



Neighbourhood Care Network Integrated Medium Term Plan 2020-2023

Caerphilly South

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Executive Summary

This Integrated Medium Term Plan (IMTP) 2020 to 2023 describes the vision for Caerphilly South 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 South locality aims to reduce demand on GP services by recruiting to the wider healthcare team, along with upskilling existing staff. The introduction of new roles to provide this prudent healthcare model, various funding routes will need to be explored to achieve these goals. Appropriate utilisation of social prescribing is planned in order to alleviate Primary care pressures.

With a significant investment in the Primary Care estate in Caerphilly South we also aim to develop 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.

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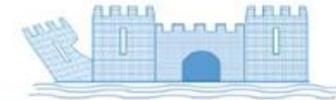
Plan on a Page

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 South Neighbourhood Care Network Plan – 2018/19



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 South 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;

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- 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 South NCN to have received funding to enable us to test components of the new model including;

- Appointment of two Practice Based Pharmacists (1.5WTE), covering practices within Caerphilly South NCN
- Establishment of a First Contact Physiotherapy Service
- Establishment of a Community Phlebotomy Service utilising primary care cluster funding
- Establishment of a Complex Wound Care Service

During 2020-2023, opportunities ahead for Caerphilly South include;

- Development of the Llanbradach - 2 Surgery building, planned to be complete in late 2020
- 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

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 South 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 –

<http://your.caerphilly.gov.uk/publicservicesboard/sites/your.caerphilly.gov.uk/publicservicesboard/files/AssessmentofLocalWellbeing2017.pdf>

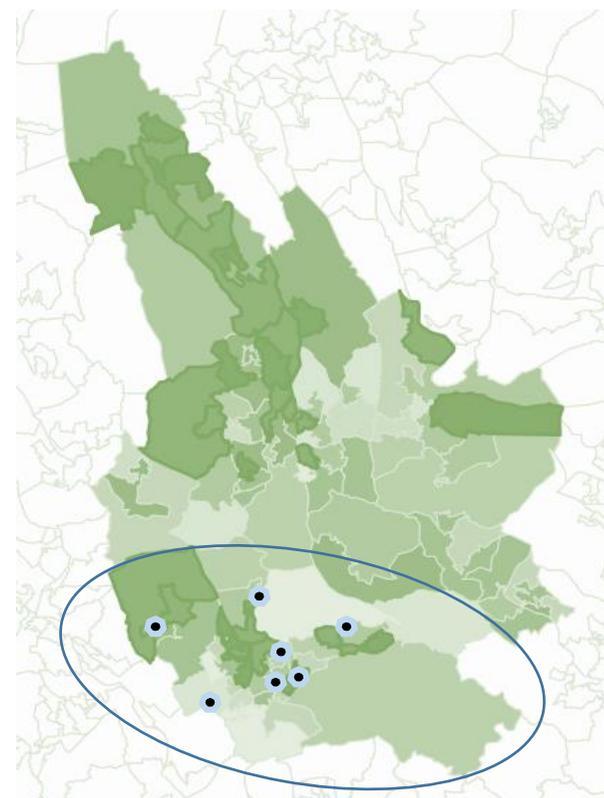
Caerphilly South NCN has a practice population of 56,463 and consists of the electoral wards of Aber Valley, Bedwas Trethomas and Machen, Llanbradach, Morgan Jones, Penyrheol, St James and St Martins.

The NCN has good road and rail transport links with some areas having easy access to the M4 and some areas are only a short distance from Cardiff which brings opportunity for good work and social links.

There are varying areas of deprivation within Caerphilly South NCN and the map opposite shading indicates levels of deprivation (the darker the shade the greater the deprivation). The areas within Caerphilly South indicated as having higher levels of deprivation include Lansbury Park, Graig Y Rhacca, elements of Penyrheol and Aber Valley

The cluster has 7 GP practices with some of these having branch surgeries also. The main practice is indicated with blue dot on map. These are Aber Medical Centre, Courthouse Medical Centre, Lansbury Surgery, Nantgarw Rd Medical Centre, Tonyfelin Medical Centre, Ty Bryn Surgery and The Village Surgery.

There are 18 primary schools (15 English, 3 Welsh), 3 English medium comprehensive schools and the lower school of 1 Welsh medium comprehensive.



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The proportion of the population aged 65 years and over was 15.5% for the community area as a whole, lower than the county borough average of 16.5% and lower than the Wales average of 18.3%. The proportion ranged from 12.8% in Aber Valley ward to 17.6% in St Martins ward.

The proportion of males aged 16-74 years who were long-term sick or disabled was higher than the county borough average of 8.6% in two out of seven wards in the community area – Penyrheol ward (11.6%) and Aber Valley ward (9.4%). Every ward apart from St Martins ward (4.4%) had a higher proportion than the Wales average of 6.5%. The proportion ranged from 4.4% in St Martins ward to 11.6% in Penyrheol ward, with an average for the community area as a whole of 7.6%.

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 three of the seven wards in the community area – St James ward (9.9%), Aber Valley ward (9.1%) and Llanbradach ward (8.2%). Only St Martins ward (3.4%) and a percentage lower than the Wales average of 6.0%. The proportion ranged from 3.4% in St Martins ward to 9.9% in St James ward, with an average for the community area as a whole of 7.2%.

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.

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- 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:

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- 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 South 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 Alun Edwards	NCN Lead	GP Partner, Ty Bryn Surgery
Alison Gough	Head of Service	ABUHB
Eira Turner	Assistant Head of Service	ABUHB
Jonathan Lewis	Network & Community Service Manager	ABUHB
Stella Montgomery	Network & Community Services Support Officer	ABUHB
GP Practice representation from all 7 Caerphilly South practices	GP & Practice Manager	Aber Medical Centre, Courthouse Medical Centre, Lansbury Surgery, Nantgarw Rd Medical Centre, Tonyfelin Medical Centre, Ty Bryn Surgery, Village Surgery
	Team Leader	District Nursing
	Team Leader	Health Visiting
	Service Manager	Local Authority - 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

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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 Alun Edwards	NCN Lead
Jonathan Lewis	Network & Community Services Manager
Stella Montgomery	Network & Community Support Support Officer
Deborah Harrington	Primary Care Contracting Manager
Angela Dawn Williams	Primary Care Service Development Manager

2.3.3 Frequency of Meetings

The Caerphilly South 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.

2.3.4 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 South.

2.3.5 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.

2.3.6 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

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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 South 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.

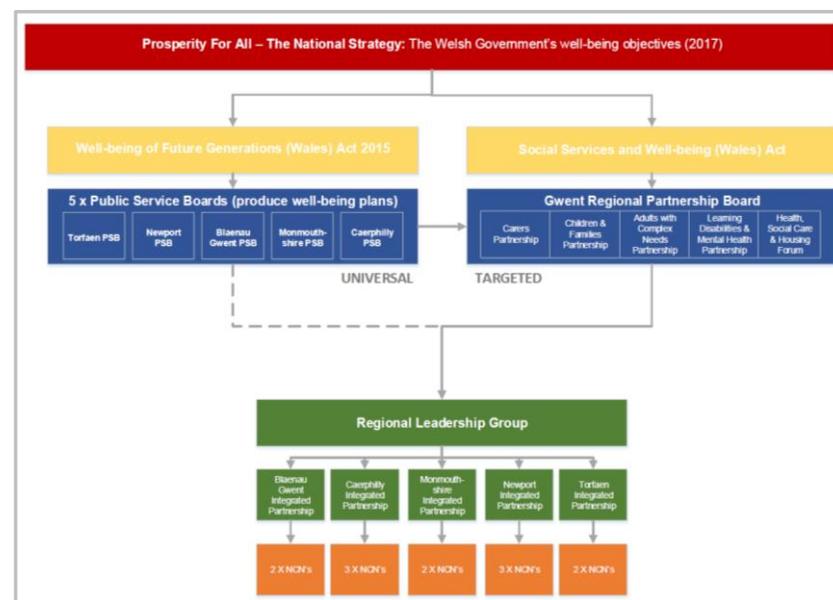
2.3.7 Reporting Framework

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.

