Neighbourhood Care Network Integrated Medium Term Plan 2020-2023

Newport East

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Executive Summary

What is this section for?

Summary of the key points of the whole document, outlining the strategic direction of the area and highlighting key learning from the population needs assessment and asset profiles. Sharing the plan on a page as a high level summary of the actions to be taken forward in the next period.

This IMTP is based on an assessment of population need in Newport East and sets out the type and distribution of health and care services that will bring the greatest benefit. It has also looked at the whole population served by the NCN to identify gaps, assets or inequity in service provision. This assessment involved a review of national and corporate priorities, epidemiological data, service utilisation data, views of professionals and managers within the NCN and intelligence from public engagement.

The Newport East NCN has a registered population of population 48,500. Newport has an ageing population and those aged 65 and over grew by 8.6% between 2011 and 2015. The population of Newport aged 65 and over is projected to rise to 37,241 by 2039 accounting for almost a quarter of the population. Within the electoral wards of Alway, Beechwood, Lliswerry, Ringland and Victoria there are 14 of the 27 lower super output areas (populations of around 1,500) in the top 20% most deprived for Wales. Pregnancy and childhood surveillance data shows that around third of children in Newport are living in poverty, teenage pregnancy rates and dental caries in 5 year olds are higher compared to Wales. Around a quarter of 4 and 5 year olds are either overweight or obese. There is a large minority ethnic community resident in the electoral wards of Victoria and Lliswerry representing 38 and 14 per cent of the population respectively. Newport East has seen an increase in its homeless population as well as other vulnerable groups such as asylum seekers and refugees and people with substance misuse problems.

The Burden of Disease report in Wales showed that cardiovascular disease and cancer are the main causes of disability adjusted life years. The main behavioural risk factors are diet, smoking, alcohol and physical activity and the clinical risks being high blood pressure, high body-mass index, high total cholesterol and high fasting plasma glucose. Musculoskeletal disorders, mental health and substance misuse problems are the main causes of years lived with a disability. Newport East NCN has a slightly lower recorded prevalence of hypertension and obesity in adults compared to the ABUHB average. Similarly, the recorded prevalence of major chronic conditions, except diabetes, is lower than the ABUHB average. Smoking prevalence was shown to be the second highest of all the NCNs with around a quarter of adults reporting smoking. Data from the cancer registry shows that a high proportion of lung cancers in Newport East are diagnosed at a late stage. Newport East has among the lowest uptake of breast, bowel and cervical screening and all are below the national target. In relation to vaccine preventable diseases Newport East has a significantly lower uptake of flu vaccination that other NCNs. In terms of scheduled childhood immunisation, the uptake in Newport of the second dose of MMR vaccine and 4-in-1 booster at age 5 is second lowest in Wales and below the level required for herd immunity.

Urgent care remains a priority area for the Health Board. Newport East has the highest rate of Primary Care Out-of-Hours contacts and has seen a slight reduction in accepted referrals to Rapid Response Services. However, although there are some large fluctuations due to small numbers, the conveyances to hospital from care homes has decreased. In terms of prudent use of resources the trends in secondary care referrals for investigations show there was a reduction to GP referral for MRI knee, slight increase in ultrasound shoulder and a sharp decrease in laboratory testing for INR associated with the introduction of the anticoagulation enhanced service. Medicines management data for Newport East NCN shows significant improvements in antimicrobial stewardship in terms of prescription rates for the 4C antimicrobials. However, future improvements are required to achieved national targets and the level an antimicrobial prescribing seen in other parts of the UK. This is crucial to prevent population spread of infection from multi-drug resistant organisms and to ensure antimicrobials remain an effective treatment for future generations. A continued focus is required on gabapentin and pregabalin (often used to treat pain and anxiety) and hypnotic and anxiolytics (often calle d sedatives) as these prescribed drugs can lead to dependence. Tramadol is also a national prescribing indicators and Newport East NCN has seen a sustained reduction in prescribing of tramadol, although there is some variation between GP practices.

The following sections set out the response from Newport East NCN to healthcare needs identified over the next three years. The first of these are a number of national or corporate priorities, including specific requirements in the Quality Assurance and Improvement Framework (QAIF) of the General Medical Service (GMS) contract 2019/20. These priorities are as follows:

1. Innovative and collaborative approaches across the NCN to achieve in-hours **GMS access standards** set by the Minister for Health & Social Services, including a digital offer

2. **Quality improvement projects** led by the NCN across a range of areas including patient safety (mandatory), reducing stroke risk and advanced care planning

3. Planning and delivery of **GP enhanced services** on an NCN footprint to ensure equity of access

4. **Demand and capacity analysis** and **workforce planning** in general practice to ensure greater efficiency, appropriate skill mix and **sustainability** of services

5. On-going review of **clinical incidents** and sharing learning within the NCN to improve quality and patient safety

6. Redesign of **urgent care pathways** and delivery of specific aspects of the **winter delivery framework** including flu vaccination, risk stratification of the frail population and effective management of those with ambulatory care sensitive conditions

In addition to these "must dos" there are a number of local priorities identified where the Newport East NCN with provide leadership and accountability for delivery. These include:

7. Improving **self-care and patient activation** with consideration given to cultural and social norms as well as other factors such as language and literacy.

8. Improving uptake of **flu vaccination** with a specific focus on 2-3 year olds and those in at risk groups such as patient with asthma and COPD

9. Continued innovation and development of the **Neighbourhood Nursing model** through self-managed teams working as part of an integrated place-based approach

10. Improving **secondary care and OOH interface** through on-going dialogue with clinical teams and peer review within the NCN

The Newport East NCN will continue to **evaluate, improve and embed existing initiatives** such as care navigation, the common ailments services, practice based pharmacists and direct access physiotherapy.

In support of NCNs the **Newport Integrated Partnership Board** will continue to support NCN development and the redesign community services to build a model of graduated care across the Borough. This will involve implementing actions arising from the Gwent Frailty Service review to ensure that care provided of the older and frail population is responsive to current and future demands. This will include opening up referrals to a wider range of advanced practitioners (initially ANPs and paramedics), new roles within the team (e.g. Physician Associate, Pharmacist, Reablement Worker) and greater integration with District Nursing teams. The Clinical Futures Service Redesign Programme has set out the need to reshape care frailty pathways around four pillars – prevention and anticipatory care, proactive home care, admission avoidance and early facilitated discharge. This will require integrated place-based teams that promote continuity, reduce hand-offs and encourage warm handovers at transition point across the system.

In addition to national, corporate and locally determined priorities the Newport East NCN will be a vehicle for delivery of other programme that are funded centrally either through ABUHB or the Regional Partnership Board. Whilst the leadership, management and funding of these programmes sits elsewhere within the health and social care system they will require significant engagement with primary care if they are to be delivered effectively and at the scale required to have impact. These programmes are the:

- **Healthy Child Wales** programme to ensure universal but proportionate approach health visiting provision. This will require close partnership working with colleagues in primary care and children's services around a range of issues including safeguarding, positive parenting, healthy child development and the promotion of healthy lifestyle choices such as smoke-free homes and childhood immunisations.

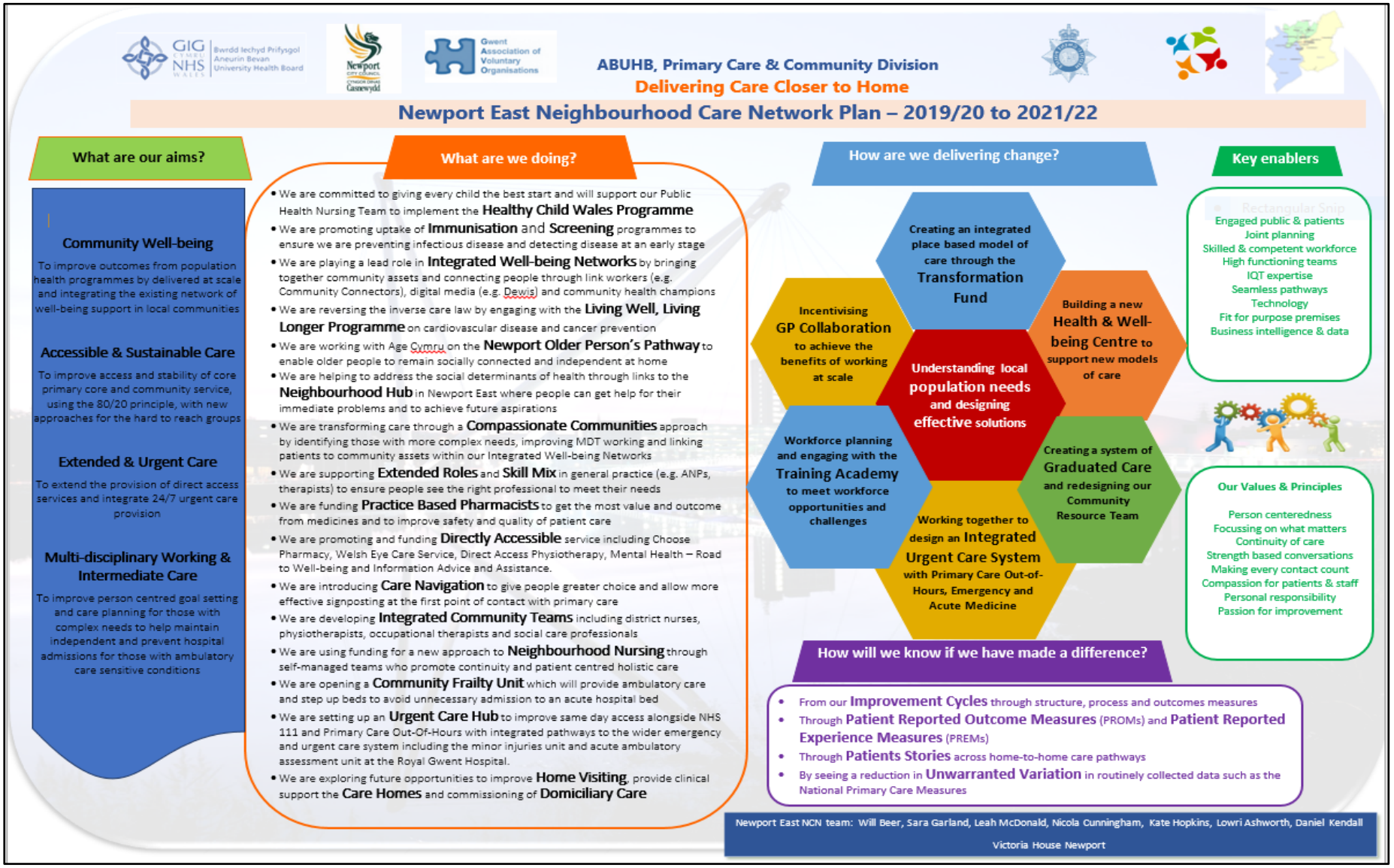
- Transformation programme including the **Workforce Academy, Compassionate Communities, 'Iceberg' CAMHS model** and **Integrated Well-being Networks**

- **Living Well, Living Longer** programme with a new focus on management of patients with identified lifestyle risk factors and a prevention pathway for people with pre-diabetes.

- **Older Persons Pathway** to ensure that people with low to moderate levels of frailty have a Stay Well Plan which will helps them to remain socially connected and maintain their independence at home.

Finally, there are four areas where the Newport East NCN recommends that greater advocacy is required to improve outcomes through concerted action across the wider system. These areas include uptake of **cancer screening services**, care and support to **homeless and vulnerable groups**, **childhood obesity** and **smoking prevalence**.

Plan on a Page



1 Introduction to the 2020-2023 Plan

What is this section for?
Introduction to the document to be developed by Head of Service and NCN Leads, setting out its purpose and overarching ambition of the plan.

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*.

Our Clinical Futures Strategy sets out how we are moving to a better balance of care by:-

- delivering most care close to home,
- creating a network of local hospitals providing routine diagnostic and treatment services, and
- centralising specialist and critical care services in a purpose build Specialist and Critical Care Centre

Primary and Community Services are at the heart of the model and central to developing a new relationship with patients as partners/co-producers in preserving, maintaining and improving their own health and wellbeing. Investing in and strengthening primary, community and social care services to create the capacity to support and treat patients in their homes and communities is a core component of our strategy.

In order to deliver on these principles, Newport Neighbourhood Care Networks ambition is to create a new, more integrated system of primary and community care in partnership with our local government and independent/third sector colleagues across Newport.

We want people to be able to access the care they need in their own 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.

The Neighbourhood Care Networks are the footprint for the development of this sustainable, social model of primary care which will support people to better manage their own health and wellbeing and to retain their independence and resilience for longer in their own homes and localities.

Our Integrated Medium Term Plan therefore reflects the agreed activity to support the creation of a seamless system of 'wellbeing' where more care is provided closer to home, and where the patient is placed at the centre of service delivery. We

aim to achieve this by delivering place-based care within each NCN footprint, with access to more specialised services at a borough or Gwent-wide level.

Newport is a multi-cultural city with its own unique atmosphere, where neighbourhoods with some of the country's highest levels of social deprivation sit next to some of those with the greatest affluence. We have the second highest proportion of population from a BME background in Wales and a growing homeless and rough sleeper population. Demand for healthcare is growing and will continue to grow; we have an aging population, with patients living longer and with more complex needs, which intensifies the challenges faced by the NHS. Although a national issue, primary and community services sustainability has impacted on the local area and our estate is also not fit to provide primary care services for now and the future.

With such challenges come opportunities, and we have been fortunate in Newport to have received funding to enable us to test components of the new model including;

- Establishment of Neighbourhood Nursing in Newport East
- Establishment of the Newport Older Persons Pathway and Stay Well Plans
- Roll out of Care Navigation in all GP practices
- GPs demonstrating leadership and best practice (e.g. Common Ailments)
- Establishment of a Direct Access Physiotherapy
- New early intervention CAMHS model,
- Appointment of Practice Based Pharmacists across all GP practices
- Establishment of a Community Phlebotomy Service utilising NCN funding

During 2020-2023, opportunities ahead for Newport include;

- Improvements GMS access and quality improvement though the QAIF within the GMS contract 2019/20
- Creating more sustainability in primary care through the incentive scheme to support skill mix and workforce academy
- Development of the Newport East Health & Wellbeing Centre in Ringland
- Development of Neightbourhood Nursing approach in line with Buurtzorg approach and District Nurses principles
- Implementation of Graduated Care
- Establishment Place Based Care model across the NCN footprint
- Further engagement with Living Well Living Longer programme and Integrated Well-Being Networks
- Implementation of the Healthy Child Wales Programme
- Engagement with the Compassionate Communities programme

- Organisational development for Practice Managers
- Proposal to redesign the NCN footprint from three to two, in line with partner service delivery needs.
- Establishment of a framework for resilience and wellbeing to guide all partners and communities to provide clarity on why wellbeing and resilience are important, and how they will be systematically improved and strengthened within Newport.

Our main challenge as an NCN will be to first embed and then sustain these changes so that they become business as usual, whilst also managing the day to day service pressures.

In order for these changes to be embedded, engagement of multiple stakeholders is vitally important and the resulting interventions evaluated in order to assess their value. Newport has developed a comprehensive communications strategy and supporting action plan to address this, crucially taking our citizens on the journey with us, so that they are continuously co-designing the model and truly own and feel responsible for not only their community but for their own health and well-being.

Our plan will set out the steps which the Newport Neighbourhood Care Networks will take over the next three years to take us closer to achieving our vision.

It sets our key priorities, milestones and implementation plans, and analyses the challenges, opportunities and risks associated with delivery and defines how we will deliver these actions, in terms of workforce configuration and financial implications.

This plan will be the cornerstone of our NCN business, enabling us to be clear and purposeful in our actions and to hold ourselves accountable for delivering our agreed priorities, for the benefit of the communities we serve.

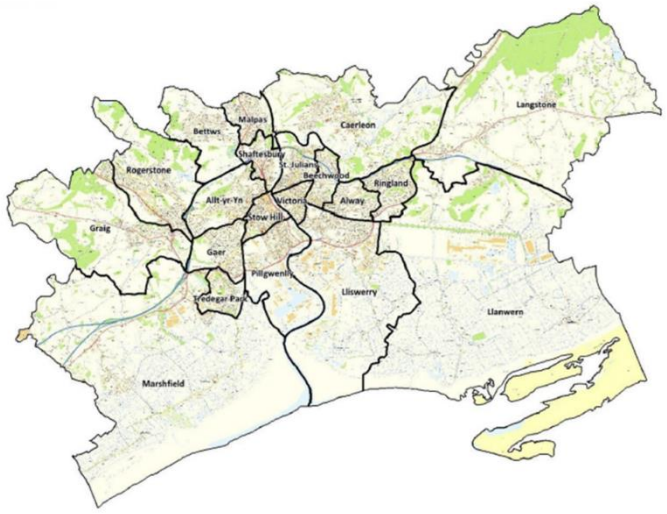
2 Overview of the Neighbourhood Care Networks

What is this section for?

This section describes the organisation of the neighbourhood care network. It should describe the long term vision for the NCN, its key goals and statement on how the NCN will plan to deliver these. It is important that NCN has well defined and transparent governance arrangements and this section should articulate these clearly, including how the NCNs will interface with the wider Health Board and other key partner organisation.

14.4 Profile of the Neighbourhood Care Network

Newport is a multi-cultural city, with a population of 153, 302 and covers a geographical area of 73.5 square miles. We have some of the most and least deprived neighbourhoods in Wales, in some instances just a walking distance apart. Geographical patterns of poverty are also reflected in health inequalities and significant differences in healthy life expectancy across the city. Certain neighbourhoods are disproportionately affected by unemployment, low incomes, poor skill levels and crime and anti-social behaviour.



Newport has the second highest proportion of population from a BME background in Wales, with 48 different languages spoken amongst 20 identified communities. Newport is also an asylum seeker dispersal area and there is a growing homeless and rough sleeper population.

Newport has been established around three Neighbourhood Care Networks; North, East and west which work collaboratively to strive to improve primary care and community services within the local area.

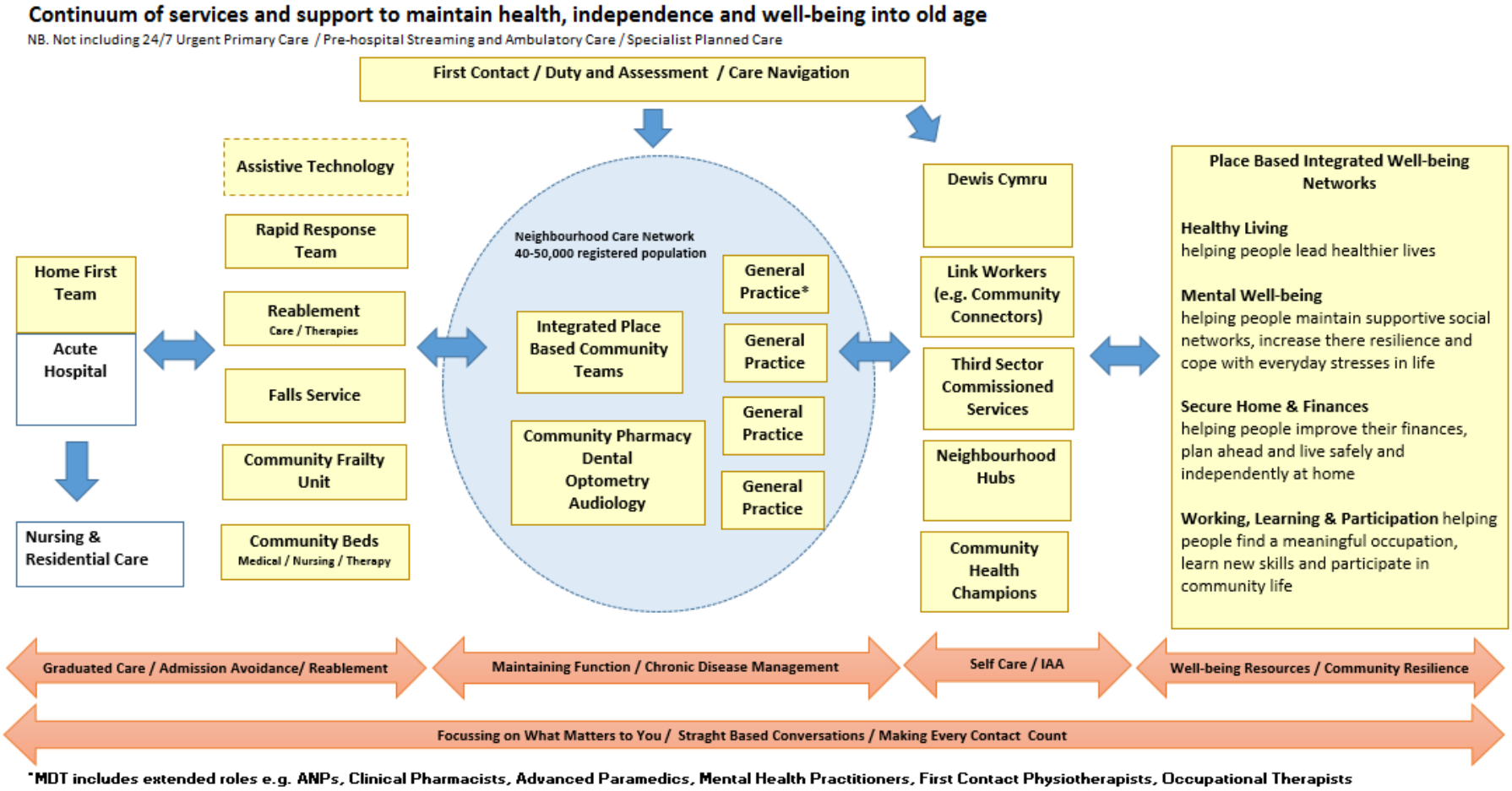
The Newport East NCN is led by William Beer, Consultant in Public Health (Aneurin Bevan University Health Board and honorary contract with Public Health Wales). They are a network of 6 GP practices which together have a combined registered population of 52,958.

