Neighbourhood Care Network Integrated Medium Term Plan Torfaen South 2020-2023

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Executive Summary

This 3 year plan sets our vision for the Torfaen South Neighbourhood Care Network Torfaen County Borough Council and the Primary and Community Division (ABUHB). It seeks to address the significant challenges we are facing both within the Borough and across Gwent which include increasing demand from an aging population, significant health inequalities, deficits in the current workforce and the implications of commissioning a new specialist and critical care centre, the Grange University Hospital in 2021 which is situated within the Borough.

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 wellbeing for everyone. Driven by the ambitions in recent documentation including Healthier Wales.

This plan outlines how we will upskill our staff and develop innovative service models, in partnership with key stakeholders including the local authority and third sector to meet the ever complex, growing needs of our population. With an aim to reducing demand on GP services through new service models, integrated teams, improved local information, support and advice and bringing care closer to home. Using various funding sources to test out new workforce models and ensuring our estate and IT infrastructure supports new ways of working.

Also delivering place based care through a hub approach bringing together health, social and third sector services. The first Hub of this kind has been developed in Blaenavon Resource Centre in the North, with further plans to scope out a central hub on the County Hospital site and one in the South of the Borough. This hub approach must be built on our estates strategy to ensure that services, equipment and infrastructure are aligned to make best use of resources and a well-trained sustainable workforce.

On a very local basis we will work closely with Public Health and our local community services to develop Integrated Wellbeing Networks which will help promote healthy lifestyles and encourage communities to actively take control of their health and wellbeing issues.

Our aims are to:-

- Improve the health and wellbeing of the local population
- Improve/support sustainability
- Expand on our CRT unit support within the community.
- Support people to stay well, lead healthier lifestyles and live independently Working collaboratively.
- Reduce health inequalities
- Deliver the Clinical Futures Strategy in primary and community care.
- Care closer to home
- Provide more easily accessible "place based" health and social care or Provide more joined up services in community settings
- 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

Aneurin Bevan University Health Board

Delivering Care Closer to Home

South Torfaen Borough

Neighbourhood Care Network Plan – 2019/20

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, Direct Access physiotherapists, academy Pharmacists/Nurses
- Raising awareness of the care and advice already available through local services using Care Navigations and QR boards, such as community pharmacies and voluntary sector teams: Care Navigation will be supporting the following services within Torfaen-
- Social Prescribers, Community Connectors, British Red Cross connectors, Minor Injuries, Emergency Eye Care, Direct Access Physiotherapy and Pharmacy.
- **Increasing access to specialist roles in the community including Diabetic Specialist Nurse, Respiratory specialist nurses, and Palliative Care services.**
- Working to increase uptake of preventative services to keep citizens well including influenza immunization / childhood immunization / smoking cessation services / weight management services / exercise schemes
- Improving effective working relationships between GP's and CRT
- Supporting community based admissions.
- Upskilling staff to support more services i.e. Respiratory
- Working with secondary care on services such as Gynaecology and women's health.

How are we delivering change?

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

Recruit, train & educate our workforce to ensure needs of population met

Use Multidisciplinary Team to undertake active signposting

"Enablers"

- Technology
- Skilled Workforce
- Partnership Working
- Financial Resource
- Fit for Purpose Estate

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.

1 Introduction to the 2020-2023 Plan

Our Primary and Community Care Division's IMPT 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 Torfaen South Network will take over the next three years to take us closer to achieving our vision. It sets out key priorities, milestones and implementation plans and analyses the challenges, opportunities and risks associated with delivery. It will also describe what it will take to deliver these actions, in terms of workforce configuration and financial implications. This plan will direct our NCN business, enabling us to be clear and purposeful in our actions and to hold ourselves accountable for delivering our priorities, for the benefits of the communities we serve.

We aim to improve the health and wellbeing of our population, supporting people to stay well, lead healthy independent lives and reduce inequalities, building on the assets that are found in the community and mobilising individuals, organisations and services to come together to realise and develop their strengths.

To deliver this we need to transform services so that our staff can work in collaboration. Developing new, integrated services, provided by well-trained confident staff, serving an empowered community through local accessible health and wellbeing services; providing the right service, at the right time, by the right person.

The NCN has considered how our vision will translate into service delivery. In May 2019 we held an NCN Workshop to identify strategic themes and priorities for the NCN Plan. This together with information drawn from an analysis of Population Needs Assessment and data benchmarking our performance at locality, Borough, Health Board and national level, has told us we need to do the following:

- Address ever increasing demand for healthcare services by an aging population who are living longer but with chronic complex conditions.
- Develop innovative and collaborative models of health and social care to address the key issues which contribute to chronic conditions notably, cancer, respiratory, heart disease and mental health.

- Tackle pockets of health inequalities in the population of Torfaen linked to socio-economic deprivation.
- Reduce the pressure on primary and community services and associated sustainability issues of recruitment and retention of staff.
- Build on our Community Resource Team Model to bring more services into peoples' homes and community settings.
- Further explore the Hub concept and in particular the virtual hub concept, where a variety of services are provided from primary care settings
- Improve our estate and IT infrastructure so that we can provide primary care services fit for now and the future.
- Bringing our services closer to home through investment in new models of care.
- Exploring the issues around child and adolescent mental health and addressing the needs of our significant Looked After Children population as part of the Adverse Childhood Events agenda.
- Improving our immunisation and vaccination rates for our targeted groups
- Work more closely with the Local Authority to understand the impact of future housing developments in their Local Development Plan

We have started to tackle these and other challenges through investing NCN funding and short term funding from other sources to test components of new models of care which include:

- Establishment of Direct Access Physiotherapy services at County Hospital.
- Appointment of extended roles including Advanced Nurse Practitioners and Pharmacists.
- Appointment of Social Prescribers to improve signposting to help, advice and support with social and wellbeing issues.
- Establishment of an Integrated Wellbeing Network in Blaenavon.
- Implementation of a Graduated Care Unit at County Hospital.
- Working with the Learning Disability and Mental Health Division to improve local primary mental and child and adolescent mental health services (*Single Point of Access for Children's Emotional Wellbeing – the SPACE Wellbeing panel)*
- Collaborative working across organisations and professions to deliver an effective flu immunisation programme.

As standards of living and advancements in medicine continue to improve so will the pressure on services continue to grow. The key challenges facing NCNs is to test out these new ways of working, and where they work, adopt them as core services; at the same time as managing day to day service pressures against a backdrop of decreasing resources.

Also to ensure our staff, partners and the citizens come with us on this journey because, without this, our endeavours will not reap the maximum benefit.

It is within this context, and in the face of these challenges, that the Torfaen South NCN will work together to deliver our plans over the next 3 years.

2 Overview of the Neighbourhood Care Networks

2.1 Profile of the Neighbourhood Care Network

Much of the following profile is extracted from the Torfaen County Borough Council Area Assessment of Local Well-being, March 2017. More detailed information is available at the following link:
http://www.torfaenpublicservicesboard.co.uk/en/Documents/Assessment-of-Well-being/Part-1-Torfaen-Well-being-Assessment.pdf

Torfaen Borough is divided into 2 NCN areas, 1 in the South of the borough and 1 in the North.

South Torfaen covers the Cwmbran area of the Borough. There are 6 GP practices and 1 branch surgery in the South with a combined practice based population of approximately 47,000.

There is a train station in Cwmbran and good road and transport links.

The latest Welsh Index of Multiple Deprivation (2019) shows that there are 3 LSOAs out of the 60 IN Torfaen that are in the top 10% most deprived in Wales Pontnewydd 1 and Upper Cwmbran (part of Thornhill) are two of these.

There are varying areas of deprivation within Torfaen South NCN. The most deprived area being Upper Cwmbran.

There are 15 primary schools including 1 welsh speaking school and 3 secondary schools including 1 welsh speaking school.

The proportion of the whole population aged 65 years and over is 25.8% which is higher than the Wales average of 18.3%.

Predicted population rise between 2016-2039 are as follows: 40% rise in 65+; 78 rise in 75+; 136% rise in 85+ with more females living longer than males and 9% fall in aged 26-64.

Alongside the predicted rise in older people within Torfaen, is a rise in those with dementia. In Torfaen the number of people with dementia aged 65 years and older is predicted to almost double from 1,232 in 2015 to 2,096 in 2035. (Source: TCBC Wellbeing Assessment 2017)

It also showed us that even in our less deprived areas there are families and individuals who are struggling with poor health, no or limited educational qualifications and unemployment or low income levels which mean their well-being is also of a lower quality than others around them.

2.2 Vision statement

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 life as possible".

Through our vision we aim to:

- Deliver the key principles of Care Closer to Home and ensure our patients are, wherever possible, able to be cared for in their own home and not in hospital.
- Establish multi-agency primary care hubs which provide a wide range of patient centred, community based services.
- Establish integrated health and social care and third sector teams to provide an increasing range of seamless care to patients.
- Ensure that our services meet the needs of our population.
- Ensure patients are actively looking after their health and wellbeing to help prevent developing chronic conditions.
- Ensure patients have the confidence and knowledge to manage their health conditions.
- Ensure that there are effective signposting mechanisms in place to ensure our patients access the right support, advice and information from the most appropriate service and in the most appropriate setting.
- Ensure our staff have a supportive working environment and opportunities for career development.
- Ensure that resources are available to invest in primary care and community services.
- Ensure health and social care estates and assets are used to their maximum benefit.

If we achieve these aims the following will be seen:

- The health and wellbeing of the local population will improve
- Services will be provided equally across the NCNs.
- Citizens will feel part of, and contribute to, the local community
- Our communities will be resilient with citizens empowered to stay well, lead healthier lifestyles and live independently
- When our citizens need to access services, they will know who to ask to signpost them to the most appropriate service.
- Access to services will be straightforward, close to home and will have the flexibility to meet individuals needs
- Services are sustainable and fit for the future.
- Should specialist expertise be required, these will be accessed in a timely manner
- Our staff feel supported, empowered and equipped to provide the services for our population.

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.
- Patients will be in hospital for the minimum amount of time.
- The organisation supports the shift of resources to primary/community care settings.

In considering the vision set locally and the national strategic direction the NCNs have undertaken workshops to translate this into service delivery. This has resulted in the following strategic themes being identified:

- To support the needs of patients at a cluster level.
- To support practices.
- To promote joined up working.
- To plan and develop services based on population needs.
- To improve communication between practices.
- To support and promote wellbeing.

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 Amanda Head	NCN Lead	ABUHB
GP Practice representation from all Torfaen South practices	GP/Primary care Representative	Clarke Avenue Practice, Cwmbran Village Surgery, Cae Teg Group, Llanyravon Surgery
Adam Harper	Housing Manager	Torfaen County Borough Council
Andrea Cook	Social Care & Housing	Torfaen County Borough Council

Name	Role	Organisation / Designation
Andrew Rowlands	Healthy lifestyle Manager	Torfaen County Borough Council
Claire Collins	Primary Care Mental Health Support service	ABUHB
Emma Davies McIntosh	Service Development lead, Integrated Wellbeing Networks	Public Health Wales
Helen Hayes	Senior District Nurse	ABUHB
Iain McMillan	Children's services	Public Health Wales
	Principle Health Promotion Specialist	Public Health Wales
Lena Evans	Families First, Early years & Flying start Operational Manager	ABUHB
	District Nurse Deputy Team Leader	ABUHB
Pat Powell	Building Stringer Bridges Facilitator	Torfaen Voluntary Alliance
Permindher Mudhur	Building Stronger Resilience Manager	Torfaen County Borough Council
Rachael Lewis	Supporting people Team Leader, Social Care Housing	Torfaen County Borough Council
Representative	Bron Afon Housing	Bron Afon Housing Association
Rhian Morgan	CRT Manager	ABUHB
Alfred Olowo Fela	District Nurse Team Leader	ABUHB
Alison Magor	District Nurse Team Leader	ABUHB
Tracy Morgan-Wallace	Borough Lead Torfaen, Family and Therapies	ABUHB

2.3.2 NCN Leadership and Support Teams

Within each borough, NCNs have a support structure consisting of fellow NCN Leads and members of the Primary Care and Community Services Division. 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	Title
Mrs Trish Edwards	Head of Service
Mrs Catherine Gregory	Assistant Head of Service
Mrs Leanne Watkins	Network Manager
Vacant	Network Support Officer
Deborah Harrington	Primary Care Contracting Manager

2.3.3 Frequency of Meetings

The Torfaen South NCN hold six 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 co-ordinates the agenda for each of the two Torfaen cluster areas and items for inclusion on the agenda can be sent to her for discussion and agreement with the NCN cluster lead.

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 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 throughout the week with NCN partners, as required, to share relevant correspondence and to facilitate local resolution of queries linked to the plan actions.

The governance arrangements ensure that good communication exists between clusters across Gwent via the NCN Leads monthly meetings and also via Torfaen Integrated Partnership Board and NCN management team meetings.

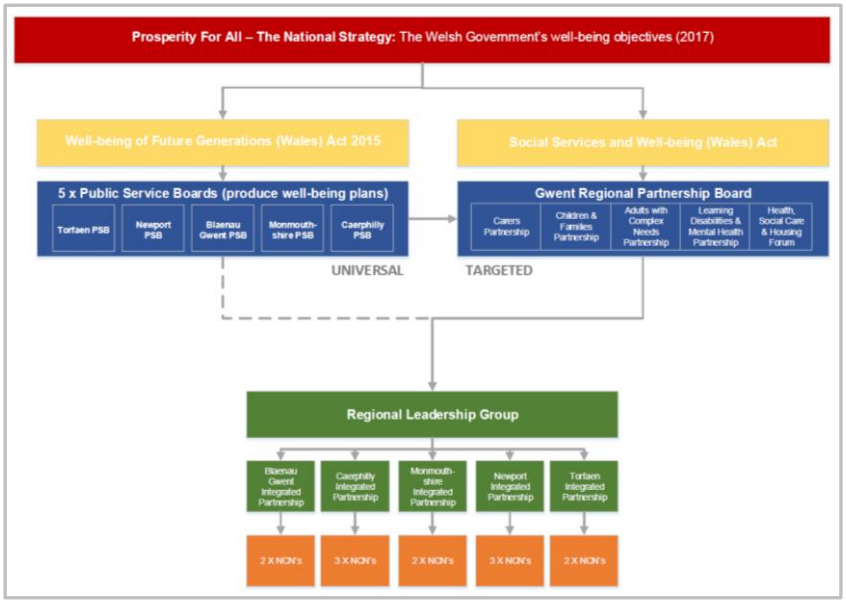
2.3.7 Reporting Framework

The NCNs form part of a wider reporting framework, as described opposite.