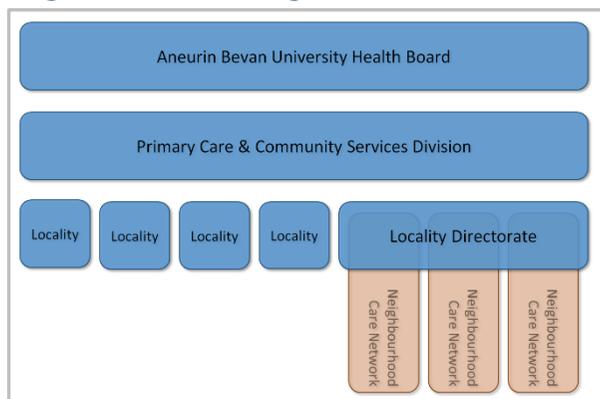
The NCNs are an operational arm of this framework, and as such have the responsibility of implementing national and regional strategy through local actions. However, the NCNs are also crucial in prioritising the implementation of these strategies depending on local circumstances.

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.



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2.3.8 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'. The plan sets out how services will be planned, delivered and designed on a regional, local authority and NCN footprint to provide more integrated care closer to home.

To deliver more care closer to home, that is seamless for patients, carers and their families the emphasis has been placed on 'service transformation' and service redesign' to create more integrated models of care including mental health, primary and community care and wellbeing services. Through the Welsh Government Transformation Fund and the Integrated Care Fund (ICF) additional resources have been secured to deliver new models of care including compassionate communities, Home First and Integrated Wellbeing Networks, and delivery is now underway and reflected in the NCN IMTP.

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. On a local authority footprint Integrated Services Partnership Boards will translate the regional vision into local delivery and support NCN to develop more integrated services closer to home, the NCN IMTP sets out this activity in detail and will align with both the Health Board IMTP and Gwent Area Plan.

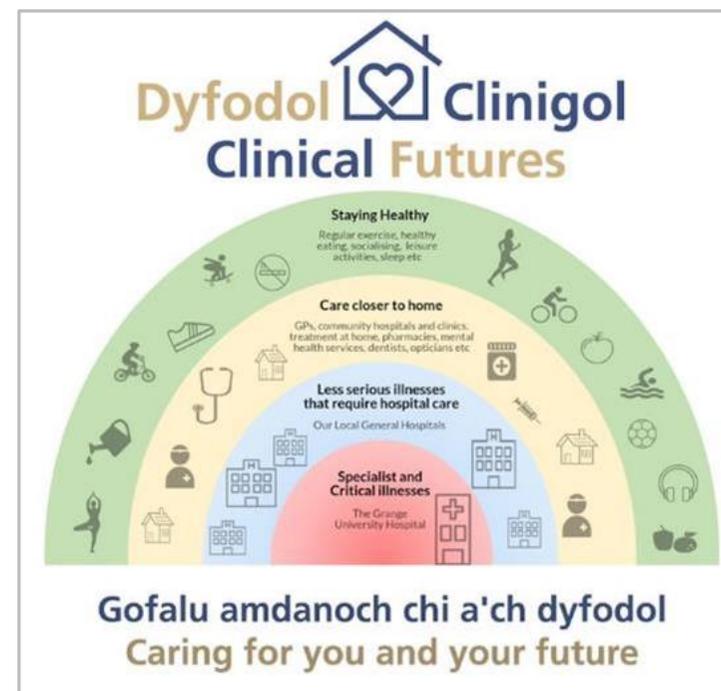
3.2 Clinical Futures Strategy

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 focused 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.

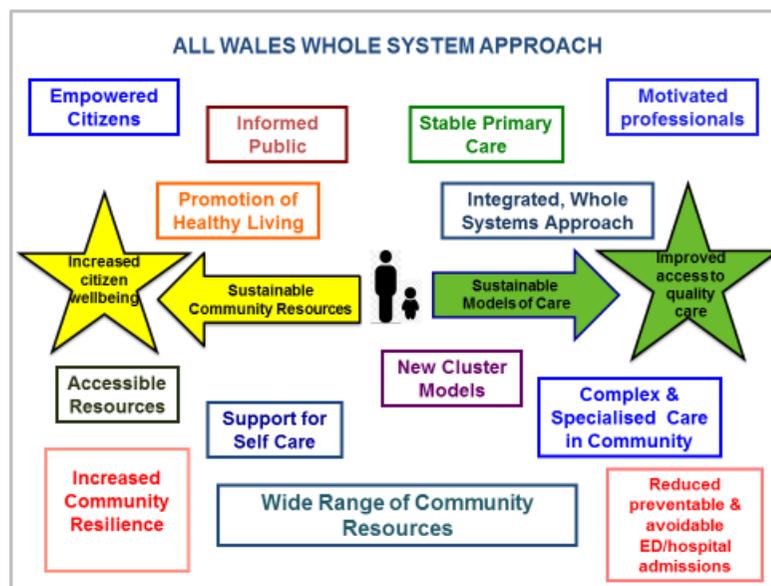


- **Standardised, best practice** processes and care pathways.
- **Sustainable** with efficient use of resources.
- **Prudent** by design, following NHS Wales's prudent healthcare principles.

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

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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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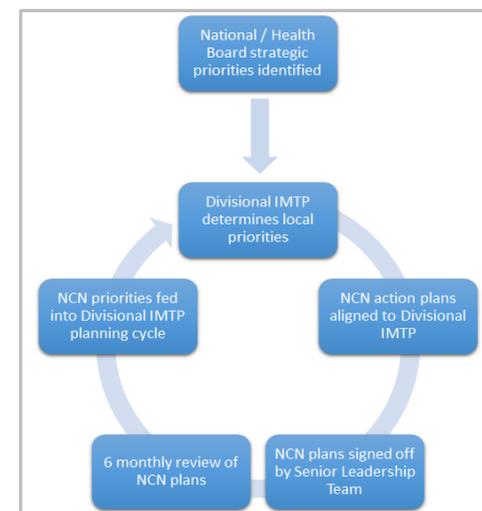
6) Digital, Data & Technology	Digital Technology Group	Utilising new developments in technology to improve communication between professionals, reduce workload for staff and enhance care and the experience of patients.	WCCIS, GP System Migration, electronic referrals, virtual consultations, electronic 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 work stream 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
<ul style="list-style-type: none"> • Increased funding for 1.5WTE Practice Based Pharmacists • Funded Practice Based Social Workers • First Contact Physiotherapy Service • Continued funding of the NCN developed Complex Wound Care Service • Multi services workshop for the provision of a single point of access for Primary Care Mental Health • Reviewed the prescribing budget on a regular basis, appropriate switches and substitutions have been made. • Dedicated session for a Sustainability Workshops • Caerphilly wide NCN event held for Voluntary Sector organisations 	<ul style="list-style-type: none"> • Pharmacists have been able to take on many of the medication reviews and prescribing issues improving access to GP services. • 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 • New service developed during 2018/19 providing first contact physiotherapy assessments within GP practices across Caerphilly • The service continues to increase the numbers of complex wounds being actively managed within the primary care setting in the Caerphilly South NCN area and reduces secondary care appointments. • SPACE service developed and rolled out across Caerphilly NCNs. • 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 • Open forum for Practices enabled shared issues and potential inter practice working to be discussed. • 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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<ul style="list-style-type: none"> • NCN funding provided for dermatoscopes and training for practices across the NCN • Improved Access - NCN funding for QR Information Pods and Care Navigation training • Funded installation of patient calling systems and waiting room BP Monitors in Practices. • Constipation Pathway developed with Health Visiting • Period Dignity initiative developed by Local Authority and disseminated across services via the NCN • Funding for Bowel Screening pilot. • Established Smoking Cessation Champions in each Practice. • Established annual flu planning process. • Established Care Navigation in Practices and community settings to enable access to services without seeing a GP. • Community Connectors. 	<ul style="list-style-type: none"> • GPs upskilled to improve the quality of referrals to secondary care dermatology. • Introduced QR code patient information pods to practice waiting rooms • Improved patient experience when attending appointments at practices • 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. • Sanitary products are freely available at Health and Local Authority venues, Sports Centres, Schools and Food Banks via this sustainable scheme • Increased uptake in responses from residents was recorded. • Identified member of staff on site to direct residents to services. • Effective process operating over past three years to ensure readiness for flu season. • Five pathways (First Contact Physiotherapy, Minor Injuries, Eye Services, Emergency Dental, Pharmacy) in operation. • Connectors attend NCN meetings to offer advice and support on services availability to residents.
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<ul style="list-style-type: none">• Dedicated sessions at NCN Meetings to provide guidance/information or raise awareness of.....	<ul style="list-style-type: none">• 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 South NCN
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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 South 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 is lower than some other NCNs. Use of My Health On line 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 South NCN are currently 57% compliant in the 5As to Access. There are currently 4 practices achieving 5As, 2 practices achieving 4As and 1 practice achieving 3As. 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 (DTCs)

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

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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 South does not have particularly high rates for smoking and low physical activity in comparison to other NCNs. Obesity rates are reasonably high. Following a large engagement event and discussion at NCN meetings, members of the NCN continue to work to tackle smoking rates and also to address rates of obesity and low physical activity together with other partners.