There are also 4 dental practices, 1 optometrist and 10 Community pharmacies situated within Newport East NCN.

14.4 Vision Statement

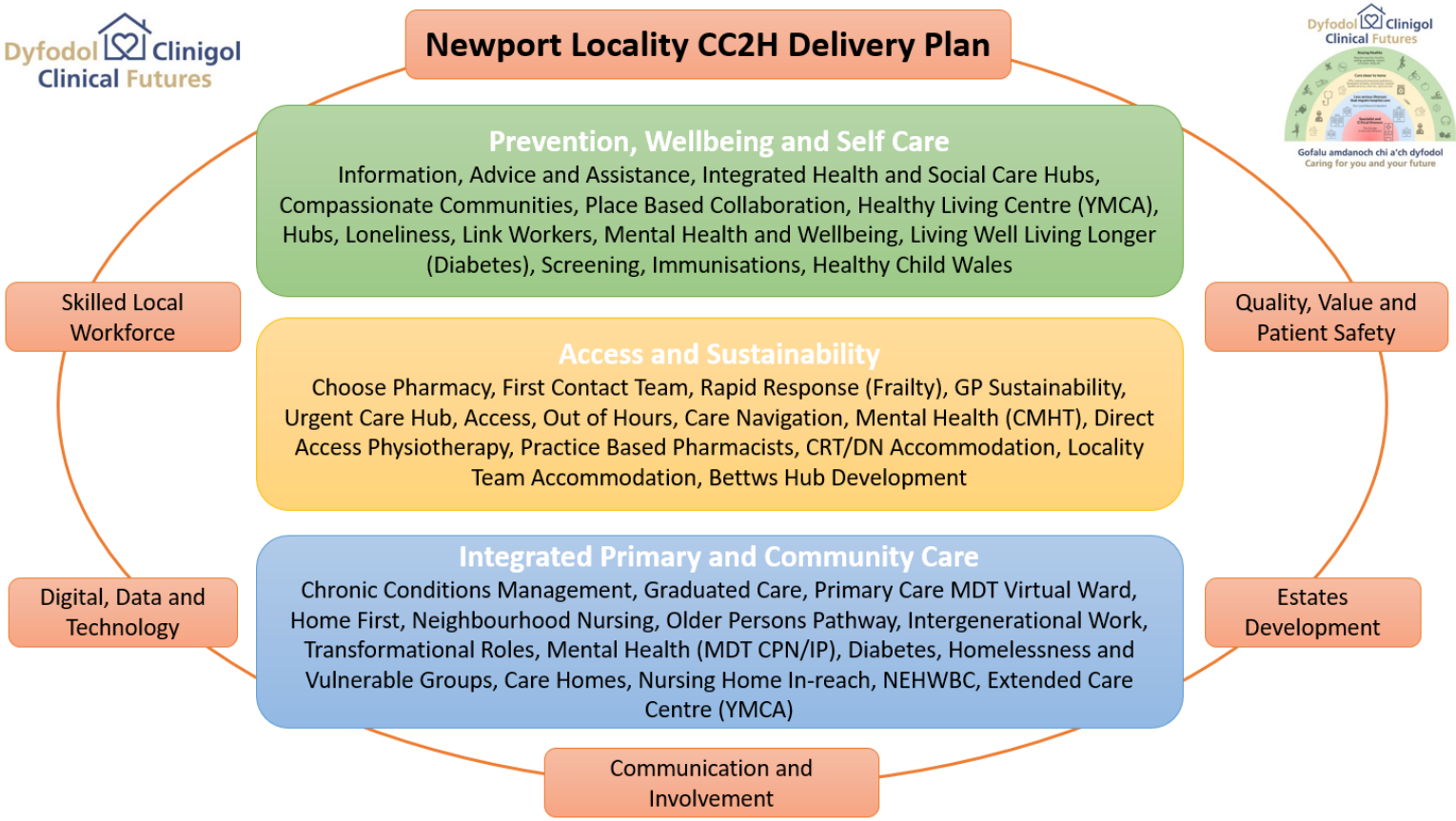
Newport aims to provide a more integrated system of primary care with community care and wellbeing services, based around each NCN footprint. Services will be designed to provide more co-ordinated care, closer to home with fewer handoffs and reduced complexity. The approach is intended to be delivered in a manner that will aim to strengthen community resilience and respond to need. The continuum of services and support to maintain health, indepednace and well-being into old age is summarised in Figure 1 (below).

Figure 1 – Continuum of services and support to maintain health, independence and well-being into old age



The **Newport Integrated Partnership Board** will continue to support NCN development and the redesign community services to build a model of graduated care across the Borough. The Newport Integrated Partnership Board have established three workstreams (see Figure 2, below) that align with the Divisional strategic workstreams (see Section 3.4) but which specifically require an integrated approach with the local authority and third sector.

Figure 2: CC2H Delivery Plan and Enablers



1. Prevention, Well-Being and Self Care

Improving long term population health through a focus on early intervention, prevention and well-being services by making sure that the right support is available at the right time, as close to home as possible. Ensuring that people have more control over their wellbeing and making decisions about their support. Organisations working together on a place basis with each other and with local people.

The RPB has successfully bid to the Transformation Fund for additional resources to accelerate implementation of the Integrated Well-being Networks (IWNs) programme. The initial focus in Newport East will be on Ringland and Alway, but this will be extended across the NCN in due course. Mapping and gap analysis has been undertaken and a number of community assets identified as providing (or having the potential to provide) well-being support. These are the Ringland Neighbourhood Hub (opening in Oct 2019), Ringland Health Centre, Lloyds Community Pharmacy, Ringland Dental Practice, Ringland Primary School, St. Gabriel's R.C. Primary School, Llanwern High School, Wellwood House, Hendre Farm Court and Milton Court Sheltered Housing, Dan-y-Graig Nursing Home, Ringland Labour Club, Ringland Presbyterian Church of Wales, Bishpool Methodist Church, Workers' Educational Association (WEA) Adult Learning and Newport Live Leisure Trust.

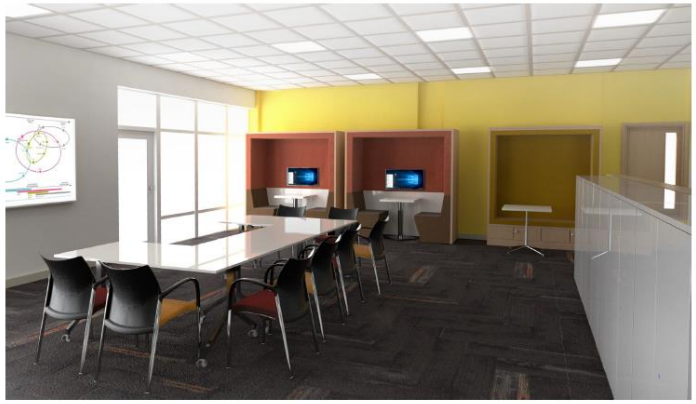
Newport City Council are opening their first Neighbourhood Hub in Ringland in October 2019 (see Figure 3, below). This will bring together a range of organisations, groups and services, organised on a place basis, under a new neighbourhood management structure. A Neighbourhood Hub Manager has been appointed to the Hub who will work alongside community development workers. There will be a range of support provided from the Hub including Flying Start, Families First, Work & Skills, Careers Service, Department for Work and Pensions Advice (e.g. benefits), Adult Community Learning, Citizen's Advice Bureau, Housing officers, Library and various community groups and voluntary organisations.

Figure 2 – Concept images and design features of the Ringland Neighbourhood Hub

3D Concept Images – Activity Space

PLACEmaking | Newport City Council | Ringland Hub Operational Services Requirements | Page 6

3D Concept Images – Training Zone



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3D Concept Images – Tea Point in Activity Space

PLACEmaking | Newport City Council | Ringland Hub Operational Services Requirements | Page 5

The IWN programme will be bringing together the current place-based 'linking roles' such as Tenancy Support Workers, Citizen Advice Workers, Community Development Workers, Care Navigators and Community Support Officers.

The next steps are to jointly agree community engagement methods to use and to produce a local engagement plan and the resource (funding or people) to carry out engagement. There is a specific objective in the programme to explore the

- Use of social media to engage and also develop community awareness and involvement
- Advice on/support other communication methods to raise community awareness and share stories
- Support to develop social prescribing model
- Local event to bring partners together and develop wellbeing offer further
- Signing up wellbeing centres and frontline signposting training

2. Access and Sustainability

Improving access to services, delivered at or close to home, is a key strategic priority for Welsh Government and is central to the Primary Care Model for Wales. Access remains a Ministerial priority for primary care and a key feature of the GMS contract underpinned by clear measurable expected achievements by March 2021. We need to better understand the barriers people face in accessing GP services and to seek insight into what "good" looks like for the people in Newport East. Improvement in access will also help to anticipate people's health needs and intervene before those needs become urgent. Under the new model, professionals will work together to provide people with a range of ways to access the right care and support, close to, or even in their home. This means a shared commitment to access and integrated working for professionals such as GPs, pharmacists, physiotherapists, social workers, OTs and people working in the third sector. This should include better use of technology and integrated information systems, particularly WCCIS and GP clinical systems. Newport City Council have rationalised the number of front doors into the system and have strengthened their First Contact and Information Advice and Assistance function. This includes ICF funding for Community Connectors that connect with people who are not already engaged with groups and activities and signpost to well-being services and support. AskSara is an online platform that has been procured which allows people to make their own assessment and purchase equipment that will enable them to live safely and independently at home.

In addition to primary and community care services the Mental Health & Learning Disabilities Division are developing innovative way of improving access to Primary Care Mental Health Support Services and are introducing a single point of access for Adult Crisis Mental Health Services. Family & Therapy Services are utilising the Transformation Fund to create a single point of access for the new 'Iceberg' CAMHS model (i.e. SPACE) and have already adopted a similar approach with the Integrated Service for Children with Additional Needs (i.e. ISCAN) and an Integrated Autism Service. Newport East are currently funding the Direct Access Physiotherapy Service at St Woolos hospital and there is potential for this to be extended to other therapy services such as audiology.

Sustainability remains an issue across a number of service areas in Newport East, particularly within general practice. The Newport Integrated Partnership Board will have a key role in joint workforce planning and optimising the use of resources across the continuum of care. The ICF and Transformation Fund are important funding streams to support joint planning and workforce development through, for example, the Health & Social Care Academy and scheme to incentive skill mix within general practice. The NIP Board should retain a strategic overview of this to ensure that the introduction of new roles within primary care does not inadvertently destabilise services in another part of the system. Innovation and quality improvement are other ways to support sustainability and the Neighbourhood Nursing model in Newport East is a good example of how this can help improve morale, reduce sickness absence and promote recruitment and retention. Finally, the NIP Board will need to continue the focus on sustainability of commissioned service within the Independent Sector, particularly domiciliary care, but also residential care and nursing homes.

3. Integrated Model of Primary and Community Care

The National Primary and Community Care Model for Wales set out a clear blueprint for providing a wider range of services in primary care, using the skills of a greater range of professionals and work closely with other services in the community through multidisciplinary teams. With increasing pressure and scrutiny on health and social care budgets it will be important for the NIP Board to resist the 'fortress mentality' where organisations and agencies act to secure their own individual interests and future, and instead establish place-based 'systems of care' in which they collaborate with other services to address the challenges and improve the health of the populations of Newport. Much of the work to improve and join up local services will be done at an intermediate level, often referred to as the level of 'place'. The NCNs will need to come together with other local providers to shape and deliver some services across a place. The NIP Board will need to use the NCNs to bring detailed knowledge of their populations and service challenges to support intelligent system-wide decisions that are sensitive to distinctive local contexts and needs.

In terms of intermediate care the Gwent Frailty Service review and Clinical Futures Service Redesign Team have identified a number of areas where care of complex older and fail people needs to evolve of the next three years. A graduated care approach is being introduced in the St Woolos Community Hospital which will allow for the implementation of a revised model of multidisciplinary care. To facilitate this 2 wards at SWH have been designated as Rehabilitation/Reablement and Complex discharge. These beds offer a step up and step down approach to care. Patients can be transferred and stepped down from acute beds, or stepped down from Community beds into Parklands Residential Reablement beds. Equally patients can step into care if admitted directly via the Clinical Frailty Team in to in patient Clinical Frailty Unit beds for patients that require short low acuity intervention before discharge home, who bypass the need to enter secondary care via the Emergency Department where they are likely to experience a longer length of stay and may physically decompensate due to this admission.

Newport's aim is to provide a more integrated system of primary care with community care and wellbeing services, based around each NCN footprint. Services will be designed to provide more co-ordinated care, closer to home with fewer handoffs and reduced complexity. The approach is intended to be delivered in a manner that will aim to strengthen community resilience and respond to need. The work that is being undertaken within the borough affects all services and will require wholescale change. New ways of working need to align and dove tail into each service as boundaries diminish and more seamless care and support is provided. Services will be required to implement a more anticipatory approach with greater participation of patients in their own care; working more collaboratively and often at greater scale. The more socially centred model of care will require a more differentiated skill mix and the supported development of new roles.

14.4 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..1 Membership

Newport East Neighbourhood Care Network

Name	Title	Organisation / Designation
William Beer	NCN Lead	Public Health Wales
Kelly Yemm	Practice Manager	Beechwood Surgery
Dr E Jones	General Practitioner	Beechwood Surgery
Kay Lau	Practice Manager	Lliswerry Surgery
Dr Al-Haj Ali	General Practitioner	Lliswerry Surgery
Kerry Hagland	Practice Manager	Park Surgery
Dr Kandhai	General Practitioner	Park Surgery
Elaine Coldrick	Practice Manager	Ringland Medical Practice
Dr Sarah Morgan	General Practitioner	Ringland Medical Practice
Wendy Hall	Practice Manager	The Rugby Surgery
Dr J Staniforth	General Practitioner	The Rugby Surgery
Gaynor Pick	Practice Manager	Underwood Health Centre
Dr James Leney	General Practitioner	Underwood Health Centre
Aimee Clement-Rees	Service Development Manager	Primary Care Unit
Ann Owen	Senior Nurse	Community Division
Sian Price	Public Health Operational Manager	Families & Therapies Division
Sharon Cooke	Clinical Programme Manager	Primary Care & Community Division
Naheed Ashraf	Carers Regional Partnership Coordinator	Primary Care Unit
Kate Hopkins	Care Closer to Home Project Manager	Partnership & Development Unit
Nicola Cunningham	Neighbourhood Care Network Manager	Newport Locality
Leah MacDonald	Assistant Head of Service	Newport Locality
Sara Garland	Head of Service	Newport Locality

Mike Curson	Senior Primary Care Pharmacist	Newport Locality
Marietta Evans	Integrated Wellbeing Network Service Development Lead	Public Health Wales
Linda Jones	Operational Health Manager	Flying Start
Kerry Phillips	Senior Midwife Manager	Midwifery
Kathryn Smith	Interim Associate Director of Operational Delivery	Executive Board
Kate Thomas	Health, Social Care & Wellbeing Coordinator	Gwent Association of Voluntary Organisations
Judith Davies	District Nursing Team Leader	District Nursing
Joanne Baker	Community Diabetes Specialist Nurse	Community Services
Karen Fitzpatrick	Community Resource Team Nurse Manager	Frailty
Dave Thomas	Pharmacist	Lliswerry Pharmacy
Virginia Morgan	Strategic and Clinical Lead	Primary Care Mental Health Support Services
Penny Gordon	Head of Nursing	Primary Care & Community Division
Patricia Bartley	Community Resource Team Manager	Frailty
Dawn Pridham	First Contact Team Manager	Newport Local Authority
Sandra Trimarco	Community Strategy & Partnership Manager	Newport Local Authority

Newport Neighbourhood Care Network Management Team

Name	**Title**	**Organisation / Designation**
Sara Garland	Head of Service	Aneurin Bevan University Health Board
Dr Graeme Yule	NCN Lead Newport North	Aneurin Bevan University Health Board
Dr Susan Thomas	NCN Lead Newport West	Aneurin Bevan University Health Board
Will Beer	NCN Lead Newport East	Aneurin Bevan University Health Board
Sara Garland	Head of Service	Aneurin Bevan University Health Board
Leah MacDonald	Assistant Head of Service	Aneurin Bevan University Health Board
Nicola Cunningham	Network & Community Services Manager	Aneurin Bevan University Health Board

Daniel Kendall	Network & Community Services Support Officer	Aneurin Bevan University Health Board
Kate Hopkins	CC2H Project Manager	Aneurin Bevan University Health Board
Aimee Clement-Rees	Service Development Manager	Aneurin Bevan University Health Board
Ann Owen	Senior Nurse – District Nursing	Aneurin Bevan University Health Board
Caroline Rowlands	Quality & Patient Safety Manager	Aneurin Bevan University Health Board
Carolyn Jones	Decision Support Analyst	Aneurin Bevan University Health Board
David Price	Community Regeneration Manager	Newport City Council
Dawn Pridham	Service Manager	Newport City Council
Dr Liam Taylor	Deputy Medical Director	Aneurin Bevan University Health Board
Gemma Burrows	Principle Public Health Practitioner	Public Health Wales
Hannah Henson	Occupational Therapy Service Manager	Aneurin Bevan University Health Board
Linda Jones	Operational Health Manager Flying Start	Aneurin Bevan University Health Board
Lori Davies	Decision Support Accountant	Aneurin Bevan University Health Board
Patricia Bartley	Community Resource Team Manager	Aneurin Bevan University Health Board
Rachel Lee	Senior Nurse - Community	Aneurin Bevan University Health Board
Sharon Cooke	Clinical Programme Manager	Aneurin Bevan University Health Board
Sian Price	Public Health Operational Manager	Aneurin Bevan University Health Board
2 Practice Manager Representatives on a rotational basis	GP Practice Manager	Aneurin Bevan University Health Board

Newport Practice Managers Forum

Name	**Practice Manager**
GP Practices	
East NCN	
Beechwood Primary Care	Kelly Yemm
Lliswerry Medical Centre	Kay Lau
Park Surgery	Kerry Hagland
Ringland Medical Practice	Elaine Coldrick
The Rugby Surgery	Wendy Hall
Underwood Health Centre	Gaynor Pick

North NCN	
Westfield Clinic	Stacey Clarke
Isca Medical Centre	Sian Moore
Malpas Brook Health Centre	Helen Rossiter
Richmond Clinic	Nichola Tayler
St Julians Medical Centre	Lynne Barry
The Rogerstone Practice	David Harris
West NCN	
Bellevue Surgery	Gill Campbell
Bryngwyn Surgery	Sandra Bogue
St Pauls Clinic	Samantha Ashford
St Davids Clinic	Karen Phillips
St Brides Medical Centre	Molly Jelly

2..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 & 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**
Sara Garland	Head of Service
Leah MacDonald	Assistant Head of Service
Will Beer	NCN Lead (East)
Dr Susan Thomas	NCN Lead (West)
Dr Graeme Yule	NCN Lead (North)
Nicola Cunningham	Network and Community Manager
Kate Hopkins	Care Closer to Home Project Manager
Daniel Kendall	Network and Community Support Officer

Lowri Ashworth	Administrative Assistant/PA
Aimee Clement Rees	Primary Care Contracting Manager
Gemma Burrows	Public Health Wales

2..3 Frequency of Meetings

- Newport NCN Meetings take place on a bi-monthly basis.
- Newport Locality Management Team Meetings take place on a monthly basis.

