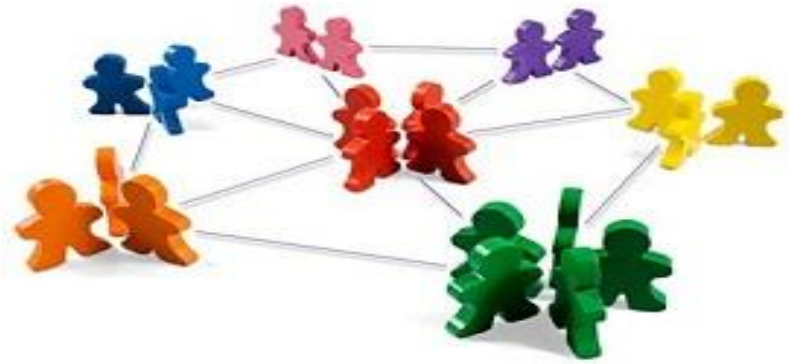
Three Year Cluster Network Action Plan 2017-2020

Monmouthshire South Neighbourhood Care Network

Year 3



Aneurin Bevan University Health Board
Delivering Care Closer to Home
Monmouthshire South Neighbourhood Care Network Plan – 2018/19

Our aims are to:-

- Improve the health and wellbeing of the local population
- Support people to stay well, lead healthier lifestyles and live independently
- Reduce health inequalities
- Support the Clinical Futures Strategy in primary and community care by delivering Care Closer to Home:-
- Ensure that services have the flexibility to meet individual needs
- Improve access to specialist expertise
- Provide a positive experience for patients and carers
- Ensure a supportive working environment and career development opportunities for our staff

Design by Caerphilly South NCN

What are we doing?

- Regularly reviewing local needs to identify priorities and develop effective solutions
- Developing primary care teams using the Primary Care Model for Wales built around traditional GP, District Nurse and Health Visitor roles
- Introducing new primary care roles to provide easier access to local services. Current examples include Social prescribers, practice based pharmacists, physiotherapists, mental health workers, primary care audiologists, paramedics, occupational therapists and social workers.
- Increasing access to specialist roles in the community including Diabetic Specialist Nurse, Heart Failure Nurse, and Palliative Care Nurse Specialist.
- Working to increase uptake of preventative services to keep citizens well including influenza immunization / childhood
- immunization / smoking cessation services / weight management services / exercise schemes
- Developing clinical pathways to improve patient experience and service quality
- Building a strong social navigation system to support community engagement
- Finding and championing local community initiatives

How are we delivering change?

"Enablers"

Technology
Skilled Workforce
Partnership Working
Financial Resource
Fit for Purpose

- Work with partners to establish wrap around health and wellbeing services
- Making best use of health and social care building
- Use of preventative, early opportunity and self-management approaches
- Understanding local needs and developing effective solutions
- Use prudent healthcare pathways to improve planned care
- Use Multidisciplinary Team to undertake active signposting
- Recruit, train & educate our workforce to ensure needs of population met

How will we know if we have made a difference?

We review health and wellbeing outcomes regularly and we learn from feedback from patients, carers and staff

Strategic Aim 1: To understand and highlight actions to meet the needs of the population served by the Cluster Network

Objective	For completion by:-	Outcome	Action/ Progress to date	RAG Rating
1.1 Healthy diet support and exercise **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 3, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1, 2, 10 • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 1, 4	**Year 3 with on-going option** NCN National Exercise Referral Scheme Midwifery Service	Healthy diet and weight in pregnancy improves the health of women, with the potential for better outcomes leading to independent health benefits in adult life Delivery of Clinical Futures – new ways of working - Care Closer to Home	• **NEW PILOT: To commission evidence based Mind & Body exercise classes for pregnant women** **Progress:** • Project group established, programme outline agreed starting April 2019 **Next steps:** • Outcomes of pilot to be agreed by project group with year-end evaluation by NCN. • Explore potential for community connector/ champions training to include wider partners e.g. NERS instructors • Consider option for clinical outcomes e.g. number of elective C-Sections etc.	
1.2 Integrated health, social care and well-being **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 3, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1, 2, 10 • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 1, 4	**On-going** South Monmouthshire Development Group (SMDG) Public Health Integrated Services Partnership Board Greater Gwent Partnership Board	Delivery of Clinical Futures - Care Closer to Home Delivery of ABUHB 3 year Integrated Plan 2017-20	• **To drive the development of Integrated Health, Social Care and Well-Being Centres in South Monmouthshire** **Progress:** • On-going estate and service modelling • On-going work to develop a clinical model with medical cover • Review of Caldicot Centre noted a range of issues being taken forward by the SMDG **Next steps:** • To explore options for Centre based 'information hubs'; • ICF funding secured in 2019 to progress plans for an integrated children's centre; • Paediatric Consultant led clinics are being considered as part of the development of the Caldicot Integrated Children's Centre. The NCN Lead has participated in an ABUHB Outpatient Transformation	