Caerphilly South NCN has always tried to maximize uptake of preventative services. Uptake of childhood immunizations, influenza immunizations and screening services are better than many NCNs. Nevertheless Caerphilly South will continue to work closely with GP practices and other partner organisations to maximize uptake where possible.

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.

Mental health provision continues to be an area where all partners feel that there are lack of services despite previous investment. Partners feel that services are not always joined up and easy to access. The potential of future secured funding opportunities would offer Caerphilly South the opportunity to emulate the success of the Mental Health Practitioner pilot in Caerphilly North NCN. Thus providing an in-house GP practice interface with Mental Health services.

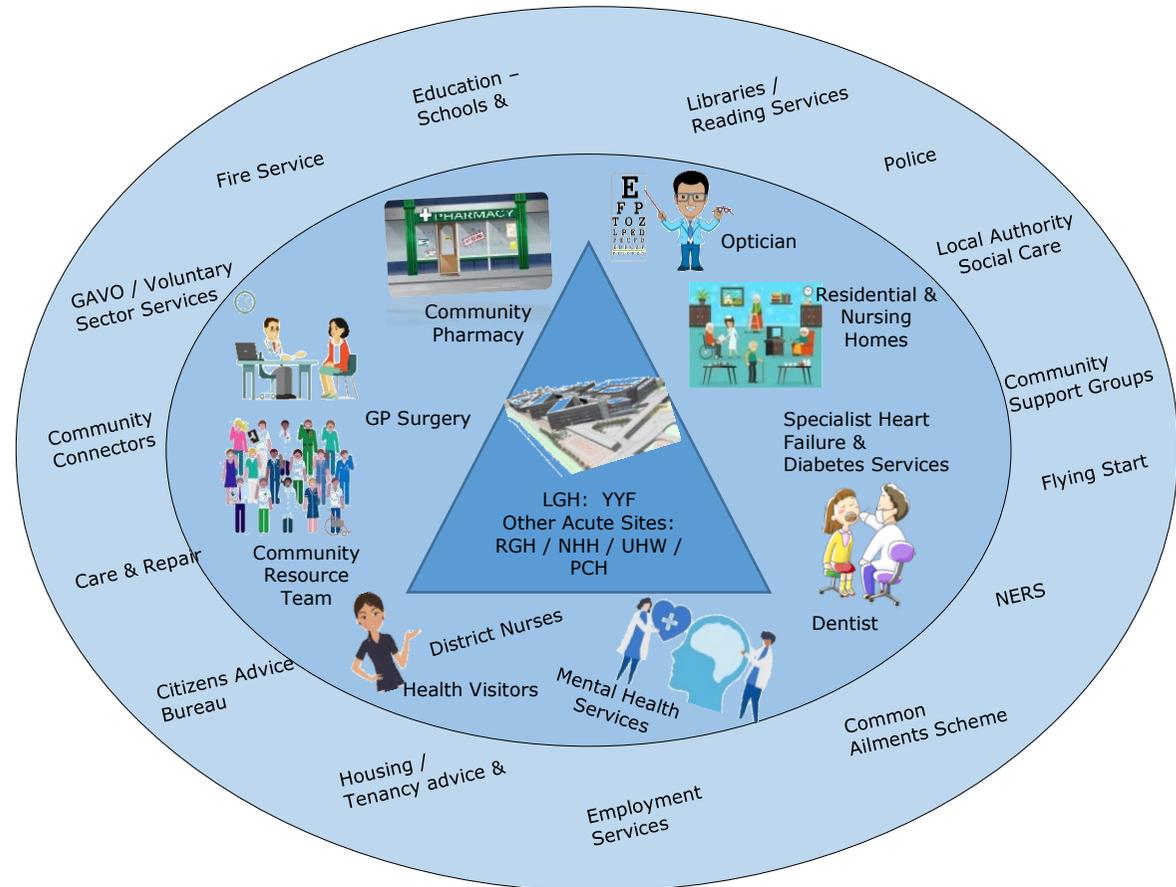
When asked to comment on specific issues partners mentioned that ambulance delays, particularly when the patients are in the GP surgery is a recurring theme. It is planned to invite a representative from WAST along to an NCN Cluster meeting during 2019/20 to discuss options to improve on the current issue.

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 such as regular attendance the Aber Valley Community Partnership and local estate development meetings. Open events have also been held with members of the Caerphilly Locality Team attending to discuss the Llanbradach development with local citizens. 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.



7 Estates Profile

7.1 Estate Profile

There are seven main surgery sites plus 6 branch surgeries within the Caerphilly South footprint.

Main Surgeries

- Three of the main sites are modern fit for purpose estate.
- Two of the seven are not fit for purpose and require high priority attention to address this. Of the two, one scheme is scheduled to commence a new build in November 2019 and scoping of potential sites for the other is ongoing and options being considered.
- 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.

Branch Surgeries

- One is a purpose built modern facility that is fit for purpose, the remaining 4 are requiring immediate attention.
- One is being addressed by the commencement of a new build facility due to complete late summer 2020
- One will be incorporated in a new site for the main practice, however the remainder will need case by case attention to address and resolve issues.
- There is one branch site that is need of some refurbishment and this will be discussed with the host practice at their annual review.

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 –

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Two place model scenario –



This scenario fits well with the team make up of district nursing principles but in terms of overall list size population for the “hub” model this is at the NCN would consider to be the upper limit.

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

As at September 2019 there are no expressions of interest from independent contractors in relation to MIGs however the NCN Lead with the support of the management team to continue to encourage uptake where need is evident. This is in relation to main and branch surgery sites. Awaiting responses to request for proposals for 2020/21.

7.3.2 Minor Improvement Grants

There has been an expression of interest from one main practice to increase office accommodation, however approval of this will be dependent on the implementation of scan and store at the practice. A formal application is awaited. There have been no other expressions of interest from independent contractors in relation to MIGs, however the NCN Lead with the support of the management team to continue to encourage uptake where need is evident. This is in relation to main and branch surgery sites. Awaiting responses to request for proposals for 2020/21.

7.3.3 Capital Pipeline Funding

Potentially for development of Health & Wellbeing Hub/Spoke within the Aber Valley being explored.

8 Workforce Profile

8.1 Current Workforce Profile

Primary Care

Role	No of staff (WTE) in post across Caerphilly South NCN
GPs Principle	38
GPs Salaried	4
GPs Registrar	3
Extended Roles	1
ANP	2
Extended Role Specialist Nurse	1
Practice Nurses	15
GP Practice - Health Care Support Workers	9
GP Practice - Admin/Clerical	97
GP Practice - Other Non-clinical	13
General Dental Practices	7
Optometry Practices	5
Community Pharmacists	14
NCN Practice Based Pharmacies	1.5
NCN First Contact Physiotherapists	1

District Nursing

Role	No of staff (WTE) in post across Caerphilly South NCN
District Nurses	23.32
Health Care Support Workers (DN Team)	3.17
Admin/ Clerical (DN Team)	1.47

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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 South
Community Pharmacies	15
Community Dental Practices	8
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.

