Monmouthshire South Neighbourhood Care Network (NCN) Annual Report 2018-19 (Year 2 of 3)

Our Network:
We are a Network of **5 GP Practices**, 4 branch surgeries & an **Integrated Health and Social Care team** working alongside the **Third Sector** to serve the populations of **Chepstow, Caldicot** & surrounding areas.

Our focus:
The concept of **Place Based Working** (PBW) focuses on the principle of community co-ordination and provides an opportunity for Adult Social Care and Health services to test preventative and **early intervention** methodologies. Evaluation of PBW in Monmouthshire offers positive evidence that further work should be considered to maximise people's individual contributions, and develop community spaces where people can **come together to develop friendships** and share experiences and support. The **Neighbourhood Care** (Cluster) **Network (NCN)** is driving the development of both well-being centres in South Monmouthshire and is linked strategically to the Monmouthshire Integrated Services Partnership Board, Greater Gwent Regional Partnership Board and aligned with The Well-being of Future Generations (Wales), Health & Social Services Wellbeing (Wales) Acts. NCN work is also driven by the **Clinical Futures and Care Closer to Home** strategies with the aim of bringing the right services closer to people's homes.

Our challenge:
The NCN supports a population of 47,301 (ABUHB data), which has seen a **2.3% increase** on 2017/18 across a large predominantly rural area. The combined total population of South and North Monmouthshire at February 2019 was 100,397, residing across **850km^2**, compared with its neighbouring borough Torfaen, which has a similar total population of 95,895, but spread across **126km^2**. Working in partnership with Monmouthshire County Council has provided access to new information, which suggests we can expect a further growth and shift in population especially along the border with England. A substantial number of **new housing developments** have been approved and are in the process of being built. The removal of the Severn Bridge toll also has the potential to impact on the population level and therefore **increasing demand** on all Primary Care services, community based Integrated Teams and Third Sector. There is a perceived affluence, which can sometimes mask differences within and between communities. Wages in 2017/18 were some **10% below the UK average** and only marginally above the Wales average. Some 34% of our working population were commuting out of county to earn a living[1]. We face many challenges to the sustainability of our Health, Social Care and Third Sector services in terms of recruitment and retention of staff, care provision, tackling isolation and loneliness, and the impact of population shift and growth. By 2036, it is estimated that the number of people aged 85 and over will increase by **147%** (from around 13,000 in 2011 to 32,000 in 2036)[2].

Sources: [1]The Well-Being of Future Generations (Wales) Act – Monmouthshire County Council Well-Being Assessment 2017/ [2]Monmouthshire SS&WBA Needs Assessment

Our Local Health, Social Care and Wellbeing Needs and Priorities:

Agreement on objectives and action for the NCN was reached through a combination of analysis of individual GP Practice Development Plans, Annual Contract Reviews, Public Health Priorities, Quality Outcomes Framework (QOF) Data and NCN meetings. The need for a 3 year NCN development plan presented an opportunity for partners to build on progress already made and involved Primary Care, Integrated Health & Social Care teams, Public Health Wales, Medicines Management and Dietetics, along with the Third Sector. The work of the NCN is underpinned by the Social Services and Well-Being & Future Generations (Wales) Acts – Population Needs Assessment, Clinical Futures & Care Closer to Home strategies. This Annual Report provides a summary of progress made against agreed priorities in year 2 and compliments the year 1 (2017/ 18) report.

We looked at the needs of our community:

- 38.4% of people in South Monmouthshire were classified as living in a rural area, the 2nd highest of 12 NCN areas;
- 382 (0.81%) of patients across the 5 GP Practices have a diagnosis of dementia, compared with 0.65% (ABUHB), 0.68% (Wales) and 0.76% (UK). In 2010 there were 286 patients, a 74.8% increase.
- Adverse weather planning ensuring business continuity across primary and community teams

Our agreed priorities for 2018/19 were:

- Building community well-being and resilience;
- Medicines Management and GP Practice Based Pharmacist;
- Monitoring of flu up-take;
- Winter preparedness and Emergency planning;
- Delivery of Care Closer to Home & Clinical Futures;
- Access to services

What we have achieved:

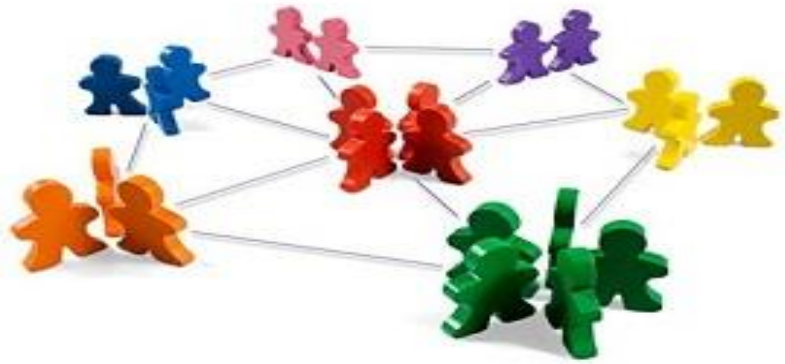
- Practice based Pharmacists providing expertise for high number of patients reliant on increasingly complex medications;
- Prescribing savings of £14,000;
- Secured funding to develop Integrated Well-Being Centres;
- Dementia Roadmap & new schemes, DEWIS Cymru funding;
- Dedicated sustainability/workforce planning discussions, introduced Care Navigation;
- Improved links with Council planning/ housing team;
- Highest flu up-take in Gwent for all three target groups
- On-going development of an Integrated Child & Family Centre
- NCN funded paediatric constipation pathway pilot leading to Pan Gwent roll-out in 2019-20

Our plans for 2019-20:

- Identify needs to underpin NCN level 3 to 5 year planning
- Work with housing colleagues to ensure local plans reflect the impact on services and workforce from the anticipated population growth;
- Support delivery of Clinical Futures & Care Closer to Home;
- GP Practice resilience, sustainability & workforce development;
- Continue strong links with Secondary Care & Third Sector;
- On-going support for the development of Integrated Well-being Centres and 'Place-Based' approach;
- Review emergency ambulance response times
- Continue to raise awareness of the work of the NCN

Neighbourhood Care Network Annual Report 2018-19

Monmouthshire South NCN (Year 2)



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	Progress	RAG Rating
1.1 Healthy diet support and exercise - Monitor the Pathway to Pregnancy (P2P) programme, review benefits of the Newport East integrated child weight management pilot & promote Making Every Contact Count (MECC) training (revised)	**Years 1, 2 & 3** NCN National Exercise Referral Scheme Midwifery	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	NCN financial year-end review of the P2P programme. The NCN had previously agreed to an extension of funding despite concerns relating to continued low-up take of the service, but with the proviso that necessary adjustments were made to try and improve participation. Having taken available data and other information into account, the NCN agreed that the programme was not sufficiently cost effective. The NCN agreed to consider other options for the same cohort of women but seeking assurances relating to cost effectiveness and outcomes prior to attributing NCN funding. The NCN received an up-date from Public Health colleagues in relation to 'Healthy Weight' guidelines (NCN up-date) following the Newport East pilot. MECC training dates shared across healthcare teams **Next steps:** NCN to facilitate transition funding for a Pregnancy Body & Mind exercise Pilot programme to run in Chepstow and Caldicot. Outcomes of pilot to be reviewed by year-end to evaluate up-take and outcomes.	
1.2 Integrated health, social care and well-being - To drive the development of Integrated Health, Social Care and Well-Being Centres in Chepstow and Caldicot	**Years 1, 2 & 3** NCN Information, Advice & Assistance teams 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	There are 2 centres in South Monmouthshire hosting Integrated Health and Social Care teams (IST). Centre development is aligned to and informed by the Public Health Integrated Well-Being Networks baseline review in 2017/18. Linked to ISPB & Greater Gwent Partnership Board priorities, modelling continues to build on the principles of Place Based Working. There are 5 centres in total across Monmouthshire with ISTs reaching across a vastly rural area of approximately 850km^2, providing local people with access to	