			Collaborative exercise aimed at reducing delays for Paediatric outpatient services and understanding optimum pathways of care.	
1.3 Public Engagement **Aligned with:** • ABUHB Integrated Medium Term Plan SP 3, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1 • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 1, 2, 4	**On-going** Management Team	Delivery of Clinical Futures - Care Closer to Home Delivery of ABUHB 3 year Integrated Plan 2017-20 Local need informs plans	• **To engage with local communities to promote Health Board and NCN priorities** **Progress:** 2019-20 schedule set for engagement via well-Being Centres **Next steps:** • Outcome of engagement to be feedback to NCN	

1.4 Enhanced well-being
 	
Aligned with:
• ABUHB Integrated Medium Term Plan SP 1, 3, 4
• A Healthier Wales 2018
• Care Closer to Home and Clinical Futures Strategies
• Primary Care Plan for Wales
• Integrated Services Partnership Board Obj. 1, 2, 10
• Gwent Regional Partnership Board App. 3
• Public Service Board Well-Being Plan Obj. 1, 4
	Year 3
	
	NCN National Exercise Referral Scheme
		Delivery of Clinical Futures - Care Closer to Home	• **NEW PILOT: Consider options & criteria for delivery of open access 'step-up' classes for people aged over 70 years**
			  • Promotion/ communication
			  • Access/ location
			  • Success/ evaluation
			  • Programme structure/ duration0
			  • Opportunist health promotion (dietary advice etc.)
			  • Exit strategy/ community connection
			
			Next steps:
			• Establish project group (Summer 2019)	

Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements

Objective	For completion by:-	Outcome	Action/ Progress to date	RAG Rating
2.1 GP Practice resilience **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 3, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1, 2, 4, 5, 8, 9 • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 1, 2, 4	**On-going** NCN Practices	Delivery of Primary Care Plan for Wales	• **NCN management team works with GP Practices to identify sustainability concerns and opportunities for shared working** **Progress:** • Annual Contract Reviews, GP Estates Prioritisation meetings and Improvement Grant process supported • New links made with Monmouthshire County Council (MCC) Housing Planning and Place-Shaping team with presentation at May NCN meeting **Next steps:** • Horizon scanning for new models; • New round of Annual Contract Reviews; • On-going participation in MCC Place-Shaping exercise	
2.2 Workforce **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 3, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1, 2, 4, 5, 9 • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 1, 2, 4	**On-going** NCN Pharmacy Directorate Practices Welsh Government (WG)	Delivery of Clinical Futures - Prudent Healthcare - Care Closer to Home Reduced number of GP visits Increased GP resilience, recruitment and sustainability	• **Review impact of NCN funded schemes against expected outcomes** **Progress:** • 2018-19: GP Practice based Pharmacists saved 200+ hours of GP time with 1,112 face to face contacts; • 2018-19: Total Phlebotomy contacts came to 3,457 with 73.1% by Health Care Support Workers (Source: District Nursing Dashboard) • 2018-19: NCN funded weekly drop-in clinic made 1020 contacts & now aligned with Cardiology avoiding long patient journeys to Royal Gwent Hospital in Newport. **Next steps:** • Continue to monitor effectiveness of other initiatives including DEWIS co-ordinator & NCN advisor roles	

		Long term sustainable community services	• **NEW: Results of South Monmouthshire GP home visit analysis (year-ending March 2019), identified a number of visits which could have been undertaken by alternative health professional** **Next steps:** • NCN funding allows up-skilling (training) of existing Integrated Services Team using formal minor illness assessment qualification for 1 x member of each Chepstow & Caldicot IST • Member of IST assesses patients uploading relevant clinical history and examination findings into medical records via WICCS and informing relevant GP Practices which can action the information remotely where appropriate	

Strategic Aim 3: Planned Care- to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface

Objective	For completion by:-	Outcome	Action/ Progress to date	RAG Rating
3.1 Improve links between Secondary Care and GMS **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 2, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1 • Gwent Regional Partnership Board App. 3	**Years 2 & 3** Practices Dermatology team	Delivery of Clinical Futures - Care Closer to Home Reduction in referrals to secondary care	• **NEW: Dermatology** **Progress:** NCNs (South & North) have agreed to commission Dermatoscopes for GP Practices in Monmouthshire. Current deficit identified in the South with only 1 GP Practice having access to a Dermatoscope therefore all 5 Practices in the cluster will be able to support the exclusion of non-cancerous lesions without the need to refer to Dermatologists in secondary care. With the percentage of cancers currently standing at approximately 9 to 10% of all referrals, it is anticipated that the use of Dermatoscopes locally will help filter out benign lesions and thus reduce demand. **Next steps:**	