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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 i.e. 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:

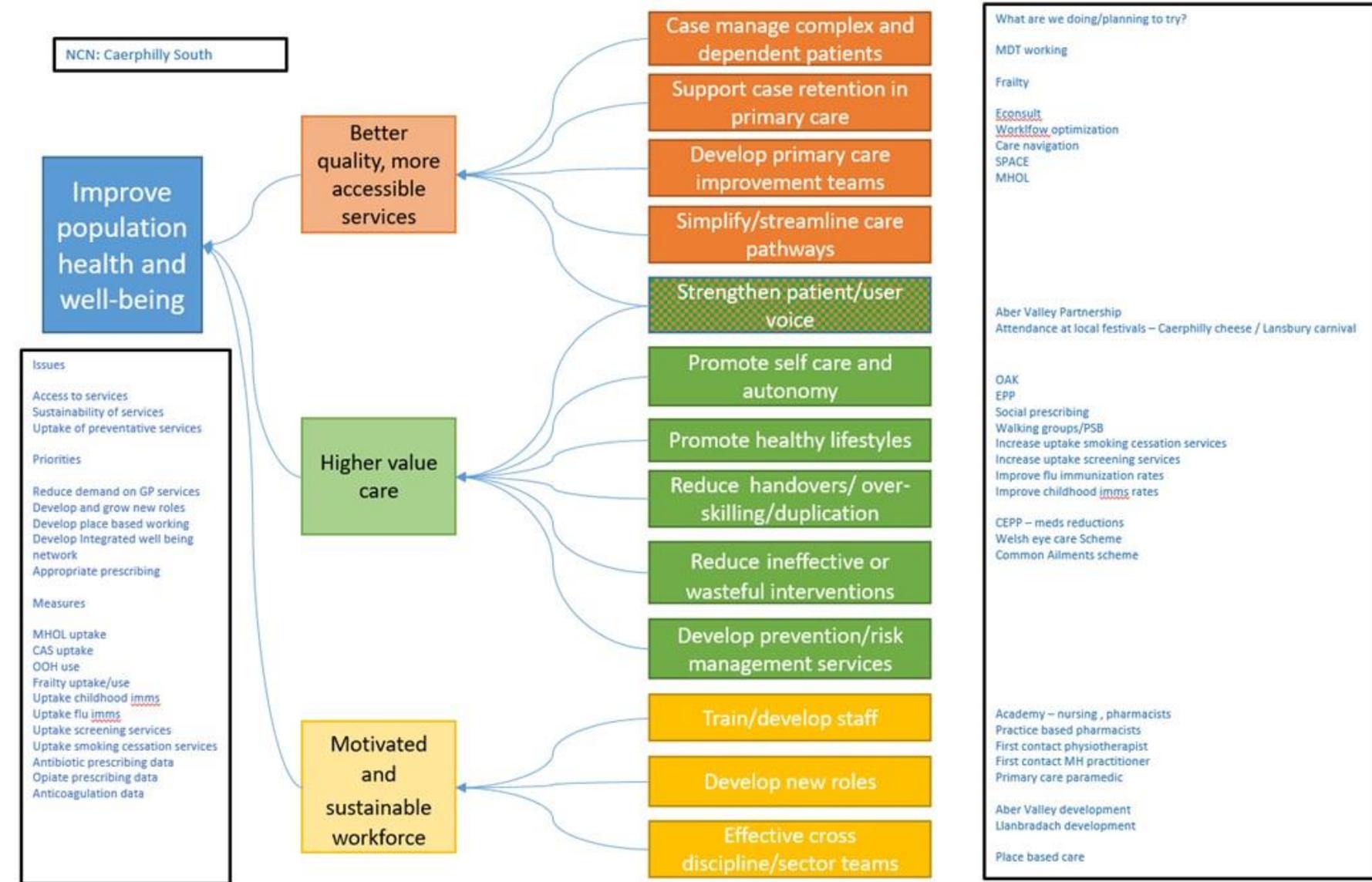
- Nutrition Skills for Life - Community Food and Nutrition Skills Course to provide training for GP practice staff to provide Foodwise courses to tackle obesity and promote healthy eating/living for patients living within Caerphilly South NCN
- Making Every Contact Count (MECC) Training for GP practice and partnership organisations staff
- Mentorship for Practice Based Pharmacists
- Continued 'Wound Care' training/guidance for associated Practice Nurses within Caerphilly South NCN
- Various training opportunities that arise for upskilling GP practice staff both clinical and non-clinical will be supported via NCN funding if deemed appropriate
- Group consultation training for Practice Nurses to deliver chronic disease management at scale within practices

9 Opportunities and Challenges for 2020-2023

9.1 SWOT Analysis

Strengths	Weaknesses
<ul style="list-style-type: none"> • Good working relationships across the NCN membership • Strong focus on innovation/development of services • Committed NCN Leadership and Support Team • Clear direction via the NCN plan on a page of what the priorities are and how these can be delivered via integrated working • NCN provides a conduit for two way partnership working 	<ul style="list-style-type: none"> • NCN budget mostly committed with very little remaining for development within the NCN • Annual variability of funding e.g. CEPP or loss of Pharmacists can impact on spending timescales • Limited resource from management team – spread thinly and not able to fulfil development work in timely manner • Organisational barriers can make integration difficult • Prescribing of opiates
Opportunities	Threats
<ul style="list-style-type: none"> • Expand and develop extended roles within GP practices • Explore potential funding sources • 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 • Closer collaboration between practices • Improve the uptake of preventative services • Introduce Telehealth option for patients & practices 	<ul style="list-style-type: none"> • Initiatives developed within the NCN being taken down due to lack of sustainable funding or not being taken on by core HB funding. • Engagement from all services to develop the place based care model • Some roles can be difficult to recruit into. • Loss of engagement when pilots/initiatives are discontinued e.g. Practice Based Social Workers

9.2 Driver Diagrams



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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	<p>Improve uptake of stop smoking services</p> <p>Develop services to make a positive interventions for obese citizens in Caerphilly</p> <p>Promote and develop services for patients who do not exercise</p> <p>Maximize uptake of influenza vaccination</p> <p>Maximize uptake of childhood immunization</p> <p>Improve uptake of screening service</p>	<p>Reduction in smoking prevalence Meet target of 5% smokers referred to stop smoking services</p> <p>Reduction in patients who are overweight/obese</p> <p>Increase in number of patients who exercise regularly</p> <p>Improved uptake in particular for the 'at risk' group</p> <p>Earlier detection of common cancers</p>	<p>Appendix -14.2.6 Appendix – 14.5 Currently failing to hit the 5% target of smokers referred</p> <p>Appendix – 14.2.6 70% of Caerphilly population considered overweight and 28% considered overweight or obese</p> <p>Appendix - 14.2.6 33% of population are active for less than 30mins per week</p> <p>Appendix 14.4.2 Not currently hitting the national target of 65% for the at risk group</p>	<p>Aligned with strategic work streams:</p> <ol style="list-style-type: none"> 1. Prevention, Wellbeing & Self-care 2. Care Closer to Home 3. Access & Sustainability

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		Improve uptake of Drug & Alcohol services within the NCN community			
2	Ensure appropriate access to primary care services and sustainability of services	<p>Promote new model of primary care</p> <p>Continue to pilot and develop new roles in Caerphilly South</p> <p>Promote and monitor use of additional services such as common ailments scheme, WECS</p> <p>Promote and monitor innovative use of IT</p> <p>Introduce Telehealth option for patients</p> <p>Utilize use of extended services and 3rd sector</p> <p>Realignment of DN services</p> <p>Contribute to winter planning</p> <p>Introduce Group Consultations for practices</p>	Ensuring care is provided by the right person at the right time in the right place	Appendix – 14.7 Improved utilisation of social prescribing and care navigation will improve referral rates across the NCN	<p>Aligned with strategic work streams:</p> <ol style="list-style-type: none"> 2. Care Closer to Home 3. Access & Sustainability 4. Implement the Primary Care Model for Wales 5. Re-designing Community Services 6. Digital data & Technology

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3	Delivery high quality care	<p>Reduce rate of opiate, tramadol, pregabalin and gabapentin prescribing.</p> <p>Deliver Quality Improvement projects in line with GP contract.</p> <p>Improve communication between services and organizations.</p> <p>Maximize Training opportunities to develop appropriate staff skills across the NCN</p>		Appendix – 14.4.1 One of the highest prescribers of Tramadol across ABUHB	<p>Aligned with strategic work streams:</p> <ol style="list-style-type: none"> 1. Prevention, Wellbeing & Self-care 5. Re-designing Community Services 7. Skilled Local workforce 10. Quality, Value & Patient Safety
4	Estates	<p>Consider estate alongside team/model requirements</p> <p>Complete development of 2 practice building in Llanbradach</p> <p>Re-align GMS services and estate in the Aber Valley</p>	<p>Introduction of place based model of care</p> <p>New build completed and providing better access to patients from two practices based in Llanbradach</p> <p>New model of integrated service provision for Aber Valley</p>		<p>Aligned with strategic work streams:</p> <ol style="list-style-type: none"> 5. Re-designing Community Services 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.

There is also potential to develop a Drop-in Advice Clinic within a premises in the NCN locality such as the one that 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.

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.

The NCN will work with ABUHB Corporate Service to develop a communication and engagement strategy.

