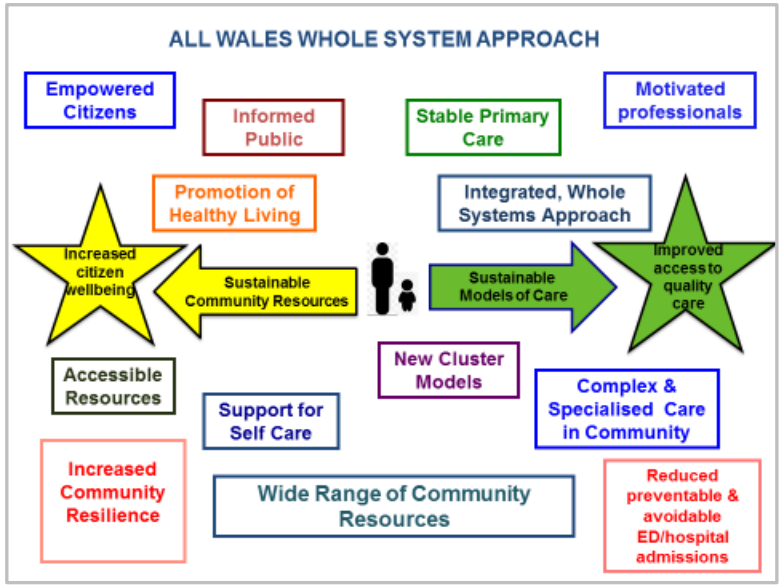
- ***Patient centred***, concentrating on safety, quality and experience.
- ***Home to home***: integrated services in the community to prevent illness and improve wellbeing, and providing care closer to home where appropriate
- ***Data*** and ***evidence*** driven, patient ***outcome*** focussed.
- ***Innovative*** and transformative, considering new ways of organising and delivering care around the patient and their careers.

- ***Standardised, best practice*** processes and care pathways.
- ***Sustainable*** with efficient use of resources.
- ***Prudent*** by design, following NHS Wales's prudent healthcare principles.

## 3.3 Strategic Programme for Primary Care

Following on from Welsh Government's '*Plan for a Primary Care Services for Wales up to March 2018*', published in February 2015, a new '*Strategic Programme for Primary Care'* was released in November 2018. This strategy builds on the work gone before and provides a direct response to '*A Healthier Wales'* from a primary care perspective.

The Transformation Model for Primary Care features heavily within this strategy, following a period of testing each component via national funding sources (i.e. pacesetter / pathfinder, cluster, integrated care fund). The model seeks to address the well-established challenges facing primary care, which includes increasing workload from a growing, aging and increasing complex population and a shortage of GP numbers to deliver the traditional model of primary care.




As a result, the model depicts a different approach to delivering services, featuring a renewed emphasis on early intervention; a focus on signposting, direct-access and social prescribing services; implementation of a new multidisciplinary workforce model; and greater utilisation of technological developments.

As a result, on a national basis, 6 key workstreams have been established to oversee this work, these include:

- Prevention and wellbeing
- 24/7 Primary Care Model
- Data & Digital Technology
- Workforce & Organisation Development
- Communication & Engagement
- Transformation and the Vision for Clusters

## 3.4 Primary Care & Community Services Integrated Medium Term Plan

The Division's IMTP is intended to provide an overarching 3 year plan, based on an assessment of both strategic priorities and operational risks. The IMTP has been broadly divided into 10 workstreams. It is intended that NCN plans will feed into these workstream areas for support and decision-making.

| Strategic Workstream | Delivery Committees | Workstream Description | Example of Priority Areas |
|---|---|---|---|
| 1) Prevention, Wellbeing & Self-care | NCN Leads Meeting | Improving long term population health through a focus on early intervention, prevention and well-being services which may prevent or delay future ill-health. Empowering the population to take greater responsibility for their own health and well-being. | Enhanced services, risk stratification, screening, immunisation, smoking cessation, tackling obesity, integrated wellbeing network |
| 2) Care Closer to Home | | Delivering care closer to home by shifting demand out of secondary care services and into primary and community settings. Implemented through re-designing services and pathways, using primary care practitioners' full scope of practice. | INR & DVT management, extended skin surgery, community audiology services, ophthalmic diagnostic & treatment centres |
| 3) Access & Sustainability | Access Group / Sustainability Board | Maintaining timely access to services and ensuring the long term sustainability of primary and community care provision, in the face of growing demands and an aging workforce. | Access standards in primary care, urgent care hub(s), GDS Reform Programme, 111 Programme, sustainability risk matrix, workflow optimisation |
| 4) Implementing the Primary Care Model for Wales | | The new Primary Care Model for Wales has been developed over recent years. Through a combination of care navigation, first contact practitioners and direct-access services, demand for primary care services is now being managed through a multidisciplinary approach. | First contact practitioners / multidisciplinary skill mix, care navigation, direct-access services, working at scale, multidisciplinary team meetings |
| 5) Re-designing Community Services | Transformation Delivery Group | Gwent is committed to developing integrated place-based teams which reduce hand-offs and increase continuity of care. New models to deploy community services more effectively, closely synchronised with primary care and social services, is a key priority for the region. | Integrated place-based teams, compassionate communities, graduated care, neighbourhood nursing, district nursing principles |

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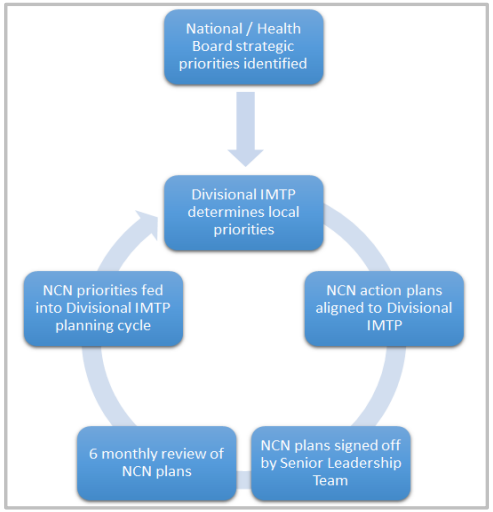
|---|---|---|---|
| 6) Digital, Data & Technology | Digital Technology Group | Utilising new developments in technology to improve communication between professionals, reduce workload for staff and enhance care and the experience of patients. | WCCIS, GP System Migration, electronic referrals, virtual consultations, electronic triage, My Health Online, escalation reporting, assistive technology, point-of-care testing |
| 7) Skilled Local Workforce | Primary Care Workforce Group | Recognising the changing workforce requirements outside of the hospital setting, this workstream focuses on the training and development of both newly qualified and existing staff in line with the new ways of working. | Primary Care Academy, Diploma Level 4 (Health & Social Care), rotational posts in community nursing, palliative care education, workforce planning, demand & capacity analysis |
| 8) Estates Development | Primary Care Estates Group | Recent estate developments outside of hospital have accounted for the new model of service delivery, providing integrated health & wellbeing hubs. However, many estates are not fit for purpose and a programme to improve facilities is underway. | Primary Care Estates Strategy, 6 facet survey of primary care estates, major / minor improvement grants, health & wellbeing hub developments, discretionary capital programme |
| 9) Communication & Involvement | Senior Leadership Team | Involving both local practitioners, patients and the general public in the planning of services is key to their success. Particularly with the changing face of primary care, an awareness of the new options for care is essential to change behaviours. | Health talks, public engagement, social media campaigns |
| 10) Quality, Value & Patient Safety | Quality & Patient Safety Committee | All services should be continually seeking opportunities to improve the way that care is delivered, making it more effective, of higher quality and safe. A quality / continuous improvement programme | Medicines management, Strategy for Falls & Bone Health, management of wounds & pressure damage, infection prevention and control, healthcare needs assessments, peer reviews, Primary Care QI Programme, advance care planning |

## 3.5 NCN IMTP Process

The NCNs are a pivotal part of providing more care closer to home and must be supported by a robust process which aligns their actions with the Health Board's IMTP and the Gwent Area Plan. In doing so, this will ensure that priorities are both fed up from the local teams delivering services, as well as ensuring a co-ordinated approach to planning on a wider scale.

Beginning in 2019, a new approach will be implemented to provide a seamless link between these previous separate planning processes.

The template for the NCN IMTPs will be more closely aligned to IMTP for the Primary Care & Community Services Division. Following development of the first NCN IMTPs, a cycle of six monthly reviews will be implemented by the Senior Leadership Team. This new approach is designed to provide a more robust framework to the local planning process and ensure a strategic join-up from intent to delivery, supported by oversight from Senior Leaders within the Health Board.



# 4 Key Achievements from the 2017-2020 Plan

Examples of NCN funded local pilot schemes and workshops held over the last 3 years in line with the key strategic aims of the NCN plan include:

| Key Achievements | Benefits/outcomes |
|---|---|
| • **Increased funding for 2.4 WTE Practice Based Pharmacists** | • Pharmacists have been able to take on many of the medication reviews and prescribing issues improving access to GP services. |
| • **Funded Practice Based Social Workers** | • Allowed every practice within the cluster access to an identified fully qualified Social Worker on the premises – Although considered a great success by GP practices the tripartite funding came to an end and the service was no longer financially supportable |
| • **First Contact Physiotherapy Service** | • New service developed during 2018/19 providing first contact physiotherapy assessments within GP practices across Caerphilly |
| • **Multi services workshop for the provision of a single point of access for Primary Care Mental Health** | • SPACE service developed and rolled out across Caerphilly NCNs. |
| • **Reviewed the prescribing budget on a regular basis, appropriate switches and substitutions have been made.** | • Regular feedback on performance and current information provided at every NCN meeting by the dedicated ABUHB Pharmacy team representative, enabling CEPP savings and awards to be made to the NCN and Practices, respectively |
| • **Dedicated session for a Sustainability Workshops** | • Open forum for Practices enabled shared issues and potential inter practice working to be discussed. |
| • **Caerphilly wide NCN event held for Voluntary Sector organisations** | • Engagement event attended by 160 representatives from the Voluntary Sector and NCN membership to establish better understanding of services across Caerphilly borough and best ways of working collaboratively. |

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| • **NCN funding provided for dermatoscopes and training for practices across the NCN** | • GPs upskilled to improve the quality of referrals to secondary care dermatology. |
| • **Improved Access - NCN funding for QR Information Pods and Care Navigation training** | • Introduced QR code patient information pods to practice waiting rooms |
| • **Funded installation of patient calling systems and waiting room BP Monitors in Practices.** | • Improved patient experience when attending appointments at practices |
| • **Constipation Pathway developed with Health Visiting** | • A pathway for children aged between 0-5 years who have delayed continence or are constipated has been developed. The NCN supported the Flying Start service to develop pathway, raise awareness, identify suitable clinic venues and funded the ERIC training for local staff to deliver the service. |
| • **Period Dignity initiative developed by Local Authority and disseminated across services via the NCN** | • Sanitary products are freely available at Health and Local Authority venues, Sports Centres, Schools and Food Banks via this sustainable scheme |
| • **Funding for Bowel Screening pilot.** | • Increased uptake in responses from residents was recorded. |
| • **Established Smoking Cessation Champions in each Practice.** | • Identified member of staff on site to direct residents to services. |
| • **Established annual flu planning process.** | • Effective process operating over past three years to ensure readiness for flu season. |
| • **Established Care Navigation in Practices and community settings to enable access to services without seeing a GP.** | • Five pathways (First Contact Physiotherapy, Minor Injuries, Eye Services, Emergency Dental, Pharmacy) in operation. |
| • **Community Connectors have been appointed to each Practice in the NCN.** | • Connectors attend NCN meetings to offer advice and support on services availability to residents. Aiming to expand into GP practices across the NCN. |

| | |
|---|---|
| • **Dedicated sessions at NCN Meetings to provide guidance/information or raise awareness of…….** | • National Audits: Improved Mental Health & Wellbeing, Liver Disease, Atrial Fibrillation Emerging model of Primary Care, Sustainability issues, Third Sector Schemes, GDAS, Integrated Services, Social Prescribing, Improved Access, Public Health Programmes, First Contact Physiotherapy, Community Diabetes Specialist Nurses, Gwent N-Gage, Dental Services, Families First, Tackling Obesity and Poverty within Caerphilly North NCN, Awareness of 'County Lines' |

# 5 Population Health Needs Assessment

We have conducted a local needs assessment by reviewing data from various sources including The Public Health Observatory, (health behaviours wales document) - Caerphilly County Borough Council Area Assessment of Local Wellbeing 2017, the Primary Care Information Portal and local data sources relating to access, prescribing and referrals. We have discussed local issues with members of the NCN (including all GP practices) and given all partners an opportunity to contribute to the plan. We have considered the key themes from the Transformation Model for Primary Care along with national issues and tier 1 WAG priorities.

Included as Section 14 - Appendix 1 is a copy of data analysis that and was used to inform the key needs identified in paragraphs above.

**Access to services**

Access to primary care services and primary care sustainability are national issues and the NCN is keen to develop plans to address these issues. Specifically it is noted that Caerphilly North has slightly higher than average OOH contacts between 6.30 and 8 and high numbers of conveyances to hospital from Residential and Nursing Homes. Data indicates that use of the common ailments scheme could be improved.

Introducing the option of Telehealth for patients to promote self-care and to improve access to GP practice clinicians. The functional platforms/apps are both extensive and bespoke to the conditions that the patients have – Diabetes Type 1&2, Heart Failure, Ischemic Heart Disease, MI/ACS, Asthma and COPD. The platforms/apps include disease specific education and also Cardiac and Pulmonary Rehabilitation.

GP practices in Caerphilly North NCN are currently 78% compliant in the 5As to Access. There are currently 7 practices achieving 5As, 2 practices achieving 4As. The NCN will work closely with all practices to ensure that the 'Access to In-Hours GMS Services Standards' are adhered to with regular monitoring. Practices will be reminded that support is available through GMS contract and via the Health Board to enable practices to make the relevant changes to achieve the standards.

Delayed Transfers of Care (DTOCs)
Non-mental health delays for Caerphilly residents in an ABUHB hospital site (exc mental health) incurred a marginal increase (1.1%) between the two year period to August 2019 and the number of associated bed days lost actually reported a

reduction of 8.9% for the period (449 days). However over recent months there has been month on month increases in both elements and the Borough are aware of the increasing pressures that are contributing to this including increasing complexity of cases, care home embargos, market availability of care provision and more recently social work resource. Health and Local Authority partners are working collaboratively to overcome issues and will particularly need to consider the implications over the winter pressures and what additional measures can be introduced to minimise impact over forthcoming months and the longer term future.

The Locality Team meets with wards and the joint hospital discharge team on a weekly basis to track not only the delays reported on the monthly snapshot census but also any delays identified on the complex list.

