PC 43
Ymchwiliad i ofal sylfaenol
Inquiry into primary care
Ymateb gan: Bwrdd Iechyd Prifysgol Aneurin Bevan
Response from: Aneurin Bevan University Health Board

Our Ref: JP/RB/jr Direct Line: [redacted] 15 February 2017

SeneddHealth@Assembly.Wales

FAO – Sarah Sargent, Deputy Clerk

Dear Sir or Madam

Health, Social Care and Sport Committee's Inquiry into Primary Care

Thank you for the opportunity to provide comments in relation to the above Inquiry. I should be grateful if you would find below comments on behalf of Aneurin Bevan University Health Board. This response provides an overview and highlights some of the key developments being taken forward and issues currently being responded to in primary care in the Gwent area in line with the areas of interest of the Inquiry. However, if you would like further information and detail about any of the elements outlined below, please do not hesitate to contact the Health Board.

Our vision in the Gwent area for the future delivery and continued development of primary care services in our local communities is a key element of our Health Board's overall Clinical Futures Strategy. We are also clear that primary care is not just about General Practice, but is also about the roles that Dentists, Pharmacists, Optometrists and wider community based services play in providing care and support to the people we serve.

Bwrdd Iechyd Prifysgol Aneurin Bevan
Pencadlys,
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: [redacted]
E-bost: [redacted]

Aneurin Bevan University Health Board
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ
Tel No: [redacted]
Email: [redacted]

In Gwent, our approach to primary care delivery is driven by and through our 12 Neighbourhood Care Networks (NCNs). We are committed to securing the future of primary care as the bedrock of 21st century NHS services and wider community based care. We are focused on offering people comprehensive first-point-of-advice, diagnosis and treatment,

together with ongoing care coordination and support. We will continue to seek to harness community assets that help prevent ill health and improve people's resilience to cope with change and everyday stresses in life. In order to achieve this, we are clear, with our partners, that primary, community, social care, third sector provision and housing services will need to be further integrated. New roles and services will need to be developed to keep people well and independent and reduce their need for unplanned hospital admissions, unnecessary long stays in hospital and the requirement for institutionalised care and also to build resilience in primary care services for the future.

Developing Primary Care Clusters (Neighbourhood Care Networks)
Our twelve well-developed NCNs (GP Clusters) comprise primary care, health and social care community providers, public health professionals and representatives of the third sector. Although our NCNs are led in the main by GPs, they are also genuine partnerships. This is demonstrated with one being led by a Public Health Specialist and another by a Senior Nurse. Individual Practice Development Plans (PDPs) have also been developed which inform 12 NCN overall plans, which then in turn inform the Health Board's Integrated Medium Term Plan. The Health Board has also established the NCNs with a network support structure to facilitate NCN development and delivery. We also have in place a Primary Care Operational Support Team to ensure that NCNs have easy access to quality improvement support and to enable GP practices to assess their capacity and demand and to secure for funding for innovative solutions. This multi-disciplinary team provides clinical support and leadership to practices who are particularly facing sustainability issues.

Through the leadership of NCNs, there will be further scope for more smaller scale service programmes and projects, but the networks also offer real opportunities for re-design on a larger scale with the potential for Gwent-wide projects and further close working with partner organisations and the Health Board's own secondary care services to genuinely realise the benefits of having integrated health organisations in Wales. We have firm foundations in the Gwent upon which to build. This greater liaison and interaction between professional groups through the NCN arrangements and wider collaborative working through our regional work on the Social Services and Well Being Act are real strengths and present further opportunities for the NCNs and the Health Board in general.

The following principles have been identified and used to underpin our development and delivery work of our NCNs:

- To be mechanisms to enable change and promote engagement;

- To facilitate collaboration across the Health Board, Local Authorities (LAs), Public Health Wales (PHW), Third Sector, Housing and local communities;
- To facilitate the integration of services;
- To enable a changed workforce skill mix and estate to support more delivery in primary care.
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In terms of the supporting NCNs, £1.1 million has been delegated to the NCN Leads already and this has provided an impetus in terms of NCN development. NCNs have determined locally their priorities for this expenditure and these have included a range of workforce developments, such as:

- Appointment of 12 Practice Based Pharmacists
- Appointment of a Practice Based Physiotherapists
- Appointment of Practice Based Social Workers

Also in addition to workforce developments there has been the development of local shared resources, such as the purchase of the Dementia Road Map across all NCNs in the Gwent area.