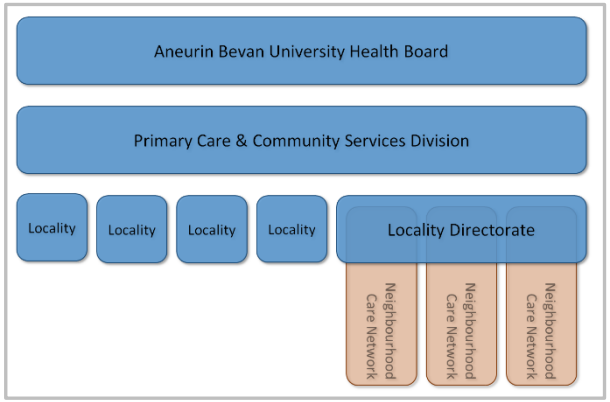
The NCNs are a key component of the Integrated Services Partnership Boards (ISPBs) in each of Gwent's five boroughs, which report to the Regional Leadership Group and onwards to the Public Service Boards and Gwent Regional Partnership Board.

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.



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'.

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.

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:

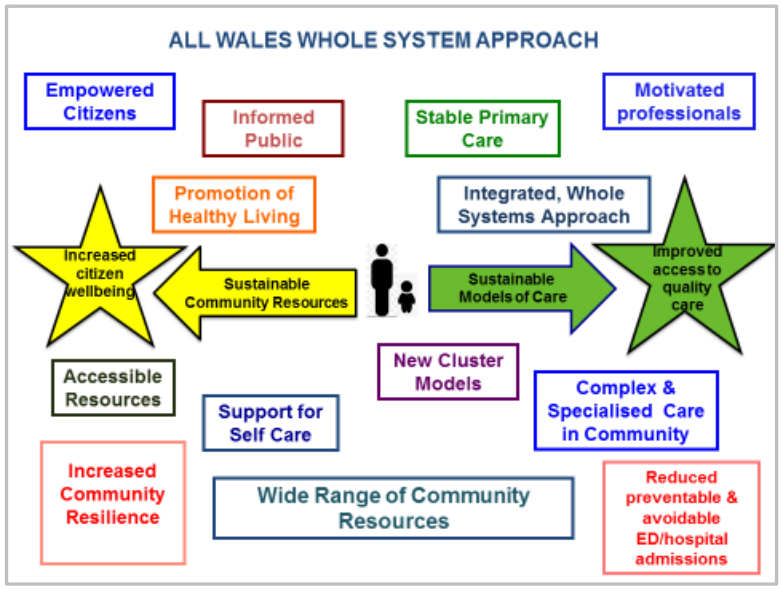
- Improve citizen well-being and patient outcomes (including patient experience) for people of all ages, by designing and delivering new models of care for the population of Aneurin Bevan University Health Board across the whole health and wellbeing system. The models are designed with a focus of prevention, 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 focussed 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 carers.
- ***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 work streams 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

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 work streams. It is intended that NCN plans will feed into these work stream areas for support and decision-making. Details of progress to date is outlined in Section 4.

Strategic Work stream	Delivery Committees	Work steam 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
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 workstream 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

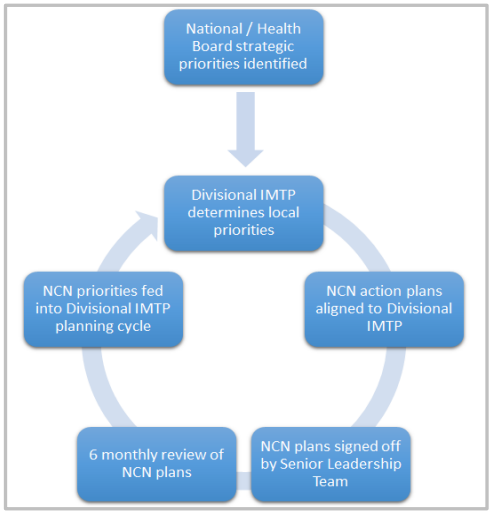
Strategic Work stream	Delivery Committees	Work steam Description	Example of Priority Areas
8) Estates Development	Primary Care Estates Group	Recent estate developments outside of hospital have accounted for the new model of service delivery, providing integrated health & wellbeing hubs. However, many 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

The table below provides an overview of the key achievements of the NCN over the last 3 year period, drawing out the benefits and outcomes:

Key achievements	**Benefits/outcomes**
Prevention, wellbeing and self-care. Care Closer to Home	
Smoking: Established Smoking Cessation Champions in each Practice. Pharmacy Level 3 Smoking Cessation Service delivered at 10 Community Pharmacies	Trained member of staff who is aware of local support services able to direct patients to local services. Enhanced with Making Every Contact Count training. Patients offered a choice of behavioural support via Help Me Quit and a treatment programme at Community Pharmacies. The number of referrals from South Torfaen to Help Me Quit was 39 and the total Quarterly GP referrals were 18
Vaccinations and Immunisations: Multi-agency task and finish group including education established to provide vaccination to target groups such as 2-3 years and over 65 years at a higher level	Maximum promotion and uptake for flu vaccinations for targeted groups. Partners fully informed about timetables and availability of vaccinations. Promotion of innovation such as 'Superhero day', weekend clinics and peer review learning
Community Pharmacy Respiratory Medicines Adherence Services Local Enhanced Service	Targeting patients who cannot attend annual asthma review in surgery hours. Improved patient outcomes, reduced medication waste, promotion of prudent prescribing
Integrated Wellbeing Networks	Linking services and people in local areas making most use of services at the right time and in the right place provided by the right people
QR Boards: Digital information accessible via devices digital cameras in every GP practice waiting room	Instantly accessible information to NHS services, self-help guides and local services
Identification of prescribing priorities	Targeted programme of work, with for example chronic pain management, and better outcomes of patients and cost savings through appropriate prescribing
ABUHB Medicines Management input - Regularly reviewed prescribing budget, with appropriate switches and substitutions	Prudent prescribing, savings in prescribing costs available to reinvest in primary care and NCNs. CEPP engagement provides audits for GP practices and GP education sessions both targeted at outlier prescribing areas

Key achievements	Benefits/outcomes
New delivery pathways have been agreed with Healthcare Professionals eg respiratory consultants.	Improved access for patients to community led respiratory services from enhanced primary care based pulmonary rehabilitation. Development of skills of existing staff within the emergency care at home department, to include review of COPD patients. This additional learning was lead and overseen by our Respiratory Specialist Nurse
Access and Sustainability. Introducing the Primary Care Model for Wales	
NCN funded Direct Access Physiotherapy service	Provides 15 slots per day Monday to Friday from County Hospital. Reduces demand on GP appointment
Practice based pharmacists including pharmacist employed by the practices	Undertaking medication reviews and prescribing issues support management of chronic conditions releases GP time and improves access for patients. Service also provided in care homes and on home visits
New service models	Using transformational funding to implement the primary care model; recruiting extended roles into primary care such as Advanced Nurse Practitioners and practice employed Pharmacists for practices to trial with a view to employing staff if successful. This eases pressure on GP services
Dedicated NCN sustainability workshops	Open forum for practices to share issues and develop solutions this was commissioned through PCC (Primary Care Consulting) through transformation funding
Care Navigation: Practice staff trained as Care Navigators to divert to services without seeing a GP.	6 Pathways across NCN area – Direct Access Physiotherapy, Minor injuries, Social prescribing, Torfaen Community Connectors, Choose Pharmacy and WECS. Patients are signposted to services to address their needs. By-passing the need for a GP appointment
Social Prescribers in every GP practice	Social prescribers provide a tailored service to manage social and well-being issues that citizens may be facing. Increased reach and speed of connectivity between primary care and wellbeing services with a 45 minute appointment available. By-passing the need for a GP appointment
Redesigning Community Services	
Implementation of Compassionate Communities Programme	Torfaen South NCN are considering how to implement the Compassionate Communities Programme at a local level
Community Resource Team/Community Frailty Unit	Collaborative working between GPs and CRT Team has been progressed to support patients within the community to avoid acute admissions utilising step up step down beds on Rowan ward for short term nursing care
Digital Data and Technology	

Key achievements	**Benefits/outcomes**
My health online	All of the practices use the MHOL system in South Torfaen
Text message reminders in South practices	Practices send text message reminders for all appointments as standard. These messages can be tailored for additional programmes e.g. Flu
Skilled local workforce	
NCN funded training	Care Navigation has empowered and supported GP reception staff to ensure that the correct questions are asked and the correct information is given back to the patients in regard to most appropriate appointment sources
Medical assistant/workflow optimisation training for practice staff	Practice clerical staff are trained to process workflow that would normally be directed to a GP. This allows GP's to prioritise other tasks
Wound care management training	Provided by DNs and Tissue Viability Nurse for practice nurses to develop improved skills in wound care management
Primary Care Academy	Nurses and Pharmacists trained to deliver Primary Care services as part of workforce planning

5 Population Health Needs Assessment

5.1 Population and Future Projections

We have conducted a local needs assessment to help us plan our services appropriately and understand the challenges, gaps and opportunities we have to improve the health and wellbeing of our populations.

We have used data from various sources including the Public Health Observatory, Torfaen County Borough Council Assessment of Local Wellbeing, 2017, the Primary Care Informational Portal and local data sources.

Included in Section 14 Appendix 1 is a copy of data analysis that has been used to inform the key needs identified in our IMPT.

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. Although in South Torfaen the average contacts to GP OOH between 6.30pm and 8.00pm have reduced. As have the amount of patients referred to assessment units per 10,000 population.

GP practices in South Torfaen are currently 90% compliant in the 5As to access. The NCN will work closely with all practices to ensure that the Access to In-Hours GMS Service Standards continue to be adhered to with regular monitoring.

We aim to continue to drive improvement in quality of care, sustainability and care closer to home by introducing new methods of improving access to primary care. By using Transformational funding and looking at introducing extended roles such as Physiotherapists, Advance Nurse Practitioners, mental health associates, social prescribers and the care navigation system to provide a prudent healthcare model. Also working closely with other Primary care contractors and the Primary Care Academy to achieve and succeed with these goals. We have maximised our estate at Blaenavon Resource Centre through collaborative working with partners and third sector colleagues to support a consistent approach in our first 'Hub'. We are progressing discussions for similar approaches in South Torfaen

The Dental Contract Reform is being implemented in Gwent. As practices progress through the stages of the programme, pathways will be developed and the expectation is for greater links to be developed with GP's, Out Of Hours, Designed 2 Smile and the wider integrated team.

Local Development Plan: It is recognised that the number of proposed/planned housing developments in the South will result in a need for additional access to all services, including GMS over the next couple of years. 383 houses will be built in the south by 2023. The NCN will work with the local authority to ensure impacts are planned for.

Delayed Transfers of Care (DTOCS)/bed days lost: Challenges faced in terms of delayed discharges from hospital include increasing complexity of cases, availability of packages of care and social work resources. Excellent collaborative working between community and social services culminating in a weekly multiagency flow meeting helps identify solutions and overcome issues.

Patient Status at a Glance Boards form part of the daily ward reviews. 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.

Healthy lifestyles and preventative services: Chronic diseases are the leading cause of mortality and morbidity in Wales and have a major impact on the expectancy of life lived in good health. The NCN are working with our partners and communities to develop an integrated approach that will target all major common risk factors of chronic conditions to prevent and manage these conditions.

Preventing ill health across the population is generally more effective at reducing health inequalities than clinical interventions. The assessment of well-being shows that healthy life expectancy is 15 years between the most deprived and the most affluent in Torfaen.

Enjoying four or more healthy behaviours - not smoking, maintaining a healthy weight, eating lots of fruit and vegetables, being physically active, having a moderate alcohol intake - can reduce the risk of diseases such as diabetes by 72%, vascular diseases by 67%, dementia by 64% and cancers by 35% when compared to those who have none or just one healthy behaviour. These risk factors also have impact on other diseases.

Adult smoking prevalence in Torfaen is 19.3% which is lower but not statistically different to the rest of Wales (20.0%). A Tier 1 Welsh Government Target for Health Boards is in place to treat 5% of the smoking population. The percentage of adults in Torfaen who reported eating five a day (WHS, 2014-15) is 29.8%, which is lower than but not statistically different to the average for Wales (32.2%).

Over a third of the population of Torfaen are physically inactive; this is higher than the Welsh average. Physical inactivity is closely related to deprivation; people are twice as likely to be physically inactive in areas of high multiple deprivation compared to their less deprived neighbours.

The percentage of adults in Torfaen who reported drinking above guidelines in 2014-15 is 35%, which is significantly less than the percentage for Wales (40.1%). However, it is important to note that survey data on alcohol consumption are known to be underestimated and likely to only capture 60% of consumption.

Torfaen has a higher rate of chronic ill health than Wales overall and for most categories most notably for rates of respiratory illness and poor mental wellbeing. Those self-reported rates from the WHS are similar to data from general practices across Torfaen for patients with diagnosed and registered chronic conditions.

The total number of people claiming Disability Living Allowance or Personal Independence Payments across all age bands across Torfaen Borough at May 2014, equated to 5,137 (Source: Daffodil). This equates to 7% of the population.

Chronic diseases have a lifelong course and place a significant burden on the patient, their families and carers. There are a number of chronic ill health conditions which are the main cause of lower life expectancy and premature mortality and which are having the biggest impact on mental health and well-being. A large proportion of this group of serious and prevalent ill health conditions can be prevented, delayed and better managed to significantly reduce the impact to wider well-being cancer, circulatory diseases (heart disease and stroke) and respiratory diseases are the highest causes of years of life lost in Torfaen.

The plans developed by NCNs have a strong emphasis on prevention and healthy behaviours aiming to reduce obesity, reduce smoking and improve uptake of physical activity. The NCN will also be working in partnership with Slimming World to tackle obesity through the provision of tokens issued by GPs that patients can use to access Slimming World Support.

Through the Care Closer to Home strategy, individuals will have access to a skilled primary and community care workforce, reducing reliance on secondary care services. Those with long term conditions will be supported to manage their self-care and well-being through structured education programmes. Chronic Condition Nurse Specialists will work from community and primary care bases making access much easier for citizens.

The further development of Integrated Well-being Networks on an NCN footprint, providing place based services, will help people lead healthier lives, improve their mental wellbeing, live safely and independently at home, have a meaningful occupation, learn new skills and participate in community life.

The NCN will continue to work with partners to help our population improve lifestyle behaviours and support them so that they become co-producers in the way that they manage their condition. Increasing self-efficacy and confidence among citizens in managing their own health and care needs is key to the success of preventing or limiting the impact of chronic conditions. We will also continue to build on our excellent networks, and service models which the NCN has established to signpost patients to information, advice and support.

We acknowledge the significant role of unpaid carers who provide support and care for family members or friends. All practices have carers information boards and a named Carers Champion who leads on the carers agenda on behalf of their practice. Primary Care provides an important role in identifying carers and our NCN will continue to ensure carers needs are considered within their plans.

Torfaen South NCN has always tried to maximise uptake of preventative services and are doing well in immunisation and screening services. We will continue to review our immunisation and screening data at NCN meetings and share practice data work to achieve and maintain national targets and promote sharing of best practice and provide support and advice to practices where uptake is lower.