12 Financial Profile

12.1 Neighbourhood Care Network

Caerphilly South NCN Cluster Funding – Annual Budget £168,150

Currently Supports:

Role / Initiative	Recurrent Annual Cost
1.5 WTE Practice Based Pharmacist	£ 91,265
1.0 WTE First Contact Physiotherapist	£ 47,076
Community Phlebotomy Team	£ 11,946
Complex Wound Care Service	£ 4,579
Independent Contractors (Top Sliced across all ABUHB NCNs)	£ 3,201
DEWIS Coordinator (Top Sliced across all ABUHB NCNs)	£ 1,973
Dementia Road Map (Top Sliced across all ABUHB NCNs)	£ 890
Total	£160,930

Since 2016-17 the Caerphilly South NCN has invested around £275,000 in GP Practice Based Pharmacist support. In 2018-19 the NCN reported that over 200 hours of GP time had been replaced and in excess of 450 contacts made by NCN pharmacists.

In 2018-19 Caerphilly South NCN introduced the First Contact Physiotherapy Service to run within all GP practices through an initial recurrent £47,200 investment.

A range of support for GP practices in Caerphilly South have been recurrently funded including specialist Advisor roles in Optometry, Dentistry and Pharmacy, investment in a Community Phlebotomy Service and for cross-practice working utilising the locally developed Complex Wound Care Service. Investments have also been made in various training opportunities to upskill Primary Care and allied services staff across Caerphilly South. 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. GP practices and member organisations of the NCN are openly encouraged to apply for access to the surplus funding via an agreed proposal process.

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 South NCN.

Transformation Funding bids that have been received from within Caerphilly South NCN include:

- Support for development and attendance of MDT meetings
- Training opportunities for developing and upskilling staff to enhance service provision with GP practices

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 South)

14.1 Population and Future Projections

Caerphilly South NCN currently serves a population of 56,463. The crude projection of population increase over the next 5 and 10 years based on list size populations is: Projection: 2025=57,106, 2030=57,620 (ABUHB)

The total population of Caerphilly South NCN for all ages is currently 56,463. When broken down by age, approximately 19.3% (10,897) were aged 0-14years, 65.2% (36,814) were aged 15-64years and 15.5% (8,752) 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 South NCN area is divided into 35 Lower Super Output Areas (LSOAs). 54.3% of the LSOAs are within the top 50% most deprived LSOAs in Wales. St James ward (Lansbury Park) is currently ranked as the most deprived LSOA in Caerphilly Borough and also in Wales as a whole.

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%

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(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 South 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 Basin Master Plan are:

- Windsor Colliery site, Abertridwr – 200-250 dwellings
- Waterloo Works, Waterloo – 545 dwellings and potential community facilities
- Catnic site, Caerphilly – 170 dwellings
- Bedwas Colliery site – 630 dwellings and potential community facilities
- Ness Tar, Caerphilly – 200 dwellings, potential offices, live/work units

(Source – CCBC, Caerphilly Basin Masterplan)

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 South is mid 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

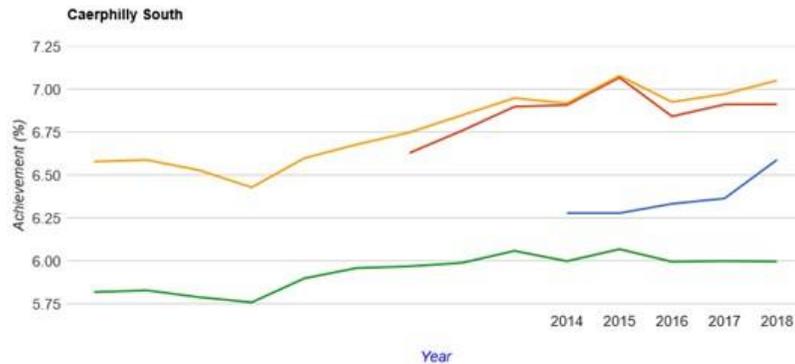
Caerphilly South has an asthma prevalence of 6.6% which is lower than the Wales and ABUHB average prevalence, however is higher than the UK prevalence of 6%. The COPD prevalence is 2.1% which is higher than the UK position of 1.93% but lower than the ABUHB and Welsh averages. The asthma prevalence has 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 South
Asthma	6.9%	7.10%	6.5%
COPD	2.2%	2.30%	2.0%

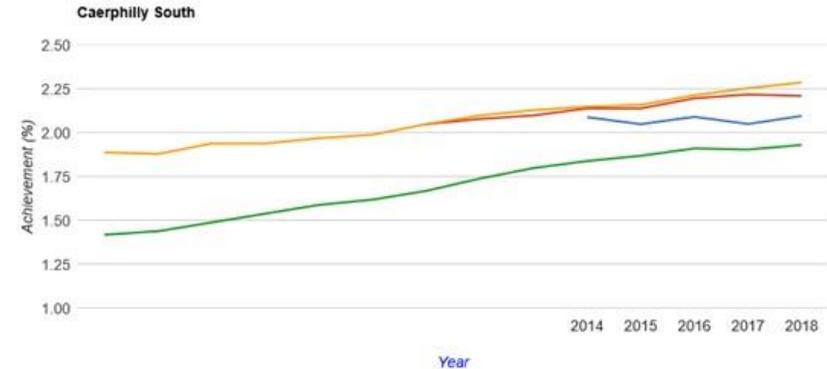
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— Caerphilly South
— Aneurin Bevan Health Board
— Wales

Asthma



Chronic Obstructive Pulmonary Disease



14.2.3 Hypertension & Heart Disease

Prevalence of hypertension is almost in line with the Welsh average at 15.6% and the ABUHB average of 16.1%. The Caerphilly South position has increased annually since 2014.

Prevalence (QOF Registers 17-18)	ABUHB	Wales	Caer South
CHD	3.7%	3.7%	3.7%
Heart failure	1.00%	1.0%	0.8%
Hypertension	16.1%	15.7%	15.6%
Atrial fibrillation	2.1%	2.2%	2.0%

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.

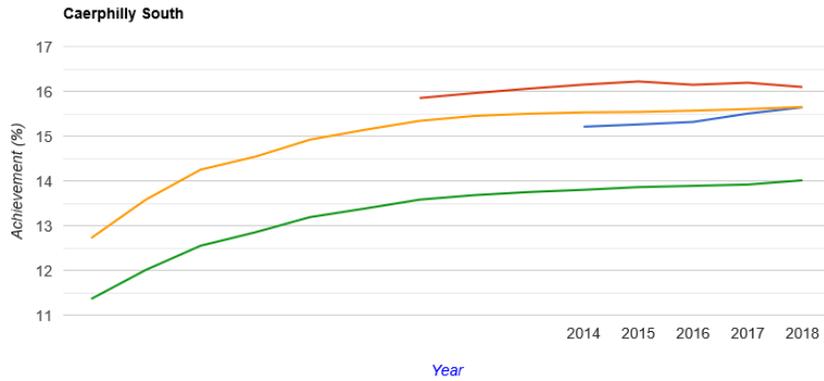
Coronary Heart Disease is aligned to the ABUHB and Wales average of 3.7%, however this is higher than the UK position of 3.2%.

Caerphilly South is 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.

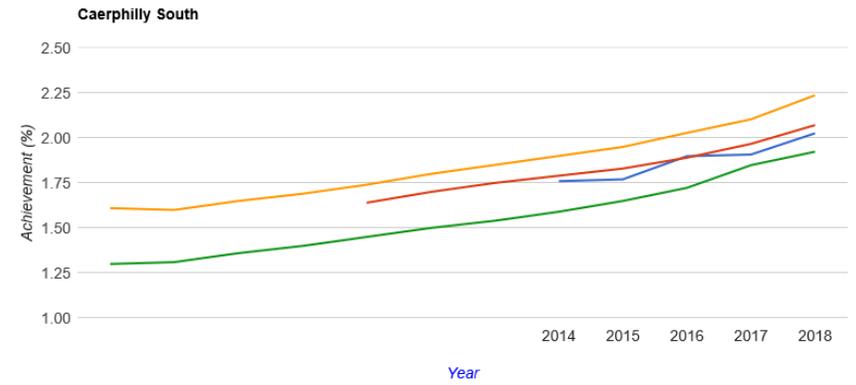
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- Caerphilly South
- Aneurin Bevan Health Board
- Wales