2..4 Secretariat Support

- *Newport NCN Meetings:* Secretariat support for each NCN meeting is provided by the Network Support Officer. Requests for agenda items are forwarded to the NSO for consideration by the appropriate NCN Lead at the weekly Newport NCN Leads meeting.
- *Newport Management Team Meetings:* Secretariat support is provided by the locality administrative officer. Requests for agenda items are forwarded to the administrative officer and are discussed at the weekly operational team meeting with the Head of Service. Agenda items are linked to the delivery of the Locality and NCN work plans.
- *Newport Practice Managers Forum:* Secretariat support is provided by the Network Support Officer. Agenda items are submitted to the NSO.

2..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 at 2.3.1 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..6 Communication

The NCN lead has one dedicated NCN day per week, working directly with the locality management team in order to progress meeting planning, NCN budget, implementation of NCN plans and objectives. This is enhanced outside of this time by email correspondence as required to facilitate local resolution of queries linked to the NCN plan. The NCN management team meetings run on a bi-monthly basis. The NCN support team, along with locality team hold weekly catch up meetings in order to progress work. The NCN leads sit on the Newport Integrated Partnership Board (NIP) and regular feedback is also given to the Divisional Leadership Team.

The Newport NCN have a very active Practice Managers forum, who meet on a bi-monthly basis. Information and updates in relation to work progression are fed both ways, from the forum to the NCN leads and support team, and back in. Two practice managers are also members of the NCN management team – with attendance rotated from all practices.

There is Regular email contact with the NCN and partners as and when applicable to circulate information.

In addition to this the NCN Team has developed a monthly Newport locality e-bulletin which provides updates against the three Newport Care Closer to Home work streams, the wider Newport community and ABUHB Clinical Futures. Information is also disseminated via the Clinical Futures Champions within GP practices, which is then shared with the rest of the staff and patients.

Twitter Account – Newport NCN are the first in ABUHB to establish their own Twitter account. This provides an opportunity to share information as soon as it is available and to monitor any feedback. The account has been live since September 2019 and is being shared at every opportunity.

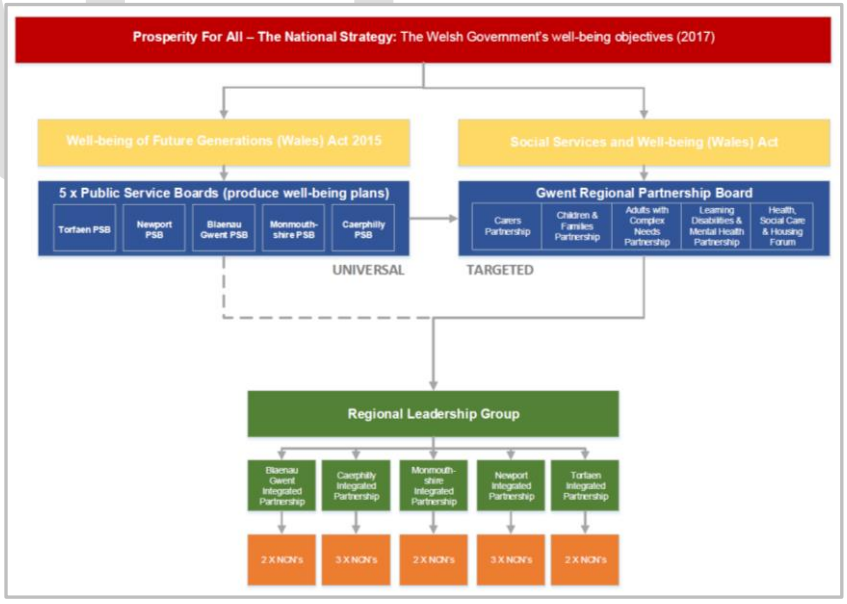
2..7 Reporting Framework

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

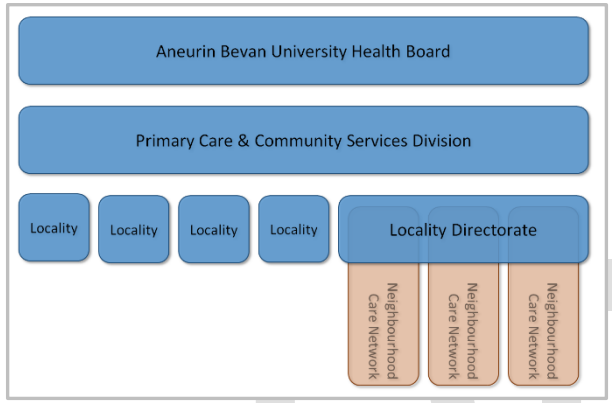
The NCNs are a key component of the Integrated Services Partnership Boards (ISPBs) in each of Gwent's five boroughs, which report to the Regional Leadership Group and onwards to the Public Service Boards and Gwent Regional Partnership Board.

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..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

What is this section for?

Although NCN plans must be developed in collaboration between all members of the network and seek to address local issues, NCNs are also part of the wider health and social care system in Wales. As a result, they must operate within a strategic framework which this section of the plans seeks to describe. When developing the locality and NCN actions (section 10), wherever possible each activity should demonstrate alignment with the strategic workstreams described in section 3.4.

Key Resources:

Well-being of Future Generations (Wales) Act (2015), Welsh Government – (link)
A Healthier Wales (2018), Welsh Government (link)
Strategic Programme for Primary Care (2018), Welsh Government (link)

14.4 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'. The plan sets out how services will be planned, delivered and designed on a regional, local authority and NCN footprint to provide more integrated care closer to home.

To deliver more care closer to home, that is seamless for patients, carers and their families the emphasis has been placed on 'service transformation' and service redesign' to create more integrated models of care including mental health, primary and community care and wellbeing services. Through the Welsh Government Transformation Fund and the Integrated Care Fund (ICF) additional resources have been secured to deliver new models of care including compassionate communities, Home First and Integrated Wellbeing Networks, and delivery is now underway and reflected in the NCN IMTP.

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. On a local authority footprint Integrated Services Partnership Boards will translate the regional vision into local delivery and support NCN to develop more integrated services closer to home, the NCN IMTP sets out this activity in detail and will align with both the Health Board IMTP and Gwent Area Plan.

14.4 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.

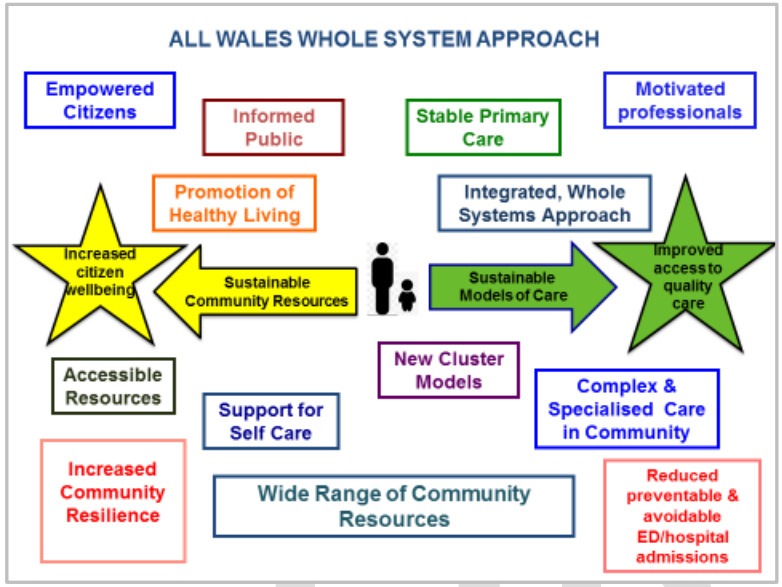
The design principles of Clinical Futures are:-

- ***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 careers.
- ***Standardised, best practice*** processes and care pathways.
- ***Sustainable*** with efficient use of resources.
- ***Prudent*** by design, following NHS Wales's prudent healthcare principles.

14.4 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 workstreams 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
- Primary Care & Community Services' Integrated Medium Term Plan

14.4 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 workstreams. It is intended that NCN plans will feed into these workstream areas for support and decision-making.

Strategic Workstream	Delivery Committees	Workstream 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

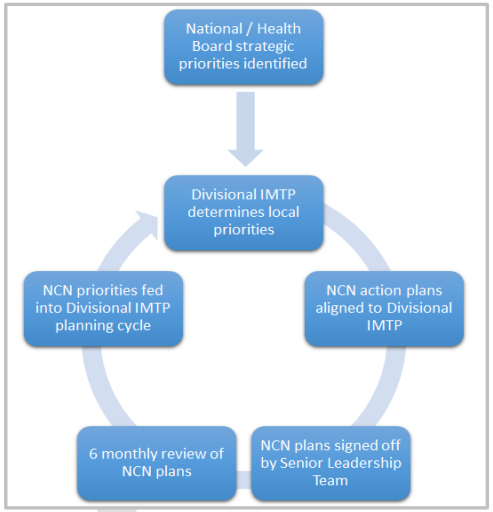
7) Skilled Local Workforce	Primary Care Workforce Group	Recognising the changing workforce requirements outside of the hospital setting, this workstream focuses on the training and development of both newly qualified and existing staff in line with the new ways of working.	Primary Care Academy, Diploma Level 4 (Health & Social Care), rotational posts in community nursing, palliative care education, workforce planning, demand & capacity analysis
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

14.4 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

What is this section for?
Overview of the achievements of the NCN over the last 3 year period, drawing out the benefits / measurable outcomes from actions delivered during the previous planning cycle.

Key Achievements	Benefits/outcomes
Sustainability A number of suitability of workshop sessions have been held with NCN meetings used to share ideas and plans around sustainability. The Transformation Fund has been used to introduced an incentive scheme to encourage GP practices to trial new and extended roles.	A number of GP practices have started introduce extended roles such clinical pharmacists, first contact physiotherapists and mental health practitioners. More recently practices have started to employ other roles, such as ANPs, through the Transformation Fund. This will remain a focus for the Newport East NCN and further work is required around workforce planning and to evaluate the extent to which skills mix can successfully address sustainability challenges.
Care Navigation NCN funding and support to introduce Care Navigation in May 2019 has enabled GP Practice reception staff and other front door staff across Newport to provide signposting and education for patients.	Six pathways have been identified in Phase 1 - Direct Access Physiotherapy, Mental Health, Common Ailments Service, Welsh Eye Care Service, Emergency Dental Service and Minor Injuries. Evidence from England has shown this can save 23 per cent reduction in GP demand. It will be fully evaluated in 2019/20.
Dewis Cymru The Newport East NCN has contributed funding to a Gwent wide post to support the use of Dewis Cyrmu online directory of well-being support. NCN funds have also been used to provide QR (Quick Response) Boards for GP practices, Royal Gwent Hospital and St Woolos.	Newport has the highest number of DEWIS users of all the NCNs across Gwent. This will help with care navigation and social prescribing as this is rolled out across the Newport East NCN.
Reducing Workload	The implementation of these schemes has not yet been fully evaluated but evidence from General Practice Development

A number of new schemes have been introduced to reduce workload and improve efficiency including workflow optimisation, self check-in and digital dictation software.	Programme in England show these schemes are part of the 10 High Impact areas that release capacity and time for patient care.
Choose Pharmacy Common Ailments Service Community pharmacies in NCN East have being delivered the scheme since 2018 allowing patients to attend for consultation, advice and medication for minor ailments.	This has freed up time for GPs and EDs to focus on those patients with more specialist and complex care needs. Newport pharmacies have carried out 2,253 direct 'choose pharmacy' appointments from April – June 2019.
Direct Access Physiotherapy Direct access physiotherapy has been introduced for patients with a MSK problems. It commenced in June 2018 with the aim of providing early physiotherapy assessment and reducing unnecessary GP appointments.	Current data has indicated that the service demand is increasing and will continue to do so with the implementation of Care Navigation. An additional 1 WTE physiotherapist is being recruited in order to expand the service to provide additional sessions in the afternoon.
Practice Based Pharmacists NCN funded practice based pharmacist roles commenced 2017. The NCN funding allows for dedicated in each practice and sharing of learning in terms of helping patients to make the best use of medicines.	Local evaluation has shown that this role can improve quality and patient safety and reduce GP demand. The role has been so successful that Beechwood Surgery have appointed their own clinical pharmacist and others are considering employing roles through the Transformation Fund.
CAMHS / Frailty / Liver Disease Pathway Audits were undertaken of patient groups from a basket for five national priorities areas. NCN workshops were held with CAMHS team, Clinical Director for Frailty and CRT Manager and Clinical Lead for Hepatology to identify improvement actions and opportunities for pathway redesign.	A new single point of access was introduced for Primary Care Mental Health Support Service for Children and Families through the Families First multi-agency joint allocation panel. An evaluation of this new model was undertaken which showed improved outcomes and patient experience in Newport when compared to a neighbouring Borough. Similarly, the new liver pathway aimed to introduce a more sensitive test to risk stratify patients and ensure appropriate referrals to secondary care for follow up fibroscan.

Neighbourhood Nursing Welsh Government funding has been received in Newport East to pilot a new model of Neighbourhood Nursing which applies aspect of the Buurtzorg approach in conjunction with District Nursing principles. Additional equipment including oximeters, Doppler machines and bladder scanners have also been purchased for district nursing teams.	Early signs are that this programme is beginning to transform district nursing in Newport East. Care aims training has had a profound effect on practice. District nurses are spending more time shadowing the Social Services First Contact team and are now more aligned to the CRT and discharge planning on the community wards. Next steps include the introduction of a new scheduling tool and the role of admin staff in care navigation.
Older Persons Pathway ABUHB, Newport City Council and Age Cymru jointly developed an integrated pathway for older people in Newport who are identified as being at risk of admission to institutionalised care and/or becoming users of more intensive packages of care.	To date, 3,229 patients have been identified as potentially requiring targeted service provision and support, enabling them to remain in their own homes than would otherwise be the case. Of these, 2,577 have had an interaction with a Care Facilitator with 1,742 undertaking support resulting in 1,184 active stay well plans.
Community Frailty Unit An ambulatory assessment area and inpatient unit has been established on the Gwanwyn Ward in St Woolos Hospital. A pilot in-reach reablement care team has also been introduced to identify frail patients for those at risk of decondition whilst they are awaiting appropriate packages of care. This forms part of a new graduated care approach to community services.	The graduated care model continues to be evaluated but experience from other areas shows that community patients are now able to receive interventions in a clinical environment (e.g. infusion therapy) and access step up or step down beds depending on their clinical need. The in-reach pilot highlighted the importance of a 'reablement ethos' on the wards from the point of admission until discharge and beyond. This will be rolled out in December 2019.

In addition to these achievements a number of initiatives have been put in place to support workforce development and professional education. This includes, for example, training for Healthcare Assistants in wound management, ECG and phlebotomy and the AMSPAR Certificate and Diploma and CIPD Level 3 in Practice Management. GDPR sessions have been funded as well as lunch and learn sessions on priority topic areas such as flu vaccination, care navigation, DEWIS and winter preparedness.

5 Population Health Needs Assessment

What is this section for?

This section should summarise needs of the population following a view of the available data on population profiles, disease prevalence and service provisions over recent years. This section should also reflect on future forecasts, based on natural development of these profiles as well as Local Development Plans (LDPs) for each area. In doing this, the NCN(s) should be better able to develop a targeted and prioritised action plan for the next 3 year period. As a consequence, the plan should be focused on areas of greatest need and therefore result in greatest value to the population as a whole.

Key resources:

GP Practice Population Profiles, Public Health Observatory (http://www.publichealthwalesobservatory.wales.nhs.uk/analysis-gp-population-profiles)
Daffodil Population Projections, Institute of Public Care (http://www.daffodilcymru.org.uk)

14.4 Population and Future Projections

An assessment of population need was carried out for Newport East to inform the type and distribution of health and care services that will bring the greatest benefit. The needs assessment looked at the whole population served by the NCN to identify gaps, assets or inequity in service provision. This assessment involved a review of national and corporate priorities, epidemiological data, service utilisation data, views of professionals and managers within the NCN and intelligence from public engagement (see Appendix 1 – Population Health Needs Assessment).

The Newport East NCN has a registered population of population 48,500. Newport has an ageing population and those aged 65 and over grew by 8.6% between 2011 and 2015. The population of Newport aged 65 and over is projected to rise to 37,241 by 2039 accounting for almost a quarter of the population. Within the electoral wards of Alway, Beechwood, Lliswerry, Ringland and Victoria there are 14 of the 27 lower super output areas (populations of around 1,500) in the top 20% most deprived for Wales. Pregnancy and childhood surveillance data shows that around third of children in Newport are living in poverty, teenage pregnancy rates and dental caries in 5 year olds are higher compared to Wales. Around a quarter of 4 and 5 year olds are either overweight or obese. There is a large minority ethnic community resident in the electoral wards of Victoria and Lliswerry representing 38 and 14 per cent of the population respectively. Newport East has seen an increase in its homeless population as well as other vulnerable groups such as asylum seekers and refugees and people with substance misuse problems.

The Burden of Disease report in Wales showed that cardiovascular disease and cancer are the main causes of disability adjusted life years. The main behavioural risk factors are diet, smoking, alcohol and physical activity and the clinical risks being high blood pressure, high body-mass index, high total cholesterol and high fasting plasma glucose. Musculoskeletal disorders, mental health and substance misuse problems are the main causes of years lived with a disability. Newport East NCN has a slightly lower recorded prevalence of hypertension and obesity in adults compared to the ABUHB average. Similarly, the

recorded prevalence of major chronic conditions, except diabetes, is lower than the ABUHB average. Smoking prevalence was shown to be the second highest of all the NCNs with around a quarter of adults reporting smoking. Data from the cancer registry shows that a high proportion of lung cancers in Newport East are diagnosed at a late stage. Newport East has among the lowest uptake of breast, bowel and cervical screening and all are below the national target. In relation to vaccine preventable diseases Newport East has a significantly lower uptake of flu vaccination that other NCNs. In terms of scheduled childhood immunisation, the uptake in Newport of the second dose of MMR vaccine and 4-in-1 booster at age 5 is second lowest in Wales and below the level required for herd immunity.

Urgent care remains a priority area for the Health Board. Newport East has the highest rate of Primary Care Out-of-Hours contacts and has seen a slight reduction in accepted referrals to Rapid Response Services. However, although there are some large fluctuations due to small numbers, the conveyances to hospital from care homes has decreased. In terms of prudent use of resources the trends in secondary care referrals for investigations show there was a reduction to GP referral for MRI knee, slight increase in ultrasound shoulder and a sharp decrease in laboratory testing for INR associated with the introduction of the anticoagulation enhanced service. Medicines management data for Newport East NCN shows significant improvements in antimicrobial stewardship in terms of prescription rates for the 4C antimicrobials. However, future improvements are required to achieved national targets and the level an antimicrobial prescribing seen in other parts of the UK. This is crucial to prevent population spread of infection from multi-drug resistant organisms and to ensure antimicrobials remain an effective treatment for future generations. A continued focus is required on gabapentin and pregabalin (often used to treat pain and anxiety) and hypnotic and anxiolytics (often called sedatives) as these prescribed drugs can lead to dependence. Tramadol is also a national prescribing indicators and Newport East NCN has seen a sustained reduction in prescribing of tramadol, although there is some variation between GP practices.