Quality of care

South Torfaen NCN Prescribing Trends

All South Torfaen practices engage in the ABUHB CEPP Prescribing Incentive Scheme. The aim of this scheme is to engage practices to improve quality and cost effective prescribing whilst aligning with and contributing to medicines management priorities and NCN objectives. The 2019-20 CEPP scheme encourages practices to focus on 5 National Prescribing Indicators (NPIs) and improve prescribing towards set targets:

National Prescribing Indicator	Unit of measure	Target for 2019–2020	CEPP points (points for movement towards)
Proton pump inhibitors	PPI DDDs per 1,000 PUs	5,954.37	2 (1 point for 5% movement towards target)
Analgesics (includes co-codamol & tramadol)	Opioid burden: opioid analgesic ADQs per 1,000 patients.	3,668.91	5 (2.5 points for 5% movement towards target)
	Gabapentin and pregabalin DDDs per 1,000 patients	1,125.21	3 (1.5 points for 5% movement towards target)
Antimicrobial stewardship	Total antibacterial items per 1,000 STAR-PUs	Reduction of 5% in March quarter 2020 Compared to baseline March quarter 2018 For practices which are in the lowest prescribing quartile in March quarter 2018:	10 No partial points

National Prescribing Indicator	Unit of measure	Target for 2019–2020	CEPP points (points for movement towards)
		rewarded 10 points for maintaining this position.	
	4C antimicrobials *coamoxiclav, *cephalosporins, *fluoroquinolones *clindamycin Items/ 1,000 patients	Reduction of 10% in March quarter 2020 Compared to baseline March quarter 2018 For practices which are in the lowest prescribing quartile in March quarter 2018: rewarded 5 points for maintaining this position.	5 No partial points

South Torfaen NCN has demonstrated an improved prescribing trend for all five NPIs. Measures are in place as part of a prescribing performance plan for all five NPIs:

Proton Pump Inhibitors: There is collaboration of the highest PPI prescribing South Torfaen practices and Ashfield Healthcare to identify and review suitable patients to reduce or withdraw PPI therapy. Prescribing education and resources to support PPI withdrawal has been offered by Ashfield Healthcare to all NCN practices.

Opioid Burden: The high dose opioid audit has been recommended to outlier practices as part of 2019-20 CEPP scheme and e-learning on opioid prescribing in chronic pain has been set as prequalifier for CEPP points.

Gabapentin and Pregabalin: The gabapentin audit has been completed at all South Torfaen practices to identify high dose gabapentin prescribing. A further audit is available for practices to audit pregabalin prescribing. Review of identified patients is ongoing.

Antibacterial Items and 4C Antibacterial Items: Two South Torfaen practices received a level 1 letter from the Welsh Chief Medical Officer indicating an antibacterial prescribing level above that of the Welsh average. Targeted audit work has been agreed at both of these practices to improve antibacterial prescribing.

South Torfaen practices reduced total antibacterial items by 6% in 2018-19, exceeding the 5% target. This is a very positive development in our antibacterial prescribing trend. Ongoing support is provided at NCN and borough level with an antibacterial focussed GP education session held in Nov 2019 for the Torfaen Prescribing Leads meeting

Patient Safety Indicators: Patient Safety Indicators from June 2019 suggest that South Torfaen Patient Safety Programme (QAIF) should focus on "Anticholinergic burden - number of patients aged 75 and over with an AEC score of 3 or more for items on active repeat, as a percentage of all patients aged 75 and over". We will extract practice level data through Audit Plus and plan to initially review anticholinergic medication in patients aged 75 and over with an Anticholinergic burden score of over 6.

Further areas for focus include "Patients with asthma who have been prescribed a beta-blocker" and "Patients aged ≥65 prescribed an antipsychotic as a percentage of all patients aged ≥65". We will discuss these patient safety indicators at an NCN meeting and devise a Patient Safety Programme for South Torfaen.

The Torfaen Quality and Patient Safety Group (QPS) provides Divisional assurance for all quality and patient safety issues across Torfaen. This platform enables escalation of significant clinical risks to the Divisional QPS Group as well as assurance in relation to safeguarding health and safety and improving the quality of healthcare. Any NCN related incidents are fed into this group. Reporting of incidents by staff has increased which gives us an ever clearer picture of what is happening in our wards and in the community.

District Nursing in Torfaen South have reported a substantial increase in diabetic patients in the community on the caseload, and the frequency of medication administration. The NCN will be working with the Specialist Diabetes Service to develop skills for health care support workers in the assessment and management of footcare for diabetic patients. Also with the acute wards to ensure patients are better educated about self care prior to leaving hospital.

The NCN will be encouraging practices to utilise the health boards datix reporting system to identify any common themes.

Clinical Audits: The NCN are currently collecting the results of the national diabetic audit for South Torfaen GP area and have held meetings to discuss. Currently data available for review is for the period. The NCN needs to review data from 2018/19 to establish whether measures put in place to improve care have been effective. We look to participate in further audit reviews as more recent data become available. Learning and action points will be discussed at NCN meetings and taken forward via the NCN IMTP Delivery Plan.

Outcome of local clinical audits/QI projects: We look forward to working on GMS contract proposed Quality Improvement projects. The NCN have identified from Stop A Stroke that we have a relatively high percentage of individuals with Atrial Fibrillation who are not anti coagulated. Practices have already commenced work to identify these individuals and are holding discussions with patients about commencing anti coagulant treatment. Learning and action points will be discussed at NCN meetings and taken forward via the NCN IMTP Delivery Plan.

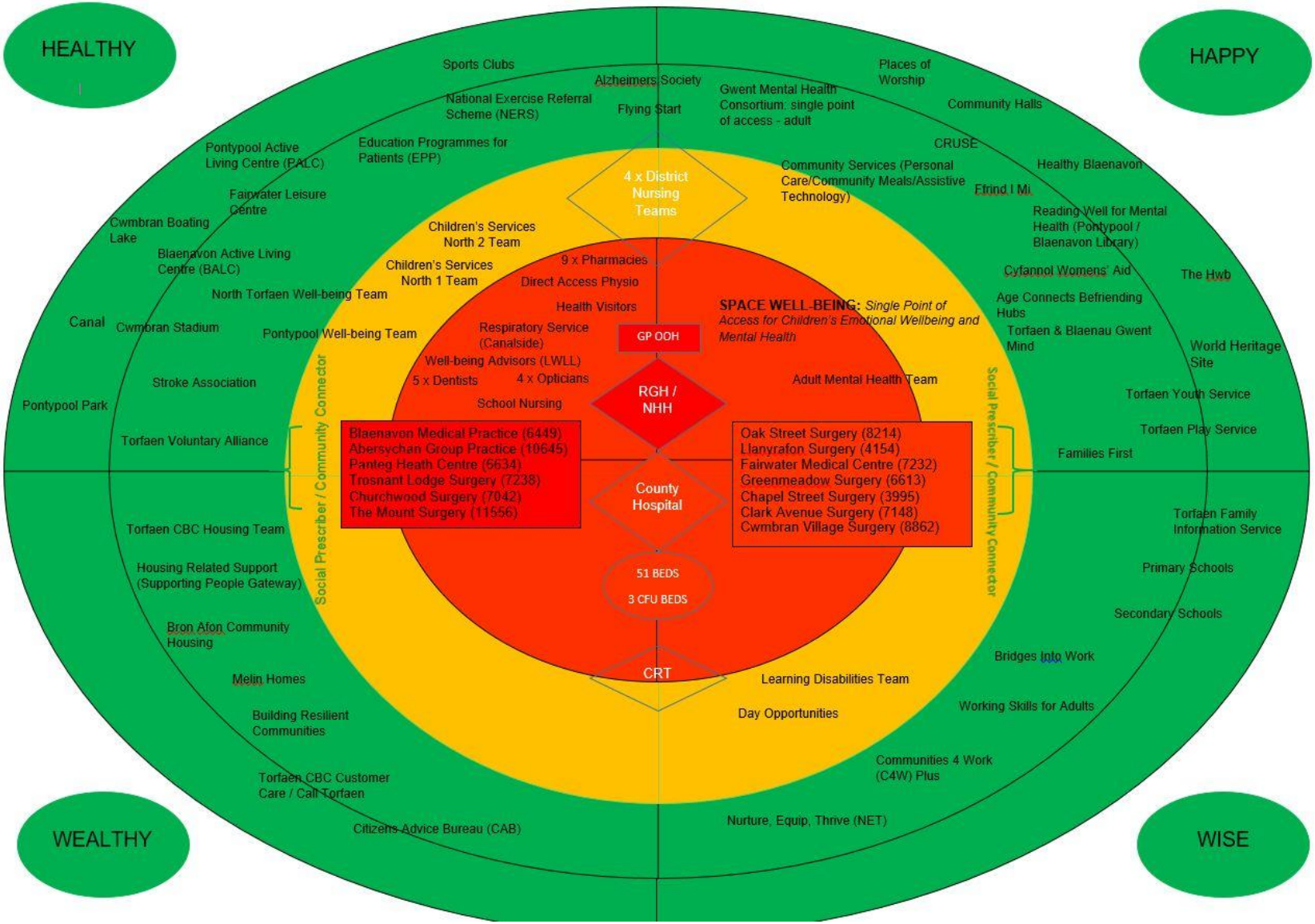
Enhanced Services: Enhanced services are delivered by GP practices in addition to their core service provision. This provides enhanced care for groups with particular clinical needs and supports the delivery of additional services in the community. Coverage across the South is in line with the populations needs. Those practices who don't provide the IUCD service have made arrangements with other practices to cross refer which continues to ensure we have adequate services.
We are awaiting the delivery of a Directed Enhanced Service for Transgender patients and will be ensuring that this service is available for all local patients through network arrangements.

Activity Benchmarking: The NCN will continue to work across practices to reduce the number of requests for ultra sound scan of shoulder and MRI of knee over the age of 45. Practice level data on these areas will be reviewed regularly to monitor improvements.

Torfaen South has high GP referrals to surgical specialties and chest x ray requests. The NCN will gain an understanding as to why this is and what can be done to reduce them.

Benchmarking in relation to urgent care shows that we have a high number of occupied bed days following an emergency admission for adults aged 65+ years per 10,000 population. The number of conveyances of people in residential homes is also high. Further investigation into these areas will be undertaken to identify areas that the NCN can influence in order to minimise hospital attendance.

6 Assets Profile



The diagram above is not exhaustive but indicates the range of provision and opportunities outside of the health and social care system to keep people well. Improved relationships and collaborative working can have a significant impact on reducing demands on all public services. A strong partnership approach to the development of integrated wellbeing networks is an important part of the action plans for the NCN.

There is considerable advantage in primary care becoming part of a wider network of assets that support the social and economic regeneration of local communities.

A place based approach is essential to building community hubs by nurturing and networking, using local assets and building on the strengths, capacity and resources available in local communities. The NCN provides an ideal footprint for this approach by overcoming organisational silos in order to make best use of the resources available. The development of an Integrated Wellbeing Network (IWN), through NCNs or clusters, allows a holistic approach to the complex interplay between material circumstances, the social environment, psychosocial factors and health behaviours. They are likely to be most effective when a community's assets are fully realised and integrated with primary care and community services.

7 Estates Profile

7.1 Estate Profile

Our estates here in Torfaen are a crucial factor in enabling NCNs and their partners to deliver Care Closer to Home, providing efficient, effective primary and community services and we clearly need to have the right buildings from which to deliver our expanded team-based model of care.

The estates that exist within Torfaen borough comprise: 12 GP Surgeries; 13 Dentists; 9 opticians; 21 Pharmacies; 1 Hub – Blaenavon Resource Centre; 5 Health board owned properties; 22 Care/Residential Homes and 50 Community beds.

The Health Board owns 2 buildings in South Torfaen:

Cwmbran Health Centre –. based in Cwmbran Town Centre and within walking distance of the main bus station the centre offers a wide range of community clinics including: Audiology/Audiometry; Child Psychology; Continence promotion; Diabetes Retinopathy; Dental; Contraception and Sexual Health; Specialist Substance Misuse Service and Orthoptics.

Brynhyfrydd Health Centre – this is the base for the 2 South District Nursing Teams.

7.2 Vision for Estates within the NCN

In Torfaen we will focus on place based care with services operating on a local population basis, supported by more specialist expertise at a wider level. Some areas in South Torfaen offer an opportunity to progress place based care, however where estate does not afford this opportunity a hub and spoke model will be developed at key locations across the Borough.

The NCN will consider estate issues, alongside IT, equipment and staff infrastructure. EG how the District Nursing service will need to change in light of the all Wales DN principles work stream.

The Health board has a vision of 3 Health and Wellbeing spaces within Torfaen along with new possibilities on the County Hospital site.

These will offer appropriate level support and care within each community through co-location of services. This will offer one front door and a model to 'screen' people to appropriate professionals based on their needs. Where services cannot be physically co-located, 'hubs' may need to be formed virtually.

Each hub will consist of an Integrated Services Team made up of therapists, nurses, social workers and care support staff. Greater emphasis will be placed on integrated working as part of a unified team, rather than separate re-ablement, home care and community nursing, where handoffs between team members are minimised to ensure greater continuity of care.

Well-being hubs will provide an opportunity to amalgamate local services, both for the convenience of professionals and the population. Each well-being hub will be different, but will consider incorporation of local services such as debt advice, housing services, community pharmacies, mental health services, GP practices, dental practices, among many others. Some hubs will also be developed with access to improved diagnostics and aligned to GP assessment beds, others with links across a network of service provision and community.

Consideration is being given to the requirements to further support Cedar Unit on County site as core Hub for the CRT to provide support to GPs.

The NCN is in very early discussions with Torfaen County Borough Council about the use of the local police station in Cwmbran as a potential health and wellbeing hub. There are also opportunities to develop further new Health and Wellbeing Hubs and the NCN is exploring the opportunity of working with Panteg House, Sebastopol and Woodland Road Centre, Croesyceiliog on developing activity and wellbeing services on these sites.

We conducted a six facet survey with the support of the Primary Care Estates Manager. This helped to assess the primary care estate in south Torfaen against: Physical Condition; functional suitability; use of space; quality; environmental management and adherence to statutory requirements. This helped the NCN to prioritise budget allocation and development requirements.

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7.3 Priority Developments

7.3.1 Major and Minor Improvement Grants

Major - None at present. Awaiting responses to request for proposals for 2020/21

Minor – 3 surgeries have requested funding for minor improvement grants

7.3.2 Capital Pipeline Funding

None at present. Awaiting responses to requests for proposals for 2020/21.

7.4 Other developments

Grange University Hospital

The Health Boards' new Grange University Hospital is being built on the Llanfrechfa Grange site, Cwmbran. This Specialist Critical Care Centre will become operational during the spring of 2021. The hospital will have 560 beds and will provide complex specialist and critical care treatment for over 600,000 people in South-East Wales. It will also provide a 24 hour acute Assessment Unit and Emergency Department. The Borough needs to more clearly understand the impact of this new hospital in terms of flow and the impact on community services.