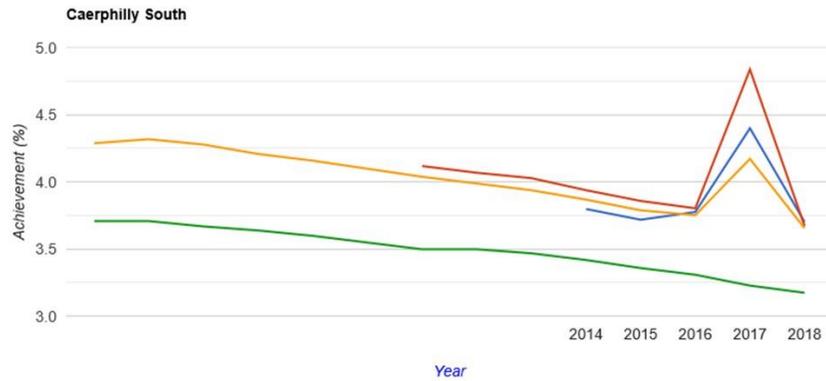
Hypertension



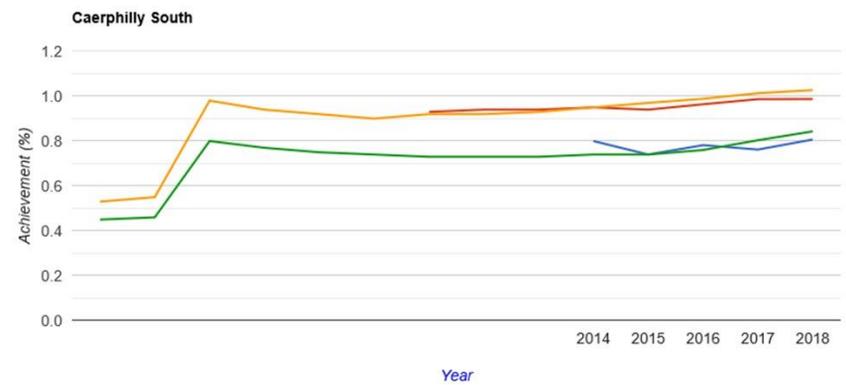
Atrial Fibrillation



Coronary Heart Disease



Heart Failure

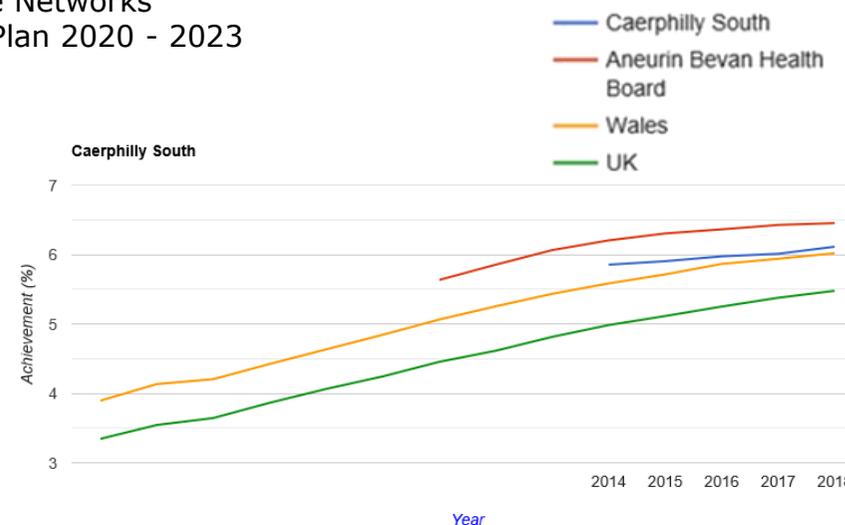


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14.2.4 Diabetes

Prevalence (QOF Registers 17-18)	ABUHB	Wales	Caer South
Diabetes	6.5%	6.0%	6.1%

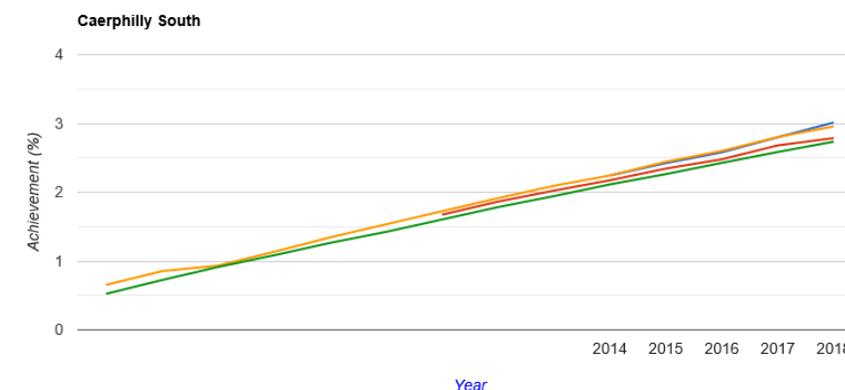
Although the Caerphilly South latest prevalence position is less than the ABUHB average it is marginally higher than the Wales average and higher than the UK prevalence. There is also a year on year increase although this is slightly less marked than the other areas reported in the graph opposite.



14.2.5 Cancer

Prevalence (QOF Registers 17-18)	ABUHB	Wales	Caer South
Cancer	2.8%	3.0%	3.0%

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 3% of the list size population. 3% is in line with the Wales picture although slightly higher than the Gwent and UK 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 –

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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 19%. 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 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%.

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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

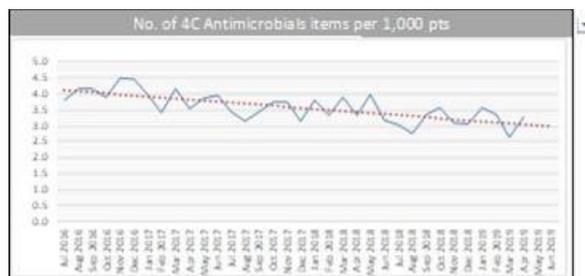
Caerphilly South is the second highest prescriber of Tramadol in Gwent and although the month on month position has improved over the last few years this remains an area of focus. Another area that requires additional attention is the increase in rate of prescribing of Gabapentin and Pregabalin which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

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

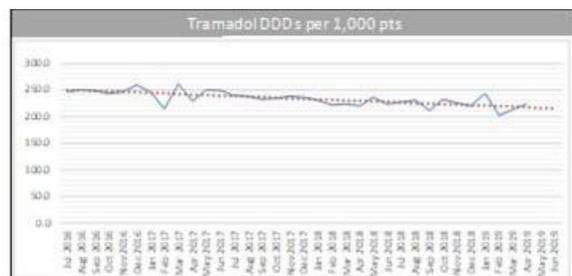
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NCN GP LIST SIZE		33,602	38,375	65,857	64,801	56,496	53,096	47,301	50,049	57,150	49,945	49,573	46,322
NCN AREA		BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
No. of 4C Antimicrobials 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

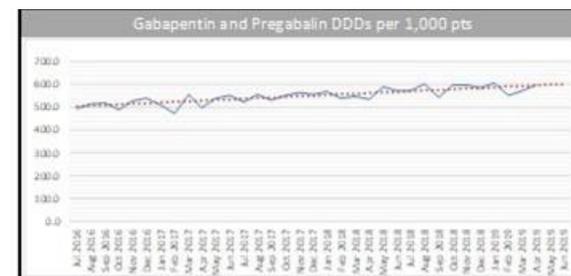
Antibiotic Prescribing



Tramadol Prescribing



Gabapentin & Pregabalin Prescribing



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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 immunisation 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 immunisation rates.

Age Group: 2 Years The NCN cluster 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 South 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 just below target at 93.6% and the 3 in 1 pre-teen booster is the lowest recorded uptake of childhood immunisations at 88.3% and although better than the Gwent majority 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%

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Flu Immunisation

When compared to the rest of Gwent, Caerphilly South appears to be doing well, however 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.

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 South 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%

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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

Cluster	Diabetes Care Processes (All Eight Care Processes)		
	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

Cluster	Diabetes Care Processes (All Eight Care Processes)								
	2014			2015			2016		
	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

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Referrals to Pulmonary Rehab 2015-17

Cluster	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		
	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

Cluster	Question		
	Current smokers (recorded as in the past 2 years) who received a behavioural change intervention and stop smoking drug prescription		
	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

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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 South 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.