There has also been focused work on models of prevention and early intervention to prevent unnecessary hospital admission and promote health and well-being with examples of developments such as the Newport Older Person Pathway, Anticipatory Care Planning in Care Homes and our award winning Living Well Living Longer Programme.

There is also the potential that NCNs could also move to directly managing some services with their own further developed governance and decision making arrangements to deliver our Care Closer to Home Strategy as supported by the Health Board. This will give them the real levers for change to influence the other areas of the NHS and wider community based services provided by a range of our partners.

The Challenges and Development of the Primary Care Workforce

The challenges for the primary care workforce are significant now and for the future. Therefore, the Health Board's Primary Care Workforce Plans aim to ensure the whole primary health team is mapped to demand and requirements, is delivering prudent healthcare, is well trained and learning is shared and particularly ensures that the correct number of staff with the right skill mix is available to meet our population's planned and unplanned health needs.

There is also the challenge of primary care estate to ensure that we have the right facilities from which our workforce can deliver 21st Century services for the population we serve and can act as genuine hubs for the delivery of integrated services, information, advice and support. We have made many recent investments in our primary care estate including new multi-disciplinary facilities such as the Rhymney Integrated Health and Social Care Resource Centre and Blaenavon Primary Care Resource Centre and an ongoing programme of estate improvements. However, it is recognised that there is much more to do.

We have also undertaken, where appropriate, work on GP practice configuration and partnership working. This builds in resilience to our current network of GP and primary care services, whilst also ensuring that we maintain local services to meet the needs of local communities.

The Health Board is also committed to ensuring that our workforce has the skills and knowledge required to take forward the services as planned and future developments. As a result we have an education and development programme in place including development for both practice nurses and healthcare support workers in primary care. Our nursing team, in conjunction with Cardiff University, has developed an accredited Foundation Course for Practice Nurses new to practice. There is also an accredited work based programme for Health Care Support Workers (HCSW) working within General Practice and this has been developed in partnership with Coleg Gwent.

Also, we are focused on improving the quality of our services and support to others and a number of local nursing homes have completed IQT silver projects to help improve quality of care in nursing homes through embedding the principles of Advanced Care Planning. This has resulted in a 30% reduction in unplanned admissions from nursing homes and reducing the impact on primary care.

As mentioned earlier, our NCNs are not only focused on GPs, but also the range of health professionals working in primary care. Our NCN pharmacists work with patients with long term conditions to manage their own health and medication, maintain independence and avoid unplanned admission to hospital. Pharmacists deliver activities such as medicines reconciliation, drug monitoring and medications reviews. This releases GP capacity as one of our responses to the challenge of securing enough GPs to deliver services going forward and it also extends the Pharmacist role.

We are also not only working to respond to the challenges of the current primary care workforce, we are seeking to develop and secure our workforce of the future. For instance, we are working with Education Departments to engage pupils to consider primary care careers – a video has been filmed to engage Year 10 pupils and above to consider careers within Primary Care.

It is clear the NHS in Wales has a particular challenge with regard to the availability of GPs for the future. Therefore, the Health Board has a project focused on clearly understanding what would be the likely effect of the retirement and failure to recruit on the number and location of GP practices in Gwent in the next 5 to 10 years. A total of 72 GPs (18.9% of GPs) are likely to retire in the next 10 years. 53 (73.6%) of these are male GPs and 19 (26.4%) are female GPs.

For example, Blaenau Gwent East NCN will lose a third of its GPs if they wait until statutory pensionable age. However, the trend is that GPs are retiring earlier so this poses more of an immediate challenge. Those areas with the greatest deprivation also have the highest percentage of GPs retiring in the

next decade. This is an example of the Inverse Care Law that we are actively addressing and seeking to reverse.