7.4 Current workforce profile

Primary Care & Community Services Locality Team

Role	Band	No of staff (WTE) in post across Torfaen
Head of Service	8C	1.00
Assistant Head of Service	8A	1.00
Network and community manager	7	1.00
Network and Community services support officer	5	VACANT 1.00
Administrator	3	1.00

Primary Care

Role	No of staff (WTE) in post across Torfaen South NCN
GP's Principle	20.48
GP's Salaried	2.2
GP's Registrar	1.75
Extended Roles	1.21
ANP	1.67
Extended role Specialist Nurse	0.44
Practice Nurse	9.55
GP Practice – HCSW	6.49

Role	No of staff (WTE) in post across Torfaen South NCN
GP Practice – Admin/Clerical	55.53
GP Practice – Other non-clinical	1.19
General Dental practices	5
Optometry Practices	4
Community Pharmacists	12
NCN Practice based Pharmacists	0.8
NCN Direct Access Physiotherapists	1 (across Torfaen)

District Nursing

Role	No of staff (WTE) in post across Torfaen South
Senior Nurse	1.00
District Nurses	18.93
Health Care Support Workers (DN Team)	3.08
NCN funded B3	0.8
Admin/Clerical (DN Team)	1.6

County Hospital

Band	Rowan	Usk & Phoenix
Senior Nurse	1.00 Across all wards	
Band 7 RGN	1.00	1.00
Band 6 RGN	2.00	2.00
Band 5 RGN	7.56	15.03
Band 2/3 HCSW	11.82	16.18
Ward Clerk	0.67	1.20

Community Resource Team

Post	Grade	WTE
Consultant Physician – CRT clinical lead	Consultant	1.00
CRT Manager	8A	1.00
Mental Health Specialist Nurse	7	1.00
Rapid Response Nurse	7	1.00
Rapid Response Nurse	6	9.00

Post	Grade	WTE
Health and Social wellbeing workers	3	2.00
Falls Manager	7	0.80
Nurse Assessor	6	1.00
COPD Nurse Specialist	7	1.00
COPD Nurse Specialist	6	1.00
COPD Administration officer	4	1.2
Emergency Care at Home Support & Wellbeing workers	4	2.62
Emergency Care at Home Support & Wellbeing workers	3	7.92
Discharge Liaison Nurse	6	1.00
Administrator	4	1.00
Administrator	2	0.4

The Community Resource Team also has numerous other staff members that are employed via TCBC but work jointly with ABUHB staff to provide services against service demand and need.

7.5 Workforce risks and drivers for change

Primary Care: Development of Place Based Care to ensure local residents are able to access and receive services as close to their home as possible. This will be achieved through development of:

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- Availability of a broader range of clinicians to undertake appropriate interventions and only necessitating a GP consultation when required. This may include physiotherapy, occupational therapists, mental health workers, pharmacists and advanced nurse practitioners.
- Development of a sustainable and effective lower level community service through recruitment of social prescribers and linking with community 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.

Community Resource Team: There is an ongoing review of the frailty service which 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. CRT have been the service leads of the Community Frailty Unit on Rowan Ward in County Hospital.

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 4 teams aligned to 12 practices within Torfaen, 2 in the South covering 6 practices. The service operates from 8.00 am to 8.00 pm 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. 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.

On reviewing the outcome of DN Principles it is evident that Torfaen are in deficit in numbers of registered staff. 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).

County Hospital: There are 50 community beds within County Hospital, with 2 of these beds being allocated for the CFU model (Community Frailty Unit). There are longstanding recruitment and retention difficulties to these community wards. The Senior Nurse is proactively progressing a rolling programme of recruitment and will work 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:

- 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

Workforce Vision

- Develop prudent approach to maximising roles across all staff groups
- GP practice – development of new roles, use of extended roles, development of community structures

- Nursing – development and support of upskilling nursing staff across all levels
- 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 and support of 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
- Nurses – develop a robust training programme that develops generalist skills across CRT, DNs and ward staff linking into practice nursing

Proposed changes

- Development of new extended roles in practice
- Develop MDT approach to support practices
- Develop IWBN
- Transformational posts and services
- Adopt district nursing principles – taking into account Care Aims training
- Skill matrices and skill mix requirements across all teams
- CRT team expansion – graduated care

7.6 Training Requirements

Training opportunities include:

- Making Every Contact Count (MECC) Training for GP practice and partnership organisations staff
- Continued 'Wound Care' training/guidance for associated Practice Nurses
- Various training opportunities that arise for upskilling staff both clinical and non-clinical will be supported via NCN funding if deemed appropriate

Borough Developments

Community Hospitals: Inpatient beds in community hospitals will continue to be utilised as step down from acute hospitals for ongoing rehabilitation and complex discharge planning, but with a greater emphasis to be placed on stepping patients up from the community. Where possible, they will be aligned to urgent care hubs and rapid response services in order that patients can be admitted to a community inpatient bed for observations or while awaiting diagnostic investigations and avoid unnecessary conveyances to a full emergency assessment unit within an acute hospital setting. This has the potential to reduce unnecessary demand on specialist beds while also reducing the risk of over-medicalisation or institutionalisation of patients.

A 'graduated' model of care will be implemented in community inpatient units, ensuring that wards have a clear admission criteria and staffing / skill mix is aligned to the specific care being delivered. Each borough will have access to 3/4 types of inpatient unit, focusing on ongoing medical needs, longer term rehabilitation, complex discharge planning and GP/Frailty assessment beds. Patients will only transfer to a community hospital when no longer requiring acute medical care which will allow Care of the Elderly medical resources, currently spread thinly across community hospitals, to be re-deployed to acute sites. Instead, community inpatient units will be predominantly nurse-led, therapy-led or GP/Frailty-led units.
Community hospitals will also continue to deliver specialist outpatient care closer to patients' homes, with visiting consultants holding regular clinics on site.

The Division are currently working on the 'graduated' care model. This is in line with the Clinical Futures plan. One of the key consideration is to decide if these wards can be Nurse or GP led or whether it needs to be a medic.

Presently, County Hospital provides Rehabilitation and Discharge Planning for patients. All wards have daily medical input and access to a non-resident on call medic out of hours.

The table below provides an overview of models of care within the Graduated Care framework that should be considered for County Hospital.

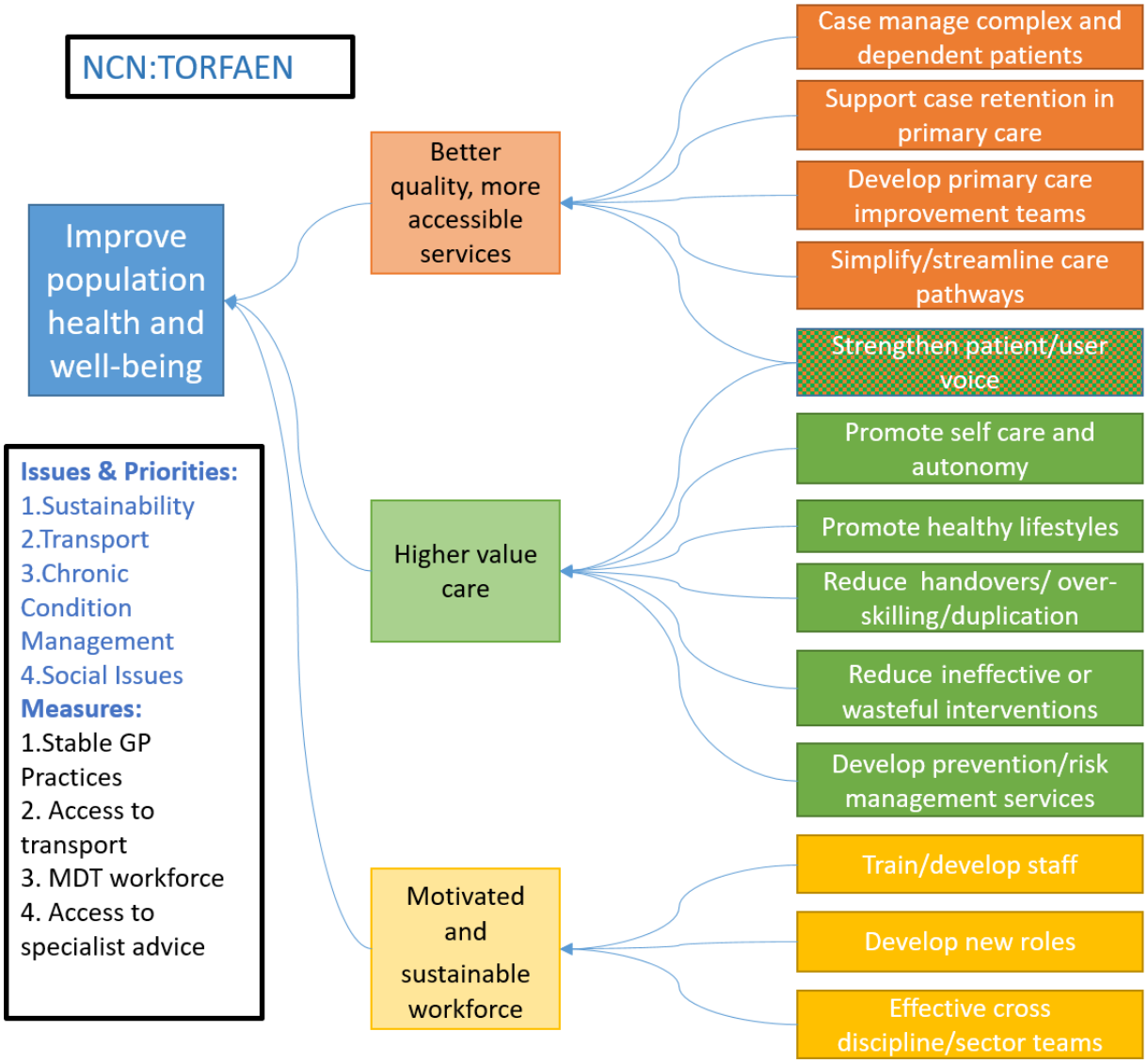
Graduation Medical Model	**Patient Criteria**	**Medical Intervention**	**Nursing Intervention**	**Other**
Patients who require medical input in the short term after a period of acute admission that are not well enough to go home with support from acute care	Medical input required as medical unstable. In hours medical support required on site. On call provided by ANP model or non-resident model of care. Patients would be stepping down from an acute admission phase.	Consultant Led model of care Regular Board/ward round intervention Named Doctor for the ward ANP support model	Nursing model by day: 1RN:8 patients 1HCSW: 8 patients Complex discharge planning	Social worker or Social Worker support officer OT Physiotherapy Pharmacy Access to diagnostics with reasonable reporting times
Community Frailty Unit *Patients who need secondary care input to support and prevent further deterioration, but do not need acute input.*	Patients who do not need acute admission but require a short period of hospital admission. Patients who require an admission for approximately 72 hours	CRT/Frailty admission rights. Regular medical input at Frailty Consultant / speciality Dr Level	1 additional Qualified and HCSW by day and 1 additional HSCW by night. Escalation of packages / increase of care required	Responsive / reactive services required in order to step care up in the community to support discharge. Social services Reablement OT Physiotherapy

8 Opportunities and challenges for 2020-2023

8.1 SWOT Analysis

Strengths	Weaknesses
• Strong working relationships within the NCN and partners • Strong Practice Managers Forum • Local authority and the NCN are fully committed to strategic direction in terms of developing integrated services where a wider range of professionals provide a seamless multiagency service • Relatively good standard or primary care and community estates	• NCN budget mostly committed with very little remaining for development within the NCN • Limited time for NCN Leads to undertake work programme
Opportunities	**Threats**
• Pressures on services provides opportunities to test new models of care • Transformational funding available to pump prime new approaches • Partners are fully on board • Opportunities to add new projects from new estates within the borough • Technology • Prescribing • Develop services at Trevethin • The Grange Hospital • IWN • Clinical Futures • Compassionate Communities • Core funding of Practice Based Pharmacist • Increase engagement from community pharmacy and NCN business	• The short term nature of the transformational funding could serve as a deterrent to test new models of care due to financial risk • Ageing workforce including GP's • GP and Practice nurse sustainability • Domiciliary care – Maintaining adequate service provision • The Grange Hospital – increase in demand for local services • Clinical Futures – Primary and community additional workload • Local development planning – (lack of health input) • Lack of required workforce • Opportunity to move NCN projects to core funding once the project has been proven • Are our Estates and IT systems conducive to adopting new ways of working

8.2 Driver Diagrams



What are we planning to try?

1) Shared roles across practices (Transformational Monies)
2) Extended Roles at practice level (Transformational Monies)
3) Increasing size of Social Prescribing pilot
4) Develop IWBN at pace
5) Establish Transport group as part of TIP
6) Increase CRT EC@H support to COPD community team to roll out principles of well-being pilot over winter period

9 Prioritised Actions 2020-2023

#	Action	Anticipated Impact	Alignment to PNA
1	To ensure we adhere to the GMS contract	Improved access Improved Cluster led planning and delivery Quality improvement Effective, consistent delivery of Wales-wide Enhanced Services	Access
2	Development of Integrated Wellbeing Network	Empowering individuals to take ownership of their health and wellbeing. Facilitate smooth navigation through health and wellbeing services.	GP Sustainability Obesity Smoking Cessation
3	Practice Based Pharmacist, support the Business Case for Core Funding.	Directly employed NCN Pharmacists have demonstrated improvement in both the safety and cost effectiveness of prescribing within Primary Care, these roles now need to be transferred into core funding.	GP Sustainability Antimicrobial Stewardship
4	Reconfiguration of Community Connectors/Social Prescribers and Social Workers	Working alongside partners in TCBC so that social needs impacting on an individual's health and wellbeing can be effectively addressed.	GP Sustainability Inequalities in Health

5	Working towards developing and expanding the Frailty Team	The Clinical Futures Care Closer to Home model will mean that more frail unwell people will be cared for in the community. The capacity and resources to ensure these individuals will be cared for in a safe, timely and compassionate manner will need to be carefully considered	Ageing Population Clinical Futures Care Closer to Home Conveyances to hospital from residential homes
6.	Working towards the implementation of Compassionate Communities	The Clinical Futures Care Closer to Home model will mean that more frail unwell people will be cared for in the community. Ensuring the correct MDT members are part of an individual's care and that hand offs are eliminated or at least reduced to a minimum.	Ageing Population Clinical Futures Care Closer to Home Conveyances to hospital from residential homes

10 Communication & Engagement Mechanisms

NCNs have worked with the Health Board on its engagement agenda in South Torfaen. The Health Board places a strong commitment on listening to and acting on the views of citizens in Gwent. Having strong relationships with people is key to how we do business and indeed how we may influence how people look after themselves and use our services when they need them.

We know that people are more open with us in spaces that are familiar to them, within their own communities and outside of a patient/clinician contact, where the relationship is very different. We also know people prefer a localised discussion, one they can be comfortable in and one which has relevance.

We will continue to take part in local engagement events and, as an NCN, develop a communication and engagement plan.
The NCN will continue to engage and communicate with our population and our staff. Working with the ABUHB Engagement Team we will set up engagement events/listening days on a six monthly basis. We will also be setting up citizen reference groups to allow focussed discussions on health and wellbeing challenges and service responses in Torfaen.