6 Assets Profile

What is this section for?

Overview of the key assets within the NCN, which may include primary care contractor sites, care homes, schools, community hubs and/or third sector providers. This section should assess whether the assets available within the NCN are being used to achieve greatest value in support of the NCNs objectives.

The diagram opposite provides a high level overview of services available within the NCN, along with a more detailed breakdown of the prevention, wellbeing and selfcare services available in the Ringland area. Through the integrated well-being networks a full mapping and gap analysis within the West NCN is being undertaken. This work will ascertain current wellbeing provision along with identifying areas where further support is required.

Results of the mapping of the Ringland area (to be extended across Newport East in due course):

- **Ringland Health Centre:** Flying Start Programme, GP surgery, smoking cessation, immunisations, health checks, PCMHT, child health
- **Lloyds Pharmacy:** Ringland Shopping Centre, provides smoking cessation levels 2 & 3, emergency contraception, medicines review, common ailments service, supervised medication consumption
- **Ringland Dental Centre:** based in the shopping centre which accepts NHS patients.
- **Ringland Hub:** Opening October 2019: Community Development Workers, CAB, Library, Youth Services, Families First, Community Café, computer suite, employment support
- **Dan-y-Graig Nursing Home:** social activities, garden
- **Wellwood House:** Extra Care housing scheme, social activities, garden
- **Hendre Farm Court Sheltered Housing:** exercise classes, wellbeing sessions, activities
- **Newport Live**: Fit & Fed and Punky Foods in local schools
- **Llanwern High School:** Fitness clubs, gardening club, dance, media club, film club, computer club, art club,
- **St. Gabriel's R.C. Primary School:** variety of extra-curricular clubs and activities that include
- football, golf, cooking, gardening, art and choir
- **Ringland Primary**: Healthy School, Fit & Fed (NL), healthy living weeks, nurture programme, school council
- **Bishpool Methodist Church:** coffee morning, friendship circle, male voice choir, story club, craft club
- **Ringland Presbyterian Church of Wales:** coffee morning
- **WEA:** range of adult learning classes

7 Estates Profile

What is this section for?

This section is intended to provide a summary of the estates within the NCN, including an assessment of their suitability to deliver the service model. This section must seek to draw out any risks with the current condition of estates and identify priority developments to modernise estate using a combination of grant funding, capital investment and third party developments, as required. This will allow the Health Board to prioritise investment over the coming years.

14.4 Estate Profile

There are 6 main surgery sites plus 1 branch surgery within the Newport East footprint.

Main Surgeries

- Most of the sites are not modern fit for purpose estate, with each requiring consideration for investment to be able to provide sustainable services into the future in terms of expansion space and refurbishment.

Branch Surgeries

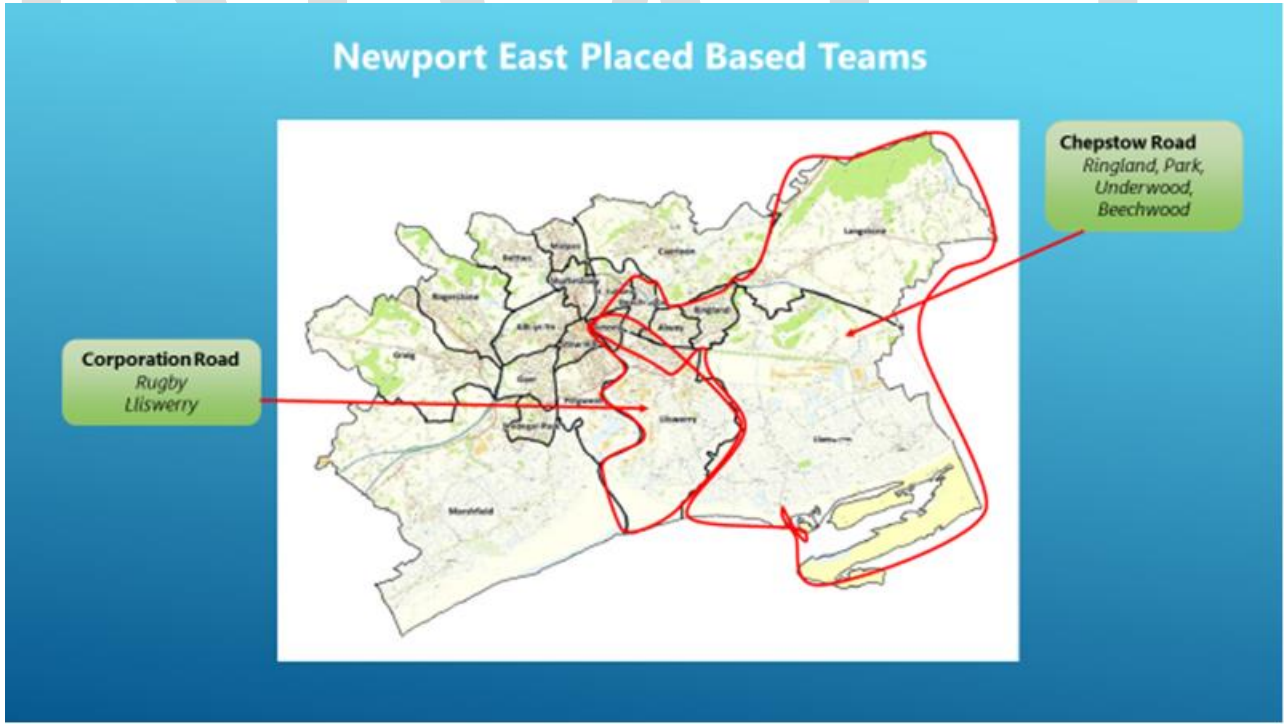
- The branch surgery is in need of refurbishment. This will be discussed with the host practice at their annual review.

Place	Practice	NCN	Practice Population	Code	Year 1-4	Year 5-9	Year 10+
Chepstow Road	Park Surgery (Newport)	Newport East	6,131	W93040 -			
	Ringland Medical Practice	Newport East	6,859				
	Underwood Health Centre	Newport East	4,290	W93125 -			
	Beechwood Surgery	Newport East	13,270	W93053 -			
	Alway Health Centre	Newport East	Branch				
Corporation Road	The Rugby Surgery	Newport East	9,350	W93044 -			
	Lliswerry Medical Centre	Newport East	4,616	W93640 -			

14.4 Vision for Estates within the NCN

The geographical area and high population of Newport are key considerations when planning the integrated "Place Based Care" hub approach. It is recognised that in some areas physical site developments offer an opportunity to progress place based care, however where estate infrastructure is more difficult a "hub & spoke" model will be considered. The NCN will consider estate alongside team/model requirements, for example, how the district nursing team will need to change in light of the all Wales DN principles work stream.

Proposals for placed based teams within Newport West are identified below, with a shared pan Newport Health, Local Authority, Third Sector and Housing Association estates plan currently in development. This is being facilitated by the Newport Integrated Partnership Board.



Newport is served by its Local General Hospital, Royal Gwent Hospital (RGH) and its Community and Mental Health Hospital, St Woolos Hospital (SWH). The community wards within SWH have a total of 69 beds with the 3 wards each having a dedicated reablement, complex discharge or stroke focus.

The Newport Community Resource Team is based at St Woolos, and the team provide a service to the whole of Newport. Due to a range of issues, including overcrowding and the condemning of some areas, the current accommodation for the team is not fit for purpose and also does not allow for required service developments to deliver care closer to home as part of the clinical futures agenda. A solution is required that can meet immediate and integrated development plans as is expected, however there is no clear Health Board plan to address this at present. Multiple options within SWH have been explored, with proposals costed and submitted for use of current vacant ward areas however required costs to develop these areas received have been prohibitive. Alternative options utilising partner premises are being considered. This will be progressed through the Quality and Patient Safety agenda led by the locality team based in Victoria House, Newport.

THE DEVELOPMENT OF AN EXTENDED CARE HUB

In order to alleviate pressures on the demand on general practice and their estates, the prospect of creating an extended care hub needs to be considered. The Extended Care hub would essentially offer more care closer to home and could house services such as mental health, direct access physiotherapy, pharmacists etc. which will relieve the ongoing current pressures on general practice. This will enable general practice to prioritise the patients with chronic conditions in a bid to reduce the need to admit into hospital.

Newport Extended Care Hub

Exploring the opportunity to offer an extended care provision for the people of Newport within a central location . . .

- Direct Access Physiotherapy
- Audiology
- Podiatry
- Diabetic Retinopathy AAA Screening
- District Nursing Clinics (dressings, post op wound care)
- Weight Management Clinics
- Health Checks (Living Well, Living Longer)
- Smoking Cessation
- Tele-dermatology
- Community Dental Service
- CLDT
- Consultant hub
- Health Visiting
- School Nursing
- Gwent Drug and Alcohol Service (GDAS)
- Community Connectors
- Memory Assessment Clinics
- CMHT

Victoria House is easily accessible from the city centre and transport links, has the opportunity to expand into the ground floor (and second floor if required) and has close links to the Newport City Council spoke of Community House, Eaton Road, which already provides Flying Start, Sure Start, Newport Mind and adult education classes and Maindee Unlimited (Library).

14.4 Priority Developments

7..1 Major Improvement Grants

As at September 2019 there are no expressions of interest from independent contractors in relation to MIGs however the NCN Lead with the support of the management team to continue to encourage uptake where need is evident. This is in relation to main and branch surgery sites. Awaiting responses to request for proposals for 2020/21.

7..2 Minor Improvement Grants

There has been an expression of interest from one main practice to increase clinical space and office accommodation. A formal application is awaited. There have been no other expressions of interest from independent contractors in relation to MIGs, however the NCN Lead with the support of the management team to continue to encourage uptake where need is evident. This is in relation to main and branch surgery sites. Awaiting responses to request for proposals for 2020/21.

7..3 Capital Pipeline Funding

In order to effectively meet the needs of the Newport East population, the Health Board, in conjunction with Newport City Council, Gwent Police, third sector organisations and Newport City Homes, are working collaboratively to promote Health & Wellbeing within the local area. The aim is to create a cohesive, healthy and vibrant community campus which:

- Provides a mix of high quality affordable homes, a modern shopping centre and attractive public spaces where anti-social behaviour is designed out of the environment
- Makes it easy for people to access support by bringing health and well-being services together and delivering this integrated provision in high quality buildings.
- Offers a broad holistic range of services and support so people can find help for both their most immediate problems and longer term aspirations
- Enabling people to gradually build up the skills and confidence they need to progress in life and build a positive future for their families

The development of the Health & Wellbeing Centre is being progressed through the Newport Integrated Partnership board, along with the Public Services Board, who have identified Ringland as one of the priority areas.

A capital investment will be required for this development. The outline business case for this investment, including the case for change is currently in development.

Newport East Health and Wellbeing Centre

Dyfodol Clinigol Clinical Futures

Aneurin Bevan University Health Board are planning to build a new integrated Health and Wellbeing Centre (H&WBC) which will open in early 2022. The new development will be at the heart of the community in Newport East. The combined health and wellbeing team will be based close to the existing Ringland Health Centre and will include:

- Your GP
- Your midwife
- Health Visiting/Flying Start
- School Nursing
- Primary Care Mental Health
- District Nursing
- Direct Access Physiotherapy
- Podiatrist (Feet)
- Pharmacist
- Dieticians
- Sexual Health
- Dentist
- Speech and Language
- Audiology (Hearing)
- Memory Assessment Service

Together with Newport City Council and Newport City Homes, the H&WBC will form part of a healthy and vibrant ***Neighbourhood Hub*** which will be available to all Newport East residents. The hub will also include:

- Library
- Community Connectors
- Adult Community Learning
- Families First
- Citizens Advice
- Housing Support

7..4 Other Developments

As part of the residential development on the old Llanwern site there is a section 106 obligation to deliver a doctors surgery on the site. This provision will be developed and discussed through the NCN group, along with the Newport Integrated Partnership Board.

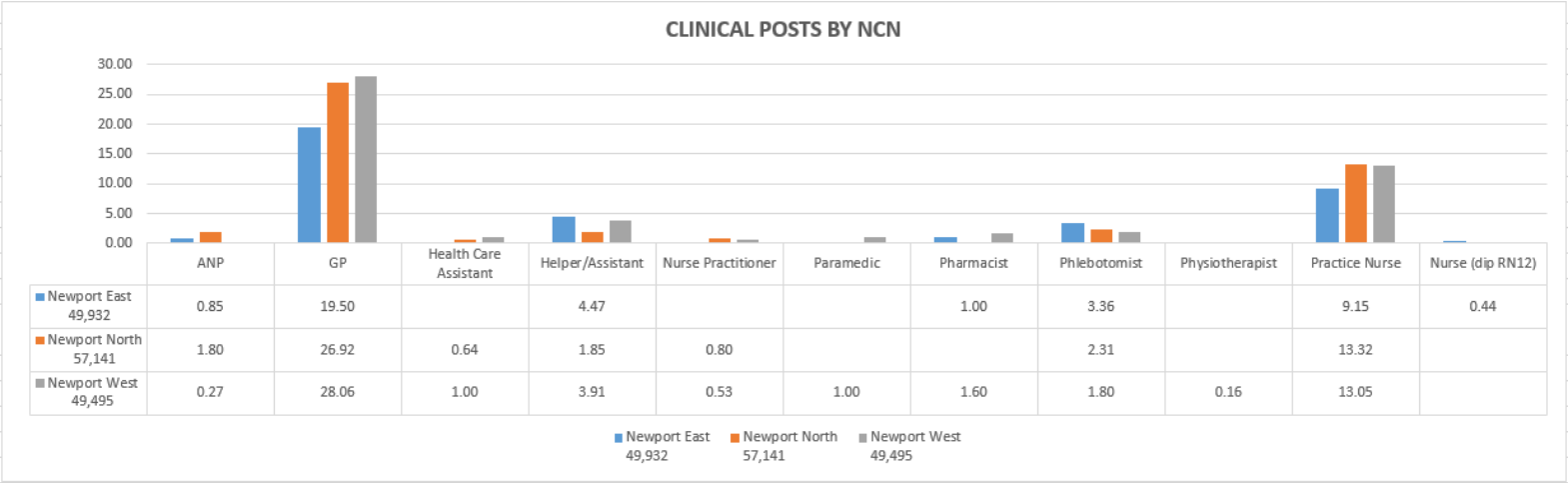
8 Workforce Profile

What is this section for?

The new models of primary care are anticipated to have a significant impact on the workforce requirements of each cluster. This section should seek to describe the current workforce profile, any risks and drivers for change (e.g. vacancy factors, change in nature of demand, etc.) and outline the training requirements needed for the future. This will help the Health Board to make necessary plans for future training provision.

14.4 Current Workforce Profile

WTE per 10,000 NCN practice population			
Staff Role	**Newport East**	**Staff Role**	**Newport East**
ANP	0.17	Paramedic	0
GP	3.91	Pharmacist	0.2
Health Care Assistant	0	Phlebotomist	0.67
Helper/Assistant	0.89	Physiotherapist	0
Nurse Practitioner	0	Practice Nurse	1.83
Nurse (dip RN12)	0.09	**Total**	**7.76**



	ANP	GP	Health Care Assistant	Helper/Assistant	Nurse Practitioner	Paramedic	Pharmacist	Phlebotomist	Physiotherapist	Practice Nurse	Nurse (dip RN12)
Newport East 49,932	0.85	19.50		4.47			1.00	3.36		9.15	0.44
Newport North 57,141	1.80	26.92	0.64	1.85	0.80			2.31		13.32	
Newport West 49,495	0.27	28.06	1.00	3.91	0.53	1.00	1.60	1.80	0.16	13.05	

District Nursing

Ringland			Beechwood		
Band	WTE	Hours	Band	WTE	Hours
7	1	37.5	7	1	37.5
6	1.8	67.5	6	2	75
5	8.55	320.6	5	9.8	367.5
4	2	75	4	2	75
3	0	0	3	0	0
3	0	0		1	37.5
2	0.53	19.88	2	0.8	30

Community Resource Team:

Post Title	Grade	WTE
Intermediate Care Consultant	Consultant	1.00
Consultant	Consultant	1.00
Speciality Doctor	Doctor	2.00
Community Physiotherapist	7	0.78
Community Physiotherapist	6	0.95
Community Physiotherapist	4	1.00
Nurse Assessor	6	1.00
Physiotherapist	7	1.30
Physiotherapist	6	4.00
Qualified Nurse	7	4.00
Qualified Nurse	6	5.79
Qualified Nurse	5	3.00
Falls Co-ordinator	7	1.00
Healthcare support worker	4	1.00
Medical Secretary	4	1.00

St Woolos Hospital (SWH):

Ward	Current Roster	WTE RN	WTE HCSW	£'000
Ruperra/Stoke		13.79	12.35	943
Early	3-3			
Late	2-3			
Night	2-1			
Twilight	0-1			
Penhow/Complex Discharge		13.79	11.19	935
Early	3-3			
Late	2-3			
Night	2-1			
Admin Band 5 (Mon-Fri)				
Gwanwyn/Reablement		15.21	13.98	1,101
Early	3-3			
Late	3-3			
Night	2-2			
TOTALS		**42.79**	**37.52**	**2,978**

14.4 Workforce Risks & Drivers for Change

8.2.1 – The Challenge

The work that is being undertaken within the borough affects all services and will require wholescale change. New ways of working needs to align and dove tail into each service as boundaries diminish and more seamless care and support is provided.

The opening of the Grange University Hospital will profoundly affect how citizens of Newport use and access the Royal Gwent Hospital. An aging population with an increased prevalence of co-morbidities, new housing and a transient city centre community brings with it challenges that the workforce needs to prepare for. An aging staff profile and national recruitment difficulties in many of our professional groups necessitate the need for modern service provision that is steeped in partnership working.

GP Sustainability

GP practices remain the bedrock of a stable, effective primary care service but current recruitment challenges mean that Newport services are under intense pressure. Ensuring the sustainability of GP practices in Newport will require those under greatest pressure to deliver all or a combination of the following components of the Emerging Primary Care Model:

- Triage systems to ensure that patients access the most appropriate service, be that a GP consultation, pharmacy, optician, etc.
- Undertaking an assessment of demand and capacity in order to ensure that existing resources are utilised most effectively.
- Implementing multidisciplinary teams / extended roles, such as practice based pharmacists, advanced paramedics, nurse practitioners, social prescribers, etc.
- Embracing technology to improve sharing of information and monitoring of specific conditions, in order to improve care for patients and reduce duplication between professionals.

8.2.2 – Visionary Influences upon the Primary Care Model

Proactive, Preventative Care Pre-Front Door

Using learning from Newport's Older Person's Pathway, and the Living Well, Living Longer programme, these early intervention services will work to identify vulnerable patients who are at risk of becoming unwell and put in place low level interventions (e.g. aids, adaptations, education, home care, etc.) or signpost to other appropriate services in an attempt to delay further deterioration and prevent unnecessary admissions to hospital.

Primary Care Services will also work closely with colleagues in Public Health Wales in order to increase utilisation of national programmes designed to prevent ill health, such as influenza and childhood immunisation, smoking cessation services, and screening services.

111 Service

The 111 service will provide the first point of access for many patients, offering advice and/or signposting where appropriate. There will also be a link to Urgent Care Hubs where they are developed. The RGH could be considered for this approach.

Common Ailments

A network of community pharmacies in each NCN will deliver the minor ailment scheme, allowing patients to attend for consultation, advice and, if necessary, to receive medication to treat minor ailments, such as mild skin conditions, coughs and colds, minor burns, among others. This will free up time for GPs and Emergency Departments to focus on those patients requiring need of more specialist / complex care.