GP Out of Hours

There is a continuing challenge to provide services for patients outside normal GP practice hours with high levels of demand for out of hours services. We have a five year plan to redesign the Out of Hours (OOH) service to ensure provision of a safe and sustainable service in the context of reduced GP availability and increasing demand. This aims to increase the skill mix in our out of hours services through employing additional nurses, Nurse Practitioners, Advanced Nurse Practitioners and Advanced Paramedics. We also have plans to increase the role of Community Pharmacies in providing advice and support for patients. We are also aiming to increase the skills and availability of non-clinical staff and Health Care Assistants to support the service.

In 2016, the Health Board received funding to develop and enhance the availability of an overnight nursing service from 20:00 to 08:00, aligned to our out of hours primary care service. This was designed to support patients who require a call at night for support such as with palliative care, ongoing planned care/treatment and catheterisation.

The funding has improved community care and support throughout the 24 hour period for all adults across the Health Board area. It has delivered enhanced service sustainability through the alignment to the existing primary care out of hours service to maximise the service available for patients, avoid duplication of effort and continues the planned care provided by district nursing and frailty teams (in hours).

Linkages across the different parts of the health and care system

The Health Board is seeking to respond to the challenges of increased demand for primary and community based care and ensuring the services we provide are integrated across the health and care system through a number of key programmes and projects top meet the needs of our communities.

Care Closer to Home (CCTH)

The CCTH strategy is being developed by service providers and users and addresses local health needs by focusing on delivering integrated care, closer to home in order to promote independent living and deliver high quality, safe care and improve patient experience and outcomes.

The strategy will enable people of all ages to stay home or close to home despite any vulnerability or frailty. They will be enabled to be part of community activities and befriending will be used to avoid loneliness and isolation. If hospital is required, people will be helped through their stay, receiving diagnostics, care and treatment to appropriately return home. People will be identified early if they need care or support to better co-ordinate the range of services and care they might require on return to their communities. This will support our already well established partnership Frailty Programme.

We have also developed a multi-agency befriending service 'Ffrind i Mi/ Friend of Mine', which was recently launched, which aims to help combat the issue of loneliness and its effects in Gwent.

The Health Board also has a community connector project aimed at tackling isolation. Local people who are 18 years or over who are vulnerable and/or isolated are linked to activities and support networks in the community.

Older Person Pathway (OPP)
Developed with Local Authorities (LAs) and the third sector, this pathway uses a risk stratification tool to identify patients who are at increased risk of use of statutory services. Patients are proactively visited, assessed and a Stay Well Plan established via a practice based Care Co-ordinator, employed by the third sector, who ensures the wider Primary Care Team and the third sector support services are deployed to help keep the people safe and at home. This programme has already seen a reduction in required GP appointments, a reduction in required home visits and a reduction on the number of required hospital admissions for those participating in the programme.

Delivering the shift of services from hospital-based care to primary care
The Health Board has undertaken a range of development work to seek to provide services appropriately in primary care settings, which means that patients do not need to travel to hospital for care and support.

Anticoagulation – The Health Board has been undertaking through 14 GP practices work to ensure there is a shared and seamless record of anticoagulation care across primary and secondary care, and an associated rationalisation of the supply of consumables through a new pan-Gwent contract. This has also generated significant cost savings.

Falls Response Unit - We have worked with the Welsh Ambulance Service NHS Trust (WAST) to develop a falls response unit. This involves the deployment of paramedic vehicles and our Community Reablement Team (CRT) to enable people who have fallen to remain at home. We are providing training and education on falls tools in the Care Home sector, to help recognise deteriorating patients and to encourage more appropriate use of services to keep people well and avoid unnecessary transport to hospital.