The aim is to continue to drive improvements in quality of care, sustainability and care closer to home by exploring/introducing methods of improving access to primary care. Introducing and utilising extended roles such as Advanced Nurse Practitioners, Physiotherapists, Mental Health Practitioners and social prescribing/care navigation to provide a prudent healthcare model while also working closely with other Primary Care contractors and the Primary Care Academy to achieve these goals. Maximising the potential of estates for better health and social care provision via hubs and GMS sites across the NCN. Understanding the whole system and importance of maintaining a sustainable integrated health and social care approach across primary/ community teams including GMS and Integrated Services Teams. In terms of maintaining a robust and responsive 'whole-team' approach, the NCN will work closely in partnership to understand the challenges locally and react accordingly.

## Healthy lifestyles and Preventative Services

Unhealthy behaviours are predictors of mortality and morbidity. Caerphilly North, has high levels of ill health across the board generally. The prevalence of diabetes, CHD, hypertension and respiratory disease is high, as are all the determinants of poor health such as smoking, obesity, poor diet, and lack of exercise and high levels of alcohol intake. Following a large engagement event and discussion at NCN meetings, members of the NCN continue to be keen to address smoking rates and also to address rates of obesity and low physical activity together with other partners.

Caerphilly North NCN has always tried to maximize uptake of preventative services. Uptake of childhood immunizations, influenza immunizations and screening services has scope for improvement and all partners are keen to try to maximize uptake where possible. Increasing Flu Uptake for 2-3 year olds is a key target and the NCN will promote ideas to form plans involving all partners to improve the uptake of flu immunisation in this age group.

**Quality of care**

Prescribing data indicates that opiate prescribing could be improved and we will develop plans which all members of the NCN can participate in to try to improve prescribing rates.

Key implementations for Caerphilly North will be incorporating the Compassionate Community initiative work and the placement of the mental health practitioners in two centres within the NCN.

Compassionate Communities will be rolling out across Caerphilly North in 2019. Preparatory work with the GP practices, CRT and district nursing will be taking place in the summer of 2019. The focus is upon prevention and self-care Communities by working together to reduce individual isolation that can lead to depression and loneliness resulting in the need for clinical intervention.

The introduction of Mental Health Practitioners at the Rhymney Integrated Health and Social Care Centre and Bryntirion Surgery has made an impact with good referral rates and excellent uptake of intervention training. Mental health provision continues to be an area where all partners feel that there are lack of services across the NCN footprint despite previous investment. Partners feel that services are not always joined up and easy to access.

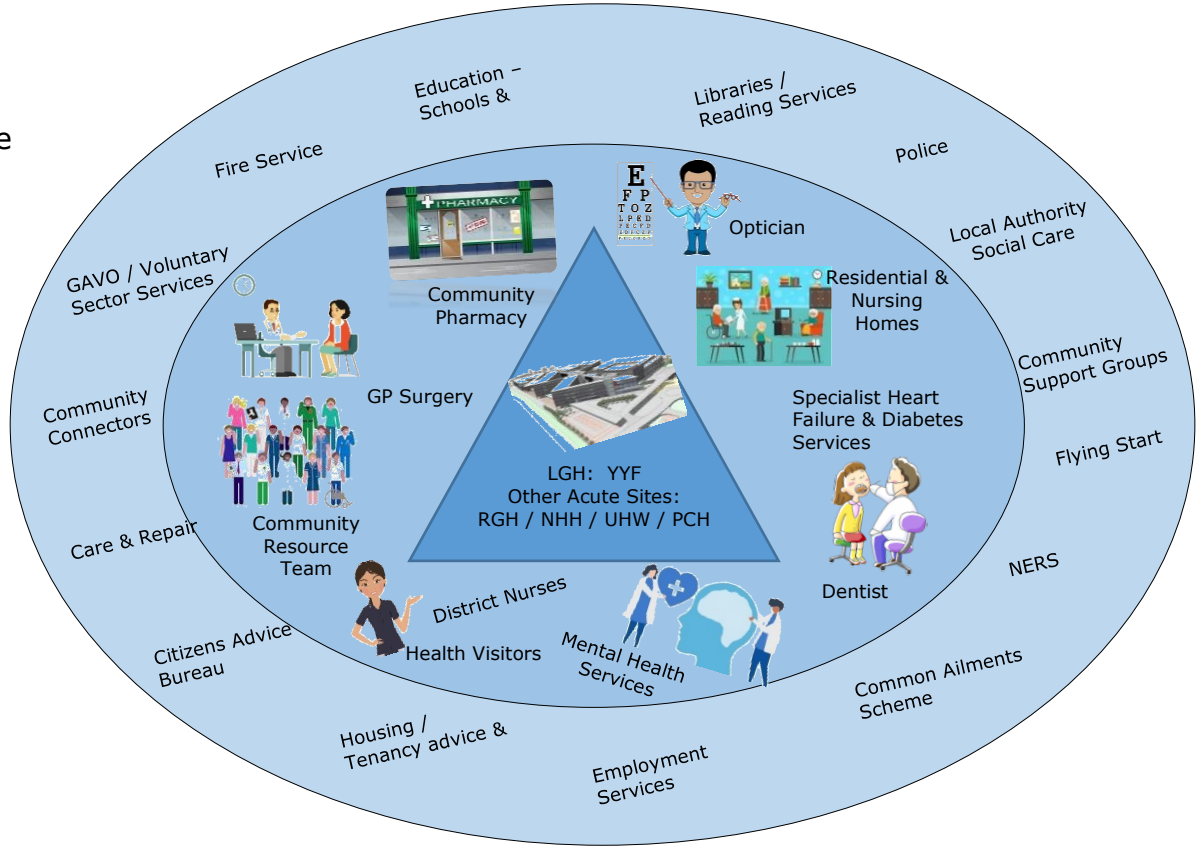
The Caerphilly Quality & Patient Safety Group [QPS] is an established health and social care forum which provides Divisional assurance for all quality and patient safety issues across Caerphilly. This platform enables escalation of significant clinical risks to the Divisional Quality and Patient Safety Group (QPSG) as well as assurance in relation to safeguarding, health and safety and improving the quality and safety of patient-centred healthcare for both staff and citizens. Any NCN related incidents or complaints are fed into this group.

The Caerphilly Locality Team will continue to attend local engagement events and local estate/service development meetings. Events are also organise by the ABUHB Engagement Team where subjects such as access to services and 'Building a Healthier Gwent' are worked through with members of the public. Feedback should feed into future planning for the NCN and wider localities.

# 6 Assets Profile

The diagram opposite give a high level overview of services available within the NCN area. With the introduction of more localised connector services there will be opportunity to complete more detailed, community local assets profiles that can be used to inform and connect organisations. This will enable services work better together to meet the needs of their community and also potentially reduce duplication of services.

More mapping will be undertaken through implementation of Compassionate Communities in Caerphilly North – the aspiration of which is to improve working lives for integrated teams, improve people outcomes and reduce population emergency admissions by developing supportive networks combine with community resource.



# 7 Estates Profile

## 7.1 Estate Profile

There are nine main surgery sites plus four branch surgeries within the Caerphilly North footprint.

**Main Surgeries**

- Five of the main sites are modern fit for purpose estate.
- Two other main practices are requiring consideration for investment into the estate infrastructure to be able to provide sustainable services into the future in terms of expansion space and refurbishment.
- Two other main practice are considered to need urgent investment for expansion and upgrading.

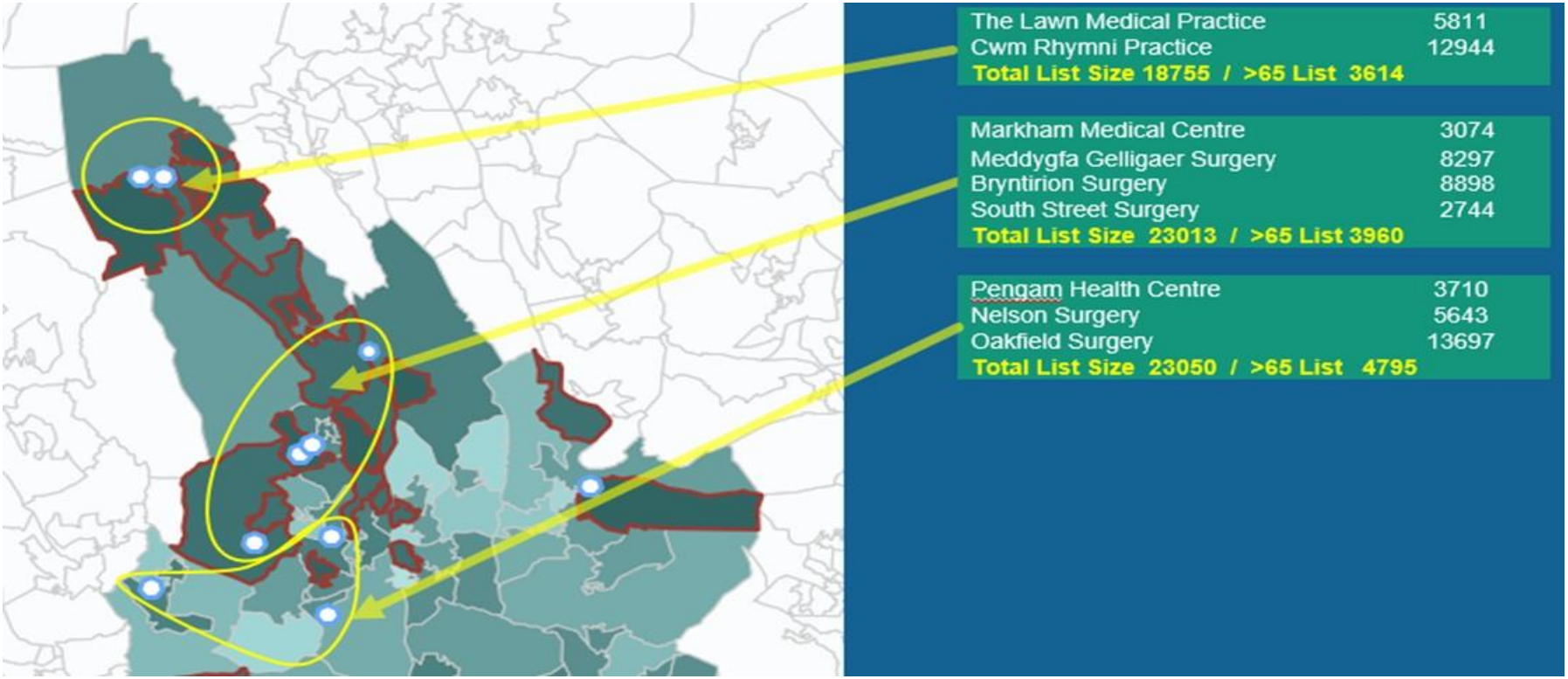
**Branch Surgeries**

- One requires immediate attention while the remaining three are considered fit for purpose or in need of minor refurbishment.

## 7.2 Vision for Estates within the NCN

The large geographical area and high population of Caerphilly are key considerations when planning the integrated "Place Based Care" hub approach. It is recognised that in some areas physical site developments offer an opportunity to progress place based care, however where estate infrastructure is more difficult a "hub & spoke" model will be considered. The NCN will consider estate alongside team/model requirements, for example, how the district nursing team will need to change in light of the all Wales DN principles work stream. For this reason the NCN has a number of scenarios that will require further consideration and decision over the coming months, the scenarios include the following –

***Three place model scenario –***




This scenario fits well with the "hub" model population of approximately 20,000, however would consist of three smaller sized district nursing teams with one team being less feasible.

Caerphilly is served by its Local General Hospital, Ysbyty Ystrad Fawr (YYF) in Ystrad Mynach. This is a new modern hospital which opened in 2011 and offers a broad range of services. The community wards within YYF have a total of 88 beds all of which are single room and en-suite shower and toilet facilities. The predominant nature of the patients these wards serve put them at a higher risk of fall category and as a result less than ideal contingency measures are required to try and help mitigate or reduce this risk. As it is evidenced through the high number and seriousness of report falls on the site consideration into ward/room layout on the community wards is required. This will be progressed through the Quality and Patient Safety agenda led by the locality team based at Llanarth House, Newbridge.

The other in-patient facility present within Caerphilly Borough is located in the Rhymney Integrated Health and Social Care Centre at Rhymney in the north of the borough. There are 11 beds that at GP led and are under model/service development to ensure they are being utilised to an optimum as a graduated care facility. This facility is a modern built unit that it fit for purpose to provide an integrated health and social care service to residents of the north of the borough but also the graduated care beds to the whole borough.

The Caerphilly Community Resource Team is based at Ty Graddfa in Ystrad Mynach which is closely located to the hospital site and they provide a service to the entire population of Caerphilly.

## 7.3 Priority Developments

### *7.3.1 Major Improvement Grants*

One surgery in discussions with the ABUHB about future investment for a major improvement grant as they are outgrowing their current premises

### *7.3.2 Minor Improvement Grants*

None at present. Awaiting responses to request for proposals for 2020/21

### *7.3.3 Capital Pipeline Funding*

None at present. Awaiting responses to request for proposals for 2020/21

# 8 Workforce Profile

## 8.1 Current Workforce Profile

| Role | No of staff (WTE) in post across Caerphilly North NCN |
|---|---|
| GPs Principle | 25 |
| GPs Salaried | 15 |
| GPs Registrar | 1 |
| ANP | 5 |
| Extended Role Specialist Nurse | 4 |
| Practice Nurses | 12 |
| Advanced Paramedic | 1 |
| Clinical Pharmacist | 1 |
| GP Practice - Health Care Support Workers | 9 |
| GP Practice - Phlebotomists | 8 |
| GP Practice - Admin/Clerical | 58 |
| GP Practice – Other Non-clinical | 21 |
| General Dental Practices | 6 |
| Optometry Practices | 4 |
| Community Pharmacies | 14 |
| NCN Practice Based Pharmacists | 2.4 |
| NCN First Contact Physiotherapists | 1 |

**Ysbyty Ystrad Fawr (YYF):**

| Band | 2.1 Oakdale Ward | 2.2 Bargoed Ward | 3.2 Penallta Ward |
|---|---|---|---|
| Band 7 RGN | 1.00 | 1.00 | 1.00 |
| Band 6 RGN | 2.00 | 2.00 | 2.00 |
| Band 5 RGN | 15.05 | 15.05 | 15.05 |
| Band 2/3 HCSW | 16.79 | 16.79 | 16.79 |

**Long Term Conditions Nurses:**

| Post Title | Grade | WTE |
|---|---|---|
| Registered Nurse | 7 | 1.00 |
| Registered Nurse | 6 | 1.00 |

**Community Service:**

| Service | Number within Caerphilly North |
|---|---|
| Community Pharmacies | 14 |
| Community Dental Practices | 5 |
| Community Optometry Practices | 6 |

**Community Resource Team:**

| Post Title | Grade | WTE |
|---|---|---|
| Intermediate Care Consultant | Consultant | 1.00 |
| Consultant | Consultant | 1.00 |
| Speciality Doctor | Doctor | 2.00 |
| Community Physiotherapist | 7 | 0.78 |
| Community Physiotherapist | 6 | 0.95 |
| Community Physiotherapist | 4 | 1.00 |
| Nurse Assessor | 6 | 1.00 |
| Physiotherapist | 7 | 1.30 |
| Physiotherapist | 6 | 4.00 |
| Qualified Nurse | 7 | 4.00 |
| Qualified Nurse | 6 | 5.79 |
| Qualified Nurse | 5 | 3.00 |
| Falls Co-ordinator | 7 | 1.00 |
| Healthcare support worker | 4 | 1.00 |
| Medical Secretary | 4 | 1.00 |

## 8.2 Workforce Risks & Drivers for Change

**Primary Care**

Development of Place Based Care to ensure local residents are able to access and receive services as close to where their live as possible. This will be achieved through development of –

- Availability of a broader range of clinicians to undertake appropriate interventions and only necessitating a GP consultation when required. This may include paramedics, physiotherapy, occupational therapists, mental health workers, pharmacists and advanced nurse practitioners.
- Development of a sustainable and effective lower level community service through recruitment of additional connectors who will be able to signpost and where necessary escalate individual cases and reduce the demand on higher level intervention services.
- Improved GP aligned multidisciplinary care approach with regular opportunity/meetings to discuss and react to specific cases before crisis point. This will require initial investment via transformational funding to ensure there is no reduction in clinical time provision for services required at the MDT and also to administer the meetings.