Health & Well-being Hubs

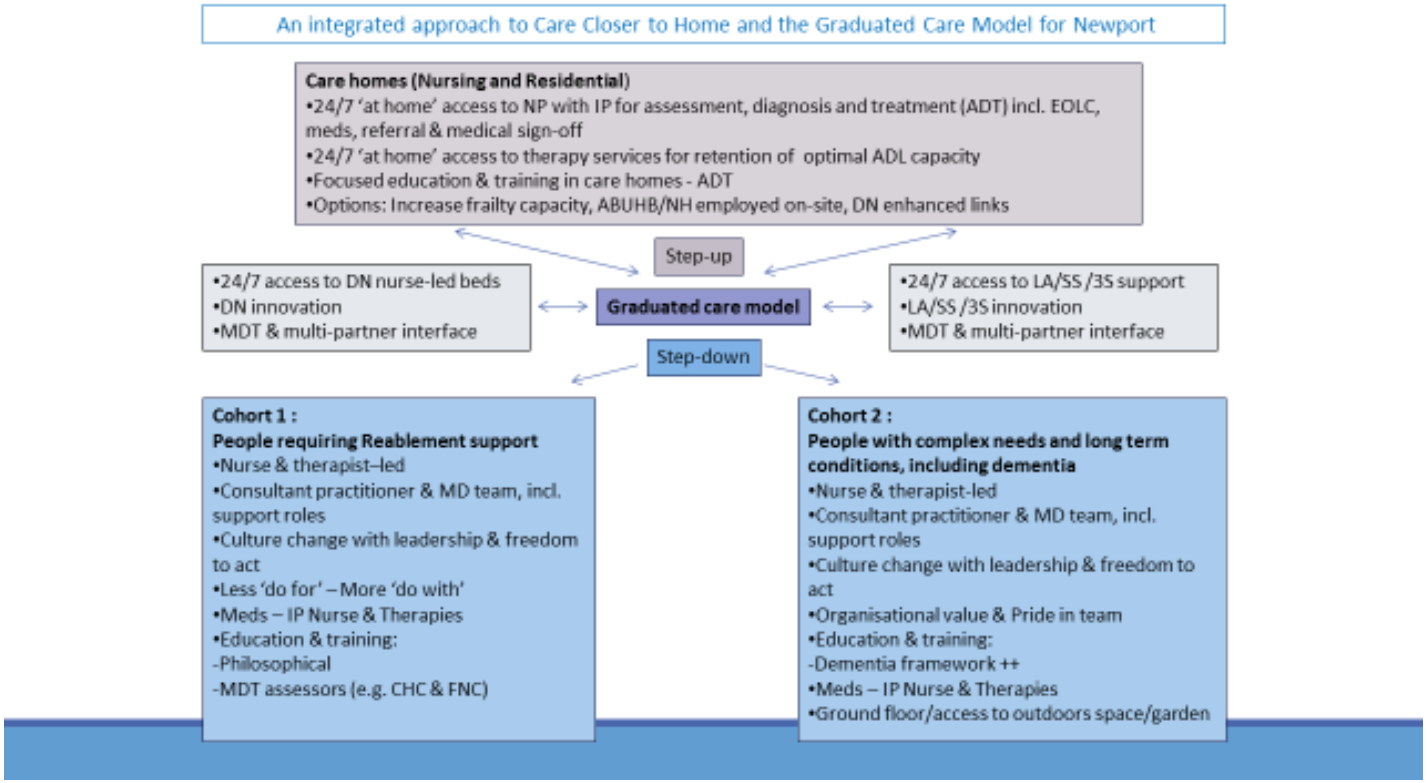
It is proposed that a vital component of offering appropriate level support and care within each community is the development of 'hubs', which will not only co-locate services and but also offer one front door and a model to 'screen' people to appropriate professionals based on their needs. This is currently being looked at by health and Local authority to make best use of resources. Newport East has been identified for the 1st Health & Well-Being hub subject to Welsh Government funding approval.

It is intended that each hub will contain 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 reablement, home care and community nursing, where handoffs between team members are minimised to ensure greater

continuity of care. Well-being hubs will act as a front-door for patients and professionals, where contact can be made (either through a physical front door or via phone) and a member of the professional team will undertake triage. In doing so, they will assess a patient's needs and assess out with advice, signpost to more appropriate support or allocate a care co-ordinator to plan and oversee their individual care needs.

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 slightly 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.

Graduated Care



Graduated Care is being introduced in the St Woolos Community which will allow for the implementation of a revised model of multidisciplinary care.

A 'Graduated Care' approach means that ward criteria / specifications are clearly defined to reflect the categories of patients and their care needs. As a result, ward models can be aligned more closely to patient need which, in turn allows for patients with similar needs to be grouped together and for staff resources to be utilised to provide more effective care. This means that patients can either be admitted directly to a ward which provides the appropriate level of non-acute care (i.e. avoiding unnecessary admission to acute inpatient unit) or, as part of their recovery from ill health, step down to a more appropriate setting.

The proposed model has to potential to maintain the delivery of excellent patient centred care while also adopting a more prudent skill mix model. As a result of a more streamlined model of care, specialist expertise will be better utilised to actually improve quality and patient safety across the wider system. As a result, it is likely that the following benefits could be realised:

- patients receive the right care in the right place and the right time;
- resources are directed and concentrated according to need, ensuring appropriate staffing levels and skill mix;
- local centres of excellence can be developed to ensure adherence to best practice and evidence-based care;
- patients experience more positive outcomes with a higher proportion of patients returning to their usual place of residence;

To facilitate this 2 wards at St Woolos Hospital will be designated at Rehabilitation/Reablement and Complex discharge. It is important that these specialist beds can be embedded before the opening of the Grange University Hospital.

These beds offer a step and step down approach to care. Patients can be transferred and stepped down from acute beds, or stepped down from Community beds into Parklands Residential Reablement beds. Equally patients can step into care if admitted directly via the Clinical Frailty Team in to in patient Clinical Frailty Unit beds for patients that require short low acuity intervention before discharge home, who bypass the need to enter secondary care via the Emergency Department where they are likely to experience a longer length of stay and may physically decompensate due to this admission.

To manage the pressures within the hospital discharge process and to meet the requirements of Social Services & Wellbeing Act (Wales) 2014 Act, the Hospital Team have adopted an 'In Reach' Model.

Social work practitioners from the local authority now attend agreed ward board rounds across both the RGH and St Woolos sites. The implementation of this approach has seen a reduction in unnecessary referrals to the hospital team which increases

capacity within the Social Work Team. It also aims to build up an ethos of reablement where we aim to empower patients to maintain their independence where possible.

It allows a multidisciplinary conversation to be undertaken around discharge planning which reflects the localities plan to merge and offer more integration of services within Community Wards/CRT/DN's. The aim is that this will improve the services that primary care can offer in caring for the patients in our population.

In order to meet the future demands of the ever growing population within Newport there has been an emphasis placed upon disease prevalence. It is important that measures and anticipated solutions are identified in terms of being able to have the capacity and skillset to meet the demand. In particular the diseases which are most dominant within Newport are:

- Diabetes
- Coronary Heart
- Smoking & Smoking Chronic Conditions
- Asthma
- Hypertension
- Cognitive Health Needs

As part of the ongoing workforce planning work that Newport has been participating with Workforce & OD, particular roles and services that target the diseases will be investigated.

8.2.3 – Workforce Vision

To aim is to achieve a work force that will fulfil the service vision of a more integrated system of primary care with community care and wellbeing services, based around each NCN footprint. Services will be designed to provide more co-ordinated care, closer to home with fewer handoffs and reduced complexity. This will require a transformation of services.

The impact of delivering this model will result in the current workforce working differently in a number of ways:

- Utilising a more differentiated skill mix
- A more socially centred model of care
- Working more collaboratively, often at greater scale
- Implementing a more anticipatory approach with greater participation of patients in their own care
- Supported development of new roles
- Further adaption and modelling to meet the changing demands of the population

A framework has been developed to set out the Primary and Community Care Service vision, with a 5 year programme plan developed from 2018/19 to deliver this change. The four stage0060s are described as:

- Keeping people healthy and well
- Promoting self-care
- Primary care services and the Neighbourhood Care Network team
- Neighbourhood hubs with specialist and enhanced services developed at a critical mass.

There are a number of strategic drivers that are influencing the delivery of community services within the ABUHB. This vision is articulated through a number of national strategies and polices. These include:

- Welsh Government – Primary Care Plan for Wales up to 2018 (2014/18)
- Gwent – Care Closer to home Strategy (2016/2017)
- Welsh Government - A Healthier Wales (2018)
- Well-being of Future Generations Act 2015

The approach is intended to be delivered in a manner that will aim to strengthen community resilience and respond to need.

8.2.4 – Proposed Changes

8.2.4.1 – St Woolos Hospital

The financial impact of implementing the Graduated Care Ward and changing the current staffing allocation is below.

Ward INCLUDE CURRENT/FUTURE BEDS	Current Roster	WTE RN	WTE HCSW	£'000	Proposed Roster	WTE RN	WTE HCSW	£'000	Additional Cost £'000
Ruperra/Stoke		13.79	12.35	943		15.21	16.78	1,215	272
Early	3-3				3-4				
Late	2-3				3-4				
Night	2-1				2-2				
Twilight	0-1								
Penhow/Complex Discharge		13.79	11.19	935		19.32	16.78	1,383	449
Early	3-3				4-4				
Late	2-3				4-4				
Night	2-1				2-2				
Admin Band 5 (Mon-Fri)					1				
Gwanwyn/Reablement		15.21	13.98	1,101		15.21	16.78	1,257	157
Early	3-3				3-4				
Late	3-3				3-4				
Night	2-2				2-2				
TOTALS		**42.79**	**37.52**	**2,978**		**49.74**	**50.34**	**3,855**	**877**

The justification for these staffing amendments are:

Ruperra Ward

There is an increase due to the increase in beds and in line with the staffing provision for ward 1 /2 at Nevil Hall Hospital (other Stroke Rehab ward). The increase in unqualified staff (HCSW) is to allow roles such as Rehabilitation Assistants to be developed with unqualified staff.

Gwanywn Ward

This ward has the biggest difference in current configuration – again reduction in RNs to 2 but with the therapy lead as this unit would be pure reablement ethos and with that reablement model continuing over the 7 days. We are looking to go to Bridgend as they have a similar model so there may be some variation with what we have put in. We talked about having an ANP on this ward to ensure that we promote daily review with minimal medical input and reduce delays (and perhaps that input needs to be frailty rather than cote??)

Penhow Ward

This ward has been modelled on 28 beds (as this is the likelihood) so an increase in 4 – these are going to need the most nursing input, both clinical and assessments (would be good to look at if there is in reach from CHC). The band 5 would be able to undertake all the ward admin duties as well as managing, arranging and servicing the meeting. The RN increase – we could look at recruitment of an RMN as this would support the development of dementia care. The benefits would be more dementia and psychological input to our most vulnerable inpatient group, a quicker turn around in CHC and meetings related to placement.

At present it is unclear what the bed configuration will be when the community wards move to Royal Gwent Hospital, however there are ongoing conversations taking place to determine the outcome.

There is ongoing work in regards to investigating the current workforce models at on the community wards in YAB. This will provide us with valuable evidence in relation to ensuring that the correct skill mix is implemented on the community wards at St Woolos.

8.2.4.2 – District Nursing

The staff in East Newport have started to adopt the Principles of Neighbourhood Nursing, it has been recognised that the current teams will need to be reconfigured in order to meet the District Nursing Principles.

By working in a more integrated way, they will become aligned with the Community Resource Team and support MDT working in Primary Care and discharge MDT planning on the community wards.

To meet DN principles this there is a need to:

- Review current team bases and activity
- Review what is needed to meet the principles
- Explore means to increase HCSW utilisation
- Encompass the development of band 4 posts
- Propose/consider team reconfiguration with DN staff
- Explore training and development needs
- Include an uplift of staff by 26% and determine the impact of this
- Work the financial implication of this

All Neighbourhood Nursing teams have undertaken Care Aims module 1 and are awaiting confirmation for module 2.The expansion of care aims across Newport community sector is dependent upon ABUHB investment.

The Neighbourhood Nursing network pilot sites will test the use of an automated clinical scheduling tool for patient visits for 6 months known as Malinko. The tool has been piloted with Cwm Taf Bro Morgannwg Health Board with positive feedback, saving of senior nursing time, sound governance and effective utilisation of staffing whilst boosting staff morale, the health board plans to roll this out across all their nursing teams. This investment of the system, Ipads and Smart Phones to enable the nurses to access the apps will potentially require further funding within the District Nursing Service if deemed successful to roll out across the community division, some of the costs maybe procured within the WCCIS funding in relation to equipment. The pilot is due to commence in Sept 2019.

A training and population needs analysis was undertaken to identify areas for service improvement and development and as part of the workforce development , training has been undertaken such as : Strength Based Leadership coaching, Care Aims Level 1 and 2, Palliative Care –ACP, Verification of Death , NEWS training, Mental Health First Aid, Clinical skills – IV's , bladder scanners. Alongside development role of Band 6 and Band 4 which is also in line with the DN Principles.

Care Aims training is enabling staff to change the conversation with patients and direct stakeholders. This change is also empowering teams to challenge constructively referrals and expectations from colleagues and patients and they have developed a new referral form. This new approach to patient conversation is beginning to evidence a reduction in caseload numbers as patients spend less time on the caseload, whilst being educated in self-care management.

District nursing teams within Newport East who have adopted the Buurtzog Principles of neighbourhood Nursing are reporting very low levels of sickness, vacancies (**1.6% vs range between 28 – 10% reported across other teams**) and improved morale. Discussions ongoing regarding the rollout of care aims training to all health teams and relevant partners in supporting this model of working.

Key areas:

- Continence Management
- End of Life Care
- Diabetes
- Information Technology

The impact of rolling out the Neighbourhood nursing model would require additional Band 6 roles which has been viewed as a clinical asset, which would also support the Care Aims and new ways of working, alongside the development and introduction of the Band 4 role. The ability to include the NCN funded Band 3 Phlebotomist's would positively impact the 80/20 RN to HCSW split in line with DN Principles. Currently the band 3 roles funded by the NCN are not included within the current staffing ratios within the DN Principles.

As part of the DN Principles the band 7 Team Leader will be supernummary. There has been an increase in band 6 appointments to ensure robust leadership and succession planning. Currently there are 8 individuals in post, however it would be advantageous if the one of the band 6 roles could develop into a clinical/ ANP role within each district nursing teams. Also this role could lead inductions/education within the borough as part of developing a new workforce undertaking new roles and skills to support care closer to home.

The introduction of the Band 4 role is under review regarding the competency framework and developing robust training.

In order to progress with a Band 7 /6 to be involved with the Community Wards for continuity of care, support in relation to discharge meeting, flow there is an importance upon having sufficient leaders in place.

An opportunity to rotate a newly qualified band 5 Registered Nurse within CRT / Community ward has been identified as it would allow the individual to have the opportunity of learning more acute skills and understanding.

Another identified opportunity is to have a regular meeting for the band 6 deputies within CRT /DN / Community wards to improve integration, communication/understanding of expectations / barriers and opportunities.

Costings:

- Band 3 Admin 30 hours approx. £18,413
- Band 6 currently have 8, require 12 for 6 teams approx. £162,648

8.2.4.3 – Primary Care MDT Working

A pilot is underway in Newport West based on the MDT model in the Cynon Valley cluster and learning from the Compassionate Communities programme in Caerphilly North and Blaenau Gwent. By working to identify patients through anticipatory care planning, with the aim to reduce:

- GP demand
- OOHs attendances
- Home Visiting Requests
- A&E attendances

The pilot in Newport West is showing promising results which could be replicated in the Newport East NCN. There are currently 5 practices within Newport West that are trialling this concept - Belle Vue Medical Centre, St Brides Medical Centre and St David's Medical Centre (commenced July 2019) with Bryngwyn Surgery joining in April 2019 and St Pauls in initial stages July 2019. An evaluation of the approach is also being developed. Due to 2 practices holding their MDT meeting on the same day this is causing the CRT team issues in that they cannot physically attend 2 meetings at the same time. To overcome this the team are purchasing equipment to skype into the meetings. One of the practices (St Brides) has requested funding to install Wi-Fi in order to accommodate the IT solutions.

Based on the needs of people being reviewed, experience is showing that social and psychological needs should be also incorporated into the MDT. MDTVW teams have identified the need to recruit personnel to maximise the potential of the MDTVW model. 3 roles have been identified that will increase the knowledge and experience within the MDT and avoid pulling on resources from already established health board services. These include OT, Mental Health and Community Connectors.

There is now an improved communication and plans identified/shared for complex patients.

The data below is in relation to an MDT at St. Brides from 1 May 2019 -12.7.2019 and indicates the identified pharmaceutical cost savings at this early stage of the process.

Medicine	Action	Benefit	Cost saving/Year
Simvastatin 10mg nocte	Stopped	Reduced Polypharmacy	£7.92
Evacal 1 bd	Stopped	Reduced Polypharmacy	£33
Cacichew D3 Forte 1bd	Stopped	Reduced Polypharmacy	£50.88
Gabapentin 300mg 3 nocte	Reduced & Stopped	Reduced polypharmacy; safety	£36
Solifenacin	Stopped	Reduced polypharmacy; safety	£430
Simvastatin 20mg nocte	Stopped	Reduced polypharmacy	£9.36
Carbocisteine Caps 375mg 2 bd to NACSYS	Change	Cost Saving	£24
Laxido	Reduced	Cost Saving	£18
Evacal 1 bd	Stopped	Reduced Polypharmacy	£33
Ventolin Inhaler	Reduced Qty	Cost Saving	£13.50
Gabapentin 300ng tds	Reduced & stopped	Reduced polypharmacy; safety	£36
Adcal D3 1bd	Stopped	Reduced polypharmacy	£48
Dosulepin to Mirtazepine change	Changed	Safety	£168
			Total £907.86

The ultimate ambition is for the Newport locality to continue to evaluate and promote the MDT concept but this will require additional resource in Nursing, OT and Physiotherapy.

8.2.4.4 – Community Resource Team

Community Frailty Units/Step Up/Step Down Beds

Area	Newport CRT
Describe the current situation: Name of ward Number of beds Number trolleys Number of beds in Care Homes Other	 Gwanwyn ward, St Woolos 2 x CFUi beds 0 0
What is your current bed capacity (including Care Homes):	As above
Details of step up/step down beds (including Care Homes):	Currently 13 Reablement non nursing beds in Parklands. To rise to 15 beds by September 2019.
Details of Ambulatory Clinics/Hot Clinics:	2 x clinic rooms available for Ambulatory Clinics at the back of holly ward, St Woolos Hospital
Progress to date:	SOP and nurse training/Processes complete. Rapid Nursing Blood transfusion training complete Newport Rapid Medical service don't have access to any beds in St Woolos for CFUi. Still awaiting ring fencing for Rapid Medical to have access to a bed in Gwanwyn ward. Parklands beds raising from 10 – 15 being project managed by NCC. Awaiting the use of final two beds.

Achievement by March 2020:	15 x Reablement non nursing beds – Parklands residential Home 2 x community Frailty medical/nursing beds in Gwanwyn ward, St Woolos.
Constraints/Issues:	Parklands beds will be freed up as long term residents move on so this may be a constraint. Newport Rapid Medical service don't have access to any beds in St Woolos for CFUi. Still awaiting ring fencing for Rapid Medical to have access to a bed in Gwanwyn ward.

Current Staffing/Proposed Staffing Configuration within CRT.