Glaucoma and Wet Age-related Macular Degeneration (AMD)
We have a Glaucoma Assessment Local Enhanced Service in a number of our Optometry Practices to provide assessment for people with glaucoma or ocular hypertension. Increasing numbers of patients are now having their follow-up assessment in optometry practices in primary care. Three Glaucoma Ophthalmic Diagnostic Treatment Centres (ODTCs) have been commissioned to deliver 4,000 follow up appointments per year within a primary care setting. Assessments, diagnostics and treatments will be undertaken within these settings releasing significant infrastructure and imaging capacity within our eye clinics and ensuring that patients have their care closer to home.

Ophthalmic Diagnostic Centre: The Health Board has also been a partner in a pioneering Ophthalmic Diagnostic Treatment Centre in Gwent, developed in Newport in partnership with Specsavers and with the support of Welsh Government funding. The Centre is the first of its kind in the UK to see a high street optician provide initial screening and referrals for people with symptoms of Wet Age-related Macular Degeneration. This approach is designed to reduce waiting times for assessment, diagnosis and treatment and make services more accessible to people in their community.

Cardiology – We have planned for three GPs with Specialist Interests to deliver a community cardiology service. They are currently undertaking the 18 month training. This initiative will result in around 2,500 cardiology consultations being undertaken in primary care from 2017/18.

Direct Access Physiotherapy (Blaenau Gwent NCN) - We also have a joint project between NCNs and our Physiotherapy Service, where patients attend a drop in session at Ysbyty Aneurin Bevan, Ebbw Vale to see a physiotherapist. This provides a speedier service for patients without the need to make an appointment with a GP and wait for the GP referral and contact from the Physiotherapy service. On average 12 patients a day are accessing the service.

Prison Services – The Health Board is also undertaking a range of work with our local prison service. The following services have been transferred from secondary care and are now in-reach services into the prison primary care services:

- Diabetes Specialist Nurses
- Physiotherapy
- Sexual Health Nurses
- Mental Health – Primary care Mental Health Support Service and Secondary Care

Diabetes - A Primary Care Diabetes Specialist Nurse (PCDSN) Team aims to ensure that patients have better controlled HbA1Cs and rational use of diabetes medication in keeping with prudent healthcare principles.

Some examples of what the team have achieved this year:

- Initiated Insulin and optimised treatment regimes at GP and Practice Nurse request
- Facilitated the discharge of hundreds of outpatients from waiting lists
- Promoted improved diabetes management within care homes, ensuring medication is effective and evidence based.
- Supported the Patient Reference Groups to improve services and represent areas and demographics of patients.
- Developed an action plan informed by patients and carers to improve diabetes care for local people.
- Reduction/prevention of admissions and referrals to secondary care through auditing waiting lists, providing waiting list discharge clinics and co-producing care plans with patients.

The preferential use of cost effective needles initiative has saved around £30K per quarter.

The Health Board has also undertaken a range of additional work on seeking to integration of services across our communities. For instance, six GP practices in Torfaen provide the link between primary care and the network of services offered in the community providing support to prevent ill-health, tackle the underlying causes of ill health and promote self-help.

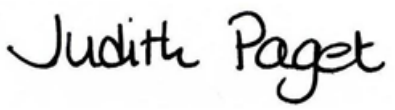
Therefore, the Health Board is committed through our NCNs and primary care services to continue to develop sustainable primary care and community services that support the delivery of care as close to home as possible. This network of services will also be focused on prevention, early identification, and early intervention, comprehensive management of chronic conditions, preventing unnecessary admission to hospital and facilitating timely and effective discharge.

However, the Health Board recognises that this is in the context of increasing demand, a population that is aging with a range of ill health and people with co-morbidities and a range of challenges with regard to capacity of these services and the availability of primary care workforce, especially GPs to respond.

Therefore, the Health Board is committed that primary care services will continue to be developed and be provided in partnership, fostering co-production to enable patients to better manage their own health. Work will also continue to further develop the mix of skills of our workforce, particularly in primary care. There will also be a continued drive to make services as accessible and equitable as possible for all our communities.

If you need further information with regard to this response, please do not hesitate to contact me.

Yours sincerely



Judith Paget
Chief Executive/Prif Weithredwr