			• GP training session led by the Dermatology team to be held later in the year with all Practices receiving retrospective locum costs; • GP clinical system searches to be undertaken at two points over a 12 month period for comparison.	
3.2 Improve links between Secondary Care and GMS **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 2, 3, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1, 2, 4, 9 • Gwent Regional Partnership Board App. 3	**Years 2 & 3** Primary and Secondary Care Out of Hours	Delivery of Clinical Futures - Care Closer to Home Reduction in secondary care admissions	• **NEW: Advance Care Planning (ACP)** **Progress:** Draft protocols in development with ABUHB ACP lead to be shared across South & North Monmouthshire to encourage and facilitate ACP documentation. If implemented, protocols will allow for improved working across Primary, Secondary and Out of Hours teams avoiding duplication. **Next steps:** • ACP training session planned for October 2019 including positives of adopting ACP and workshops to share good practice. Outcome: Anticipate reduction in hospital admissions and CC2h. • GP clinical system searches to be undertaken at two points over a 12 month period for comparison.	

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management. To address winter preparedness and emergency planning

Objective	For completion by:-	Outcome	Action/ Progress to date	RAG Rating
4.1 Winter preparedness and emergency planning **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 2, 3, 4 • ABUHB Winter Plans • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales	**On-going** Practices NCN Community Teams NCN partners	Delivery of ABUHB Integrated Winter Plan	• **Continue to undertake business continuity and adverse weather plan reviews (revised year 3)** **Progress:** • 2018-19 Business Continuity/ Winter Planning: Monmouthshire Borough team 2018/19 Winter Plan informed by dedicated NCN and Annual Contract Review discussions. Monmouthshire County Council/ Integrated Services Teams Winter Pressures Plan in place.	

• Integrated Services Partnership Board Obj. 1 • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 2, 4			Range of cross-practice working options considered including GP Extended Hours Offer, triaging of patients and dispensing if appropriate governance/ permissions are in place. • Dedicated flu up-take discussions held at NCN meetings. Year-end review showed higher up-take than the All Wales average across the three target groups. <u>Source IVOR:</u> • >65 years: **74.1%** • <65 years: **56.7%** • 2-3 year olds: **64.1%** **Next steps:** • NEW: WhatsApp group developed to include all PMs ensuring rapid communication between practices and health board during adverse weather events • NEW: Business continuity plans between practices in development • Potential role for TeamNet (allows easy sharing of practice procedures) to be considered in year 3 – preliminary discussion needed • NEW: Clinical system migration provides opportunity for patients to be seen by other Practices if agreed across NCN	
4.2 'Medical Model' (Monmouthshire IMTP 2019/20) **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 2, 3, 4 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1, 2, 4, 6, 7, 10	**On-going** NCN Care of the Elderly Directorate Integrated Services Partnership Board	Delivery of Clinical Futures – Care Closer to Home	• **PILOT: Local planning includes clinical support to community teams aimed at preventing Secondary Care Hospital admission (revised year 3)** **Progress:** • On-going planning around developing a Community Frailty Unit and in-hours Urgent Primary Care 'Hub' facilitating direct admissions to Chepstow Hospital from the community, to carry out multi-disciplinary assessments. Designed to enable community and	

• Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 2			primary care staff to manage patients at risk of admission in community settings. **Next steps:** • Progress monitored via ISPB action plan and Clinical Futures GP lead	
4.3 Ambulance response times **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 2 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1	**Year 3 & on-going**	Delivery of Clinical Futures – Improving Quality and Safety of Patient Care	• **NEW: Undertake review of emergency ambulance response times to inform planning** **Progress:** • Liaising with the clinical futures team and WAST regarding emergency ambulance response times in Monmouthshire with focused discussions at 2019-20 NCN meetings. Initial review undertaken by NCN lead identified 'hot-spots' and impact on responses within a large geographical/ rural area. **Next steps:** • Undertake regular reviews at NCN level with opportunity to build cross NCN working with the North.	