	DEWIS Cymru		additional Information, Advice & Assistance following a successful Integrated Care Fund (ICF) bid in 2018. A joint ABUHB/ Monmouthshire County Council (MCC) Partnership Estates Group has been established to identify available asset and opportunities for integration or co-location if possible. **Next steps:** A comprehensive review of the Caldicot Centre was carried out in early 2018 noting a range of issues with patient access and security. An application for ICF funding was successful in early 2019 with plans to further develop the site as an integrated children's centre - on-going.	
1.3 Public Engagement (linked to 2.1) **-** To engage with local communities to promote Health Board and NCN priorities	**Years 2 and 3** Partnerships ABUHB engagement team NCN	Delivery of Clinical Futures - Care Closer to Home Delivery of ABUHB 3 year Integrated Plan 2017-20	'Community of Practice' engagement programme locally linked to Clinical Futures and Primary Care Communications Campaign. 'Talk Health' community based workshops held to share progress of Care Closer to Home and Clinical Futures strategies. Choose Pharmacy minor ailments scheme rolled-out and promoted via network team – priority pathway as part of Care Navigation roll-out in 2019. NCN participation in local Engage 4 Change events. **Next steps:** NCN team developing ideas for raising awareness of the work of the NCN e.g. Care Closer to Home etc. with face to face contact planned at each of the well-being centres; Engagement options being planned for 2019/20 with focus on high footfall areas and face to face approach	

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	Progress	RAG Rating
2.1 GP Practice resilience - NCN management team works with GP Practices to identify sustainability concerns and opportunities for shared working	**Years 1, 2 & 3** NCN GP Practices Monmouthshire Housing Integrated Services Partnership Board	Delivery of Primary Care Plan for Wales	The NCN continues to work with GP Practices to identify and support existing and new initiatives aimed at maintaining a sustainable General Medical Service. This includes Annual Contract Reviews, NCN and GP Estates Prioritisation meetings, Improvement Grant applications, GP age profiling, actual and anticipated population growth, housing developments, workforce pressures and other potential issues. On-going NCN commitment to supporting the Transformational agenda with additional roles in Primary Care (linked to 2.2). Additional NCN funding agreed to increase Practice Based Pharmacist time in 2018 and three Care Navigation workshops funded for GPs and reception staff. Promotion of the Community Pharmacy minor ailments and Choose Well schemes across the NCN. **Next steps:** Horizon scanning for new roles, roll-out of Care Navigation	
2.2 Workforce - Review impact of NCN funded initiatives i.e. Practice Based Pharmacist, District Nursing (DN) Health Care Support Worker (HCSW) Phlebotomy Service and drop-in HCSW clinics	**Years 1,2 & 3** NCN ABUHB Welsh Government (WG)	Delivery of Clinical Futures - Prudent Healthcare - Care Closer to Home	GP Practice based Pharmacists continue to support Practice sustainability and have saved over 200 hours of GP time with 1,112 face to face contacts in 2018/19. All 12 NCNs fund a District Nursing based Phlebotomy service delivered by Healthcare Support Workers. A Welsh Audit Office (WAO) review of District Nursing in February 2015 indicated that 35% of referrals were for venepuncture, representing a significant demand on the service. To support delivery of the ABUHB Care Closer to Home & Clinical Futures strategies providing services at times & settings convenient for patients, a mobile HCSW service was	

			funded to release DN time. Of the 3,457 patient contacts made between March 2018 and February 2019, 73.1% of those were by HCSWs. (Source: District Nursing Dashboard) An NCN funded weekly drop-in clinic had 1020 contact between January 2018 and 2019. An annual review confirmed excellent patient and colleague satisfaction relating to ease of access and quality of service. This service is now aligned with a new Cardiology assessment clinic avoiding long patient journeys to the Royal Gwent Hospital in Newport. The HCSW who delivers the clinic received an ABUHB recognition award in 2018 for Living the Health Board values. DEWIS Cymru: NCN co-ordinator role funded to promote roll-out and development of the Directory Of Services, aimed at improving public and professional access to information – monitored vi NCN meetings and DEWIS project group. **Next steps:** Continue to monitor effectiveness of roles and services.	

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	Progress	RAG Rating
3.1 Paediatrics PILOT - To improve links between Secondary Care Paediatric Consultant teams and GPs	**Years 2 & 3** (revised) GP Practices NCN	Delivery of Clinical Futures - Care Closer to Home	Implementation of a Consultant Paediatrician email advice line for GPs & community teams with reduced inappropriate referrals to secondary care and hospital appointments. Streamlined processes allow for the management of complex cases remotely, in partnership with GPs. **Next steps:** 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.	