**Community Resource Team**

There is an ongoing review of the frailty service which and will inform the service model requirements within Gwent. However it is recognised locally that the CRT is an integral part of place based care and are essential in terms of admission avoidance and expediting discharge from hospital.

There has been some inclusion in the tables on following pages of current thinking on requirements however this element of the workforce plan will be confirmed and adapted following recommendations from the review.

**District Nursing**

The District Nursing Service within the Borough provides a broad range of nursing services to support acute care at home, complex care at home and end of life care at home. The service is a key member of the NCN cluster and works in collaboration with other members of the NCN to ensure service sustainability.

The service consists of 7 teams aligned to 23 practices within Caerphilly but also to a number of tertiary GP practices within other Health Boards. The service operates from 8am to 8pm 7 days per week and referrals can be made by both professionals and the general public.

Each team consists of a Team Manager and Team Leader who both hold a specialist practitioner qualification in district nursing and they are supported by a team of registered and support staff. The teams undertake planned and unplanned contacts.

Unplanned are same day face to face contacts with a patient that is done without prior scheduling. It is often an urgent referral requiring a home visit. The planned contacts are face to face contacts with a patient that is scheduled for the following day or thereafter.

There is also a requirement to review the role of the Health Care Support Worker where limitations currently exist in the ability to undertake specific duties/tasks, thus necessitating a registered nurse to undertake lower level interventions.

On reviewing the outcome of DN Principles it is evident that Caerphilly are in deficit in numbers of registered staff.

The current number of registered staff in post is 75.73 wte and healthcare support workers 10.21. Using the DN principle calculation of 1 registered district nurse per 415 resident population aged 65+ gives a registered DN workforce of 86.3 wte and a HCSW establishment of 21.6 (based on the DN principle of 80/20 ratio).

**Ysbyty Ystrad Fawr**

There are 88 community beds within YYF and there is no plan to change this. There has been longstanding recruitment difficulties to the community wards, however recently there has been some improvement in this area and the current vacancy factor has reduced to 5.53 registered staff and 2.77 health care support workers (as at 1st Aug 2019).

There will need to be a rolling programme of recruitment in line with turnover and the senior nurse is working with HR and divisional nurse educational leads in relation to this.

**Other Considerations**

In addition to the above there are also a number of other factors that need to be considered in ensuring a sustained and effective workforce including –

- The potential of creating rotational community nursing posts that will work across the three services outlined above (DN/CRT/YYF).
- Workforce age profile
- Changes to state pension age and implications on having an increasing aging workforce
- Skill mix and upskilling of current workforce
- Funding arrangements for fixed term initiatives and posts

### *8.2.1 – Workforce Vision*

- Develop prudent approach to maximising roles across all staff groups
  - GP practice – development of new roles, use of connectors, development of community structures
  - Nursing – development of b4/3 HCSW roles to include therapy skills, enablement model etc
  - Development of ANP model between areas ie hospital/CRT/District nursing to provide advanced practice in a synergistic way across all services

- Working with LA and third sector ensure that integration across all services is maximised to prevent handoffs and poor patient experience. Reduce barriers between services by strong management and leadership and development of robust pathways

- Development of rotational posts both to attract and retain staff but more importantly to ensure skills are appropriate for changing models, this must be underpinned by a robust training mechanism
  - Consider the development of a more generic role across hospital and CRT with the potential implementation of a model that includes district nursing
  - B5 nurses – develop a robust training programme that develops generalist skills across CRT, DNS and ward and a model of pool staffing that reflects this. Consider how this links to practice nursing
  - HCSW – further develop the enablement model by staff working in hospital and across CRT

**Proposed changes**

- Development of rotational posts –
- Development of new extended roles in practice
- Develop MDT approach to support practices
- Develop IWBN
- Compassionate Communities
- Adopt district nursing principles – taking into account Care Aims training
- Skill mix in District Nursing – Look at Band 4 posts
- CRT team expansion – graduated care

## 8.3 Training Requirements

Training opportunities including:

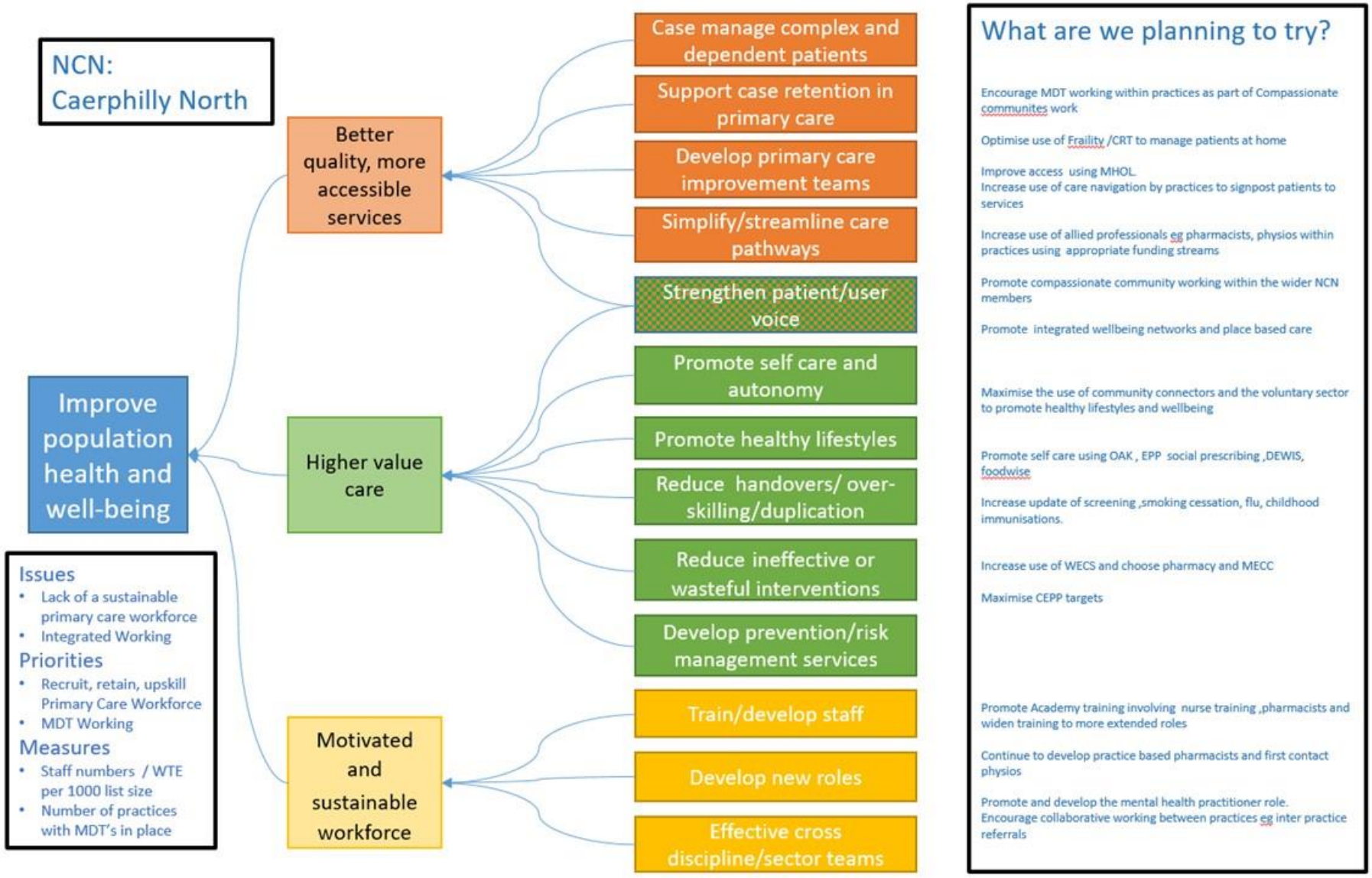
- Nutrition Skills for Life - Community Food and Nutrition Skills Course to provide training for GP practice staff to provide Foodwise courses to tackle obesity and promote healthy eating/living for patients living within Caerphilly North NCN
- Making Every Contact Count (MECC) Training for GP practice and partnership organisations staff
- Mentorship for Practice Based Pharmacists
- Various training opportunities that arise for upskilling GP practice staff both clinical and non-clinical will be supported via NCN funding if deemed appropriate

# 9 Opportunities and Challenges for 2020-2023

## 9.1 SWOT Analysis

| Strengths | Weaknesses |
|---|---|
| • Good working relationships across the NCN membership<br>• Strong focus on innovation/development of services<br>• Committed NCN Leadership and Support Team<br>• Clear direction via the NCN plan on a page of what the priorities are and how these can be delivered via integrated working<br>• NCN provides a conduit for two way partnership working | • NCN budget mostly committed with very little remaining for development within the NCN<br>• Annual variability of funding e.g. CEPP or loss of Pharmacists can impact on spending timescales<br>• Limited resource from management team – spread thinly and not able to fulfil development work in timely manner<br>• Organisational barriers can make integration difficult<br>• Lack of sustainable Primary Care workforce<br>• Prescribing of opiates |
| **Opportunities** | **Threats** |
| • Expand and develop extended roles within GP practices<br>• Explore potential funding sources<br>• Development of place based care models and hubs incorporating the medical element and the social wrap around services required to support sustainable services for the local population<br>• Closer collaboration between practices<br>• Implement Compassionate Communities within Caerphilly North NCN<br>• Transformation funding has enabled the development of GP practice MDTs.<br>• Introduce Telehealth option for patients & practices | • Primary Care recruitment difficulties. With a small number of single handed GP surgeries this issue is a concern.<br>• Initiatives developed within the NCN being taken down due to lack of sustainable funding or not being taken on by core HB funding.<br>• Engagement from all services to develop the place based care model<br>• Some roles can be difficult to recruit into.<br>• Loss of engagement when pilots/initiatives are discontinued e.g. Practice Based Social Workers |

## 9.2 Driver Diagrams



# 10 Prioritised Actions 2020-2023

| # | Objective | Action(s) | Anticipated Impact | Alignment to PNA *(Section 5)* | Alignment to Strategic Workstream *(Section 3.4)* |
|---|---|---|---|---|---|
| 1 | Reduce impact of behavioural determinants of mortality and morbidity | Improve uptake of stop smoking services | Reduction in smoking prevalence<br>Meet target of 5% smokers referred to stop smoking services | Appendix -14.2.6<br>Appendix – 14.5<br>Currently failing to hit the 5% target of smokers referred | Aligned with strategic work streams:<br>1. Prevention, Wellbeing & Self-care<br>2. Care Closer to Home<br>3. Access & Sustainability |
| | | Develop services to make a positive interventions for obese citizens in Caerphilly | Reduction in patients who are overweight/obese | Appendix – 14.2.6<br>70% of Caerphilly population considered overweight and 28% considered overweight or obese | |
| | | Promote and develop services for patients who do not exercise | Increase in number of patients who exercise regularly | Appendix - 14.2.6<br>33% of population are active for less than 30mins per week | |
| | | Maximize uptake of influenza vaccination | Improved uptake in particular for the 'at risk' group | Appendix 14.4.2<br>Not currently hitting the national target of 65% for the at risk group | |
| | | Maximize uptake of childhood immunization | | | |
| | | Improve uptake of screening service | Earlier detection of common cancers | | |

| | | | | | |
|---|---|---|---|---|---|
| | | Improve uptake of Drug & Alcohol services within the NCN community | | | |
| 2 | Ensure appropriate access to primary care services and sustainability of services | Promote new model of primary care<br><br>Continue to pilot and develop new roles in Caerphilly North<br><br>Promote and monitor use of additional services such as common ailments scheme, WECS<br><br>Promote and monitor innovative use of IT<br><br>Introduce Telehealth option for patients<br><br>Utilize use of extended services and 3rd sector<br><br>Realignment of DN services<br><br>Contribute to winter planning<br><br>Implement Compassionate Communities model | Ensuring care is provided by the right person at the right time in the right place. Improved population wellbeing and resilient communities | Appendix – 14.7<br>Improved utilisation of social prescribing and care navigation will improve referral rates across the NCN | Aligned with strategic work streams:<br>2. Care Closer to Home<br>3. Access & Sustainability<br>4. Implement the Primary Care Model for Wales<br>5. Re-designing Community Services<br>6. Digital data & Technology |

| | | | | | |
|---|---|---|---|---|---|
| 3 | Delivery high quality care | Reduce rate of opiate, tramadol, pregabalin and gabapentin prescribing.<br><br>Deliver Quality Improvement projects in line with GP contract.<br><br>Improve communication between services and organizations.<br><br>Maximize Training opportunities to develop appropriate staff skills across the NCN | Better qualified and informed staff across the NCN providing care at highest level | Appendix – 14.4.1<br>NCN practices are high prescribers of opiates | Aligned with strategic work streams:<br>1. Prevention, Wellbeing & Self-care<br>5. Re-designing Community Services<br>7. Skilled Local workforce<br>10. Quality, Value & Patient Safety |
| 4 | Estates | Consider estate alongside team/model requirements | Introduction of place based model of care | | Aligned with strategic work streams:<br>5. Re-designing Community Services<br>8. Estates Development |

The key themes from the Transformational Model for Primary Care have been considered and will also be highlighted throughout the development of the 3 Caerphilly NCNs Delivery Plans.