11 Financial Profile

11.1 Neighbourhood Care Network

Torfaen South annual budget is £187,388

A total of £64,935 of this budget is committed to pay for:

Independent Adviser (Optom, Dental, Pharmacy)
Community Phlebotomy
Direct Access Physio therapy
Dementia Roadmap

In addition the practices within South Torfaen we awarded £24,381 in PER funding.

The use of £133,561 uncommitted funding is being considered in relation to a range of developments including:

Reconfiguration of the Community Connector/Social prescriber model
Bladder scanners for the District Nursing teams
Care & Repair Torfaen staying Healthy at home initiative
Jayex system upgrade and additional screens
Communication technology
Training on current I.T templates

The borough is utilising Transformation funding to develop resilience within primary care by supporting workforce stabilisation across GP surgeries, developing pharmacy support for patients who are at home and unwell, and developing CRT to support the needs of the population in the nursing homes as well at the wider community.

Transformation Programme Funding: Torfaen Borough is utilising Transformational Funding to develop resilience in primary care by supporting workforce stabilisation across GP surgeries, developing pharmacy support for patients who are at home and unwell, and developing CRT support to GP practices. This in turn supports developing a 'one front door' approach to avoid hand offs and provide more seamless support to citizens. The table below shows how Transformation funding has been used in the southhe

TRANSFORMATION WORK STREAM	WTE ANTICIPATED	WTE APPOINTED	WTE VACANT	PROGRESS	NOTES
Torfaen South skill mixing					
- Additional CRT resource	2	2	0	APPOINTED	
- Advanced nurse practitioner	1	0	1	ADVERTISED	
- Clinical pharmacist	0.2	0.2	0	APPOINTED	
- Clinical pharmacist	1	0	1	ADVERTISED	
- Nurse practitioner	1	0	1	ADVERTISED	
- Mental health practitioner	1	1	0	APPOINTED	
PHASE TWO WORKFORCE STABILISATION SUB-TOTALS	**6.2**	**3.2**	**3**	**0**	

Workforce stabilisation across GP surgeries: Robust engagement with practices has occurred to understand extended roles required to support practices, this has included reviewing job descriptions and undertaking a home visiting audit. Identifying the need for a home visiting service, mental health support and increased numbers of Advanced Nurse Practitioners support practices and their populations:

Mental Health Practitioners: A large burden of care for General Practice is due to acute and chronic mental health and wellbeing problems. The development of an integrated response including prompt response to acute and chronic distress is needed ranging from continued development of low level interventions and self-help options to more intense professionally centred interventions.

Paramedics in General Practice: Within Wales these roles have been explored and it is clear that Paramedics will be able to support primary care. The practices feel that paramedic role could effectively support on call work.

Through our IMPT the NCN will work to support practices to pilot Mental Health and Paramedic roles in line with the development of the Transformational Funding agenda.

CRT pharmacy: Transformational Funding has been used to employ a Pharmacy Team to deliver a clinical service to the CRT. Work has involved medicines reconciliation (ensuring effective communication of changes to medicines regimens as patients move between care settings); advice to the CRT on medicines choice, dose, administration and monitoring; de-prescribing of medicines including

high risk medicines such as opioids, gabapentinoids and antidepressants; support to patients, through home visits, to administer their medicines safely; communication with primary and secondary care.

CRT support to GP practices: Care and Residential Homes: A home visiting service to support patients in Care and Residential homes has been discussed at NCN level. The audit undertaken by practices highlighted that a range of patients could have been seen by an appropriate colleague other than a GP. A working group has been established to pilot a CRT Care and Residential Home visiting service to support patients with ACP planning and remaining well in their usual place of residence.

CRT support to GP practices: Weekend Working: Pharmacy have been given the opportunity to employ additional Band 6 Rapid Nursing staff to support increased capacity at the weekend, with the aim to ensure referrals received later in the week can be safely managed in the community.

Development of Urgent Care Hub: In developing these community hubs, plans will account for any service support which needs a critical mass and may need to be provided on a borough rather than NCN basis or community footprint. As a result, one well-being hub in each borough may also act as an enhanced urgent care hub, where access to specialist advice and diagnostics will allow GPs to provide a more holistic assessment and treatment for urgent walk-in cases, potentially reducing unnecessary conveyances to hospital.

Rapid response services (e.g. Rapid Medical) will also be delivered on a borough-wide basis and would preferably be located in urgent care hub developments, providing both a mobile service across the borough but also enabling closer working with / better support to those GPs managing urgent presentations within the urgent care hub.

Integrated Care Fund: Advancements in information management and technology (IM&T) presents exciting opportunities to change the way that we deliver care and communicate with our patients. IM&T has the potential to allow professionals to monitor patient care and identify trends which require early intervention (remote monitoring of diabetic patients, risk-stratification of GP lists, vital signs clinical monitoring systems); to consult electronically with patients to (askmyGP, skype in care homes); to direct patients to more appropriate services without the need for a GP consultation (electronic triage systems); to reduce waste through online appointment and reminder systems (My Health Online, My Health Text); and to plan services based on better intelligence (e.g. simulation modelling, askmyGP).

The Division must seek to further harness the potential of IM&T to make services more effective in the coming years. Significantly, 2018/19 will see the implementation of a Welsh Community Care Information System (WCCIS), enabling greater collection and analysis of data, as well as facilitating swift sharing of important clinical information between community care, primary care, secondary care and social care services. However, the risks posed by adopting a new digital system in sectors that are predominantly paper based at present cannot be underestimated.

Locally, NCNs will work through how to support key areas such as: Falls, social prescribing electronic platform and keeping patients well at home.

Priority unfunded developments

Expansion of CRT: To further support patients in the community there is a requirement to ensure that CRT capacity is increased, this will include increased Rapid Medical and Nursing support, as well as Emergency care at Home. This will further support GP practices to access responsive support to ensure patients are kept well in the community, avoiding admissions. This closely links to the Graduated Care principles for the Borough and will be developed with engagement from GPs. It is important to note this work as part of the IMPT to reference the requirement for funding to meet future capacity.

Out of Hours support: There is interest in looking at an internal Out of Hours GP model, particularly within the South NCN, this would include a practice providing appointments after 6.30 on behalf of other GPs, and this could also include weekend appointments. This project will need to be developed to assess the Workforce requirement and associated funding. It is referenced in this IMPT as a way to support reduction of ED attendances and increase access to GP services.

Care home support: The Borough has accessed Transformational funding to pilot CRT support to care homes, the principles of which aim to reduce home visits to care and residential homes that do not need the skills of a GP, increase Anticipatory Care Plan in place for patients who reside in these settings and ensure a Comprehensive Geriatric Assessment is complete for good practice. This pilot is being developed, with the view to it being successful funding to continue will be required

12 Actions to Support Cluster Working and Maturity

South Torfaen is in a fortunate position with strong working relationships within the NCN and Partners and a good level of engagement with NCN members. We are supported by the Health Board including data provision, additional funding to support our significant sustainability issues (Transformation funding), clinical/quality improvement projects (COPD Interface work) and leadership meetings. We have increasing collaboration with TCBC with stronger working links with third sector.

In order to increase our NCN maturity, to further develop our operational ability and to deliver the more ambitious plan that we are progressing, we need to look to these partnerships for further engagement and involvement in the NCN plans. This section provide details of ways in which we can achieve this.

We need ongoing support from the Health Board, the Council and Partners for the Torfaen Integrated Partnership to develop and thrive.

We request that the Health Board consider bringing successful projects that the NCN have been funding, into core funding.

Work has already been undertaken to improve communication with the Primary Care and Contracting Team, consolidating this to improve the communication in both directions is important.

NCN Leads are contracted for a day each week so it is crucial to consider how this time is most effectively used.

Within NCN teams which have now developed to allow a greater scope of work and influence it is critical that we have continuity of roles, with any gaps filled as soon as possible. Consideration for the role of Service Development Lead for IWBN, who sits within our team in Torfaen to continue beyond the current fixed term.

A development event for the whole NCN, to ensure all are clear about the purpose of and their role within the NCN, would allow us to communicate a shared vision and increase engagement across the NCN.

NCNs need support from ABUHB and Partners to effectively plan for Clinical Futures and Care Closer to Home.

We would require collaboration from the Health Board and Partners both in the development and implementation of our Winter Pressures Plan.

NCNs are provided with a great deal of data, we need help in the interpretation and practical application of this information, along with support to identify what data we really need in order to continuously improve.

Ongoing help with access to named support GDPR to ensure compliance with the law is not a barrier to improvement.

We require support from ABUHB and NWIS with finding technical solutions to issues we face. This is particularly critical with the imminent change in GP clinical IT systems.

Other areas requiring support:

- Health Board support with Winter Preparedness
- Public Health input into Population Needs Assessment and Chronic Disease data
- Continued development of Torfaen Frailty services with expansion of CFU
- Continued increased engagement of Community Pharmacy at NCN level
- We are fortunate in Torfaen South to have good engagement from Primary and Community Care as well as our.

14 Appendices

APPENDIX 1 TORFAEN HEALTH NEEDS ASSESSMENT

DTOCS/bed days

Delayed Transfers of Care		Population ≥ 75*	DTOCs reported in last 3 months	Avg. monthly DTOCs per 10,000 pop.
	Blaenau Gwent	6,031	6	3.3
	Torfaen	**8,339**	**33**	**13.2**
	Newport	11,973	61	17.0
	Monmouthshire	10,352	55	17.7
	Caerphilly	14,616	84	19.2

Bed Days Lost Since Last Census		Population ≥ 75*	Bed days lost in last 3 months	Avg. monthly bed days lost per 10,000 pop.
	Blaenau Gwent	6,031	117	65
	Newport	11,973	906	252
	Torfaen	**8,339**	**633**	**253**
	Caerphilly	14,616	1,204	275
	Monmouthshire	10,352	880	283

Healthy lifestyles and preventative services:

Disease register: Table 1

Baseline Data per 10,000 Population

Borough		Practice List Size			% of pop. living in the 2 most deprived fifths	Disease Registers (2017/18)														
		Total	Over 65 years of age	Percentage over 65 years of age		Asthma	Chronic obstructive pulmonary disease	Atrial fibrillation	Cancer	Cardiovascular disease	Coronary heart disease	Dementia	Depression	Diabetes	Epilepsy	Heart failure	Hypertension	Influenza	Learning disability	Obesity
Blaenau Gwent	East	33,719	6,582	20%	82%	706	354	191	233	775	456	63	1,092	787	93	143	1,989	2,524	47	1,437
	West	38,377	7,566	20%	66%	734	273	198	258	506	394	66	722	697	87	124	1,678	2,420	50	1,156
Caerphilly	East	65,790	12,754	19%	40%	606	193	161	220	330	334	40	794	577	69	67	1,515	2,134	38	1,072
	North	64,848	12,369	19%	73%	769	277	216	281	463	447	72	1,074	763	93	109	1,874	2,515	65	1,419
	South	56,473	10,636	19%	44%	637	205	191	280	441	373	60	711	603	75	76	1,553	2,254	48	1,034
Monmouthshire	North	52,841	13,721	26%	15%	685	197	280	379	549	392	90	712	623	67	157	1,730	2,847	33	1,118
	South	47,455	10,453	22%	9%	696	153	221	310	480	349	73	854	556	62	90	1,529	2,460	29	999
Newport	East	49,885	7,789	16%	59%	650	176	156	225	409	325	38	1,017	621	69	69	1,335	1,989	40	1,032
	North	57,029	11,091	19%	32%	689	179	170	280	470	329	66	1,003	558	75	85	1,513	2,252	42	972
	West	49,539	7,663	15%	71%	628	217	146	214	577	312	73	1,091	610	73	82	1,383	1,962	54	1,075
Torfaen	North	49,550	10,228	21%	56%	783	254	227	259	534	411	56	1,077	710	82	113	1,731	2,493	46	1,066
	South	45,964	8,843	19%	46%	694	225	196	244	395	391	67	807	631	83	91	1,609	2,317	49	962
Gwent Total		**611,470**	**119,695**	**20%**	**48%**	**8,279**	**2,703**	**2,353**	**3,183**	**5,928**	**4,514**	**765**	**10,955**	**7,735**	**928**	**1,205**	**19,440**	**28,167**	**539**	**13,343**

Rates of chronic ill health in Torfaen compared to Wales overall

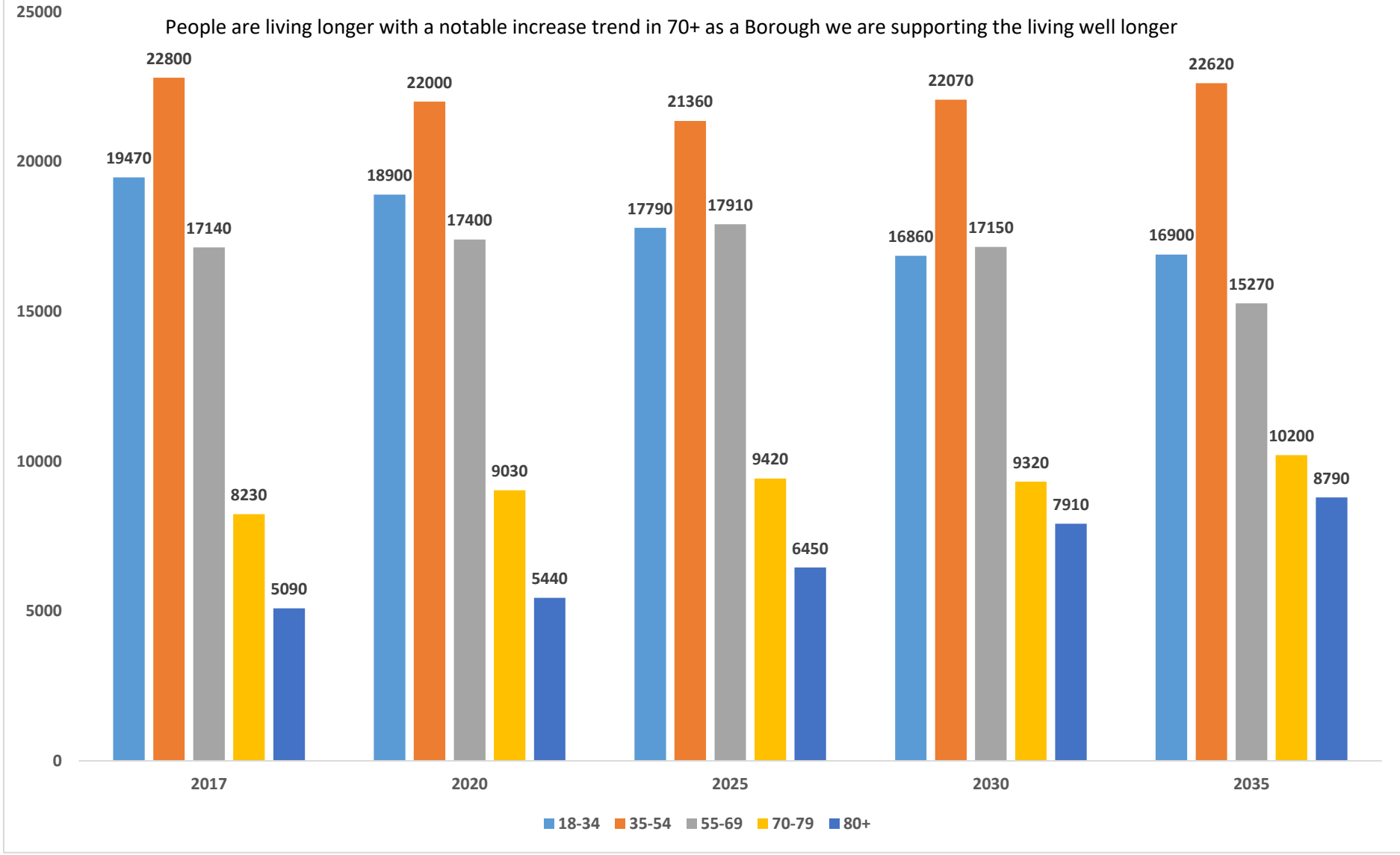
Tables 1 and 2 show that Torfaen has a higher rate of chronic ill health than Wales overall and for most categories, most notably, the disease register shows for rates of respiratory illness and poor mental wellbeing. Those self-reported rates from the WHS are similar to data from general practices across Torfaen for patients with diagnosed and registered chronic conditions.

