Freedom of Information Request	FOI 21-110	23rd March 2021

1. Other than an inflationary uplift, has the Community Health Services contract or budget allocation increased, decreased, or remained the same during the 2019/20 and 2020/21 financing years?

For the period defined the budget allocation has remained the same, however, all budgets are reviewed yearly to determine service demand.

2. Does the Health Board's contact or agreement for Community Health Service specifically include the provision of care, or services, for ambulatory sensitive conditions which are designed to prevent emergency admission to hospital?

As part of the delivery of care Aneurin Bevan University Health Board (ABUHB) reflect the ethos of A Healthier Wales and aims to provide care as close to home as possible. The organisation has eleven (11) Neighbourhood Care Networks (NCN) that support the development of a place based care model enabling individuals to seek solutions close to home for many of the conditions covered by the Ambulatory Care Sensitive Conditions (ACSC) guidance.

The Health Board comprises of a number of divisions including Primary Care and Community Services (PCCS) and Unscheduled Care Division (USD) however, all clinical divisions deliver elements of their service in the community. This may be as part of outpatient clinics based in community facilities closer to individuals homes or as an outreach to support citizens either by telephone or in their own home.

For the purposes of this request the services supported by the PCCS Division will be discussed however it is important to recognise the pivotal role of teams across the Health Board. These include cardiac, ENT, dermatology and rheumatology specialist nurses etc. This group of staff provide outreach support to patients and their families, teaching to other medical colleagues and clinic support in local hospitals.

The PCCS services work closely with GP colleagues and wider specialist teams to support individuals to stay safely at home and ensure that care is delivered as prescribed and supports the management of symptoms and conditions.

3. Is the prevention of admission to hospital with one or more ambulatory sensitive condition a specific component or target for the Board's district nursing services?

The prevention of admission of all individuals is a priority for the Health Board and is reflected in the Clinical Futures Strategy and Care Closer to Home programmes. The community nurses pay an important part in this process, supporting individuals to stay safely at home under the guidance of the patient's general practitioner. District Nurses however provide care to those patients who are essentially housebound whilst the wider group of individuals living with an ACSC are supported by their GP and consultant, seeking intervention as appropriate from the community response team.

The District Nurse role recognises the importance of ensuring that all individuals are supported to remain safely at home and patients with conditions described as ACSC are frequently on their caseload.

Within PCCS a number of specialist nurses support individuals with diabetes and respiratory conditions – specifically asthma and COPD, providing advice and support to these groups of patients in order to prevent admission and support the delivery of flu and Covid vaccination programmes to housebound patients.

4. Has the Health Board developed services, in the last two years (2019/20 and 2020/21 financial years), which are designed to prevent admission to hospital for patients with ambulatory sensitive conditions?

- Development of support to care homes – CATCH team working with care homes to support residents to stay safely in the home and avoid admission

- Diabetes Specialist teams – development of work to review use of insulin and provide services close to home

- A collaborative approach to the prevention of hospital admission of COPD patients during the winter months. The winter planning work stream was designed and supported by the Community Home Oxygen Service, the Primary Care Respiratory Team and the Frailty Service. Housebound patients are highlighted by the GP practices. Patients were visited by the teams based on the patient's respiratory condition; a medication review, current symptoms and self-management planning were discussed. The purpose is to collaborate with the patient direct them to appropriate resources for advice, treatment and support in order to prevent an unnecessary admission to hospital.

- In addition to the previous example the COPD service working collaboratively with WAST, developed a pilot working with WAST to support the referral of individuals who have called 999 back to CRT, ensuring that services are provided within an agreed timeframe to support individuals to stay in their own home and not to be conveyed to hospital.

- The development of the use of the National Early Warning Score across district nursing to support the recognition of deterioration and commencement of appropriate treatment

- Implementation of the Trial Without Catheter in the Community Policy

- Care Aims Training to promote patient empowerment in the management of ACSCs

- Sepsis and Falls education within Residential Care Homes which has supported all residents, including those with ACSC to remain in their home of choice, preventing admission to hospital

5. If the answer to question 3 was yes – were these services to develop:

- **New Teams within the Community Health Services**
- **Ambulatory Care in the Hospital Setting**
- **Existing Community Health Services and Teams**
- **Primary Care – General Practice Services**
- **Other (briefly describe)**

- A new team has been developed including support for those patients deemed socially vulnerable as part of a pilot in Newport. This team will include general nursing and mental health support and will support individuals, many living with ACSC, to manage their condition successfully.

- The Covid pandemic meant a different way of working for district nursing and community response nursing teams. Examples of this are evident where individuals with cellulitis, COPD etc are provided with additional care to support the individual to stay at home

- The Compassionate Communities Initiative has supported multidisciplinary working by enabling core professionals to discuss and support patients with specific conditions, many on the ACSC list, to remain at home by recognising increased need and agreeing a course of action

- In line with GMS contract relaxation guidance, a daily call has been introduced with GPs across Gwent to allow sharing of information and seeking support providing opportunity for discussion of specific individuals where appropriate.