# 11 Communication & Engagement Mechanisms

The NCN support team aims to develop a programme of public engagement to be extended across Caerphilly in order to gauge the views of local people, and therefore influence services locally. Rotation of engagement events also allows the team the opportunity to discuss key Health board strategies such as Clinical Futures and Care Closer to Home, and reflect known issues in that particular locality.

This will provide an opportunity also to discuss the impact of new housing developments and how the NCN is working with Caerphilly County Council housing colleagues to ensure they are aware of local pressures with GP practice sustainability etc.

With the implementation of Compassionate Communities underway a Drop-in Advice Clinic within The Rhymney Integrated Health & Social Care Centre has been recently piloted in Caerphilly North where patients have the opportunity of being able to drop-in and sit with services such as Citizens Advice, The Police, Housing Tenancy and Employment on a specific afternoon. Feedback from the GP practice based at the centre, the citizens attending and the associated services is very positive. Possible expansion of the initiative is currently in consultation.

The NCN aims to introduce Telehealth technology. Telehealth platforms and apps easily accessed via smart phones and tablets will promote self-care for chronic disease patients and improve access and sustainability for GP practices. By utilising this technology it is anticipated that patients will make less inappropriate visits to their GP due to increased confidence in their self-care.

# 12 Financial Profile

## 12.1 Neighbourhood Care Network

Caerphilly North NCN Cluster Funding – Annual Budget £234,360

Currently Supports:

| Role / Initiative | Recurrent Annual Cost |
|---|---|
| 2.2 WTE Practice Based Pharmacist | £ 141,246 |
| 1.0 WTE First Contact Physiotherapist | £ 46,698 |
| Community Phlebotomy Team | £ 16,342 |
| Independent Contractors (Top Sliced across all ABUHB NCNs) | £ 4,347 |
| DEWIS Coordinator (Top Sliced across all ABUHB NCNs) | £ 2,682 |
| Dementia Road Map (Top Sliced across all ABUHB NCNs) | £ 1,210 |
| **Total** | **£212,525** |

Since 2016-17 the Caerphilly North NCN has invested around £423,000 in GP Practice Based Pharmacist support. In 2018-19 the NCN reported that over 250 hours of GP time had been replaced and in excess of 400 contacts made by NCN pharmacists.

In 2018-19 Caerphilly North NCN introduced the First Contact Physiotherapy Service to run within all GP practices through an initial recurrent £47,000 investment.

A range of support for GP practices in Caerphilly North have been recurrently funded including specialist Advisor roles in Optometry, Dentistry and Pharmacy, investment in a Community Phlebotomy Service. Investments have also been made in various training opportunities to upskill Primary Care and allied services staff across Caerphilly North. The introduction of innovative use of digital and clinical technology and equipment has also been supported to enable Primary Care services to provide a wider range of options for patients. The NCN continues to horizon scan with the aim of developing a portfolio of existing and proven schemes, and potential new pilot projects.

Another funding stream available for proposals is the Small Grants process which is joint funded with the LA and Health Board with a pot funding of £25K. Caerphilly NCN Management Team will have the role of reviewing the schemes once key areas have been met through the application process. Future initiatives that are currently unfunded include that of Practice Based Community Connectors to improve on the provision of social prescribing across Caerphilly North NCN.

Within Caerphilly North, the locality and GP practices have also benefitted from the Transformation Programme funding due to its high levels of depravation and GP practices sustainability issues.

5 x WTE Community Connectors in alignment with Compassionate Communities
2 x WTE Advanced Nurse Practitioners
1 x WTE Mental Health Practitioner
1 x WTE GP Practice Pharmacist
1 x WTE Band 5 Nurse to release Nurse Practitioner to see more complex patients
Support for development and attendance of MDT meetings

Applications for funding are also being made via ICF and Transformation for a community café run by a local social enterprise within the Rhymney Integrated Health & Social Care Centre.

# 13 Actions to Support Cluster Working and Maturity

- A financial framework is required to consider successful NCN cluster initiatives and establish continuing funding and development across the health board, where appropriate. Failure to establish such processes will risk rapid disengagement from NCNs – also add about difficulties of short term funding such as CEPP rewards/Transformation funding

- Role of Public Health – Improved Public Health engagement to enhance the utilisation of relevant data.

- Welsh Community Care Information System WCCIS- access to information to enable Health & Social Services staff to work together and deliver services and support for individuals, families and communities

- Clarity and simplification and availability of data/ dashboards KISS

- Continued cross practice working including shared training opportunities to improve sustainability and access

- Improved communication with other Health Boards cluster initiatives/schemes to help shared learning and outcomes

- Working closer with Third Sector organisations for opportunities for wider delivery of initiatives

# 14 Appendix 1 – Population Health Needs Assessment (Caerphilly North)

## 14.1 Population and Future Projections

Caerphilly North NCN currently serves a population of 64,801. The crude projection of population decrease over the next 5 and 10 years based on list size populations is: Projection: 2025=59,642, 2030=55,597 (source ABUHB)

The total population of Caerphilly North NCN for all ages is currently 64,801. When broken down by age, approximately 18.2% (11,974) were aged 0-14years, 65.2% (42,250) were aged 15-64years and 16.6% (10,757) aged 65 and over. (Source: 2011 Census). As of 1st April 2019, a total of 187,231 people of all ages were registered with a GP in Caerphilly Borough (Primary Care capitation report)

Total population (Caerphilly Borough 18yrs and over)

| 2017 | 2020 | 2025 | 2030 | 2035 |
|---|---|---|---|---|
| 142,550 | 143,520 | 145,170 | 146,970 | 148,020 |

(Source: Daffodil)

The most recent data available via Daffodil shows that 1.51% of the Caerphilly borough population are from Black and Minority Ethnic groups (BME) as drawn from the 2011 census.

The Caerphilly North NCN area is divided into 33 Lower Super Output Areas (LSOAs). 80.0% of the LSOAs are within the top 50% most deprived LSOAs in Wales. Twyn Carno1 LSOA is currently ranked as the 7th most deprived LSOA in Wales and the 2nd most deprived in Caerphilly Borough.

The number of people aged 16 and over predicted to be living alone in Caerphilly Borough in 2017 was 37,279, with a projected increase to 41,895 (12.4%) by 2035, the second highest in Gwent. This compares with a predicted shift of (8.9%) in Torfaen, (5.2%) In Blaenau Gwent, (11.4%) in Monmouthshire and (17.6%) in Newport. (Source: Daffodil)

In 2011, 0.66% (936) of people aged 16 and over in Caerphilly Borough, were living in a dwelling with no central heating, the second lowest in Gwent. The highest was Monmouthshire with 1.42% (1,042), followed by Newport had 1,309 (1.14%), Torfaen 631 (0.86%),) and the lowest was Blaenau Gwent with 370 (0.65%). (Source: Daffodil)

The number of people predicted to be providing unpaid care (all ages) in Caerphilly in 2017, equated to 22,792, anticipated to rise by 1.8% (440) by 2035. This is the second highest predicted rise behind Newport where the prediction is a rise of 11.9%

(2,164). Blaenau Gwent is predicted to see the highest drop of 378 (4.1%) and Torfaen the lowest at 86 (1%) with Monmouthshire also predicted to drop by 1.8% (221). (Source Daffodil)

The total number of people claiming Disability Living Allowance or Personal Independence Payments across all age bands across Caerphilly Borough at May 2014, equated to 10,400 the highest in Gwent (Source: Daffodil)

The total number of people in Caerphilly Borough aged 18 and over, receiving Employment & support allowance, Incapacity Benefit, or Severe Disablement Allowance in Monmouthshire at May 2014 equated to 10,812, the highest in Gwent (Source: Daffodil).

In 2017, Caerphilly Borough's average of unemployment for Males was 6.6%, and Females was 3.7% (source CCBC Local Wellbeing Assessment)

GP practices in various areas within Caerphilly North NCN will need to be aware of the implications of the Caerphilly Local Development Plans (LDPs) – Key developments opportunities on brownfield sites with existing settlements as highlighted in the Caerphilly Borough Council LDP are:

- Concrete Yard, Deri – Up to 26 dwellings
- Land south of Merthyr Rd, Princetown – 68 dwellings
- Ty Du, Nelson – 200 houses
- Penallta Colliery – 100 residential units
- Part Mart site, Tir Y Berth – 173 dwellings
- New Rd, Ystrad Mynach – 18 dwellings
- Greenhill School Site – 37 houses
  (Source – CCBC, Caerphilly LDP)

## 14.2 Health & Physical Disabilities

### *14.2.1 QOF Disease registers*

The table below gives an overview of a selection of key QOF disease registers (2017-18). In terms of comparison with the other 11 NCN clusters in Gwent, Caerphilly North is mid to high ranging in all elements, however it is important to consider the all Wales and UK prevalence and it is also imperative that the change over time is considered. This is outlined on the following pages.

| Prevalence *(QOF Registers 17-18)* | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Asthma | 6.9% | 7.5% | 6.4% | 7.0% | 6.6% | 6.9% | 7.3% | 6.3% | 7.0% | 6.5% | 7.9% | 7.0% |
| COPD | 3.4% | 2.8% | 2.1% | 2.6% | 2.1% | 2.0% | 1.6% | 1.8% | 1.7% | 2.2% | 2.6% | 2.3% |
| Cancer | 2.4% | 2.8% | 2.4% | 2.6% | 3.0% | 4.0% | 3.4% | 2.3% | 2.9% | 2.2% | 2.7% | 2.6% |
| CHD | 4.4% | 4.0% | 3.4% | 3.9% | 3.7% | 3.9% | 3.5% | 3.2% | 3.3% | 3.1% | 4.1% | 3.9% |
| Heart failure | 1.4% | 1.3% | 0.7% | 0.9% | 0.8% | 1.6% | 1.0% | 0.7% | 0.8% | 0.8% | 1.1% | 1.0% |
| Hypertension | 19.3% | 17.5% | 15.8% | 16.6% | 15.7% | 17.5% | 15.8% | 13.3% | 15.4% | 14.1% | 17.6% | 16.1% |
| Atrial fibrillation | 1.9% | 2.1% | 1.8% | 2.0% | 2.0% | 3.0% | 2.4% | 1.6% | 1.8% | 1.6% | 2.4% | 2.1% |
| Diabetes | 7.7% | 7.1% | 6.1% | 7.1% | 6.1% | 6.3% | 5.8% | 6.2% | 5.7% | 6.4% | 7.2% | 6.4% |

### *14.2.2 Respiratory Conditions*

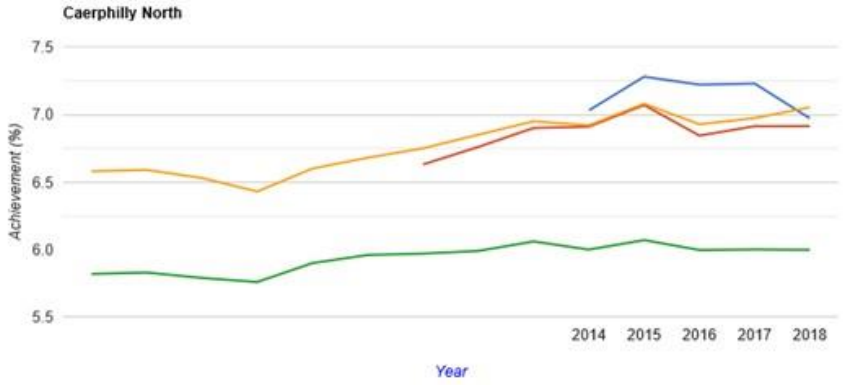
Caerphilly North has an asthma prevalence of 7.0% which is lower than the Wales average but higher than the ABUHB average prevalence, and also higher than the UK prevalence of 6%. The COPD prevalence is 2.6% which is higher than the UK position of 1.93% and higher than the ABUHB and Welsh averages. The asthma prevalence has increased year on year since 2014, the COPD reported position has remained relatively static over the same period.

| Prevalence *(QOF Registers 17-18)* | ABUHB | Wales | Caer North |
|---|---|---|---|
| Asthma | 6.9% | 7.10% | 7.0% |
| COPD | 2.2% | 2.30% | 2.6% |

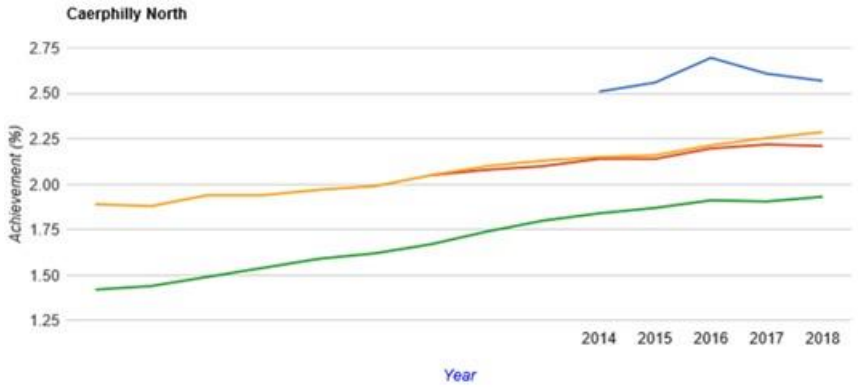


Caerphilly South
Aneurin Bevan Health Board
Wales
UK

**Asthma**




**Chronic Obstructive Pulmonary Disease**




### *14.2.3 Hypertension & Heart Disease*

| Prevalence (QOF Registers 17-18) | ABUHB | Wales | Caer North |
|---|---|---|---|
| CHD | 3.7% | 3.7% | 3.9% |
| Heart failure | 1.00% | 1.0% | 0.9% |
| Hypertension | 16.1% | 15.7% | 16.6% |
| Atrial fibrillation | 2.1% | 2.2% | 2.0% |

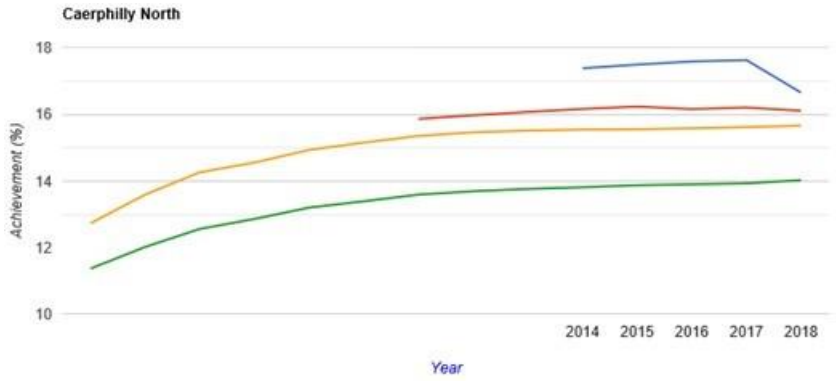
At 16.6% prevalence of hypertension is higher than the Welsh average of 15.7% and the ABUHB average of 16.1%.The Caerphilly North position has increased annually since 2014.