Table 2

Currently Treated For	**% Torfaen**	**Wales**
Chronic Illness	**54**	**51**
High Blood Pressure	**19**	**17**
Respiratory Illness	**18**	**15**
Mental Condition	**15**	**13**
Arthritis	**14**	**12**
Heart Condition	**9**	**8**
Diabetes	**8**	**6**

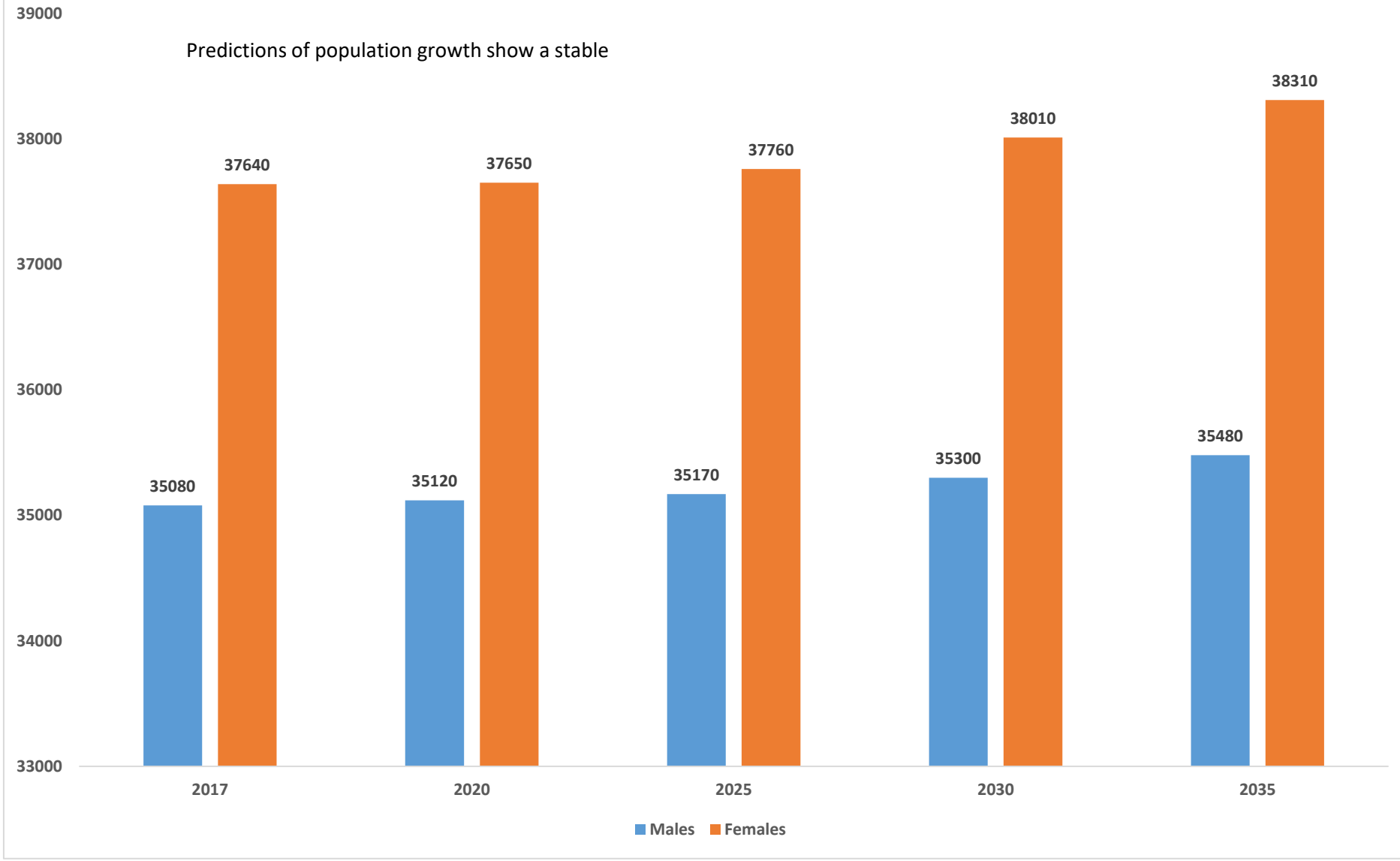
Population by age Torfaen

People are living longer with a notable increase trend in 70+ as a Borough we are supporting the living well longer



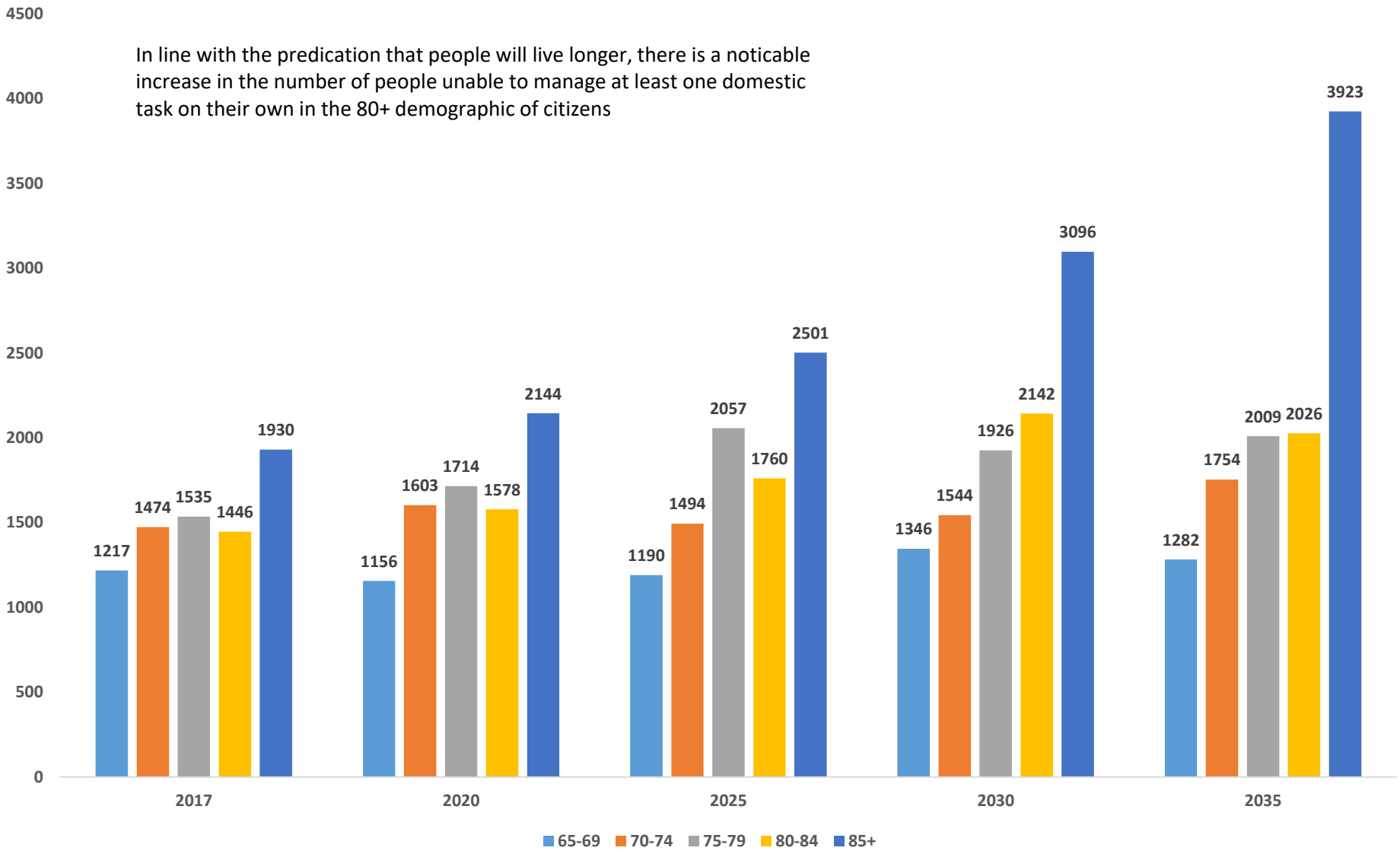
Population of Torfaen Males v Females

Predictions of population growth show a stable

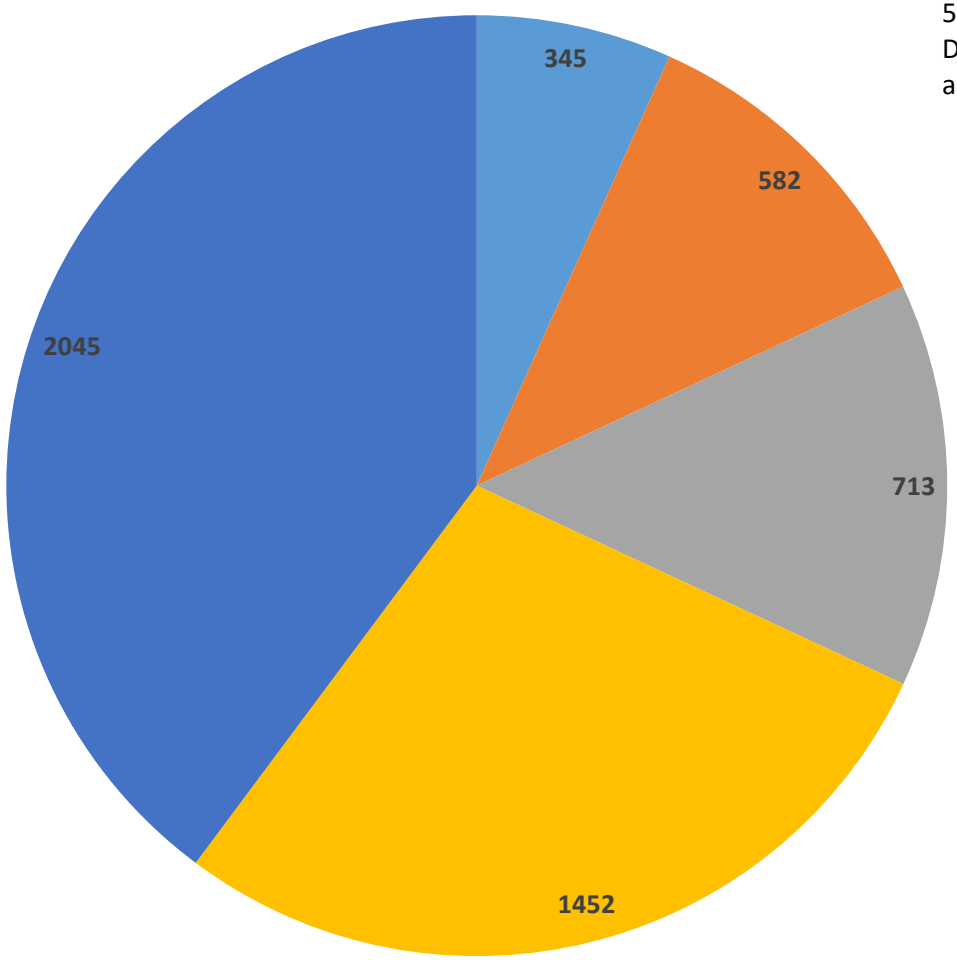


Males and Females unable to manage at least one domestic task on their own

In line with the predication that people will live longer, there is a noticable increase in the number of people unable to manage at least one domestic task on their own in the 80+ demographic of citizens



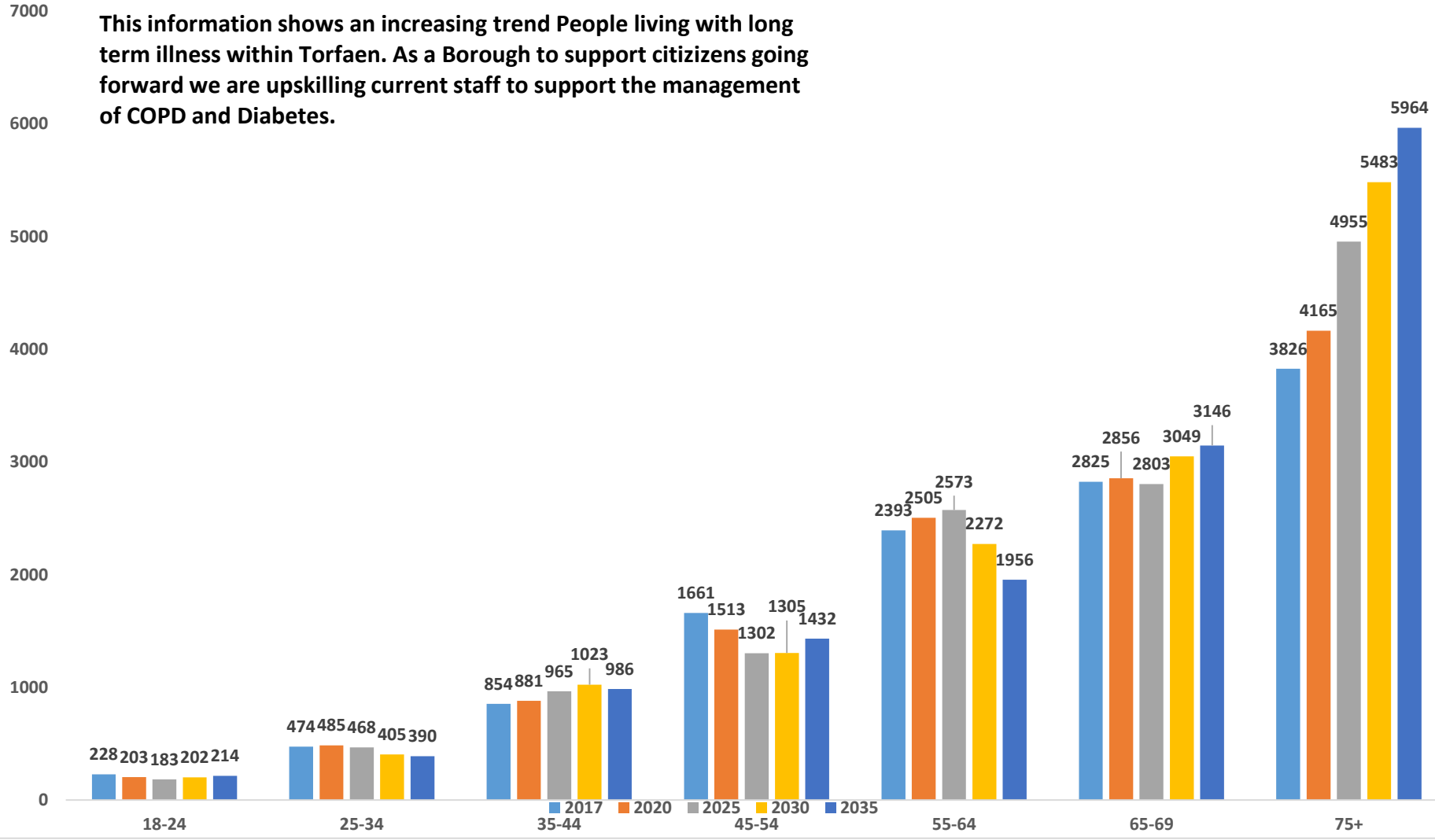
People in Torfaen claiming DLA or PIP



5137 citizens in Torfaen are claiming for DLA or PIP. The majority of those claiming are aged 45+

People living with limiting long term illness within Torfaen

This information shows an increasing trend People living with long term illness within Torfaen. As a Borough to support citizens going forward we are upskilling current staff to support the management of COPD and Diabetes.