Area	Role	Role Objective	Approximate Costs
Rapid Medical/Rapid Nursing	1 x Band 7 ANP	This has been filled as a band 7 as we another Band 7 undertaking ANP portfolio within CRT.	£48,692
	1 x Band 5	To be filled as a band 4 Clinical assessment team support worker	£32,549
	2 x Band 4 HCSW	To Support Rapid Nursing/Medical/Ambulatory Clinics/Falls clinic/Mental Health Practitioners required	£53,770
	2 x Band 6 nurse	The role of Rapid Medical/Rapid Nursing is under review within the Frailty Workforce group, this will have an impact on our Rapid service	£81,324

		nursing needs if we are to widen our services and develop. As we stand at the moment, to develop and maintain ambulatory clinics and also maintain an overview of CFUi beds and all the NCNs there needs to be an additional 2wte allocated to the team.	
Parklands Development Project No further resource required allocation already in place as follows via NCC ICF funding:	1 x Band 5 Rotational Physiotherapist	In place (September 2019 update) ICF funding via Parklands 1WTE Reablement Assistant (to be in place by September 2019) ICF funding via Parklands	£32,594
	0.5 Occupational Therapy Technician	With NCC Grading panel funded via NCC ICF (Parklands)	£23,017 band 3 £26,885 band 4
	1 x Band 5 rotational Physiotherapist		£32,549
Gwanwyn Therapy Ward /Carer Development Programme	1 x Band 6 Physiotherapist	To support In Reach discharge programme and Carer Development programme No extra reablement carer funding required – final posts currently at interview stage	£40,662

Occupational Therapy Service	1 WTE Occupational Therapy Assistant required	To fulfil commitments to support O/Ts undertaking ICOT/Frailty role & duty. Funded via ICF (Parklands)	£23,017 band 3 £26,885 band 4
GENERAL	1 x Band 5 Operational/Business Support (potentially an upgrade from a band 4 to a band 5)	To assist in the development, monitoring and maintenance of service development The role will work across STW, Parklands, DN's and CRT to support Tredegar Ward integrated community hub. Funding still required	£32,549
CRT Customer Service Front Door	4 x Band 3 WTE will be required	7 days 8am -8pm based on our care Coordinator model. This team will take referrals, input on WCCIS and take all referral/customer related queries for the service. Outcome of the Blaenau Gwent WCCIS /SPA Referral Process Pilot will inform the future direction of Newport Frailty Reablement & Falls Service referral process .	£92,068

14.4 Training Requirements

Training opportunities including:

- Rollout of Care Aims to all primary & community staff and partner staff groups (e.g. IAA team)
- Making Every Contact Count (MECC) Training for GP practice and partnership organisations staff – to be a requirement of Care Navigation training

- Robust CPD programme
- OD programme for practice managers – to be developed and driven through the existing practice managers forum
- Mentorship for Practice Based Pharmacists
- Various training opportunities that arise for upskilling GP practice staff both clinical and non-clinical will be supported via NCN funding if deemed appropriate

The NCN are about to commence a demand and capacity exercise using software specifically designed to both establish demand and calculate the required capacity to meet that demand. Read codes generated from each practice are uploaded into the software which then assigns the relevant Health Care Practitioner to each and every single remaining 'Demand' Read Code entered and aggregates the data and calculates the number, and types, of HCP required to meet the Demand for the Cluster. One of the benefits of understanding demand in this way is improved workforce planning at practice and cluster and level.

9 Opportunities and Challenges for 2020-2023

What is this section for?

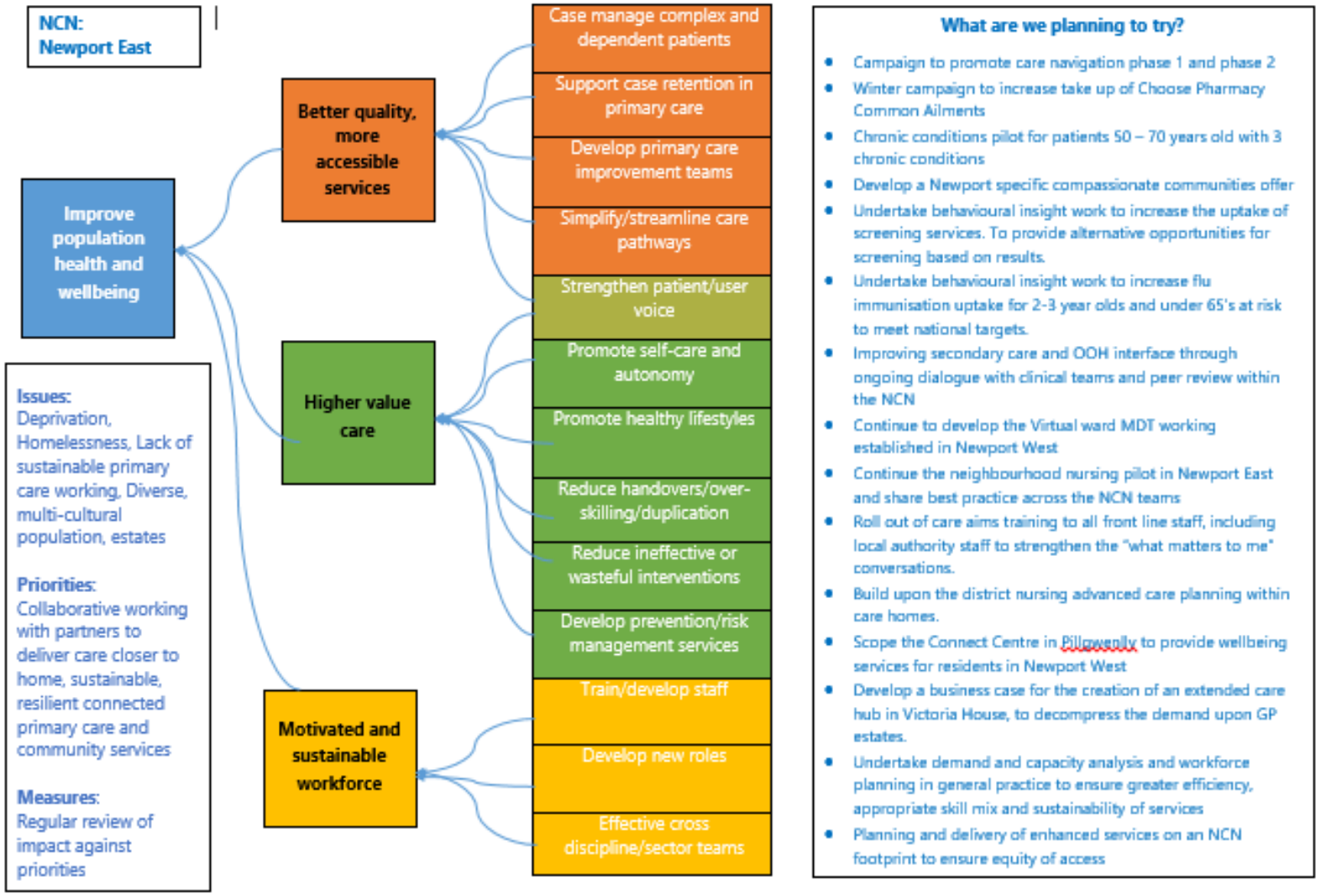
Based on assessment of the information provided so far in this document, what are the strengths, weakness, opportunities and threats to the NCN over the next 3 year period? Using driver diagrams developed by the NCN, this analysis should then be used to inform the actions / objectives of the NCN.

14.4 SWOT Analysis

Strengths	Weaknesses
What does the directorate / service do better than others? What positive feedback is regularly received from patients or colleagues? What impact has it had on delivering a more effective healthcare system?	*What could the directorate improve about its service provision? In what areas does the service compare poorly with peers / national benchmarking?*
Neighbourhood Nursing which has created a new and innovative approach to district nursing **Newport Older Persons Pathway** which ensures that people with mild to moderate frailty receive a Stay Well Plan **Skill mix** with extended roles introduced in general practices such as clinical pharmacists, physiotherapists and **Care Navigation** that provides greater choice and direct patients to a wider range of service **Practice Manager Forum** which allows the exchange of expertise, learning and consistent approaches **Neighbourhood Hubs** that brings together a range of well-being support and service (e.g. debt advice) under a neighbourhood management structure **Prescribing and medicines management** particularly in areas such as antimicrobials and tramadol **GP leadership** for new initiatives such as the common ailments service and flu vaccination **Direct Access Physiotherapy** allowing self-referral for MSK assessment and onward referral for further assessment and treatment, investigations or advice for self-care	**Flu vaccination** uptake which is significantly lower compared to other areas in Gwent and there is significant variation between GP practices **Screening uptake** remains low in Newport East and is significantly below national targets **Primary Care Out-of-Hours** contacts are higher than other NCN in ABUHB **Access** continues to be a challenge for GP practices in Newport East and the Minister has recently set national access standards **Culturally appropriate** services and language barriers in specific communities **Homeless and other vulnerable groups** have specific healthcare needs and further investment in outreach provision is required to support the GP enhanced services Integration of place based community team Communication **Public engagement** and behavioural insight for specific population segments to understand opportunities for service redesign, self-care, improvements in access and increase uptake of preventative programmes such as immunisation and screening

Early intervention CAMHS model with multi-agency referrals into Families First joint allocation panel	**Child health** to ensure that we take a concerted approach to tackling adverse childhood experiences in Newport East and as a system try to address other health outcomes such as dental caries and childhood obesity
Opportunities	**Threats**
What is on the horizon which could help to improve the service? What elements of the environment could the service use to its advantage? E.g. developments in technology or enhanced scope of professional practice.	*What is on the horizon that could cause difficulties for the directorate in the coming years? E.g. workforce shortages, funding reductions, increases in demand, etc.*
Capital investment in the Newport East Health & Well-Being Centre is a huge opportunity for the NCN **Living Well Living Longer** programme to increase the reach into the community and provide dedicated lifestyle support for people identified at risk as well as a pre-diabetes pathway **Healthy Child Wales Programme** which will transform the way health visiting services are provided to ensure all children in Newport East have the best start in life **Compassionate Communities** programme which will transform the delivery care for people with more complex needs by combining routine clinical practice and community development **Secondary care interface** by reviewing pathways, peer review and improved communication between primary and secondary care clinicians **Practice Manager** organisational development programme for those that completed the AMSPAR diploma **NCN footprint reconfiguration** – reduction from 3 to 2, supporting place based approach	**Demographic changes** with increasing levels of multiple-morbidity within the population **Workforce stability** across a number of different teams **Clinical engagement** in the Clinical Futures Service Redesign to ensure a shared understanding in primary care and mechanism for highlighting risks and issues **Llanwern housing development** and potential impact on primary care services and estates **Maintaining outcomes** from the transformation programme at the end of the Welsh Government funding period **Widening health inequalities** and the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need

14.4 Driver Diagrams



10 Prioritised Actions 2020-2023

What is this section for?
Based on the information gathered so far, the NCN should now be in a position to identify the key areas where it needs to prioritise its efforts over the coming 3 year period. This section should describe the priority actions only. A more in depth delivery plan is attached as an appendix.

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Worksteam *(Section 3.4)*
1	Innovative and collaborative approaches across the NCN to achieve in-hours **GMS access standards** set by the Minister for Health & Social Services, including a digital offer	• Undertake demand and capacity analysis • Carry out workforce planning to optimise skill mix • Continue to implement care navigation • Develop cluster wider approaches to telephony • Explore digital solutions such as SMS messaging and email • Review evidence for other consultation types e.g. Group consultations, Skype, email • Feedback improvement at NCN meetings against national measures	Ensuring care is provided by the right person at the right time in the right place. Patients will have more control over their wellbeing and making decisions about their support. Improved population wellbeing and resilient communities To improve access and enable better target achievement by recruiting the	Appendix – 14 Improved utilisation of social prescribing and care navigation will improve referral rates across the NCN	Primary Care and Community IMTP 2020-2023 - Access and sustainability workstream

			appropriate skills to meet demand Develop and support a common language between partners (care aims)		
2	**Demand and capacity analysis** and **workforce planning** in general practice to ensure greater efficiency, appropriate skill mix and **sustainability** of services	• Project future needs based on population assessment (i.e. demography and epidemiology) • Undertake demand and capacity analysis to assess current and future workforce requirements • Create opportunities to develop the workforce within their existing scope of practice • Support professional education to progress to Advanced Practice with Independent Prescribing status where required • Carry out workforce planning to optimise skill mix • Incentive GP practices to trial extended roles • Engage with the workforce academy to ensure a 'pipeline' of qualified and experience professionals	Increased GP sustainability Reduced individual practice workload Opportunity to share best-practice Improved GP relationships Opportunity to build NCN maturity	Sustainability challenges in Primary Care Access standards Inverse Care Law	

3	**Quality improvement projects** led by the NCN across a range of areas including patient safety (mandatory), reducing stroke risk and advanced care planning	• Agree priorities from basket of quality improvement projects • Support IQT training with lead GP in each practice • Build IQT capacity and expertise • Develop driver diagrams in NCN meetings • Establish measurement system • Discuss potential tests of change in NCN meetings and implement PDSA cycles • Share learning at NCN meetings	Reduced avoidable hospital admissions Improved patient & family engagement Better understanding of vulnerable individuals/ communities Requirements Ability to connect with isolated people Increased ambulance capacity to reduce response times	Delivery of QAIF High level of deprivation seen across wards within the NCN. Smoking prevalence in Newport East was second highest of all NCNs in ABUHB at 25.4%	Primary Care and Community IMTP 2020-2023 – Quality, Value & Patient Safety workstream
4	Planning and delivery of **GP enhanced services** on an NCN footprint to ensure equity of access	• Review current provision of enhanced service against local needs • Discuss the optimal configuration of enhanced services at NCN meetings • Ensure sufficient service volumes including for specific population groups (e.g. homeless)	Increased GP sustainability Reduced individual practice workload Improved GP relationships	Appendix 14 – identified inequity in service in the delivery of enhanced services.	Primary Care and Community IMTP 2020-2023 - Access and sustainability workstream

			Opportunity to build NCN maturity		
5	On-going review of **clinical incidents** and sharing learning within the NCN to improve quality and patient safety	• Strengthen incident reporting • Further develop QPS Group • Create opportunities for peer review • Share and socialise learning	Opportunity to share best-practice Opportunity to build NCN maturity	Appendix 14 – Incidents & Concerns	Primary Care and Community IMTP 2020-2023 – Quality, Value & Patient Safety workstream
6	Redesign of **urgent care pathways** and delivery of specific aspects of the **winter delivery framework** including flu vaccination, risk stratification of the frail population and effective management of those with ambulatory care sensitive conditions	• Undertake risk stratification and population segmentation • Create evidence based plans for each segment of the population particularly those with ambulatory care sensitive conditions • Identify variation in referrals to medical and surgical assessment units • Develop insight into how patients make decisions about use of the urgent care system including OOH • Build insight into pathway design and communication campaign with the public	Increased uptake of flu immunisations to reach the national target Improved emergency response times Reduction in avoidable admissions Improved patient & family experience	Newport East has the highest rate of Primary Care Out-of-Hours contacts and has seen a slight reduction in accepted referrals to Rapid Response Services. Newport East has a significantly lower uptake of flu vaccination that other NCNs.	Primary Care and Community IMTP 2020-2023 – Prevention, Wellbeing & Self-Care, Communication & Involvement workstreams

		• Identify ways of improving communication with secondary care clinicians • Work with Clinical Futures Service Redesign Team on new pathways designed to manage unscheduled demand (e.g. pre-hospital streaming, single discharge pathway, etc.) • Undertake peer review of patients that could be managed through alternative pathways • Agree NCN approach to the primary and community care aspects of the winter delivery plan framework			
7	Improving **self-care and patient activation** with consideration given to cultural and social norms as well as other factors such as language and literacy.	• Review evidence base for option to promote self-care and patient activation • Carry out public and patient engagement to co-produce approaches • Assess the extent to which cultural and social norms as well as literacy and language barriers affect people's capability to self-care • Develop and evaluate self-care projects including resources for patients and professionals	To be successfully managing cohorts of patients aged 40–64, with pre-estimated QRisk2 scores of 10% or greater. To be identifying pre-diabetes patients and reviewing capacity to deliver a Prediabetes	Profile and population needs – 48+ different languages spoken within the NCN	Primary Care and Community IMTP 2020-2023 – Wellbeing & Self Care worksream

			Management Service Reduced demand on health service Improved signposting to services Improved health activation & Improved wellbeing of population Provide more options for patient choice/access Improved sustainability of services		
8	Improving uptake of **flu vaccination** with a specific focus on 2-3 year olds and those in at risk groups such as patient with asthma and COPD	• Undertake behavioural insight to better understand attitudes and the factors that affect parental behaviour • Design immunisation services in light of behavioural insight • Develop and implement communication campaign, including social media, to shift	Increase in the number of flu immunisations to reach the national target.	Newport East has a significantly lower uptake of flu vaccination that other NCNs. In terms of scheduled childhood immunisation, the uptake in Newport of the second dose of MMR vaccine and 4-in-1	Primary Care and Community IMTP 2020-2023 - Prevention, Wellbeing & Self-care workstream

		public opinion, attitudes and decision making • Evaluate the impact of financial incentives to drive improvement • Feedback IVOR data and share improvements and learning through NCN meetings		booster at age 5 is second lowest in Wales and below the level required for herd immunity.	
9	Continued innovation and development of the **Neighbourhood Nursing model** through self-managed teams working as part of an integrated place-based approach	• Continue to implement the Neighbourhood Nursing pilot • Ensure that the pilot is effectively evaluated so that learning can be shared with other District Nursing teams • Extend the Care Aims training across community teams • Explore the potential for an integrated community nursing model with rotation posts • Use the Neighbourhood Nursing pilot as the foundation for implementing of Compassionate Communities and setting up effective MDT meetings	Implement new ways of working and learning across all DN teams Improved patient experience and control over their own wellbeing and support. Improve capacity within nursing teams as patient care becomes more individualised and the most appropriate support is available at home and in the community.	A training and population needs analysis to identify areas of need where improvements could be made and the knowledge and skills the teams required to address the identified need were undertaken with Newport East prioritised for the pilot	Primary Care and Community IMTP 2020-2023 – Re-designing Community Sevices, Prevention, Wellbeing & Self-care workstreams

10	Improving **secondary care and OOH interface** through on-going dialogue with clinical teams and peer review within the NCN	• Facilitate two-way communication between primary and secondary care colleagues through NCN meetings • Identify ways that the workload that falls between primary and secondary care can be best managed • Identify ways of getting widespread change in practice around shift of work into primary care (e.g. request for Fit Notes, onward referrals, follow up of test results, requests for blood tests) • Create opportunities for peer review of patients that are referred inappropriately to secondary to inform professional education and pathway redesign • Improve access to specialist advice at the point of decision making (e.g. advice lines) • Look at options to address some of issues associated with prescribing across the interface	Improved communication and access for colleagues and patient care	Appendix 14 – Incidents & Concerns Newport East has the highest rate of Primary Care Out-of-Hours contacts and has seen a slight reduction in accepted referrals to Rapid Response Services	Primary Care and Community IMTP 2020-2023 – Communication & Involvement

The Newport East NCN will continue to **evaluate, improve and embed existing initiatives** such as care navigation, the common ailments services, practice based pharmacists and direct access physiotherapy.

Newport East NCN will be a vehicle for delivery of other programme that are funded centrally either through ABUHB or the Regional Partnership Board. Whilst the leadership, management and funding of these programmes sits elsewhere within the health and social care system they will require significant engagement with primary care if they are to be delivered effectively and at the scale required to have impact. These programmes are the:

- **Healthy Child Wales** programme to ensure universal but proportionate approach health visiting provision. This will require close partnership working with colleagues in primary care and children's services around a range of issues including safeguarding, positive parenting, healthy child development and the promotion of healthy lifestyle choices such as smoke-free homes and childhood immunisations.

- Transformation programme including the **Workforce Academy, Compassionate Communities, 'Iceberg' CAMHS model** and **Integrated Well-being Networks**

- **Living Well, Living Longer** programme with a new focus on management of patients with identified lifestyle risk factors and a prevention pathway for people with pre-diabetes.

- **Older Persons Pathway** to ensure that people with low to moderate levels of frailty have a Stay Well Plan which will helps them to remain socially connected and maintain their independence at home.

Finally, there are four areas where the Newport East NCN recommends that greater advocacy is required to improve outcomes through concerted action across the wider system. These areas include uptake of **cancer screening services**, care and support to **homeless and vulnerable groups**, **childhood obesity** and **smoking prevalence**.

11 Communication & Engagement Mechanisms

What is this section for?
Overview of how the NCN will intend to engage with the population to communicate the challenges facing services and involve users in the planning of new developments.