Atrial Fibrillation is 2.0% which is similar to the ABUHB and Welsh average. The prevalence is higher than the UK average. Anticoagulation of patients with AF has been identified as a national priority and should be considered for the IMTP.

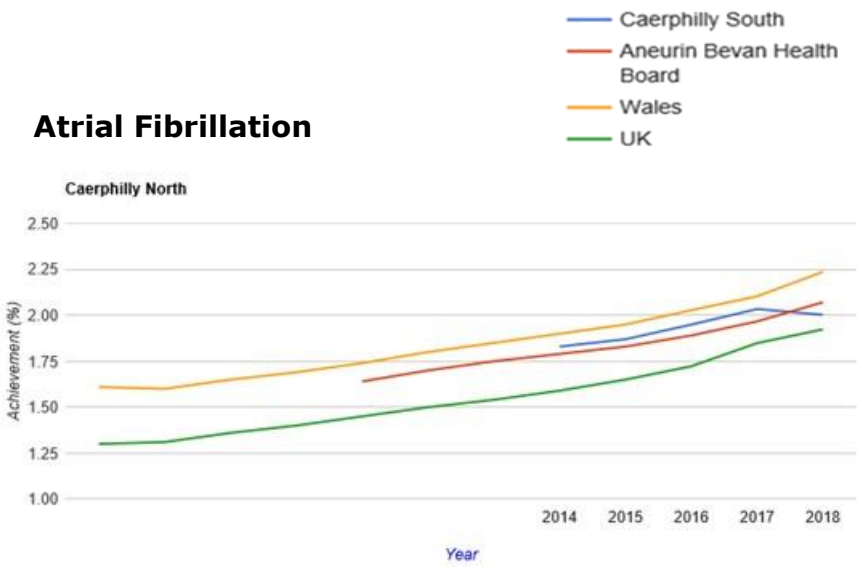
Coronary Heart Disease at 3.9% is higher than the ABUHB and Wales average of 3.7%, and higher than the UK position of 3.2%.

At 0.9% Caerphilly North is almost in line with the UK average of 0.8% in prevalence of people on the GP register with heart failure, this is better than ABUHB and Wales average and has remained relatively static since 2014.

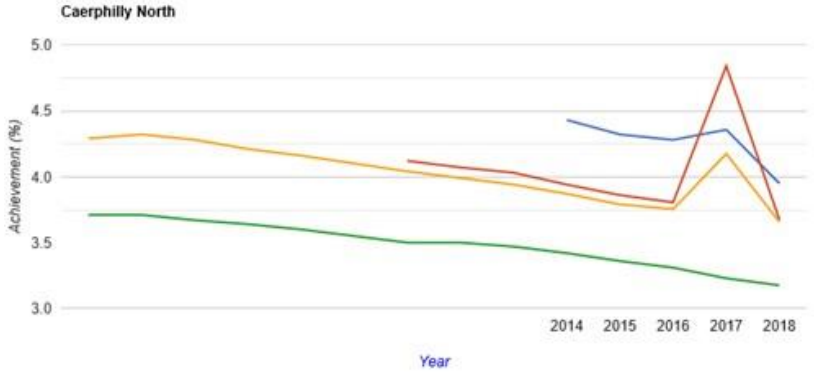
## Hypertension



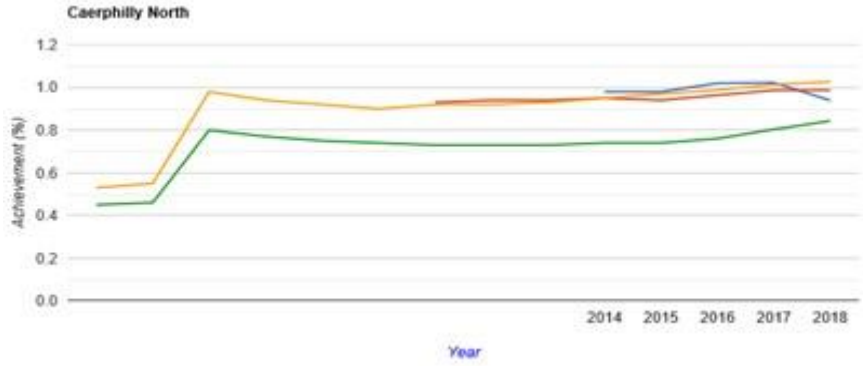

## Atrial Fibrillation




## Coronary Heart Disease



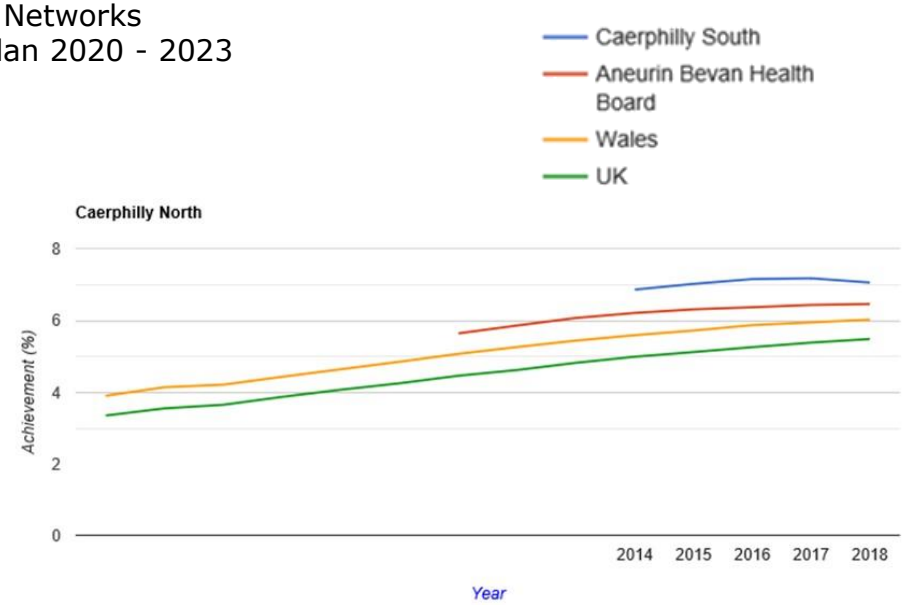

## Heart Failure



### *14.2.4 Diabetes*

| Prevalence (QOF Registers 17-18) | ABUHB | Wales | Caer North |
|---|---|---|---|
| Diabetes | 6.5% | 6.0% | 7.1% |

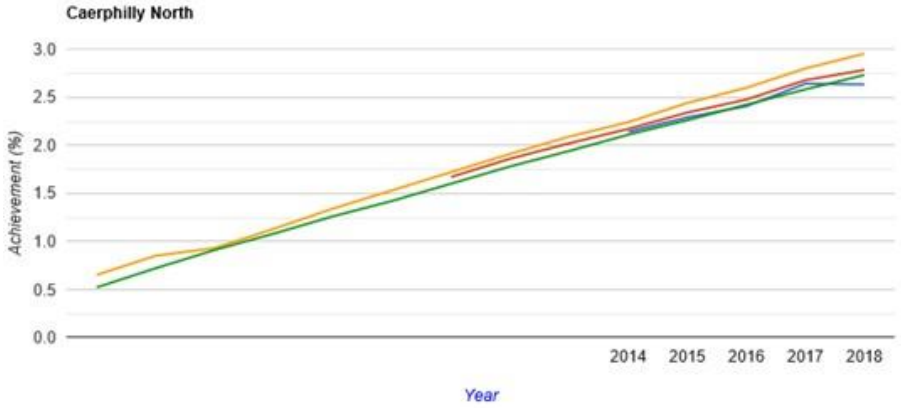
Caerphilly North's latest prevalence position is higher than the ABUHB and Wales averages. There is also a year on year increase although this is slightly less marked than the other areas reported in the graph opposite.




### *14.2.5 Cancer*

| Prevalence (QOF Registers 17-18) | ABUHB | Wales | Caer North |
|---|---|---|---|
| Cancer | 2.8% | 3.0% | 2.6% |

The QOF register of all cancer patients defined as a 'patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003' has increased by 0.2% year on year since 2014 and now stands at 2.6% of the list size population. This is slightly less than the Wales and ABUHB positions reported position of 2.8 and 2.7% respectively.



### *14.2.6 Other Areas of Prevalence (source PC Needs Assessment for Wales)*

The other areas of prevalence that could be considered contributory factors in the above are shown in the table below –

| NCN GP LIST SIZE | | 33,602 | 38,375 | 65,857 | 64,801 | 56,496 | 53,096 | 47,301 | 50,049 | 57,150 | 49,945 | 49,573 | 46,322 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NCN AREA | | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
| Smoking | *2013-14* | 26% | 24% | 19% | 23% | 23% | 15% | 17% | 25% | 20% | 25% | 23% | 23% |
| Healthy Eating | *2014* | 30% | 31% | 33% | 31% | 32% | 35% | 35% | 31% | 33% | 34% | 32% | 32% |
| Physical Activity | *2014* | 29% | 29% | 30% | 29% | 29% | 29% | 29% | 30% | 29% | 29% | 29% | 30% |
| Alcohol Misuse | *2014* | 26% | 26% | 27% | 27% | 27% | 26% | 27% | 27% | 27% | 27% | 26% | 27% |
| Obesity | *2017-18* | 13% | 12% | 11% | 12% | 10% | 11% | 10% | 11% | 9% | 11% | 12% | 10% |


Smoking – the current NCN prevalence is 23%. The target is for 5% of population to attend stop smoking services. We should report against these targets and develop plans to meet or maintain attendance at stop smoking services. Caerphilly Borough as a whole has as smoking prevalence of 21% of the population

Across Caerphilly borough 70% of the population are considered overweight or and 28% considered overweight or obese. 80% of the population do not eat 5 portions of fruit and vegetables a day and 33% are active for less than 30 minutes a week. 19% of the population drink more than the guidelines recommended. Following discussion with all NCN members at a combined NCN event, obesity and healthy eating have been identified as an area of need by professionals and service users. We aim to develop plans to meet these needs.

Mental Health - Following discussion with all NCN members and collating views from combined NCN events access to mental health services has been identified as an area of need by professionals and service users

The number of people aged 5 years and above in 2017, predicted as having a common mental health problem as classified by Daffodil, was 23,777 with a slight rise predicted to 24,690 in 2035. In terms of dementia, Daffodil predicts that in 2017 there were 48 people aged between 30 and 64 with early onset dementia, reducing to 45 in 2035. There were 2,186 people aged 65 and above reported as having dementia in 2017, rising to 3,781 in 2035, a shift of 73%.

People living with long term illness – (see 14.2.1). This has also been identified as an area of need by professionals and service users. We aim to develop plans to meet the needs of patients with long term illness by also utilising Social Prescribing to direct patients to the most appropriate source of care.

Across the borough 70% of the population is considered to be overweight and 28% of the population are considered overweight or obese. 80% of the population do not eat 5 portions of fruit and vegetables a day and 33% are active for less than 30 minutes a week. 19% of the population drink more than the guidelines recommended. (Source: Public Health Wales)

13,555 people across Caerphilly Borough are unable to manage at least one domestic task and 6,011 are unable to manage at least one activity on their own. (Source: Daffodil)

## 14.3 Incidents & Concerns

Feedback from professionals indicates that ambulance waits are a frequent concern +remain overly long and GPs report having been stuck for long periods with patients who need transporting to hospital.

## 14.4 Patient Safety Indicators

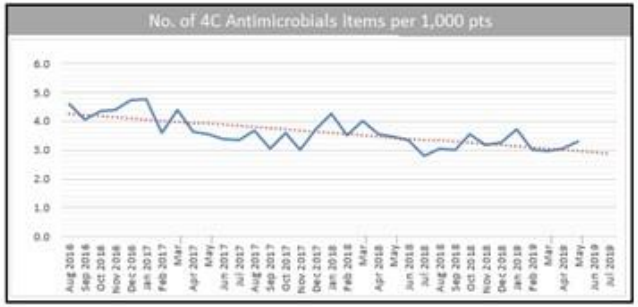
### *14.4.1 Prescribing rates*

Caerphilly North is the fifth highest prescriber of Tramadol in Gwent and although the month on month position has improved over the last few years this remains an area of focus. Another area that requires additional attention is the increase in rate of prescribing of Gabapentin and Pregabalin which is showing an increasing trend in the graphs shown. There has been some success in the reduction of antibiotic prescribing and Caerphilly North compares mid-range across the Gwent clusters.

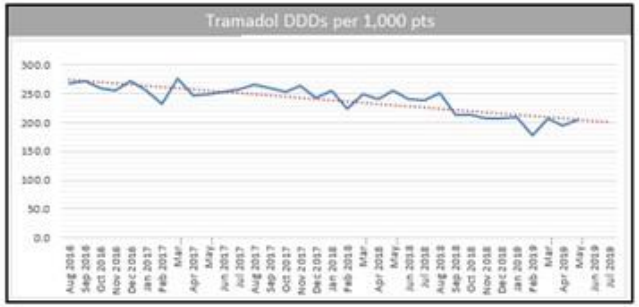
The NCN needs to develop plans to meet these areas of concern.

| | NCN GP LIST SIZE | *33,602* | *38,375* | *65,857* | *64,801* | *56,496* | *53,096* | *47,301* | *50,049* | *57,150* | *49,945* | *49,573* | *46,322* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **NCN AREA** | **BG East** | **BG West** | **Caer East** | **Caer North** | **Caer South** | **Mon North** | **Mon South** | **Newp East** | **Newp North** | **Newp West** | **Torf North** | **Torf South** |
| No. of 4C Antimicrobials items per 1,000 pts | *Feb 2019 - Apr 2019* | 10.3 | 10.5 | 10.1 | 9.0 | 9.3 | 11.1 | 8.1 | 7.8 | 7.8 | 6.9 | 11.3 | 9.4 |
| Tramadol DDDs per 1,000 pts | *Feb 2019 - Apr 2019* | 397.6 | 597.7 | 647.3 | 580.8 | 637.2 | 399.5 | 392.3 | 571.1 | 325.8 | 321.8 | 581.2 | 398.4 |
| Gabapentin and Pregabalin DDDs per 1,000 pts | *Feb 2019 - Apr 2019* | 2044.1 | 1985.8 | 1789.8 | 1743.0 | 1731.9 | 1341.1 | 1252.3 | 1285.3 | 1461.7 | 1647.8 | 2435.4 | 2168.9 |

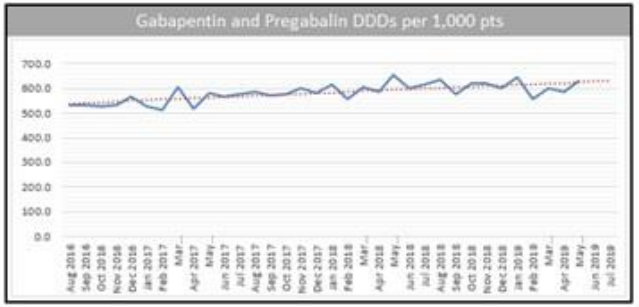
**Antibiotic Prescribing**




**Tramadol Prescribing**




**Gabapentin & Pregabilin Prescribing**



### *14.4.2 Immunisation rates, etc.*

Immunisation rates are regularly reviewed at NCN cluster meetings and individual practices data shared. This promotes sharing of best practice and offers support and advice to practices where uptake is lower. It has been noted that as immunization rates have decreased nationally, the incidence of measles has increased. The NCN needs to be mindful of this and develop plans to maintain and increase immunization rates.