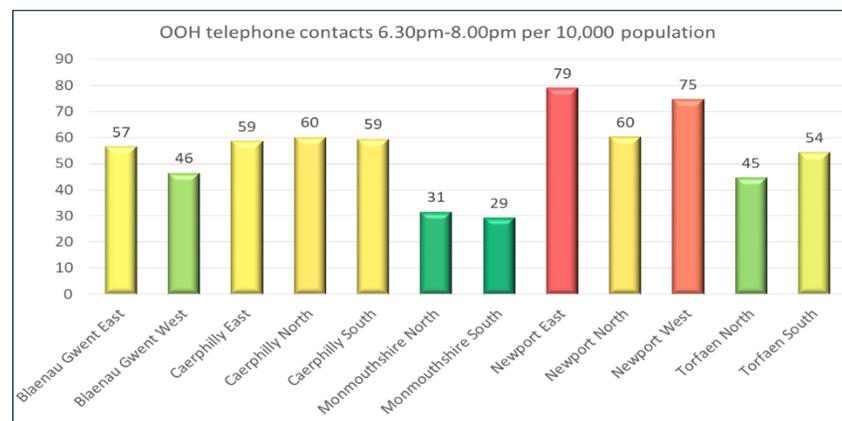
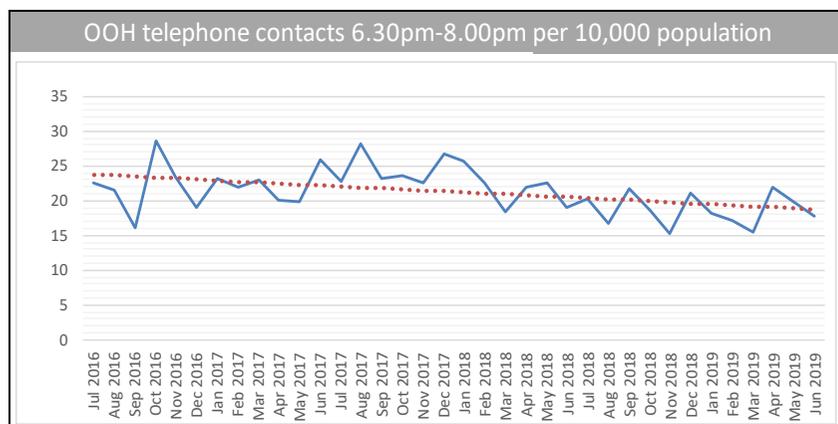
NCN AREA		BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
Planned Care (per 10,000 population)													
GP referrals to non-surgical specialties (All Wales)	Jan 2019 - Mar 2019	200	199	156	176	123	165	152	143	159	169	219	174
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 South as having a high level of inappropriate ED attendances at 64 per 10,000 population. There is also a higher number of occupied bed days following an emergency admission for adults aged over 65 years per 10,000 population. The number of conveyances of people in residential homes within Caerphilly is high, however this could be due to the higher number of residential beds within the area so this benchmark is likely to be inappropriate in this instance, there could though be some further investigation into this to determine themes etc.

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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

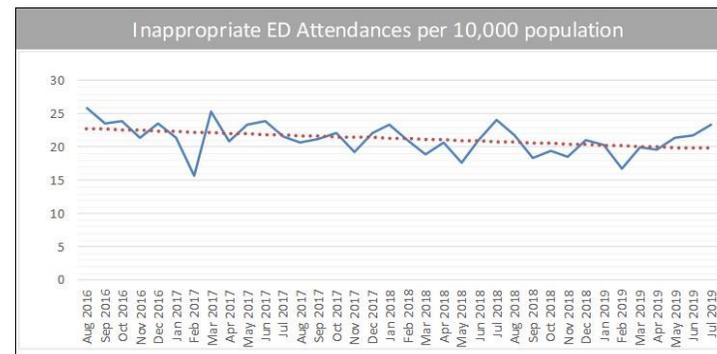
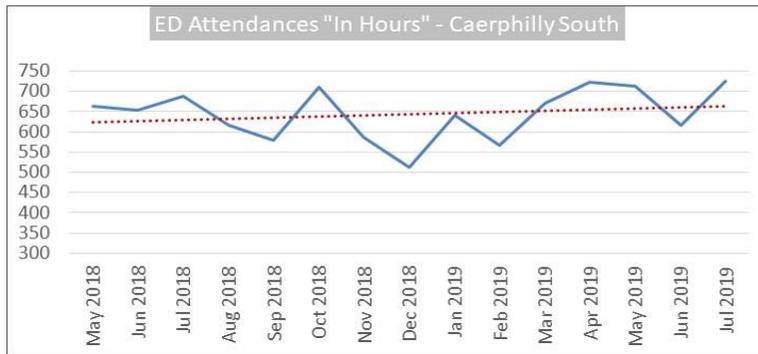
The graphs below show the Caerphilly South OOH Telephone Contacts between 6.30pm and 8.00pm and how the NCN compares to other Gwent cluster areas. Although a declining number which may indicate improved access within the in hours general practice service, the cluster when compared to other areas could 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.



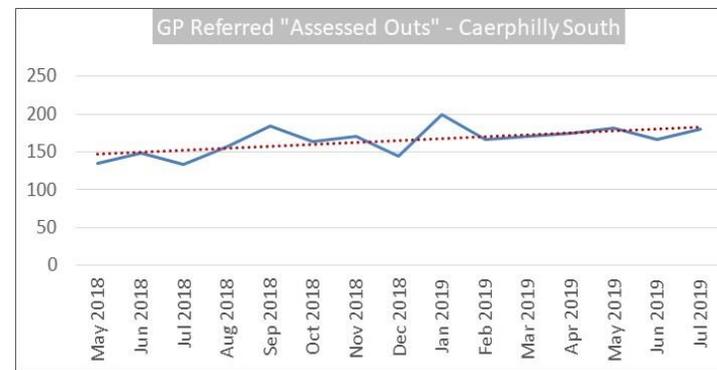
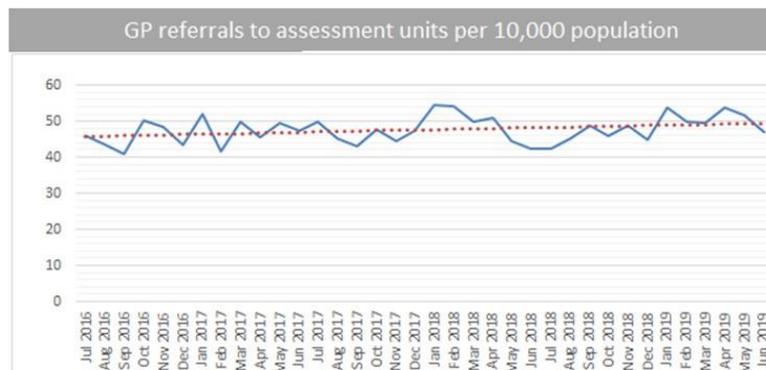
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Between May 2018 and July 2019 there was an increase in the monthly reported new ED attendances at ABUHB sites on weekdays (Mon to Fri) between 8am and 8pm.

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?

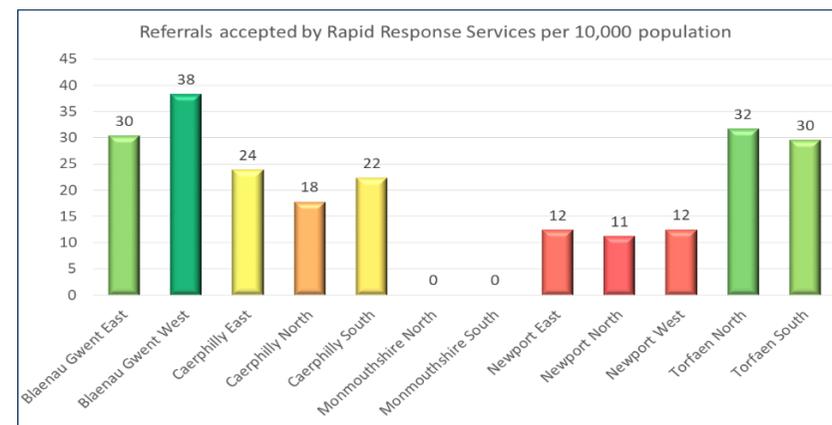
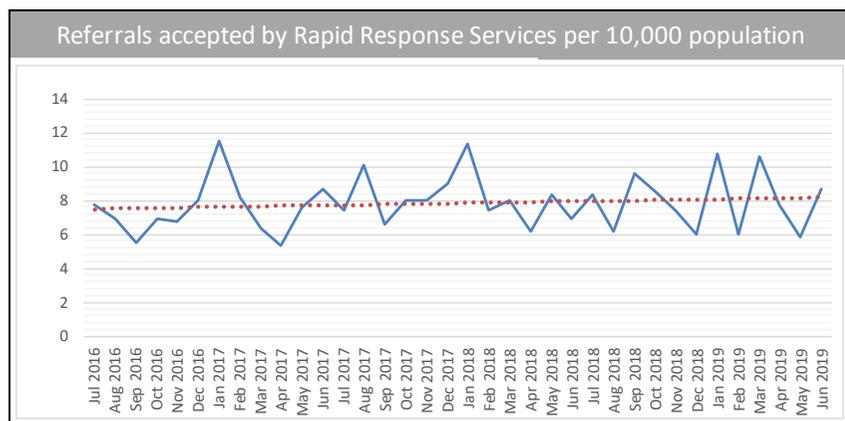


The number of GP referrals into ABUHB assessment units is on a general increasing trend of which those "assessed out" are also increasing.