The Newport NCN team recognise that the delivery of relevant, appropriately targeted communication and collaborative engagement with the local population is fundamental to successfully delivering Care Closer to Home, for, and with the people of Newport. Also recognised was the need to provide a coordinated approach across all partners.

A copy of the Newport Care Closer to Home Communication strategy, developed and endorsed by the Newport Integrated Partnership Board can be found at Appendix 15.

Engagement Events

SWH Garden Project - The Newport Locality team along with a number of organisations and charities have been working hard to oversee a garden project that will rejuvenate one of the existing four gardens at St Woolos Hospital.

The project has been supported by Rubin Lewis O'Brien Law, Melin Homes, Growing Spaces, Wood Shed, Carol Wheeler, Works & Estates, Facilities, and Newport Locality with the aim to provide the patients along with their relatives and staff members an area that they can relax away from the ward setting.

The garden was officially opened by the Mayor and Mayoress of Newport on Friday 16th August. The opening ceremony was attended by patients and their families and ward staff.

Newport East HWBC – In preparation for the developer engagement event, the Newport Locality undertook a pre-engagement exercise in the Ringland area.

- Key stakeholders including local councillors and the Assembly Member for Newport East were briefed on the proposed development prior to any engagement
- An email was sent to local stakeholders including schools, pharmacies, dentists, community council, housing providers and local businesses to outline the proposal and provide an opportunity to feedback any comments about the planned development.
- An email account and a communications log was set up to record any comments received.

- A bi-lingual leaflet was produced. Copies were made available to the local GP Practice, dentist and pharmacy. A thousand copies were hand delivered to the local residents within the immediate locality to update them on the situation and ask for comments.
- No comments have been received to date. We are still awaiting a date for the formal engagement process to commence.

In September 2019 the Locality Team headed up a '**Talk Health**' event at the Newport Centre in Newport. The event was well attended, with items discussed including the delivery of Care Closer to Home in the borough, the Health Board's Clinical Futures Programme which overarches the modernisation of Health services provision across Gwent along with an overview of the service, workforce and estates changes that are taking place now and in the future. The presentation was well received and questions and discussions for topics raised were positive. Feedback relating to the strengthening of communications with members of the public were relayed, along with concerns regarding isolation within communities. These comments have been fed back into the team's working plans for progression and are noted for action within the IMTP.

12 Financial Profile

What is this section for?
This section should describe the financial implications of the NCN plan, including identification of any anticipated slippage or unfunded schemes.

14.4 Neighbourhood Care Network

Newport East NCN Cluster Funding – Annual Budget £ 140, 576

Currently Supports:

Role / Initiative	Recurrent Annual Cost
Practice Based Pharmacist	£ 85, 303
Direct Access Physiotherapy	£ 13, 632
Community Phlebotomy Team	£ 12, 560
First Practice Management Subscription	£ 699
Independent Contractors (Top Sliced across all ABUHB NCNs)	£ 2,648
DEWIS Coordinator (Top Sliced across all ABUHB NCNs)	£ 1, 155
Dementia Road Map (Top Sliced across all ABUHB NCNs)	£ 736
Total	**£ 116, 733**

Since 2016-17 the Newport East NCN has invested around £250, 000 in GP Practice Based Pharmacist support. This sum comprises salary and training costs.

The NCN has been funding a Direct Access Physiotherapy Service based at St Woolos Hospital for all Practices to be able to refer to.

A range of support for GP practices in Newport East have been recurrently funded, through central top slicing of the NCN Budget allocation, which include specialist Advisor roles in Optometry, Dentistry and Pharmacy and investment in a Community Phlebotomy Service, along with support to the development of DEWIS.

Investments have also been made in various training opportunities to upskill Primary Care and allied services staff across Newport East.

Although overspent against the annual budget, when including brokerage funds and PER monies the NCN is currently underspent.

Initiatives currently being discussed through the NCN for spend include dissemination of the Care Aims training and the commissioning of behavioural engagement and insight analysis to support local communication and engagement, along with the development of a home management service, which would require an additional investment of £ 133, 057.

Transformation Programme Funding

The following funding has been allocated to the Newport East NCN to potentially recruit staff to Extended Roles within Primary Care. The aim of these Roles is to reduce demand and pressure on GP capacity.

2 x WTE Clinical Pharmacist
3 x Advanced Nurse Practitioner
4 x Mental Health Practitioner
1 x clinical paramedic

13 Actions to Support Cluster Working and Maturity

What is this section for?

This section should be used by the NCN to indicate any areas where it feels it needs support from the Health Board and other partners (e.g. Local Authority, Third Sector) to help develop and deliver its plan. This may be in the form of development opportunities for members of the NCN, support to engage interdependent agencies or assistance from specialist departments of the NHS/Welsh Government (e.g. informatics, estate development, etc.).

- A financial framework is required to consider successful NCN cluster initiatives and establish continuing funding and development across the health board, where appropriate.
- WCCIS- access to information for primary & community care
- Continued cross practice working including shared training opportunities to improve sustainability and access
- Working closer with Third Sector organisations for opportunities for wider delivery of initiatives
- Strengthening of the Integrated Partnership Board governance arrangements
- Support for progression of CRT accommodation options
- A Co-Developed robust CPD programme

Appendices

14.4 Disease Registers

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**

14.4 Health Resources Assessment

Basline Data

Borough		Practice List Size			Primary Care Staff in Post					Community Nursing Staff in Post						CRT Staff in Post			Community Hospital Staff in Post					Total Staff in Post
		Total	Over 65 years of age	Percentage over 65 years of age	General Practitioners	Extended Roles *(employed by practice)*	General Dental Practices	Optometry Practices	Community Pharmacy Practices	Rapid Response Nursing *	Out of Hours Nursing ^	Primary Care Specialist Nursing ^	Chronic Conditions Nursing *	District Nursing	Healthcare Support Workers	Medical *	Social, Therapy & Other Profs *	Support Workers / Carers *	Medical *	Nursing *	Therapy *	Pharmacy *	Healthcare Support Worker *	
Blaenau Gwent	East	33,719	6,582	20%	11.88	3.15	8	3	7	4.19	1.49	1.26	0.00	20.24	3.23	0.93	4.39	12.22	1.58	22.92	-	0.47	19.53	125.47
	West	38,377	7,566	20%	17.01	1.75	6	5	9	4.81	1.71	1.45	0.00	21.31	1.78	1.07	5.05	14.05	1.82	26.35	-	0.53	22.44	141.13
Caerphilly	East	65,790	12,754	19%	28.01	3.96	11	8	14	5.41	2.88	2.45	0.71	21.88	3.67	1.43	9.50	14.31	-	22.06	-	-	21.81	171.08
	North	64,848	12,369	19%	28.76	7.12	7	3	15	5.25	2.79	2.37	0.69	29.93	3.91	1.38	9.21	13.88	-	21.39	-	-	21.16	172.85
	South	56,473	10,636	19%	32.89	0.00	13	5	14	4.51	2.40	2.04	0.59	22.65	3.17	1.19	7.92	11.94	-	18.39	-	-	18.19	157.89
Monmouthshire	North	52,841	13,721	26%	28.64	2.78	-	-	-	3.18	3.10	2.63	2.87	25.77	2.97	0.57	8.72	18.29	1.25	17.44	-	0.11	15.09	133.40
	South	47,455	10,453	22%	22.32	2.95	-	-	-	2.42	2.36	2.01	2.18	15.87	2.11	0.43	6.64	13.94	0.95	13.28	-	0.09	11.49	99.05
Newport	East	49,885	7,789	16%	18.26	1.85	-	-	-	5.27	1.76	1.49	0.29	23.37	1.60	1.23	5.19	7.99	1.35	12.85	-	0.13	11.02	93.65
	North	57,029	11,091	19%	24.54	2.44	-	-	-	7.50	2.51	2.13	0.42	15.59	1.52	1.75	7.38	11.37	1.92	18.30	-	0.19	15.69	113.25
	West	49,539	7,663	15%	26.69	5.08	-	-	-	5.19	1.73	1.47	0.29	25.25	3.80	1.21	5.10	7.86	1.33	12.64	-	0.13	10.84	108.61
Torfaen	North	49,550	10,228	21%	27.26	3.40	-	-	-	6.76	2.31	1.96	1.61	21.03	4.27	1.07	5.78	13.59	1.93	17.95	-	0.21	17.25	126.39
	South	45,964	8,843	19%	24.44	1.94	-	-	-	5.84	2.00	1.70	1.39	20.57	4.77	0.93	5.00	11.75	1.67	15.52	-	0.19	14.91	112.61
Gwent Total		**611,470**	**119,695**	**20%**	**290.70**	**36.42**	**45.00**	**24.00**	**59.00**	**60.33**	**27.04**	**22.96**	**11.05**	**263.48**	**36.80**	**13.20**	**79.88**	**151.19**	**13.79**	**219.09**	**0.00**	**2.05**	**199.41**	**1,555.39**

Baseline Data per 10,000 Population

Borough		Practice List Size			Primary Care Staff in Post					Community Nursing Staff in Post						CRT Staff in Post			Community Hospital Staff in Post					Total Staff in Post
		Total	Over 65 years of age	Percentage over 65 years of age	General Practitioners	Extended Roles *(employed by practice)*	General Dental Practices	Optometry Practices	Community Pharmacy Practices	Rapid Response Nursing *	Out of Hours Nursing ^	Primary Care Specialist Nursing ^	Chronic Conditions Nursing *	District Nursing	Healthcare Support Workers	Medical *	Social, Therapy & Other Profs *	Support Workers / Carers *	Medical *	Nursing *	Therapy *	Pharmacy *	Healthcare Support Worker *	
Blaenau Gwent	East	33,719	6,582	20%	3.52	0.93	2.37	0.89	2.08	1.24	0.44	0.37	0.00	6.00	0.96	0.28	1.30	3.62	0.47	6.80	-	0.14	5.79	37.21
	West	38,377	7,566	20%	4.43	0.46	1.56	1.30	2.35	1.25	0.45	0.38	0.00	5.55	0.46	0.28	1.32	3.66	0.47	6.87	-	0.14	5.85	36.78
Caerphilly	East	65,790	12,754	19%	4.26	0.60	1.67	1.22	2.13	0.82	0.44	0.37	0.11	3.33	0.56	0.22	1.44	2.18	-	3.35	-	-	3.32	26.00
	North	64,848	12,369	19%	4.43	1.10	1.08	0.46	2.31	0.81	0.43	0.37	0.11	4.62	0.60	0.21	1.42	2.14	-	3.30	-	-	3.26	26.65
	South	56,473	10,636	19%	5.82	0.00	2.30	0.89	2.48	0.80	0.43	0.36	0.11	4.01	0.56	0.21	1.40	2.11	-	3.26	-	-	3.22	27.96
Monmouthshire	North	52,841	13,721	26%	5.42	0.53	-	-	-	0.60	0.59	0.50	0.54	4.88	0.56	0.11	1.65	3.46	0.24	3.30	-	0.02	2.86	25.25
	South	47,455	10,453	22%	4.70	0.62	-	-	-	0.51	0.50	0.42	0.46	3.34	0.44	0.09	1.40	2.94	0.20	2.80	-	0.02	2.42	20.87
Newport	East	49,885	7,789	16%	3.66	0.37	-	-	-	1.06	0.35	0.30	0.06	4.69	0.32	0.25	1.04	1.60	0.27	2.58	-	0.03	2.21	18.77
	North	57,029	11,091	19%	4.30	0.43	-	-	-	1.32	0.44	0.37	0.07	2.73	0.27	0.31	1.29	1.99	0.34	3.21	-	0.03	2.75	19.86
	West	49,539	7,663	15%	5.39	1.03	-	-	-	1.05	0.35	0.30	0.06	5.10	0.77	0.24	1.03	1.59	0.27	2.55	-	0.03	2.19	21.92
Torfaen	North	49,550	10,228	21%	5.50	0.69	-	-	-	1.36	0.47	0.40	0.32	4.24	0.86	0.22	1.17	2.74	0.39	3.62	-	0.04	3.48	25.51
	South	45,964	8,843	19%	5.32	0.42	-	-	-	1.27	0.43	0.37	0.30	4.48	1.04	0.20	1.09	2.56	0.36	3.38	-	0.04	3.24	24.50
Gwent Total		**611,470**	**119,695**	**20%**	**4.75**	**0.60**	**0.74**	**0.39**	**0.96**	**0.99**	**0.44**	**0.38**	**0.18**	**4.31**	**0.60**	**0.22**	**1.31**	**2.47**	**0.33**	**3.58**	**0.00**	**0.05**	**3.26**	**25.44**

14 Appendix 1 – Population Health Needs Assessment

14.4 Population and Future Projections

The total population of Newport East NCN for all ages is currently 48, 500 (Source: ABUHB).Newport East currently serves a population of 48, 500.

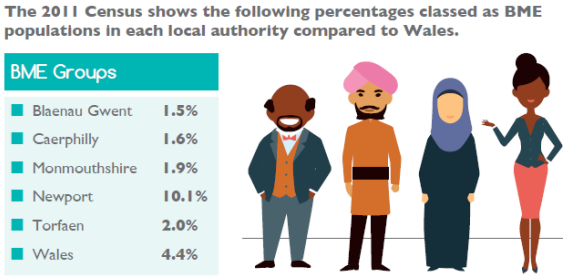
Newport has an aging population, with an increase of 8.6% in those aged 65 and over seen between 2011 and 2015 and projected to rise to account for almost a quarter of the population by 2039 (37,241)

Total population (Newport Borough 18yrs and over)

2017	2020	2025	2030	2035
117,640	119,760	123,260	127,720	132,530

(Source: Daffodil)

The most recent data available via Daffodil shows that 10.1% of the Newport borough population are from Black and Minority Ethnic groups (BME) as drawn from the 2011 census, with the largest minority ethnic communities in Victoria (37.8%) and Lliswerry (13.9%). A further breakdown of the Welsh Index of Multiple Deprivation shows that of the wards within the East:



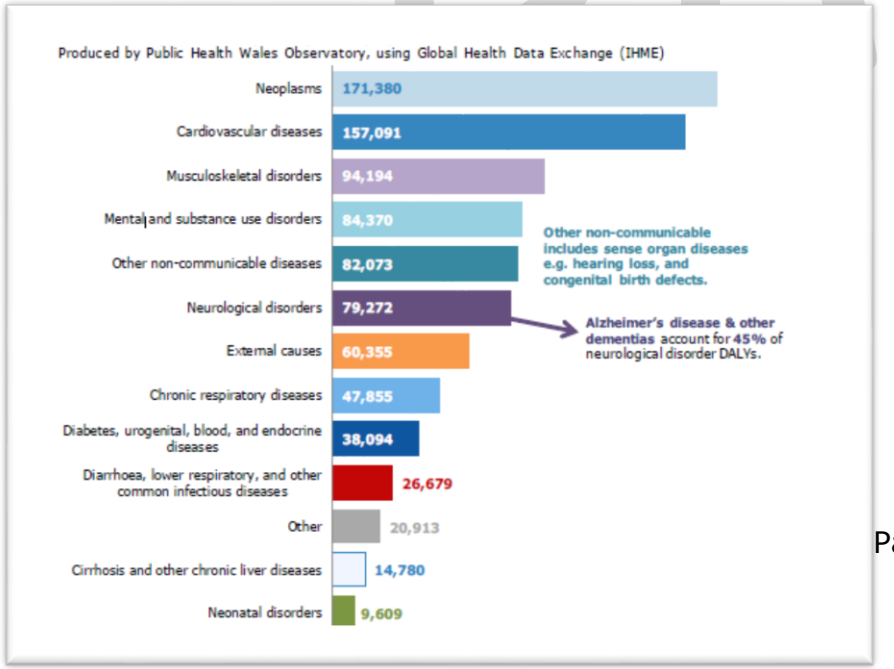
- Alway has 2 of the 6 LSOAs in the top 10% most deprived in Wales for multiple deprivation
- Beechwood has 1 of 5 LSOAs in the top 20% most deprived in Wales for multiple deprivation
- Langstone has 2 of the 3 LSOAs in the top 20% for the 'Access to Services' domain
- Llanwern has 1 of the 2 LSOAs in the top 20% for the 'Access to Services' domain
- Lliswerry has 3 of the 7 LSOAs in the top 20% most deprived in Wales for multiple deprivation
- Ringland has 4 of the 6 LSOAs in the top 20% most deprived in Wales for multiple deprivation
- Victoria has all 4 LSOAs in the top 20% most deprived in Wales for multiple deprivation

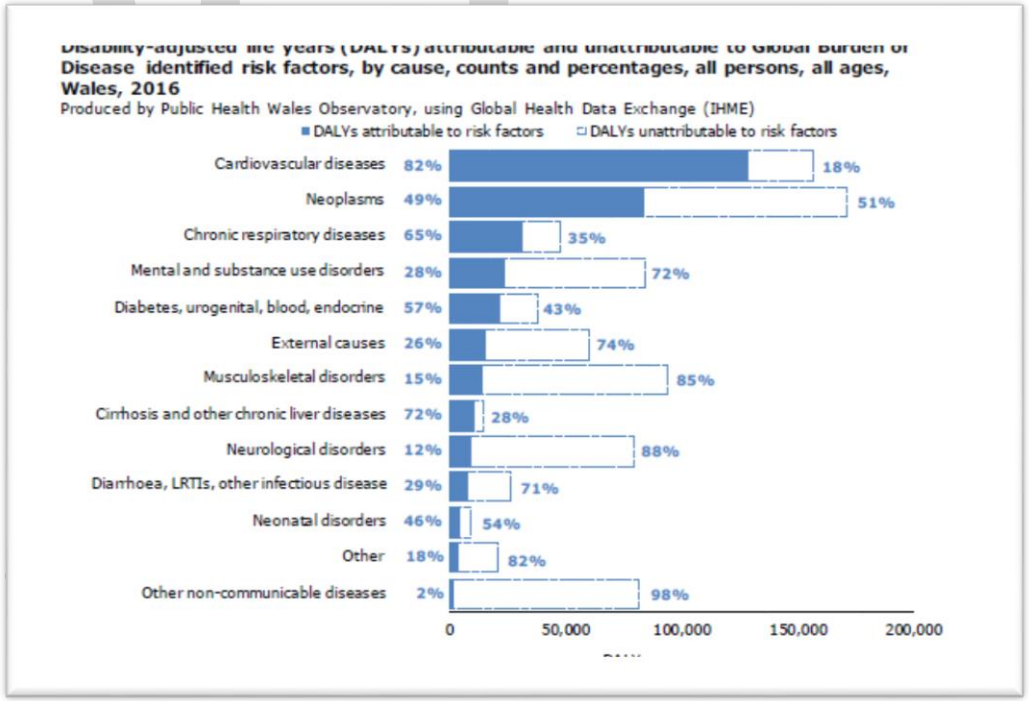
The NCN has a high level of homeless and vulnerable groups including asylum seekers and people with substance misuse problems.