**Age Group: 2 Years** Caerphilly North NCN achieves the national target of 95% for the Age 2 immunisation group.

| NCN AREA | | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Childhood Immunisations - Age 2** | | | | | | | | | | | | | |
| MMR1 - Uptake % | *Mar 2019* | 96.4% | 97.5% | 98.0% | 96.0% | **96.5%** | 94.5% | 97.6% | 96.3% | 93.2% | 93.9% | 95.2% | 96.5% |
| PCVf - Uptake % | *Mar 2019* | 96.7% | 97.7% | 98.5% | 96.6% | **96.5%** | 94.8% | 98.7% | 96.2% | 93.4% | 93.7% | 96.6% | 96.9% |
| Hib/Men C - Uptake % | *Mar 2019* | 95.3% | 97.2% | 97.4% | 95.8% | **96.0%** | 93.7% | 98.7% | 95.8% | 91.4% | 93.1% | 95.2% | 96.7% |

**Age Group: 5 Years** Caerphilly North is comparing relatively well to other cluster areas within Gwent, however is just below the national target of 95%.

| NCN AREA | | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Childhood Immunisations - Age 5** | | | | | | | | | | | | | |
| MMR2 - Uptake % | *Mar 2019* | 90.5% | 91.0% | 94.0% | 92.3% | **92.4%** | 87.0% | 92.0% | 89.1% | 89.0% | 86.0% | 91.2% | 91.6% |
| 4 in 1 Pre Sch Booster - Uptake % | *Mar 2019* | 92.6% | 92.6% | 94.7% | 94.8% | **93.5%** | 93.3% | 97.6% | 90.7% | 88.1% | 89.1% | 93.1% | 92.5% |

**Age Group: 16 Years** One of the 3 elements of this age group is above target (MMR1), however MMR2 is below target at 92.9% and the 3 in 1 pre-teen booster is the lowest recorded uptake of childhood immunisations at 87.2% and is an area where compliance could be improved.

| NCN AREA | | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Childhood Immunisations - Age 16** | | | | | | | | | | | | | |
| MMR1 - Uptake % | *Mar 2019* | 94.6% | 94.4% | 96.9% | 96.2% | **97.5%** | 87.0% | 88.8% | 96.0% | 94.3% | 92.4% | 97.4% | 95.9% |
| MMR2 - Uptake % | *Mar 2019* | 88.6% | 91.7% | 92.4% | 92.9% | **93.6%** | 78.2% | 84.8% | 90.8% | 88.6% | 87.6% | 93.5% | 91.7% |
| 3 in 1 Pre Teen Booster - Uptake % | *Mar 2019* | 90.2% | 86.6% | 90.6% | 87.2% | **88.3%** | 85.6% | 80.0% | 88.5% | 82.4% | 81.2% | 87.8% | 90.6% |

## Flu Immunisation

When compared to the rest of Gwent, Caerphilly North appears to be comparing at mid to low-range. The uptake of flu immunisation is still below target and is an area that could be improved.

The flu immunization rates, whilst reasonable in comparison to other NCNs, do not reach national targets and the NCN needs to continue to develop plans to improve uptake. Particular attention needs to be made to the 2-3yrs uptake.

| NCN AREA | | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Flu Immunisations** | | | | | | | | | | | | | |
| ≥ 65 Years - Uptake % | *Apr 2019* | 63.5% | 69.2% | 66.1% | 67.6% | **71.5%** | 73.9% | 61.1% | 65.2% | 71.3% | 65.9% | 68.5% | 73.5% |
| < 65 Years "At Risk" - Uptake % | *Apr 2019* | 38.1% | 51.0% | 43.8% | 44.4% | **48.5%** | 51.2% | 54.9% | 43.7% | 48.4% | 45.3% | 44.7% | 48.9% |
| 2-3 years - Uptake % | *Apr 2019* | 37.3% | 43.6% | 47.5% | 37.6% | **53.1%** | 56.3% | 58.3% | 41.2% | 52.9% | 36.9% | 42.9% | 63.4% |

## Screening uptake

Caerphilly North NCN performs relatively well compared to other cluster areas in Gwent.
However, the NCN does not reach national targets and should continue to develop plans to meet these targets.

| NCN AREA | | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Screening Uptake** | | | | | | | | | | | | | |
| Bowel Screening | *2017-18* | 50% | 54% | 56% | 55% | 59% | 62% | 60% | 51% | 58% | 49% | 56% | 53% |
| Breast Screening | *2017-18* | 72% | 73% | 74% | 71% | 74% | 76% | 78% | 68% | 73% | 63% | 74% | 74% |
| Cervical Screening | *2017-18* | 76% | 78% | 79% | 77% | 79% | 80% | 82% | 72% | 80% | 72% | 77% | 79% |

## 14.5 Clinical Audits

*Performance against the measured care processes has worsened over time. This may be due to the fact these processes are not read coded as diligently as they were.*
*The NCN should continue to reflect on these measures and consider plans to address any worsening of performance.*

*Diabetes*

| | Diabetes Care Processes (All Eight Care Processes) | | |
|---|---|---|---|
| Cluster | 2015-16 | 2016-17 | 2017-18 |
| Caerphilly East | 51.04 | 45.54 | 38.37 |
| Caerphilly North | 48.12 | 42.66 | 41.86 |
| Caerphilly South | 47.51 | 42.38 | 45.43 |
| ABUHB | 50.93 | 47.29 | 46.20 |
| All Wales | 48.82 | 45.24 | 44.24 |

*Referrals to Structured Education*

| | Diabetes Care Processes (All Eight Care Processes) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2014 | | | 2015 | | | 2016 | | |
| Cluster | Newly Diagnosed | Offered % | Attended % | Newly Diagnosed | Offered % | Attended % | Newly Diagnosed | Offered % | Attended % |
| Caerphilly East | 222 | 81.08 | 1.35 | 215 | 80.00 | 1.40 | 220 | 79.09 | 0.45 |
| Caerphilly North | 301 | 83.06 | 0.66 | 278 | 67.27 | 0.36 | 197 | 64.47 | 0.00 |
| Caerphilly South | 175 | 82.29 | 2.86 | 167 | 74.85 | 1.20 | 194 | 75.77 | 0.52 |
| ABUHB | 2301 | 79.53 | 1.74 | 2170 | 70.05 | 0.78 | 2113 | 66.16 | 0.38 |
| All Wales | 12,035 | 73.50 | 1.35 | 12627 | 70.87 | 1.29 | 11401 | 67.84 | 1.89 |

*Referrals to Pulmonary Rehab 2015-17*

| | Question | | | | | |
|---|---|---|---|---|---|---|
| | Any MRC score recorded and referred for pulmonary rehabilitation in past 3 years | | | MRC score of 3-5 referred for pulmonary rehabilitation in the past 3 years | | |
| Cluster | Numerator | Denominator | Percentage | Numerator | Denominator | Percentage |
| Caerphilly East | 136 | 733 | **18.55** | 98 | 235 | **41.70** |
| Caerphilly North | 332 | 1301 | **25.52** | 243 | 483 | **50.31** |
| Caerphilly South | 212 | 835 | **25.39** | 166 | 290 | **57.24** |
| ABUHB | 2215 | 8816 | **25.12** | 1586 | 3013 | **52.64** |
| All Wales | 10179 | 47974 | **21.22** | 7621 | 15190 | **50.17** |

*Smoking and Behavioural Change Intervention – patients with COPD – 2015-17*

| | Question | | |
|---|---|---|---|
| | Current smokers (recorded as in the past 2 years) who received a behavioural change intervention and stop smoking drug prescription | | |
| Cluster | Numerator | Denominator | Percentage |
| Caerphilly East | 75 | 598 | **12.54** |
| Caerphilly North | 136 | 1088 | **12.50** |
| Caerphilly South | 64 | 628 | **10.19** |
| ABUHB | 1013 | 7292 | **13.89** |
| All Wales | 4383 | 35045 | **12.51** |

## 14.6 Enhanced Services

The enhanced services that are delivered across Caerphilly North NCN are listed below. There are no inequalities in access due to shortfall in delivery of enhanced services at present.

| Practice | Code | DES | | | | | | | | | | | NES | | | | | | | | | LES | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Pneumococcal | Childhood Imms | Learning Disability | Minor surgery - Fee A | Minor surgery - Fee B | Diabetes Gateway | Prophylaxix Antivirals Care Homes | Mental Health | CARE HOME | Anti-coagulation Level A | Anti-coagulation Level B | GLP1 Initiation | GLP1 Monitoring | Flu Immunisation | Unscheduled Immunisations | Non-Routine Imms | Substance Misuse | Shingles | Rota virus | Meningitis | Minor Surgery Non-Registered Patient | DOAC | DOAC Monitoring | Depo-Provera | Deppo Sayana Press | Contraceptive Implants (Nexplanon) | Depression/Lithium | IUCD Registered | IUCD - Non registered | Near Patient Testing | Extended Hrs | Denusomab | Pertussis | Gonadorelin/Zoladex |
| Bryntirion | W95068 | Y | Y | Y | Y | Y | | | | Y | | Y | | | Y | Y | | | Y | Y | Y | Y | | | Y | | Y | | Y | | Y | | | Y | Y |
| The Lawn | W95013 | Y | Y | Y | Y | Y | | Y | Y | Y | Y | | | | Y | Y | Y | | Y | Y | Y | | Y | | Y | | | Y | | | Y | | | Y | Y |
| Markham | W93010 | Y | Y | Y | Y | | Y | | | Y | | Y | | | Y | Y | | | Y | Y | Y | | Y | | Y | | | | | | Y | | | Y | Y |
| Meddygfa Cwm Rhymni | W95081 | Y | Y | Y | Y | Y | Y | | Y | Y | Y | | | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | | | | Y | Y | Y | Y | Y |
| Meddygfa Gelligaer | W95050 | Y | Y | Y | Y | Y | Y | | Y | | Y | | | | Y | Y | | Y | Y | Y | Y | | Y | | Y | | Y | Y | Y | | Y | Y | | Y | Y |
| Nelson | W95043 | Y | Y | Y | Y | Y | | Y | | | | Y | | | Y | Y | | | Y | Y | Y | | | Y | Y | | | | | | Y | | Y | Y | Y |
| Oakfield | W95065 | Y | Y | Y | Y | Y | Y | Y | | Y | Y | | Y | Y | Y | Y | Y | | Y | Y | Y | | Y | Y | Y | Y | Y | | Y | Y | Y | Y | Y | Y | Y |
| Pengam | W93614 | Y | Y | Y | Y | Y | | | | Y | Y | | | | Y | Y | | | Y | Y | Y | | | | Y | | | | | | Y | | Y | Y | Y |
| South St | W95078 | Y | Y | | | | Y | | | Y | | Y | | | Y | Y | Y | Y | Y | Y | Y | | | | Y | | | | | | Y | | | Y | Y |

## 14.7 Activity Benchmarking

### *14.7.1 GP Referrals*

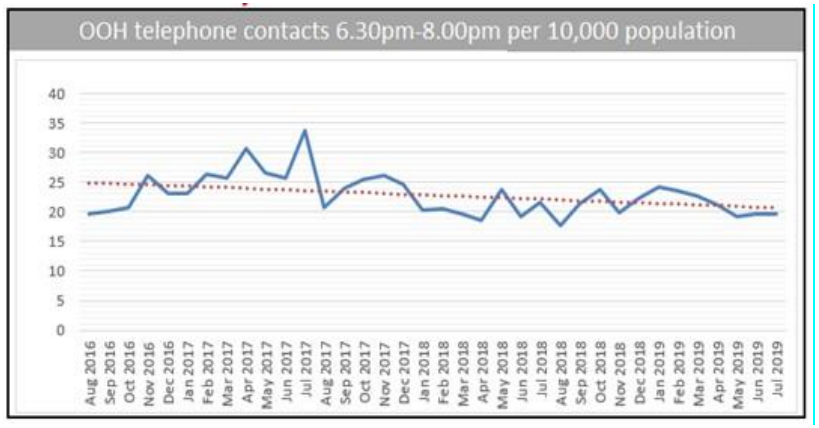
The table below outlines GP referrals for specialist consultation with any Welsh provider and also to radiology within ABUHB. Caerphilly North is performing relatively well in all elements when comparing to other clusters. The NCN should continue to monitor these metrics and should consider plans to address any change in performance. There is no particular issues for the cluster in any of the indicators reported when benchmarking to other areas.