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	Progress	RAG Rating
4.1 Winter preparedness and emergency planning – Undertake business continuity and adverse weather planning reviews **PILOT –** Evaluate 2017/18 Flu immunisation up-take for 2-3	**Years 1,2 & 3** Practices NCN Community Teams NCN partners **Year 2** GP consultancy	Delivery of ABUHB Integrated Winter Plan 2018/19	**Business continuity/planning:** Monmouthshire Borough team development of 2018/19 Winter Plan informed by dedicated NCN and Annual Contract Review discussions. Complimented by the Monmouthshire County Council/ Integrated Services Teams Winter Pressures Plan. Range of cross-practice working options considered including: GP Extended Hours Offer, triaging of patients and dispensing if appropriate governance/ permissions are in place.	

year olds across South Monmouthshire GP Practices & recommend best practice to improve up-take	NCN		2019-20: Up-take of new clinical system providing an opportunity for patients to be seen by other Practices if agreed across the NCN. Improved links and information sharing between community pharmacy team and NCNs - adverse weather action plan in place. **Flu monitoring (South):** Dedicated discussion held at NCN meetings. Year-end position shows higher up-take achieved than the All Wales average across the three cohorts: >65 years: **74.1%** (Highest in Gwent – Wales: 68.2%) <65 years: **56.7%** (Highest in Gwent, target met/ Wales: 43.8%) 2-3 year olds: **64.1%** (Highest in Gwent – Wales: 49.3%) In 2018 the NCN agreed a review of flu up-take in 2 and 3 year olds, to be informed by NICE guidance with findings presented to the NCN. A range of ideas for trying to further improve up-take in this age group were considered to be taken forward in 2019/ 20.	
4.2 'Medical Model' (adapted from Year 1) **–** Local planning includes access to clinical support and admission avoidance	**Years 1,2 & 3** NCN Lead ABUHB Integrated Services Partnership Board	Delivery of Clinical Futures – Care Closer to Home	Planning forms part of the Clinical Futures and Care Closer to Home strategies including potential focus for developing a Community Frailty Unit and in-hours Urgent Primary Care Hub. On-going bed pilot with direct admissions to Chepstow Hospital from the community, to carry out multi-disciplinary assessments. Designed to enable community and primary care staff to manage patients at risk of admission in community settings. **Next steps:** Progress monitored via ISPB action plan	

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	Progress	RAG Rating
5.1 All Wales Clinical Governance Practice Self-Assessment Toolkit (CGPSAT)	**Years 1,2 & 3** Practices NCN	Delivery of Clinical Futures – Improving Quality and Safety of Patient Care	Practices access toolkit via GPOne website	

Strategic Aim 6: Other Locality issues

Objective	For completion by:-	Outcome	Progress	RAG Rating
6.1 Prescribing – GP Practices are supported to identify financial efficiencies for reinvestment with performance benchmarking across Practices and NCNs	**Years 1,2 & 3** Prescribing Advisors Practices NCN	Delivery of Clinical Futures – Improving Quality and Safety of Patient Care	GP Practices worked together to achieve Clinical Effectiveness Prescribing Programme (CEPP) savings of £14,093, made available to the NCN and invested in dermatology scoping equipment. **Next steps:** Continue to monitor effectiveness of roles and performance against other NCNs	
6.2 Dementia – To support development of local schemes for people with dementia in South Monmouthshire	**Years 2 & 3 (revised)** NCN National Exercise Referral Scheme (NERS) Integrated Services Partnership Board	To support delivery of the WG dementia action plan for Wales (2018/2022) & 'A Dementia Friendly Nation' Delivery of Care Closer to Home	£200,000 committed by ABUHB for people with dementia and carers to access community based schemes. **Combined exercise and educational scheme:** Piloted from January to March 2019 in Chepstow and Caldicot. Twice weekly session for sufferers of early vascular dementia providing supervised exercise sessions supported by leisure centre NERS staff, educational support and advice together with arts, crafts and reminiscence sessions supported by the Local Authority educational staff.	

			Bridges Community Care Scheme: Car Scheme co-ordinators register, recruit and support volunteer drivers enabling people with dementia to access health appointments and facilities. Promoted by Community Mental Health Teams, GP practices and other health and social care professionals. **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 their carers. **Next steps:** ISPB to evaluate effectiveness of schemes in 2019/20	