Quality of care

Immunisation and screening rates

Age Group - 2 Years: Torfaen South NCN has performed well and continues to strive to meet national targets and will liaise with colleagues in well performing NCN areas to glean any best practice that we can adopt

		BG East	BG West	Caer East	Caer South	Caer South	Mon South	Mon South	Newp East	Newp South	Newp West	Torf South	Torf South
Childhood Immunisations - MMR1 - Age 2 - Uptake %	*Mar 2019*	96.45%	97.49%	97.97%	96.04%	96.47%	94.52%	97.63%	96.33%	93.20%	93.88%	95.17%	96.51%
Childhood Immunisations - PCVf - Age 2 - Uptake %	*Mar 2019*	96.75%	97.74%	98.55%	96.59%	96.47%	94.78%	98.68%	96.19%	93.37%	93.73%	96.55%	96.95%
Childhood Immunisations - Hib/Men C - Age 2 - Uptake %	*Mar 2019*	95.27%	97.24%	97.39%	95.77%	96.01%	93.73%	98.68%	95.78%	91.38%	93.12%	95.17%	96.73%

Age Group - 5 Years: Torfaen South compares relatively well to other cluster areas in Gwent however it is just below the national target of 95%. The NCN will analyse practice data and present at NCN meetings to establish areas of best practice and where improvements can be made to improve uptake.

		BG East	BG West	Caer East	Caer South	Caer South	Mon South	Mon South	Newp East	Newp South	Newp West	Torf South	Torf South
Childhood Immunisations - MMR2 - Age 5 - Uptake %	*Mar 2019*	90.50%	91.01%	93.97%	92.32%	92.38%	86.96%	91.97%	89.15%	89.05%	86.00%	91.21%	91.56%
Childhood Immunisations - 4 in 1 Pre Sch Booster - Age 5 - Uptake %	*Mar 2019*	92.61%	92.63%	94.66%	94.79%	93.47%	93.26%	97.57%	90.66%	88.08%	89.13%	93.10%	92.50%

Age Group - 16 Years: South Torfaen continue to perform extremely well in immunisations for MMR1 and MMR2. However the 3 in 1 pre teen booster is low and is an area where compliance could be improved.

		BG East	BG West		Caer East	Caer South	Caer South	Mon South	Mon South	Newp East	Newp South	Newp West	Torf South	Torf South
Childhood Immunisations - MMR1 - Age 16 - Uptake %	*Mar 2019*	94.61%	94.39%		96.91%	96.25%	97.51%	87.03%	88.84%	96.01%	94.28%	92.36%	97.44%	95.86%
Childhood Immunisations - MMR2 - Age 16 - Uptake %	*Mar 2019*	88.55%	91.71%		92.35%	92.94%	93.61%	78.24%	84.80%	90.80%	88.56%	87.60%	93.49%	91.72%
Childhood Immunisations - 3 in 1 Pre Teen Booster - Age 16 - Uptake %	*Mar 2019*	90.24%	86.63%		90.59%	87.24%	88.28%	85.56%	80.05%	88.50%	82.42%	81.20%	87.77%	90.63%

Flu immunisation: The NCN continues to perform well in this area and has developed a multi-agency flu action plan and continues to discuss best practice within NCN meetings

		BG East	BG West	Caer East	Caer South	Caer South	Mon South	Mon South	Newp East	Newp South	Newp West	Torf South	Torf South
Flu Immunisatic - ≥ 65 Years - Uptake %	*Apr 2019*	63.52%	69.21%	66.14%	67.61%	71.50%	73.85%	61.14%	65.18%	71.32%	65.91%	68.49%	73.54%
Flu Immunisation - < 65 Years "At Risk" - Uptake %	*Apr 2019*	38.12%	51.05%	43.79%	44.36%	48.48%	51.19%	54.94%	43.68%	48.44%	45.30%	44.65%	48.90%
Flu immunisation 2-3 years - Uptake %	*Apr 2019*	37.34%	43.65%	47.54%	37.59%	53.14%	56.31%	58.30%	41.16%	52.91%	36.86%	42.88%	63.40%

Screening uptake: The NCN took part in the bowel screening pilot which saw uptake improvements.Unfortunately when the pilot ended levels reduced. Conversations are ongoing to address this. The NCN is performing well in breast and cervical screening.

	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%

Enhanced Services

	DES													NES									LES																
Practice Name		**Pneumococcal**	**Childhood**	**Asylum Seeker**	**Learning**	**Violent**	**Minor surgery - Eye A**	**Minor surgery - Eye B**	**Diabetes**	**Prophylaxix**	**Mental Health**	**CARE HOME**	**Anti-**	**Anti-**	**Homeless**	**GLP1 Initiation**	**GLP1**	**Insulin**	**Insulin**	**Flu**	**Unscheduled**	**Non-Routine**	**Substance**	**Shingles**	**Rota virus**	**Meningitis**	**Minor Surgery**	**DOAC**	**DOAC**	**Depo-Provera**	**Depo/Sayana**	**Contraceptive**	**Depression/Lit**	**IUCD**	**IUCD - Non**	**Near Patient**	**Extended Hrs**	**Denusomab**	**Pertussis**	**Gonadorelin/Z**	**Extended Skin**
Oak Street Surgery		Y	Y		Y		Y	Y	Y	Y	Y	Y	Y			Y	Y			Y	Y	Y		Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	
Llanyravon Surgery		Y	Y	Y	Y		Y	Y			Y	Y		Y						Y	Y	Y		Y	Y	Y				Y			Y			Y		Y	Y	Y	
New Chapel Street		Y	Y		Y		Y	Y	Y		Y	Y	Y							Y	Y	Y		Y	Y	Y		Y	Y	Y						Y		Y	Y	Y	
Cwmbran Village		Y	Y		Y		Y	Y	Y	Y		Y	Y							Y	Y			Y	Y	Y		Y	Y	Y		Y		Y	Y	YL3	Y	Y	Y	Y	
Clark Avenue Surgery		Y	Y		Y		Y	Y	Y		Y	Y	Y				Y			Y	Y			Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	
Cae Teg Health Centre		Y	Y		Y		Y	Y	Y	Y	Y	Y	Y							Y	Y			Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	

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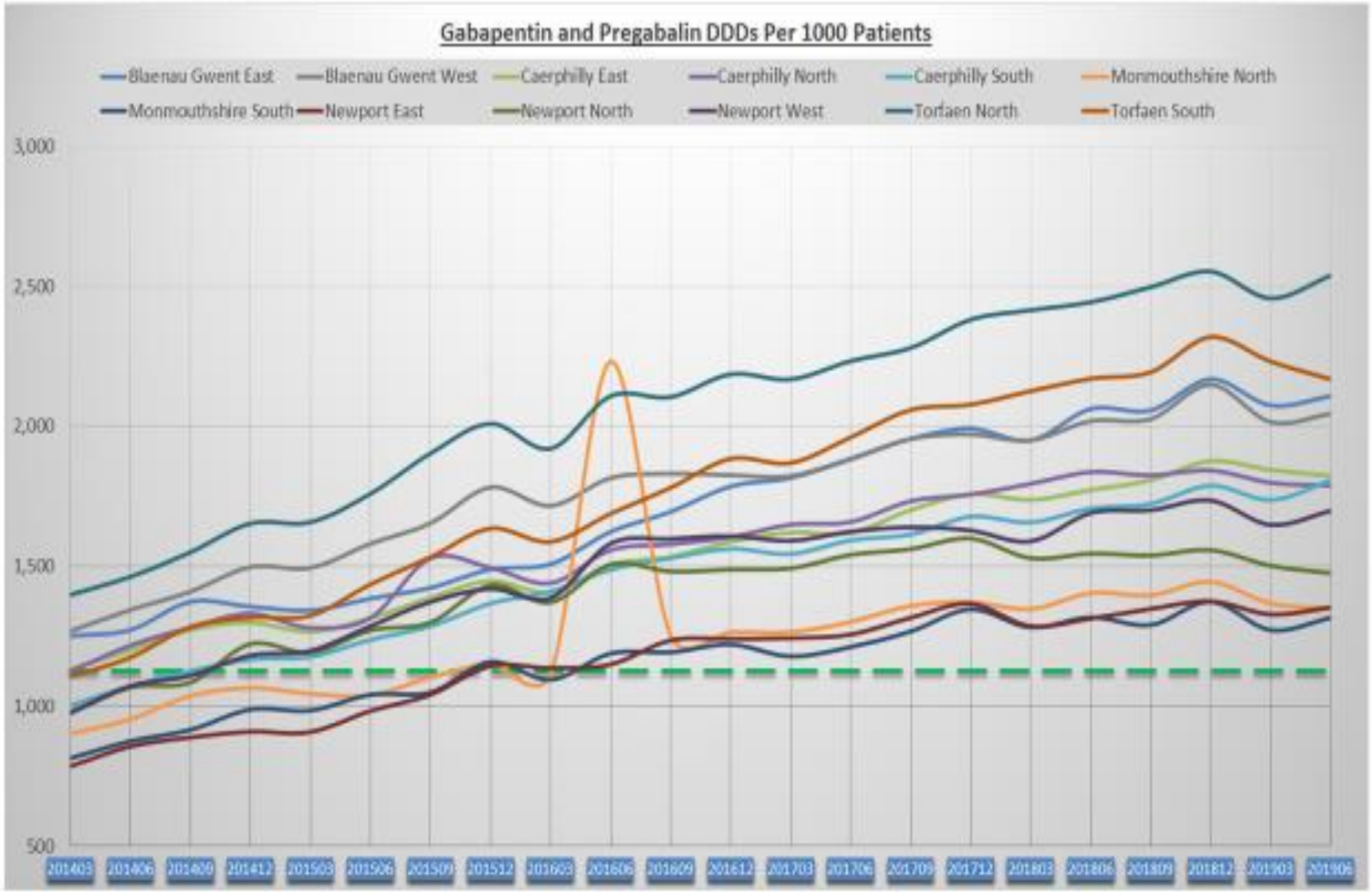
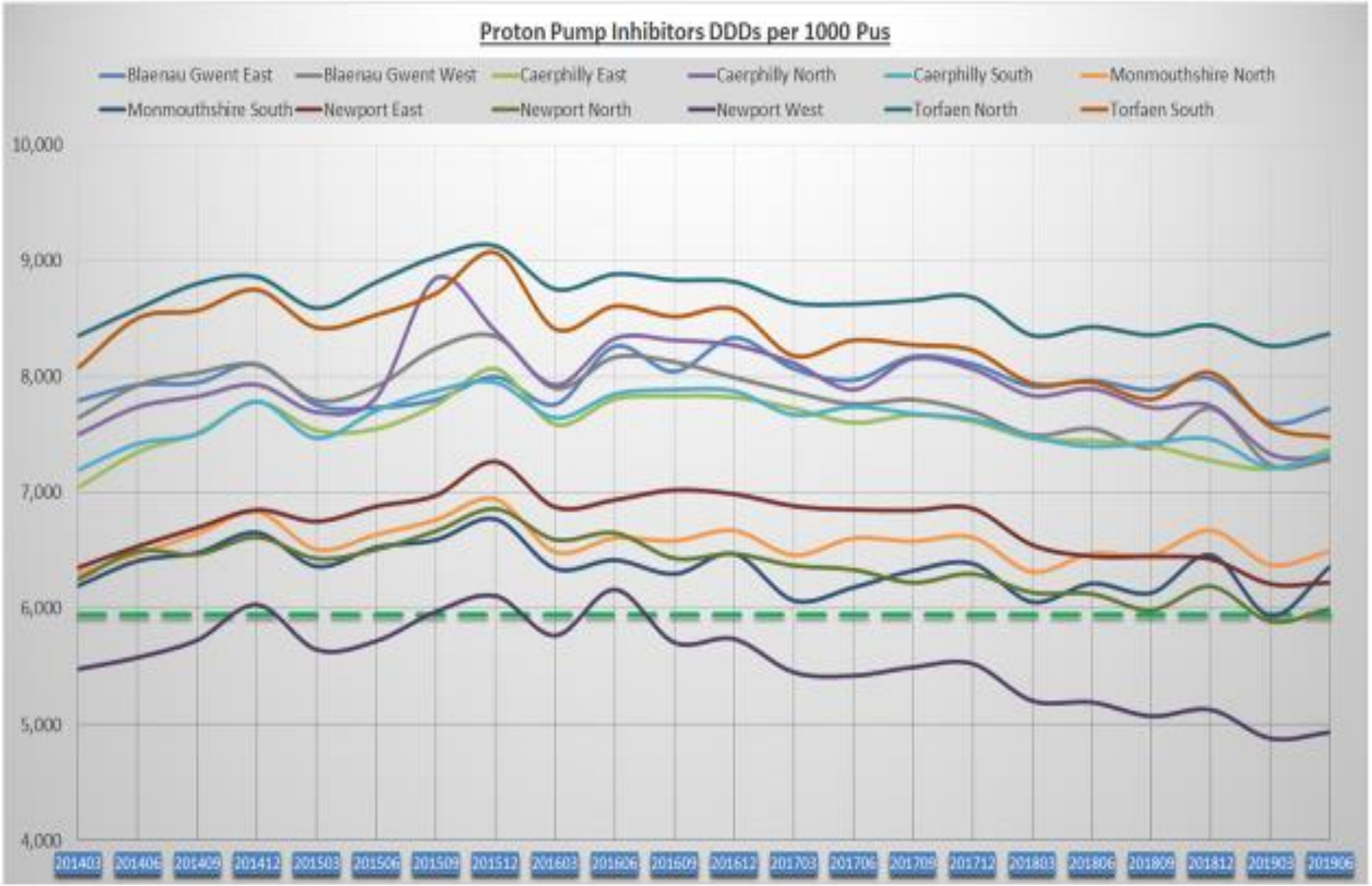
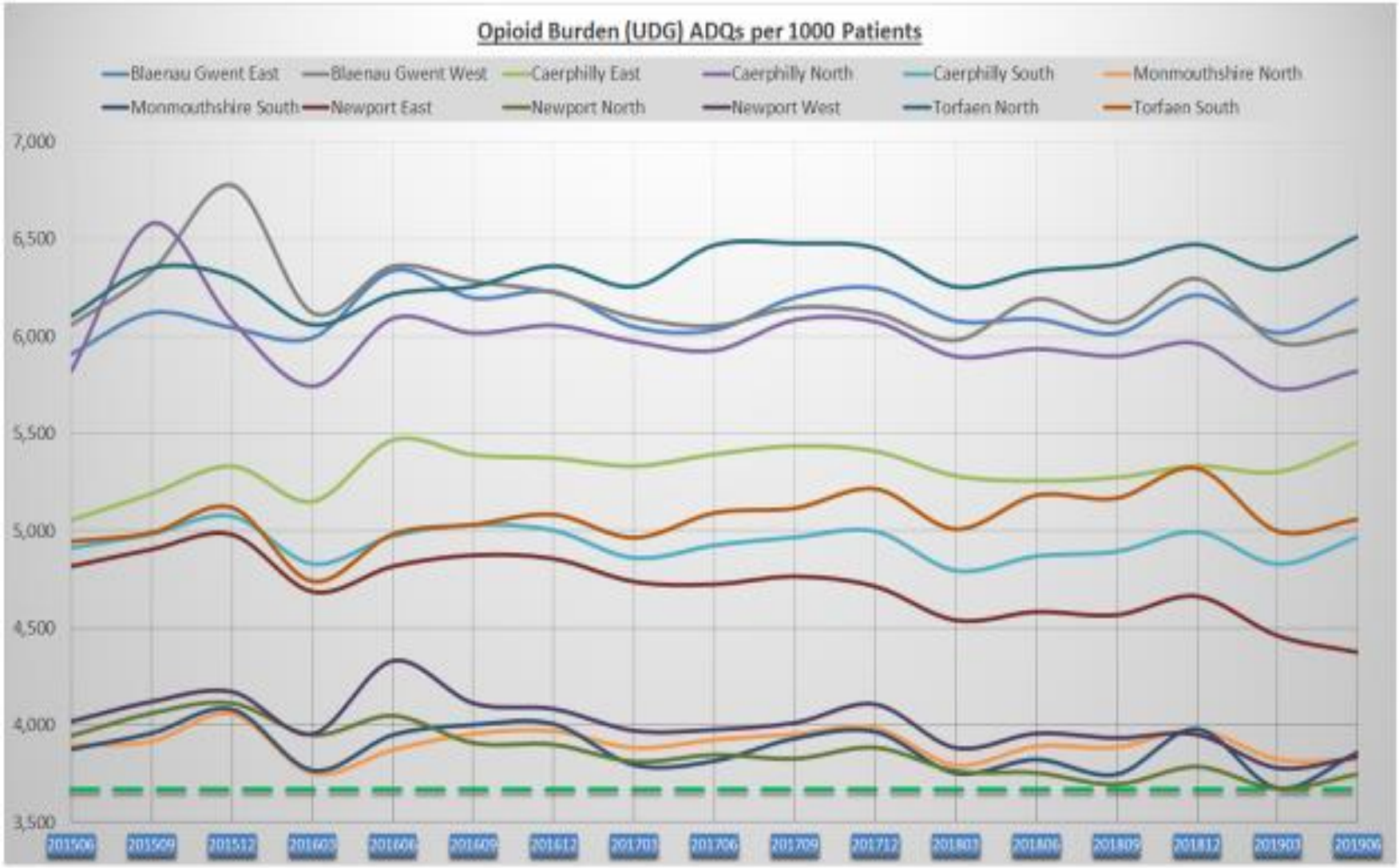
National Prescribing indicators