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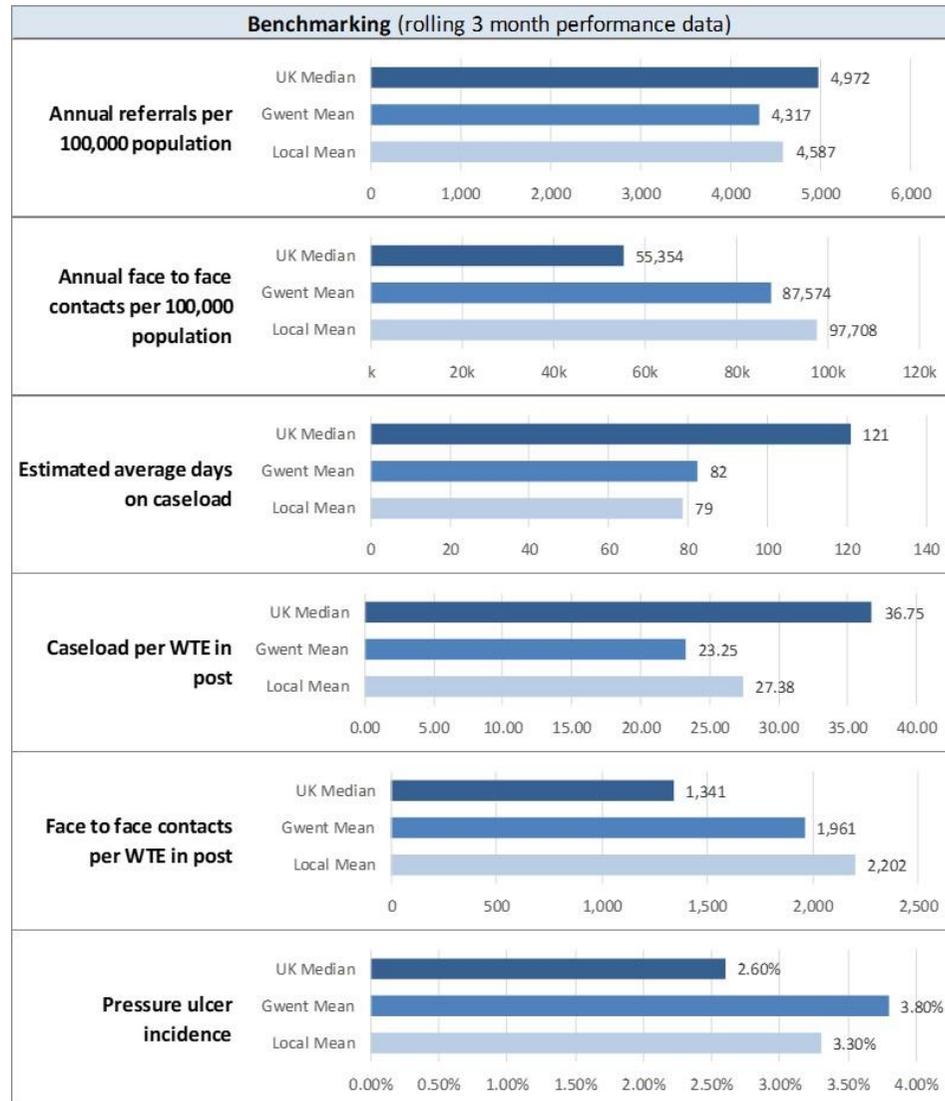
The Community Resource Team in Caerphilly are a core service that offers an alternative to hospital in the first instance by offering a rapid response to referred need. The number of accepted referrals to this service has remained on a relatively flat trend over the last year for Caerphilly South patients 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 two district nursing teams based in Caerphilly South who in the year to July 2019 saw an average of 4579 face to face contacts per month. 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.

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District Nursing Benchmarking - Caerphilly

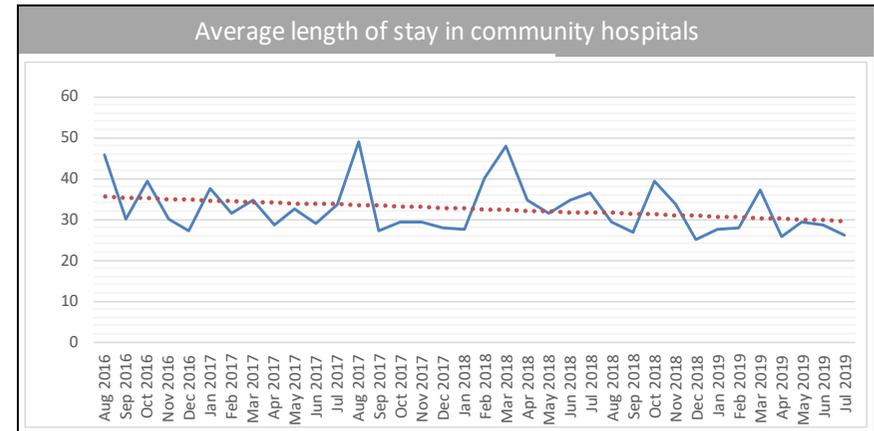
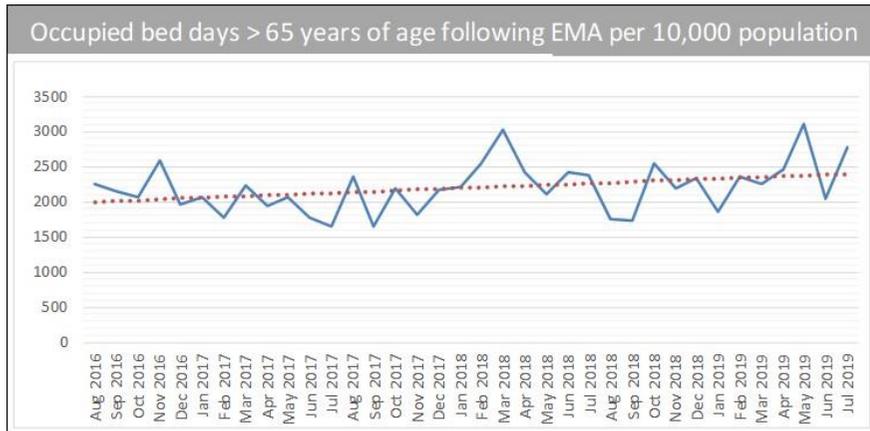
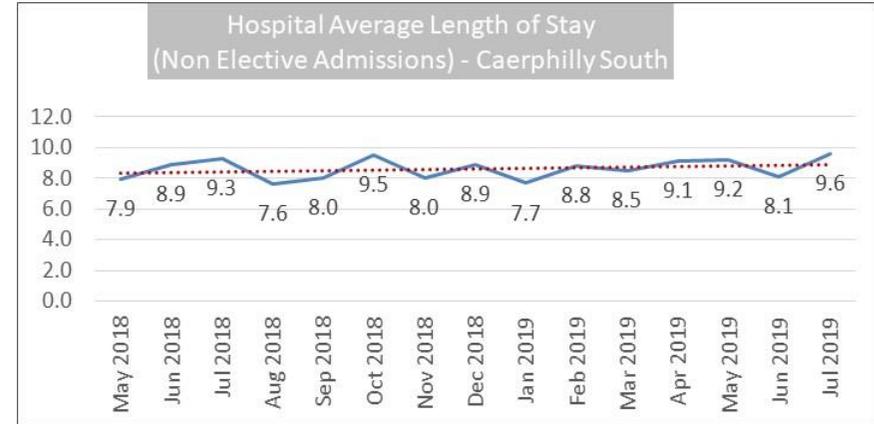


* UK Mean based on data submitted to NHS Benchmarking Network for period 2014/15

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14.7.2 Hospital Based Services

The Average Length of stay for patients registered with a Caerphilly South GP practice who were a non-elective admission for the period shown below was 8.6 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.



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15 Appendix 2

15.1 Health Resources Assessment

Baseline 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

Neighbourhood Care Networks
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16 Appendix 3

16.1 Baseline Data - Workforce

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