Strategic Aim 5: Deliver consistent, effective systems of Clinical Governance and Information Governance. To include actions arising out of peer review Quality and Outcomes Framework (when undertaken)

Objective	For completion by:-	Outcome	Action/ Progress to date	RAG Rating
5.1 All Wales Clinical Governance Practice Self-Assessment Tool (CGPSAT) **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales	**Year 3 & on-going** Practices NCN	Delivery of Clinical Futures – Improving Quality and Safety of Patient Care	• **Ensure all practices have access to the toolkit** • **NEW 1:** Promote cross-practice working sharing good clinical practice and non-clinical governance measures • **NEW 2:** Initiate Social media groups to build on to encourage increased sharing and discussion regarding individual practice systems policies and procedures • **NEW 3:** Potential role for TeamNet (allows easy sharing of practice procedures) to be considered in year 3 – preliminary discussion needed	

• Gwent Regional Partnership Board App. 3			**Progress:** • Practices access toolkit via GPOne website **Next steps:** • Monitor progress against new action	

Strategic Aim 6: Other Locality issues

Objective	For completion by:-	Outcome	Action/ Progress to date	RAG Rating
6.1 Prescribing **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1 • A Healthier Wales 2018 • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 1, 2	**On-going** Medicines Management Team Practice Based Pharmacists (PBP) NCN	Delivery of Clinical Futures – Improving Quality and Safety of Patient Care	• **GP Practices are supported to identify financial efficiencies for reinvestment** • **Performance benchmarked across Practices and other NCNs** • **NEW 1:** Scope potential for NCN pharmacists to have allocated time to work with the NCN Lead and Prescribing Advisor to target CEPP/ PER savings and address any safe prescribing issues as they arise • **NEW 2:** Warning alerts to be designed with NCN pharmacy team for prescribing anti-biotics and analgesia items as per CEPP guidance • **NEW 3:** Community Pharmacy: Quarterly meetings to cover safe communication between primary care and community pharmacy, local pharmacy initiatives along with stock related issues and any other matters as they arise. Meetings initiated in year 3 to include all local community pharmacists, NCN pharmacists, Practice Managers, Practice Pharmacists and dispensing leads **Progress:** 2018-18 CEPP/ PER savings totalled £14,093 2019-20 CEPP/ PER savings totalled £tbc **NEW 2:** 4C antibiotic protocols designed by NCN clinical lead and Practice based pharmacist in response to a NCN cluster target to	

			reduce 4C prescribing. An MSU alert was shared following a significant increase in MSU requests in 2018-19 by South Monmouthshire Practices and helps check if the MSU is necessary. Simple warning alerts and advice when 4C items are prescribed are imported onto the Emisweb clinical system. **Next steps:** • Continue to monitor effectiveness of roles and performance against other NCNs	
6.2 Dementia **Aligned with:** • ABUHB Integrated Medium Term Plan SP 1, 3, 4 • A Dementia Friendly Nation • Care Closer to Home and Clinical Futures Strategies • Primary Care Plan for Wales • Integrated Services Partnership Board Obj. 1, 2, 3, 4, 6, 7, 9, 10 • Gwent Regional Partnership Board App. 3 • Public Service Board Well-Being Plan Obj. 2, 4	**On-going** NCN Dementia Multi-Agency Group (D-MAG) Practices Third sector Integrated Services Partnership Board (ISPB)	To support delivery of the WG dementia action plan for Wales (2018/2022) & 'A Dementia Friendly Nation' Delivery of Care Closer to Home	• **To support development of local schemes for people with dementia** • **NEW 1:** Advanced Care Planning: Training day planned for all Monmouthshire Practices and IST members (October 2019) with an afternoon dedicated to ACP delivered via Macmillan team. • **NEW 2:** Active plans to develop IT configuration to better encourage and support documentation of ACP, with follow up data analysis, to see if increased documentation has occurred and better understand obstacles to ACP **Progress:** Aneurin Bevan University Health Board allocated £200,000 to the Monmouthshire Integrated Services Partnership Board to oversee the introduction of new community based projects for people with dementia and carers aimed at increasing access to support closer to home. The following schemes have so far been approved by the ISPB: • **Combined exercise and educational scheme:** Piloted from January to March 2019 in Chepstow and Caldicot with additional funding agreed by ISPB for full-year funding. • **Bridges Community Car Scheme:** Volunteer drivers enable people with dementia to access health appointments and facilities. • **Creative Lives/ Active Lives:** Provision of free sessions for a professionally led, local community based creative education programme for people with dementia and carers, to build new	

			relationships and connections, increasing their well-being and reducing loneliness and social isolation. • **Respite Bed:** Service Level Agreement in place to support respite options for people living with dementia/ functional mental health issues and carers. **Next steps:** ISPB to evaluate effectiveness of schemes in 2019/20	