Proton Pump Inhibitors DDDs per 1000 Pus
Blaenau Gwent East
Blaenau Gwent West
Caerphilly East
Caerphilly North
Caerphilly South
Monmouthshire North
Monmouthshire South
Newport East
Newport North
Newport West
Torfaen North
Torfaen South
10,000
9,000
8,000
7,000
6,000
5,000
4,000
201403
201406
201409
201412
201503
201506
201509
201512
201603
201606
201609
201612
201703
201706
201709
201712
201803
201806
201809
201812
201903
201906


Opioid Burden (UDG) ADQs per 1000 Patients
Blaenau Gwent East
Blaenau Gwent West
Caerphilly East
Caerphilly North
Caerphilly South
Monmouthshire North
Monmouthshire South
Newport East
Newport North
Newport West
Torfaen North
Torfaen South
7,000
6,500
6,000
5,500
5,000
4,500
4,000
3,500
201506
201509
201512
201603
201606
201609
201612
201703
201706
201709
201712
201803
201806
201809
201812
201903
201906

Patients safety indicators

Cluster	Period	Indicator description	Numerator
Torfaen South	201906	Patients with asthma who have been prescribed a beta-blocker.	116
Torfaen South	201906	Patients aged ≥65 prescribed an antipsychotic as a percentage of all patients aged ≥65.	166
Torfaen South	201906	NSAIDs in CKD - number of patients who are not on the CKD register but have an eGFR of < 59 ml/min and have received a repeat prescription for an NSAID within the last 3 months, as a percentage of all patients who are not on the CKD register	35
Torfaen South	201906	Concurrent prescriptions of warfarin and oral NSAID.	3
Torfaen South	201906	Female patients aged 14 – 45 years with a prescription for sodium valproate	11
Torfaen South	201906	Women with a past medical history of venous or arterial thrombosis who have been prescribed combined hormonal contraceptives (CHC).	0
Torfaen South	201906	Anticholinergic burden - number of patients aged 75 and over with an AEC score of 3 or more for items on active repeat, as a percentage of all patients aged 75 and over.	384
Torfaen South	201906	Current prescription of oestrogen-only hormone replacement therapy in a women without any hysterectomy read codes.	84
Torfaen South	201906	Concurrent prescriptions of verapamil and beta-blocker.	2
Torfaen South	201906	Patients with a peptic ulcer who have been prescribed NSAIDs without a PPI	4
Torfaen South	201906	NSAIDs in CKD – number of patients on the CKD register (CKD 3-5) who have received a repeat prescription for an NSAID within the last 3 months, as a percentage of all patients on the CKD register	21
Torfaen South	201906	Current prescription of aspirin in child under 16 (unless specialist recommended). From April 2019	3
Torfaen South	201906	Patients aged ≥65 who have been prescribed an NSAID plus aspirin and/or clopidogrel, without gastroprotection (PPI or H2 receptor antagonist), as a percentage of all patients aged ≥65.	12

Activity benchmarking

The NCN will continue to work across practices to reduce the number of requests for ultra sound scan of shoulder and MRI of knee over the age of 45. Practice level data on these areas will be reviewed regularly to monitor improvements.

Torfaen South has high GP referrals to surgical specialties and chest x-rays. The NCN will continue to monitor this.

NCN AREA		BG East	BG West	Caer East	Caer South	Caer South	Mon South	Mon South	Newport East	Newport South	Newport West	Torfaen South	Torfaen South
NCN List Size		*33,563*	*38,404*	*65,889*	*64,886*	*56,463*	*53,399*	*47,335*	*48,499*	*58,942*	*50,651*	*49,661*	*46,571*
GP refs to non-surgical specialties	*Mar 19 - May 19*	211	208	168	172	139	186	164	156	162	171	211	171
GP refs to Trauma & Orthopaedics	*Mar 19 - May 19*	88	103	72	63	55	81	56	51	65	67	90	78
GP refs to surgical specialties excluding T&O)	*Mar 19 - May 19*	379	378	376	339	294	348	337	309	333	337	393	329
GP refs for MRI Knee (AB)	*May 19 - Jul 19*	11.02	7.55	7.74	6.32	6.91	9.74	13.73	6.80	5.60	8.29	8.86	10.31
GP refs for ultrasound shoulder (AB)	*May 19 - Jul 19*	3	3	3	2	2	3	3	5	1	3	2	3
GP refs for chest x-ray (AB)	*May 19 - Jul 19*	141	122	98	86	113	111	101	84	92	90	149	104
GP refs for sample testing MSU urine (AB)	*Apr 19 - Jun 19*	262	222	254	258	207	275	254	207	215	211	248	195

Benchmarking in relation to urgent care shows that we have a high number of occupied bed days following an emergency admission for adults aged 65+ years per 10,000 population. The number of conveyances of people in residential homes is also high. Further investigation into these areas will be undertaken to identify themes.

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NCN AREA		BG East	BG West	Caer East	Caer South	Caer South	Mon South	Mon South	Newport East	Newport South	Newport West	Torfaen South	Torfaen South
NCN List Size		*33,563*	*38,404*	*65,889*	*64,886*	*56,463*	*53,399*	*47,335*	*48,499*	*58,942*	*50,651*	*49,661*	*46,571*
Refs accepted Rapid Response Services	*May 19 - Jul 19*	33.07	40.10	27.47	18.34	20.37	-	-	13.40	11.71	13.43	34.84	27.48
Conveyances to hospital from residential homes	*May 19 - Jul 19*	20	22	81	8	77	20	36	4	50	51	75	54
Conveyances to hospital from nursing homes	*May 19 - Jul 19*	33	49	40	16	35	33	30	16	19	54	4	19
GP referrals to assessment units	*May 19 - Jul 19*	176.98	184.36	199.73	126.68	149.48	119.67	134.36	173.41	166.27	227.44	177.00	176.29
Average days medically fit prior to 'complex' discharge from RGH & NHH	*Jul 19*	0.83	0.83	2.65	2.65	2.65	2.17	2.17	3.49	3.49	3.49	1.49	1.49
Average length of stay in community hospitals	*Jul 2019*	17	19	37	32	26	36	41	35	35	33	27	34
Occupied bed days > 65 years of age following EMA	*May 2019 - Jul 2019*	7368	9144	6197	3535	7920	5031	5912	7325	7988	9156	7649	7837
Inappropriate ED Attendances	*May 2019 - Jul 2019*	59	54	59	57	62	8	7	25	22	30	25	20

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The figures for individual District Nurse Teams are shown below: Torfaen South 1 has an extremely high average days on active caseload and work will be undertaken with the team to cleanse the data and identify why this is.

		Average days on active caseload	Active caseload per WTE	Visits per WTE each month	% of visits that are unplanned	% of active caseload that are CHC	% patient dying with EOL care	% venep'ture by HCSW	% active caseload on SKIN bundle	% active caseload with a pressure ulcer	Monthly spend per patient on active caseload	Monthly bank & agency per patient on caseload
		3 months rolling	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*
Blaneau Gwent	East Blaneau Gwent	74	19.17	118	5.4%	1.1%	41.9%	59.0%	21.3%	2.6%	£176.69	£0.13
	West Blaenau Gwent	125	21.34	154	5.5%	1.4%	26.4%	55.0%	14.5%	3.5%	£158.34	£1.54
Caerphilly	Bargoed	81	21.62	181	7.9%	1.6%	66.7%	65.8%	21.4%	5.6%	£141.11	£8.16
	Denscombe	75	26.74	155	11.0%	0.5%	26.5%	62.4%	7.4%	5.4%	£128.19	£0.00
	Pontllanfraith	69	27.51	185	5.5%	0.6%	43.3%	70.4%	4.1%	4.0%	£127.24	£3.32
	Rhymney	87	28.57	175	8.9%	0.7%	33.3%	73.6%	14.0%	2.8%	£116.19	£0.52
	Risca	256	34.20	193	3.8%	0.7%	16.7%	70.1%	3.7%	3.3%	£103.24	£0.95
	Ty Bryn	127	25.45	196	9.5%	1.5%	38.5%	54.4%	9.7%	3.7%	£129.87	£13.41
	Ystrad Mynach	57	21.65	169	12.6%	0.7%	41.2%	16.7%	7.8%	4.9%	£143.77	£2.05
Monmouthshire	Abergavenny	88	28.10	185	5.3%	2.0%	70.8%	62.4%	24.8%	3.8%	£131.94	£6.59
	Caldicot	90	22.98	107	7.6%	0.0%	0.0%	75.1%	18.8%	10.9%	£122.95	£7.10
	Chepstow	40	16.47	98	7.2%	0.8%	100.0%	78.4%	20.2%	4.7%	£187.25	£0.00
	Monmouth	90	20.90	116	13.4%	0.8%	78.9%	85.2%	18.0%	2.4%	£142.69	£5.51
	Usk / Raglan	115	24.58	160	4.2%	0.6%	0.0%	31.3%	45.7%	1.5%	£122.35	£28.86
Newport	Central East	80	16.63	123	4.8%	2.1%	84.6%	39.5%	4.0%	4.9%	£171.29	£2.10
	Central West	54	24.62	173	11.6%	3.3%	54.5%	28.9%	19.0%	8.7%	£117.97	£13.17
	North East / West	56	19.58	157	4.8%	1.7%	47.8%	62.2%	6.3%	4.0%	£160.17	£7.71
	South East	48	14.84	111	12.4%	3.4%	50.0%	64.2%	17.3%	4.8%	£189.24	£15.95
	South West	64	22.12	178	7.2%	2.5%	41.7%	57.0%	23.3%	3.2%	£146.73	£9.32
Torfaen	North 1	107	21.18	162	5.7%	1.4%	80.0%	83.8%	29.9%	4.0%	£166.43	£0.00
	North 2	119	21.71	184	6.8%	2.7%	11.5%	59.2%	9.6%	5.7%	£151.45	£12.37
	South 1	230	24.27	176	8.3%	3.3%	75.0%	71.3%	24.9%	2.4%	£159.30	£3.43
	South 2	88	21.97	170	11.8%	3.8%	85.7%	80.6%	6.8%	8.6%	£141.74	£12.78
	Upper Quartile	66	25.03	180	5.5%	0.7%	72.9%	72.5%	21.4%	3.3%	£127.72	£1.24
	Median	87	21.97	169	7.2%	1.4%	43.3%	62.4%	17.3%	4.0%	£142.69	£5.51
	Lower Quartile	111	21.04	138	10.2%	2.3%	29.9%	56.0%	7.6%	5.2%	£159.73	£10.85
	Local Target	-	-	-	-	-	-	-	-	-	-	-
	Welsh Benchmark	-	-	-	-	-	-	-	-	-	-	-
	UK Benchmark (16/17)	121	36.75	112	-	-	-	-	-	2.6%	-	-