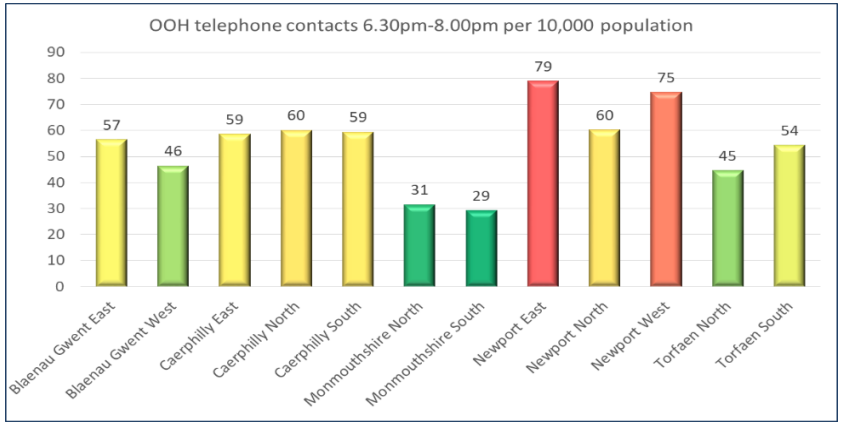
| NCN AREA | | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Planned Care (per 10,000 population)** | | | | | | | | | | | | | |
| GP referrals to non-surgical specialties (All Wales) | *Jan 2019 - Mar 2019* | 200 | 199 | 156 | 176 | 123 | 165 | 152 | 143 | 159 | 169 | 219 | 174 |
| GP referrals to Trauma & Orthopaedics (All Wales) | *Jan 2019 - Mar 2019* | 96 | 102 | 70 | 58 | 59 | 85 | 61 | 51 | 69 | 70 | 95 | 74 |
| GP referrals to surgical specialties (All Wales excluding T&O) | *Jan 2019 - Mar 2019* | 355 | 380 | 371 | 350 | 288 | 321 | 324 | 294 | 355 | 345 | 406 | 355 |
| GP referrals for MRI Knee (ABUHB) | *Apr 2019 - Jun 2019* | 7.74 | 7.56 | 7.29 | 5.71 | 6.20 | 8.85 | 11.63 | 5.19 | 5.25 | 5.81 | 8.27 | 9.07 |
| GP referrals for ultrasound shoulder (ABUHB) | *Apr 2019 - Jun 2019* | 3 | 3 | 3 | 2 | 2 | 3 | 3 | 4 | 1 | 3 | 2 | 2 |
| GP referrals for chest x-ray (ABUHB) | *Apr 2019 - Jun 2019* | 129 | 123 | 98 | 91 | 121 | 112 | 107 | 74 | 94 | 94 | 151 | 105 |
| GP referrals for sample testing MSU urine (ABUHB) | *Apr 2019 - Jun 2019* | 261 | 223 | 254 | 258 | 207 | 276 | 254 | 200 | 222 | 214 | 249 | 196 |

The benchmark information reported by the Division in relation to urgent care shows Caerphilly North as having a high level of inappropriate ED attendances at 61 per 10,000 population. There is a low number of occupied bed days following an emergency admission for adults aged over 65 years per 10,000 population.

| | NCN AREA | BG East | BG West | Caer East | Caer North | Caer South | Mon North | Mon South | Newp East | Newp North | Newp West | Torf North | Torf South |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Urgent Care** | | | | | | | | | | | | | |
| Referrals accepted by Rapid Response Services per 10,000 population | *Apr 2019 - Jun 2019* | 30.36 | 38.31 | 23.84 | 17.75 | 22.30 | - | - | 12.39 | 11.20 | 12.41 | 31.67 | 29.58 |
| Conveyances to hospital from residential homes | *Apr 2019 - Jun 2019* | 22 | 24 | 75 | 7 | 68 | 18 | 37 | 1 | 45 | 50 | 69 | 68 |
| Conveyances to hospital from nursing homes | *Apr 2019 - Jun 2019* | 28 | 40 | 36 | 15 | 37 | 33 | 28 | 17 | 24 | 54 | 3 | 15 |
| GP referrals to assessment units per 10,000 population | *Apr 2019 - Jun 2019* | 168.14 | 185.28 | 193.45 | 125.46 | 152.22 | 116.02 | 139.32 | 169.43 | 166.93 | 223.65 | 182.76 | 187.38 |
| Average days medically fit prior to 'complex' discharge from RGH & NHH | *Jun 2019* | 0.80 | 0.80 | 1.96 | 1.96 | 1.96 | 1.59 | 1.59 | 2.65 | 2.65 | 2.65 | 2.32 | 2.32 |
| Average length of stay in community hospitals | *Jun 2019* | 19 | 16 | 26 | 24 | 29 | 30 | 28 | 34 | 23 | 31 | 39 | 34 |
| Occupied bed days > 65 years of age following EMA per 10,000 population | *Apr 2019 - Jun 2019* | 7559 | 9052 | 6337 | 3256 | 7688 | 5244 | 5394 | 7212 | 7762 | 9563 | 8494 | 7556 |
| Inappropriate ED Attendances per 10,000 population | *Apr 2019 - Jun 2019* | 62 | 58 | 60 | 61 | 64 | 8 | 7 | 24 | 23 | 29 | 23 | 22 |

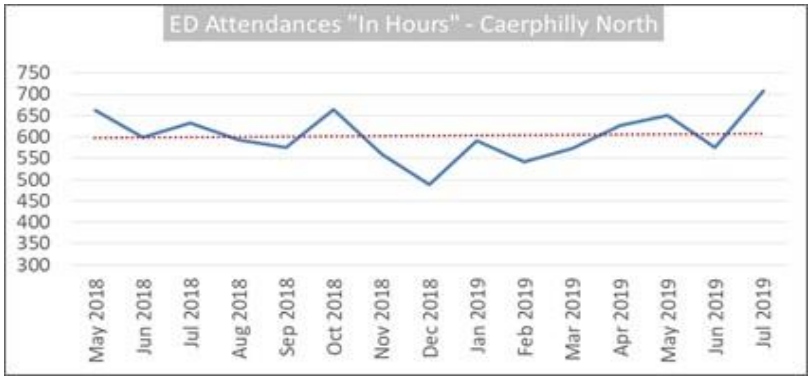
The graphs below show the Caerphilly North OOH Telephone Contacts between 6.30pm and 8.00pm and how the NCN compares to other Gwent cluster areas. Although a declining number which may indicate improved access within the in hours general practice service, the cluster when compared to other areas could consider ways to improve this further to become best in Gwent. Primary care access has been identified as a national issue and some of this data reflects issues with access. The NCN should continue to develop plans to improve access to primary care services.

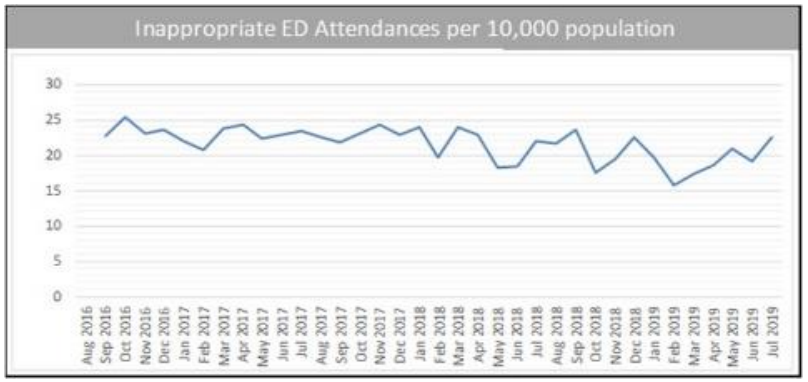


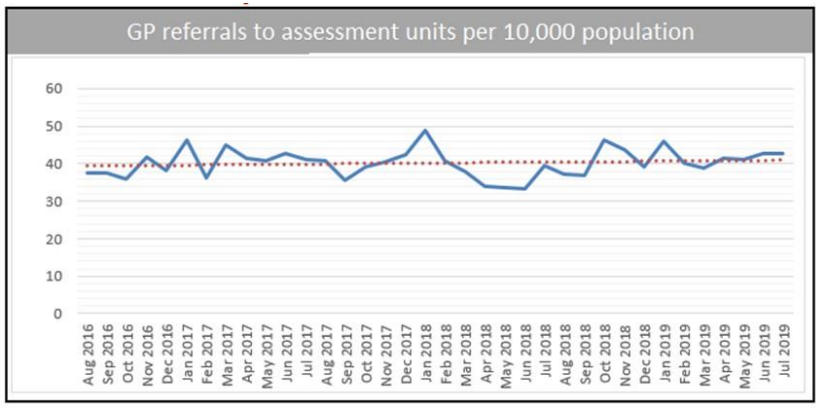
Between May 2018 and July 2019 there was an increase in the monthly reported new ED attendances at ABUHB sites on weekdays (Mon to Fri) between 8am and 8pm.

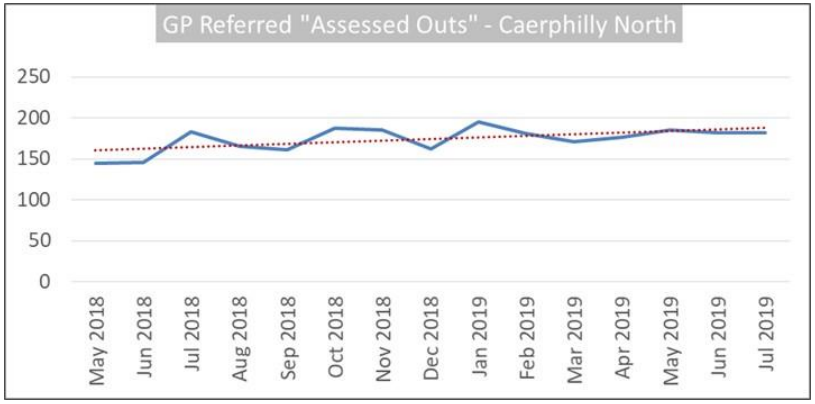
The graph "Inappropriate ED Attendances" is based on coding that denotes the Clinician's assessment as to whether the patient meets the BAEM (British Association for Emergency Medicine) Standards for Emergency Department Attendances determined by asking the following question:  In your clinical opinion does this patient meet the BAEM Standards for an Emergency Department?



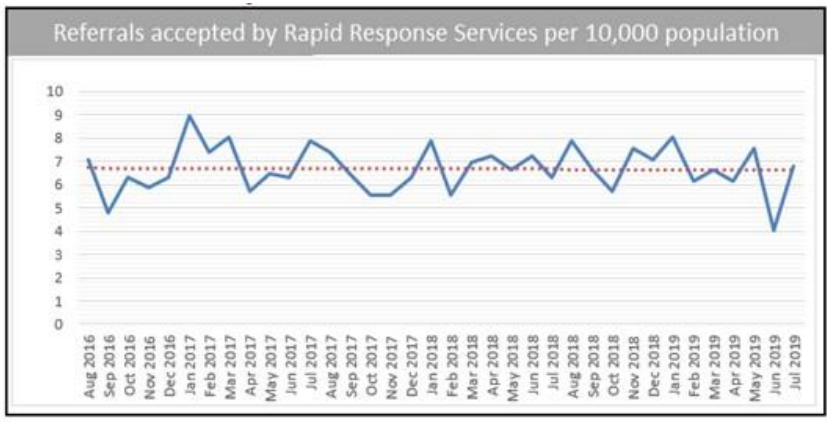



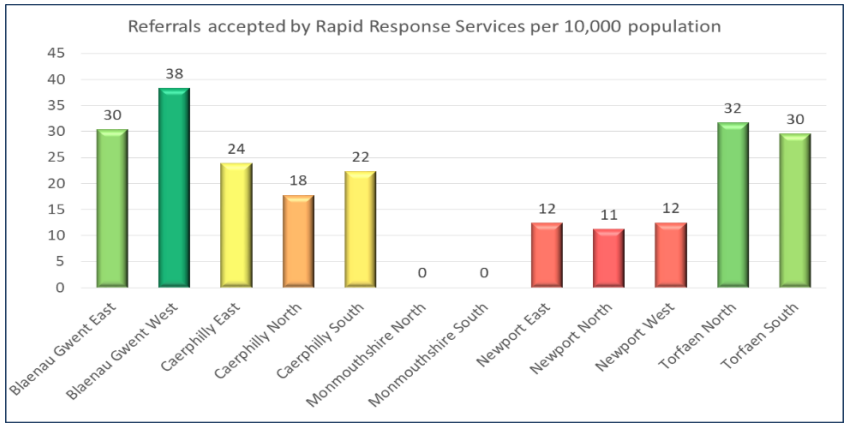

The number of GP referrals into ABUHB assessment units is on a general increasing trend of which those "assessed out" are also increasing.



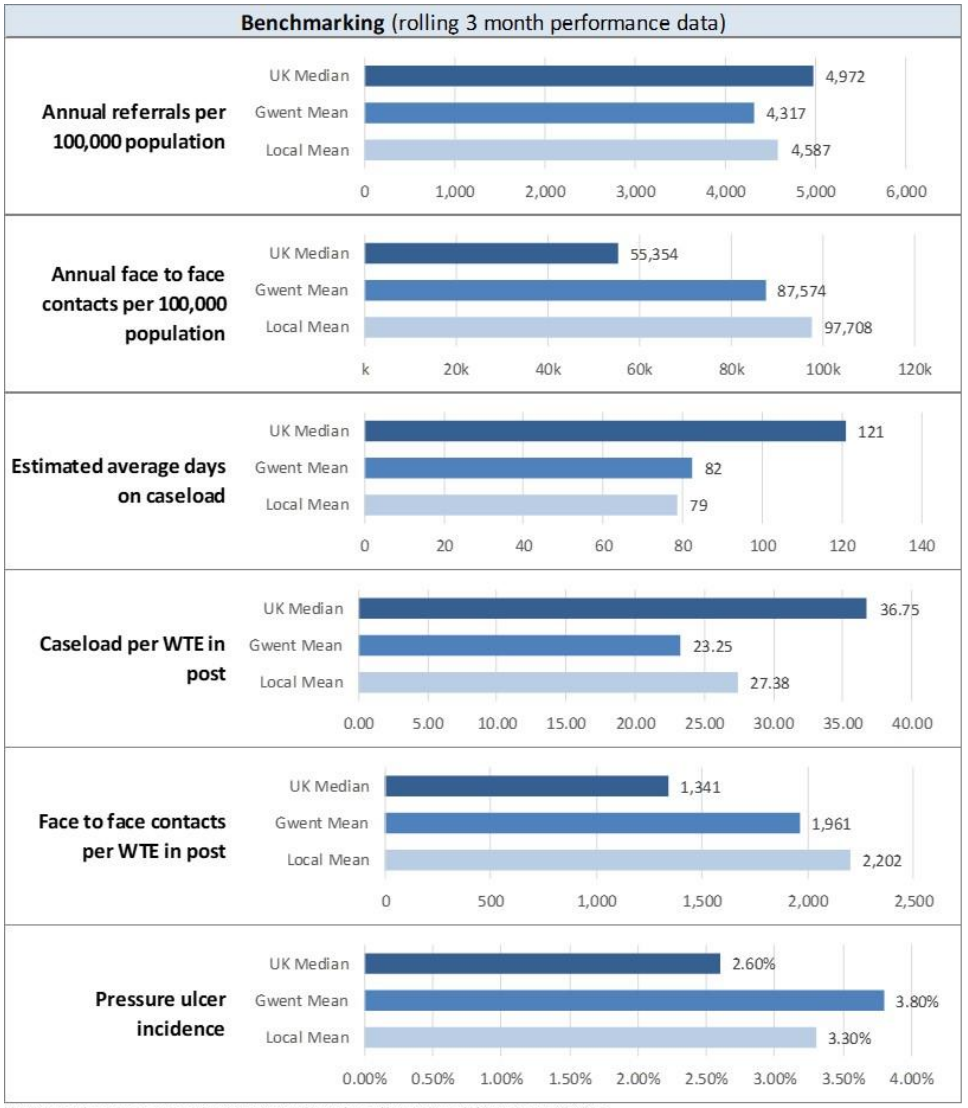
The Community Resource Team in Caerphilly are a core service that offers an alternative to hospital in the first instance by offering a rapid response to referred need. The number of accepted referrals to this service has remained on a relatively flat trend over the last year for Caerphilly North patients and would need to increase this number to meet the achievement of accepted referrals in Blaenau Gwent and Torfaen. This could be achieved through further development of a graduated care model within the borough as well as looking at individual practice level data to determine areas of lower referrals rates to understand reasons and encourage use of this service.




