Our aims are to:-

- Understand & highlight actions to meet the needs of NCN population
- Ensure sustainability of core GP services & access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements
- Ensure that patient's planned care needs are met through prudent care pathways, facilitating rapid, accurate diagnosis & management & minimising waste/ harms. To highlight improvements for primary care/secondary care interface.
- Provide high quality, consistent care for patients presenting with urgent care needs & support the continuous development of services to improve patient experience, coordination of care & the effectiveness of risk management. To address winter preparedness & emergency planning.
- Deliver consistent, effective systems of Clinical Governance & Information Governance.
- Address other Locality specific issues

Aneurin Bevan University Health Board

Delivering Care Closer to Home

Caerphilly North Neighbourhood Care Network Plan – 2018/19

What are we doing?

- Provide easily accessible "place based" health and social care to the citizens of Caerphilly North.
- Review and adapt the current model of integrated services based at Rhymney Integrated Health & Social Care Centre
- Work with providers to ensure health and social care services are sustainable.
- Continue developing primary care teams including traditional GP, DN and HV roles as well as any new roles. There should be excellent communication within the team with minimal or no "hand-offs".
- Utilize new primary care roles to help facilitate accessible health care. Where appropriate, these should be part of "place based working". Roles could include; Social prescriber / Practice based pharmacist / First contact physiotherapist / Mental health worker / Primary care audiologist / Primary care paramedic / Primary care OT/ Social worker.
- Ensure appropriate utilization of local services such as community pharmacy and 3rd sector services
- Ensure appropriate utilization and easily accessibility of specialist roles such as Diabetic Specialist Nurse, Heart Failure Nurse, and Palliative Care Nurse Specialist.
- Utilize appropriate preventative services to keep citizens well including influenza immunization / childhood immunization / smoking cessation services / weight management services / exercise schemes
- Ensure appropriate utilization of current high quality health and social care estate.
- Work to reduce antibiotic usage

How are we delivering change?

- Work with partners to establish wrap around health and wellbeing services
- Work with Local Authority in relation to estate prioritisation & rationalisation
- Use of preventative, early opportunity and self-management approaches
- **Integrated Approach on Caerphilly North NCN Footprint**
- Use prudent healthcare pathways to improve planned care
- Recruit, train & educate our workforce to ensure needs of population met
- Use Multidisciplinary Team to undertake active signposting

"Enablers"

- Technology
- Skilled Workforce
- Partnership Working
- Financial Resource
- Fit for Purpose Estate

How will we know if we have made a difference?

Primary Care / NCN Dashboard Measure Monitoring