There are a total of 7 district nursing teams in Caerphilly borough and in the year to July 2019 they saw an average of 15415 face to face contacts with patients per month. There are three district nursing teams based in Caerphilly North. The service is currently geographically aligned and not GP practice aligned which can result in teams having to link with a higher than necessary number of GP practices. The complexity of caseload has over recent years increased and there is an increasing number of insulin dependent housebound diabetics requiring medication visits by the service which is putting additional pressures on the registered workforce.

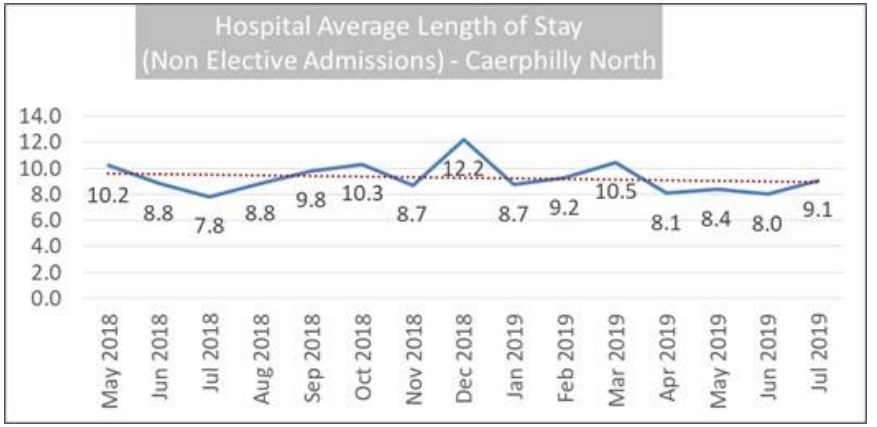
District Nursing Benchmarking - Caerphilly

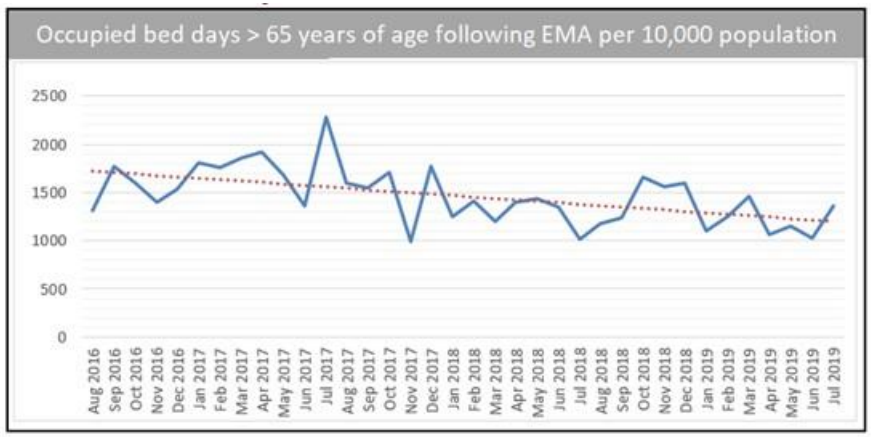


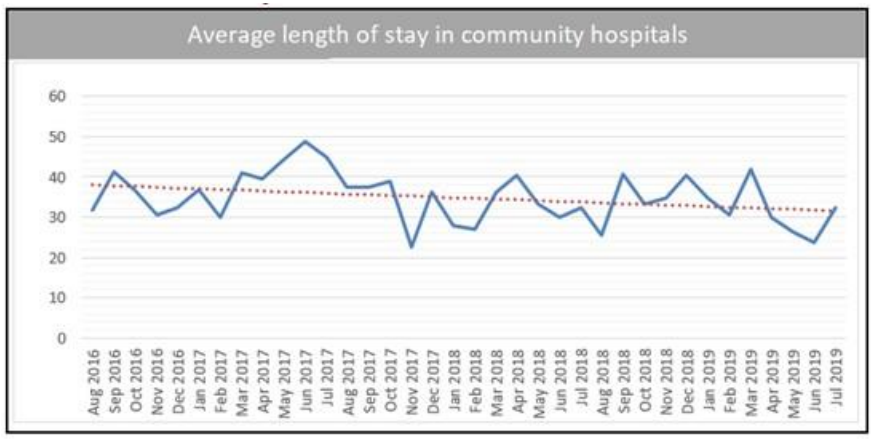

* UK Mean based on data submitted to NHS Benchmarking Network for period 2014/15

### *14.7.2 Hospital Based Services*

The Average Length of stay for patients registered with a Caerphilly North GP practice who were a non-elective admission for the period shown below was 9.2 days. It can be noted the average length of stay for patients in a community hospital setting is slightly reducing but that the occupied bed days for residents aged over 65 years following an emergency medical admission has increased.



# 15 Appendix 2

## 15.1 Health Resources Assessment

**Basline Data**

| Borough | | Practice List Size | | | Primary Care Staff in Post | | | | | Community Nursing Staff in Post | | | | | | CRT Staff in Post | | | Community Hospital Staff in Post | | | | | Total Staff in Post |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | Over 65 years of age | Percentage over 65 years of age | General Practitioners | Extended Roles *(employed by practice)* | General Dental Practices | Optometry Practices | Community Pharmacy Practices | Rapid Response Nursing * | Out of Hours Nursing ^ | Primary Care Specialist Nursing ^ | Chronic Conditions Nursing * | District Nursing | Healthcare Support Workers | Medical * | Social, Therapy & Other Profs * | Support Workers / Carers * | Medical * | Nursing * | Therapy * | Pharmacy * | Healthcare Support Worker * | |
| Blaenau Gwent | East | 33,719 | 6,582 | 20% | 11.88 | 3.15 | 8 | 3 | 7 | 4.19 | 1.49 | 1.26 | 0.00 | 20.24 | 3.23 | 0.93 | 4.39 | 12.22 | 1.58 | 22.92 | - | 0.47 | 19.53 | 125.47 |
| | West | 38,377 | 7,566 | 20% | 17.01 | 1.75 | 6 | 5 | 9 | 4.81 | 1.71 | 1.45 | 0.00 | 21.31 | 1.78 | 1.07 | 5.05 | 14.05 | 1.82 | 26.35 | - | 0.53 | 22.44 | 141.13 |
| Caerphilly | East | 65,790 | 12,754 | 19% | 28.01 | 3.96 | 11 | 8 | 14 | 5.41 | 2.88 | 2.45 | 0.71 | 21.88 | 3.67 | 1.43 | 9.50 | 14.31 | - | 22.06 | - | - | 21.81 | 171.08 |
| | North | 64,848 | 12,369 | 19% | 28.76 | 7.12 | 7 | 3 | 15 | 5.25 | 2.79 | 2.37 | 0.69 | 29.93 | 3.91 | 1.38 | 9.21 | 13.88 | - | 21.39 | - | - | 21.16 | 172.85 |
| | South | 56,473 | 10,636 | 19% | 32.89 | 0.00 | 13 | 5 | 14 | 4.51 | 2.40 | 2.04 | 0.59 | 22.65 | 3.17 | 1.19 | 7.92 | 11.94 | - | 18.39 | - | - | 18.19 | 157.89 |
| Monmouthshire | North | 52,841 | 13,721 | 26% | 28.64 | 2.78 | - | - | - | 3.18 | 3.10 | 2.63 | 2.87 | 25.77 | 2.97 | 0.57 | 8.72 | 18.29 | 1.25 | 17.44 | - | 0.11 | 15.09 | 133.40 |
| | South | 47,455 | 10,453 | 22% | 22.32 | 2.95 | - | - | - | 2.42 | 2.36 | 2.01 | 2.18 | 15.87 | 2.11 | 0.43 | 6.64 | 13.94 | 0.95 | 13.28 | - | 0.09 | 11.49 | 99.05 |
| Newport | East | 49,885 | 7,789 | 16% | 18.26 | 1.85 | - | - | - | 5.27 | 1.76 | 1.49 | 0.29 | 23.37 | 1.60 | 1.23 | 5.19 | 7.99 | 1.35 | 12.85 | - | 0.13 | 11.02 | 93.65 |
| | North | 57,029 | 11,091 | 19% | 24.54 | 2.44 | - | - | - | 7.50 | 2.51 | 2.13 | 0.42 | 15.59 | 1.52 | 1.75 | 7.38 | 11.37 | 1.92 | 18.30 | - | 0.19 | 15.69 | 113.25 |
| | West | 49,539 | 7,663 | 15% | 26.69 | 5.08 | - | - | - | 5.19 | 1.73 | 1.47 | 0.29 | 25.25 | 3.80 | 1.21 | 5.10 | 7.86 | 1.33 | 12.64 | - | 0.13 | 10.84 | 108.61 |
| Torfaen | North | 49,550 | 10,228 | 21% | 27.26 | 3.40 | - | - | - | 6.76 | 2.31 | 1.96 | 1.61 | 21.03 | 4.27 | 1.07 | 5.78 | 13.59 | 1.93 | 17.95 | - | 0.21 | 17.25 | 126.39 |
| | South | 45,964 | 8,843 | 19% | 24.44 | 1.94 | - | - | - | 5.84 | 2.00 | 1.70 | 1.39 | 20.57 | 4.77 | 0.93 | 5.00 | 11.75 | 1.67 | 15.52 | - | 0.19 | 14.91 | 112.61 |
| **Gwent Total** | | **611,470** | **119,695** | **20%** | **290.70** | **36.42** | **45.00** | **24.00** | **59.00** | **60.33** | **27.04** | **22.96** | **11.05** | **263.48** | **36.80** | **13.20** | **79.88** | **151.19** | **13.79** | **219.09** | **0.00** | **2.05** | **199.41** | **1,555.39** |

# 16 Appendix 3

**Baseline Data per 10,000 Population**

| Borough | | Practice List Size | | | Primary Care Staff in Post | | | | | Community Nursing Staff in Post | | | | | | CRT Staff in Post | | | Community Hospital Staff in Post | | | | | Total Staff in Post |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | Over 65 years of age | Percentage over 65 years of age | General Practitioners | Extended Roles *(employed by practice)* | General Dental Practices | Optometry Practices | Community Pharmacy Practices | Rapid Response Nursing * | Out of Hours Nursing ^ | Primary Care Specialist Nursing ^ | Chronic Conditions Nursing * | District Nursing | Healthcare Support Workers | Medical * | Social, Therapy & Other Profs * | Support Workers / Carers * | Medical * | Nursing * | Therapy * | Pharmacy * | Healthcare Support Worker * | |
| Blaenau Gwent | East | 33,719 | 6,582 | 20% | 3.52 | 0.93 | 2.37 | 0.89 | 2.08 | 1.24 | 0.44 | 0.37 | 0.00 | 6.00 | 0.96 | 0.28 | 1.30 | 3.62 | 0.47 | 6.80 | - | 0.14 | 5.79 | 37.21 |
| | West | 38,377 | 7,566 | 20% | 4.43 | 0.46 | 1.56 | 1.30 | 2.35 | 1.25 | 0.45 | 0.38 | 0.00 | 5.55 | 0.46 | 0.28 | 1.32 | 3.66 | 0.47 | 6.87 | - | 0.14 | 5.85 | 36.78 |
| Caerphilly | East | 65,790 | 12,754 | 19% | 4.26 | 0.60 | 1.67 | 1.22 | 2.13 | 0.82 | 0.44 | 0.37 | 0.11 | 3.33 | 0.56 | 0.22 | 1.44 | 2.18 | - | 3.35 | - | - | 3.32 | 26.00 |
| | North | 64,848 | 12,369 | 19% | 4.43 | 1.10 | 1.08 | 0.46 | 2.31 | 0.81 | 0.43 | 0.37 | 0.11 | 4.62 | 0.60 | 0.21 | 1.42 | 2.14 | - | 3.30 | - | - | 3.26 | 26.65 |
| | South | 56,473 | 10,636 | 19% | 5.82 | 0.00 | 2.30 | 0.89 | 2.48 | 0.80 | 0.43 | 0.36 | 0.11 | 4.01 | 0.56 | 0.21 | 1.40 | 2.11 | - | 3.26 | - | - | 3.22 | 27.96 |
| Monmouthshire | North | 52,841 | 13,721 | 26% | 5.42 | 0.53 | - | - | - | 0.60 | 0.59 | 0.50 | 0.54 | 4.88 | 0.56 | 0.11 | 1.65 | 3.46 | 0.24 | 3.30 | - | 0.02 | 2.86 | 25.25 |
| | South | 47,455 | 10,453 | 22% | 4.70 | 0.62 | - | - | - | 0.51 | 0.50 | 0.42 | 0.46 | 3.34 | 0.44 | 0.09 | 1.40 | 2.94 | 0.20 | 2.80 | - | 0.02 | 2.42 | 20.87 |
| Newport | East | 49,885 | 7,789 | 16% | 3.66 | 0.37 | - | - | - | 1.06 | 0.35 | 0.30 | 0.06 | 4.69 | 0.32 | 0.25 | 1.04 | 1.60 | 0.27 | 2.58 | - | 0.03 | 2.21 | 18.77 |
| | North | 57,029 | 11,091 | 19% | 4.30 | 0.43 | - | - | - | 1.32 | 0.44 | 0.37 | 0.07 | 2.73 | 0.27 | 0.31 | 1.29 | 1.99 | 0.34 | 3.21 | - | 0.03 | 2.75 | 19.86 |
| | West | 49,539 | 7,663 | 15% | 5.39 | 1.03 | - | - | - | 1.05 | 0.35 | 0.30 | 0.06 | 5.10 | 0.77 | 0.24 | 1.03 | 1.59 | 0.27 | 2.55 | - | 0.03 | 2.19 | 21.92 |
| Torfaen | North | 49,550 | 10,228 | 21% | 5.50 | 0.69 | - | - | - | 1.36 | 0.47 | 0.40 | 0.32 | 4.24 | 0.86 | 0.22 | 1.17 | 2.74 | 0.39 | 3.62 | - | 0.04 | 3.48 | 25.51 |
| | South | 45,964 | 8,843 | 19% | 5.32 | 0.42 | - | - | - | 1.27 | 0.43 | 0.37 | 0.30 | 4.48 | 1.04 | 0.20 | 1.09 | 2.56 | 0.36 | 3.38 | - | 0.04 | 3.24 | 24.50 |
| **Gwent Total** | | **611,470** | **119,695** | **20%** | **4.75** | **0.60** | **0.74** | **0.39** | **0.96** | **0.99** | **0.44** | **0.38** | **0.18** | **4.31** | **0.60** | **0.22** | **1.31** | **2.47** | **0.33** | **3.58** | **0.00** | **0.05** | **3.26** | **25.44** |