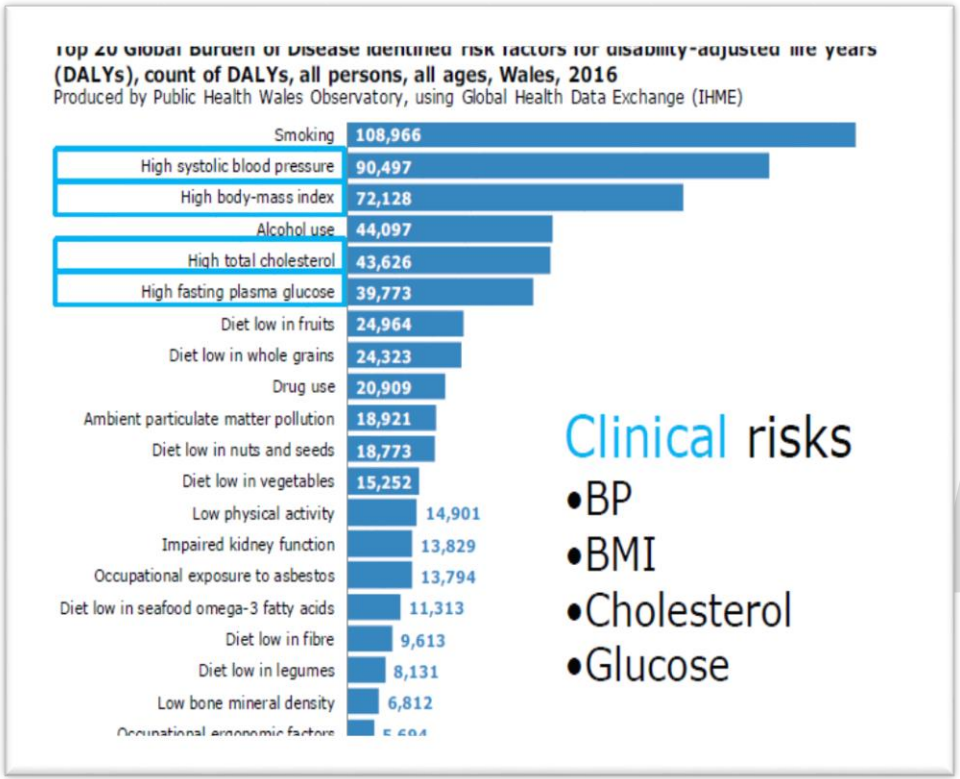
14.2 Health & Physical Disabilities

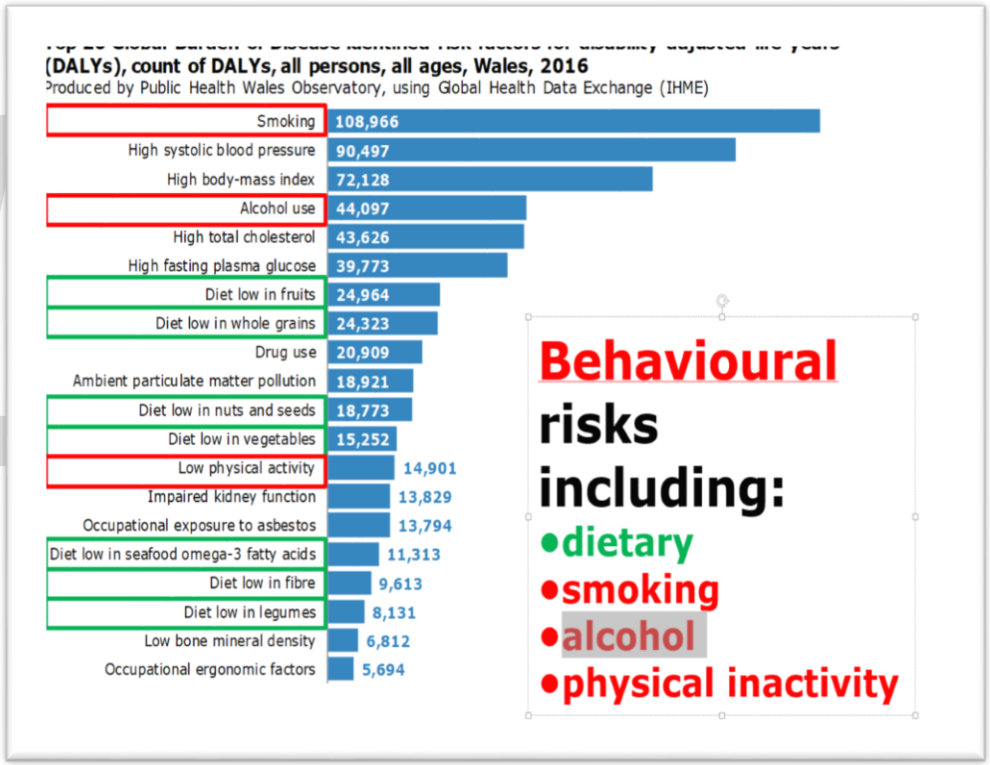
14.4.1 Epidemiology

- Cardiovascular disease and cancer are still the main cause of DALYs i.e. the number of years lost due to ill health, disability and early death
- Musculoskeletal disorders and mental and substance misuse problems are the main causes of years lived with a disability
- Recorded prevalence of hypertension and obesity in adults is lower in Newport East than the ABUHB average
- Recorded prevalence of major chronic conditions in Newport East, except diabetes, is lower than the ABUHB average
- Smoking prevalence in Newport East was second highest of all NCNs in ABUHB at 25.4%
- A large proportion of patients in Newport East with lung cancer were diagnosed at a late stage






(DALYs), count of DALYs, all persons, all ages, Wales, 2016
Produced by Public Health Wales Observatory, using Global Health Data Exchange (IHME)
Smoking 108,966
High systolic blood pressure 90,497
High body-mass index 72,128
Alcohol use 44,097
High total cholesterol 43,626
High fasting plasma glucose 39,773
Diet low in fruits 24,964
Diet low in whole grains 24,323
Drug use 20,909
Ambient particulate matter pollution 18,921
Diet low in nuts and seeds 18,773
Diet low in vegetables 15,252
Low physical activity 14,901
Impaired kidney function 13,829
Occupational exposure to asbestos 13,794
Diet low in seafood omega-3 fatty acids 11,313
Diet low in fibre 9,613
Diet low in legumes 8,131
Low bone mineral density 6,812
Clinical risks
•BP
•BMI
•Cholesterol
•Glucose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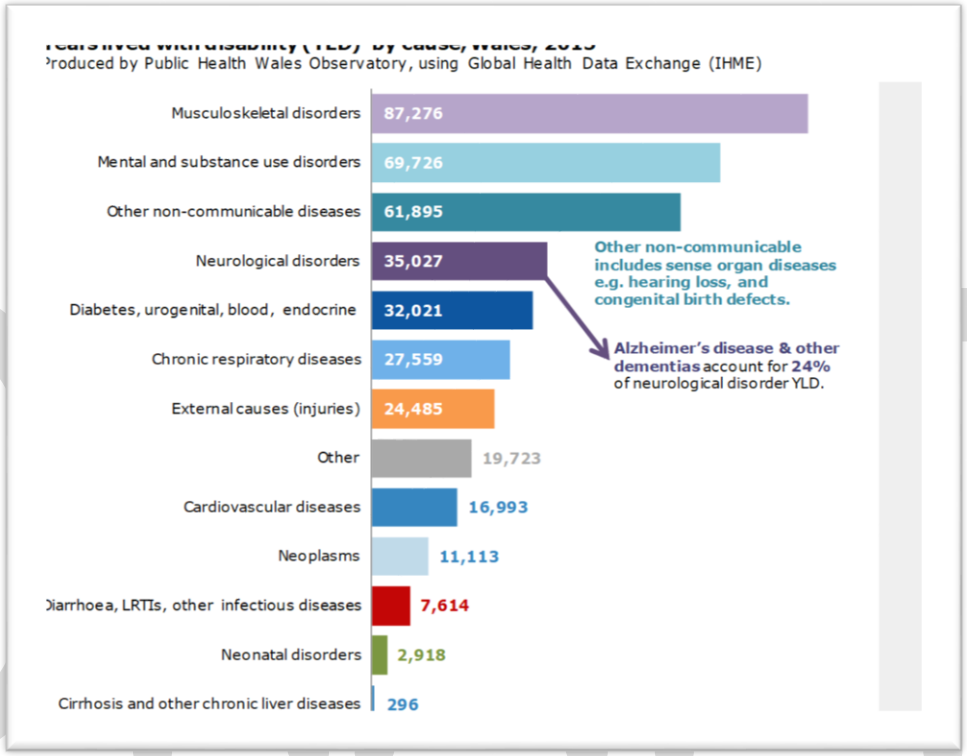
Diet low in nuts and seeds 18,773
Diet low in vegetables 15,252
Low physical activity 14,901
Impaired kidney function 13,829
Occupational exposure to asbestos 13,794
Diet low in seafood omega-3 fatty acids 11,313
Diet low in fibre 9,613
Diet low in legumes 8,131
Low bone mineral density 6,812
Occupational ergonomic factors 5,694
Behavioural risks including:
•dietary
•smoking
•alcohol
•physical inactivity



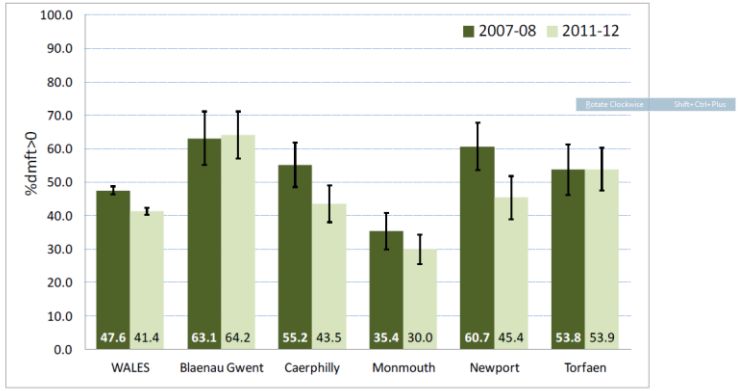
- The uptake of breast, cervical and bowel cancer screening is *substantially* lower than ABUHB
- Cancer prevalence based on the number of people alive with the disease at 31/12/2015
- Newport East had a lower percentage of men diagnosed with bowel cancer in the year prior and in >1 to 5 years prior compared to ABUHB. There was a higher percentage diagnosed >5 to 10 years prior and lower percentage diagnosed >10 to 20 years.

- Newport East had a slightly lower percentage of women diagnosed with bowel cancer in the year prior compared to ABUHB. There was a slightly higher percentage diagnosed in >1 to 5 years and >10 to 20 years prior but lower percentage diagnosed >5 to 10 years.

14.4.1 Pregnancy and Childhood Surveillance

- 33% of children are living in poverty
- Teenage pregnancy rate higher than Wales
- Lower uptake of childhood immunisation
- Higher rates of dental caries
- 22.8% of 4 and 5 year olds were overweight or obese

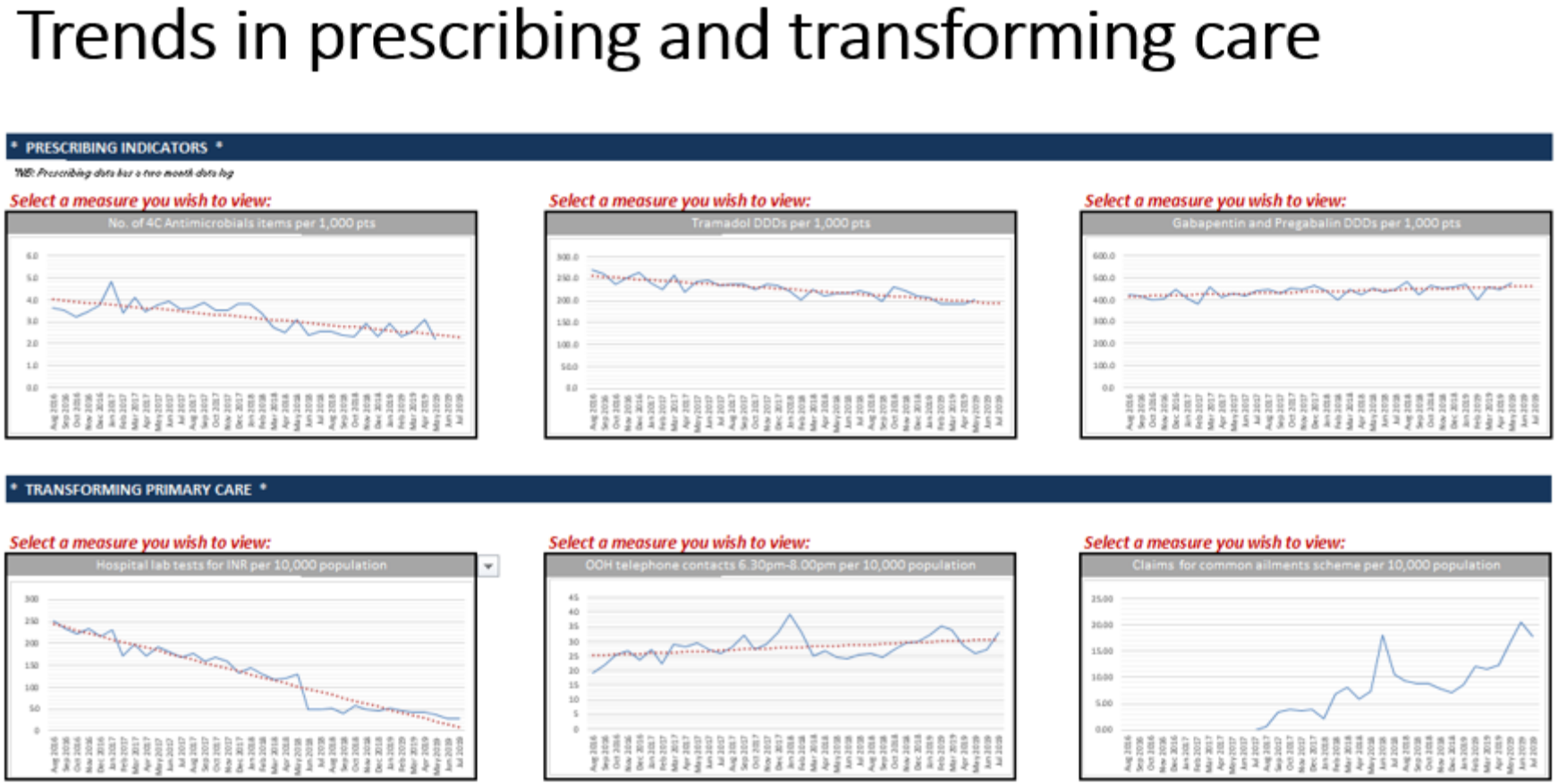
Figure 8 Percentage of 5 year olds with caries experience (%dmft>0) in unitary authorities within Aneurin Bevan Health Board, 2007-8 compared with 2011/12



14.4 Incidents & Concerns

Feedback from professionals indicates that ambulance waits are a frequent concern and remain overly long and GPs report having been stuck for long periods with patients who need transporting to hospital.

14.4 Patient Safety Indicators



14.4 Clinical Audits

We are currently collecting the results of the national diabetic audit for Newport East NCN and will be meeting to review and discuss. However, results show well controlled Hba1c figures with patients receiving regular reviews. Learning and action points will be taken forward via the NCN IMTP Delivery Plan.

Quality Improvement programmes to commence (2019/20) to include patient safety, reducing stroke risk and advanced care planning.

14.4 Enhanced Services

The enhanced services that are delivered across the NCN are listed below. There is an inequality in access in relation to the homeless enhanced service which is being considered on a pan Newport basis by all NCN's. The provision of all enhanced services, ensuring eqity of access for all is being addressed on a place based approach.

Newport Enhanced Services

		DES																			LES																	
Practice Name	NCN	Pneumococcal	Childhood Imms	Asylum Seeker	Learning Disability	Violent Patients	Minor surgery - Fee A	Minor surgery - Fee B	Diabetes Gateway DES	Mental Health	CARE HOME	Anti-coagulation Level A	Anti-coagulation Level B	Homeless	GLP1 Monitoring	Flu Immunisation	Unscheduled Immunisations	Non-Routine Imms	Substance Misuse	Shingles	Rota virus	Meningitis	Minor Surgery non-Registered patients	DOAC	DOAC Monitoring	Depo-Provera	Depo/Sayana Press	Contraceptive Implants (Nexplanon)	Depression/Lithium	IUCD Registered	IUCD - Non registered	Near Patient Testing	Extended Hrs	Denusomab	Pertussis	Gonadorelin/Zoladex	Extended Skin Surgery
Park Surgery	Newport East	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y			Y	Y	Y						Y			Y	Y	
The Rugby Surgery	Newport East	Y	Y	Y	Y		Y	Y						Y		Y	Y			Y	Y	Y				Y						Y			Y	Y	
Ringland Hlth Cent	Newport East	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y			Y	Y			Y	Y	Y				Y		Y		Y		YL3		Y	Y	Y	
Beechwood Surgery	Newport East	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	
Underwood Health Centre	Newport East	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
Lliswerry Medical Centre	Newport East	Y	Y	Y	Y				Y	Y		Y				Y	Y	Y		Y	Y	Y		Y		Y		N	Y			Y	Y	Y	Y	Y	

14.4 Activity Benchmarking

14.4.1 Service Utilisation – NCN Dashboard Indicators

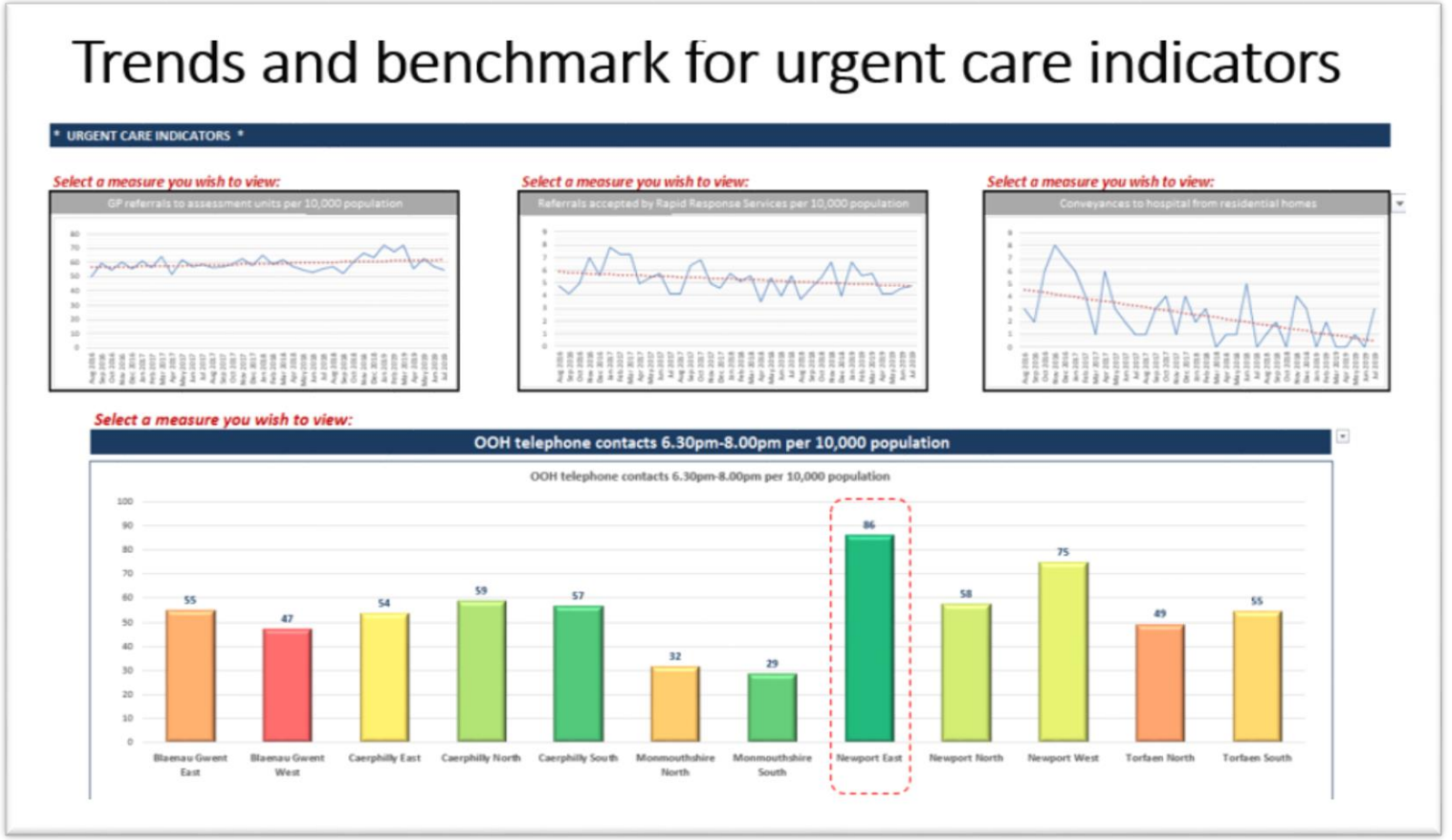
Increased compared to 2018:

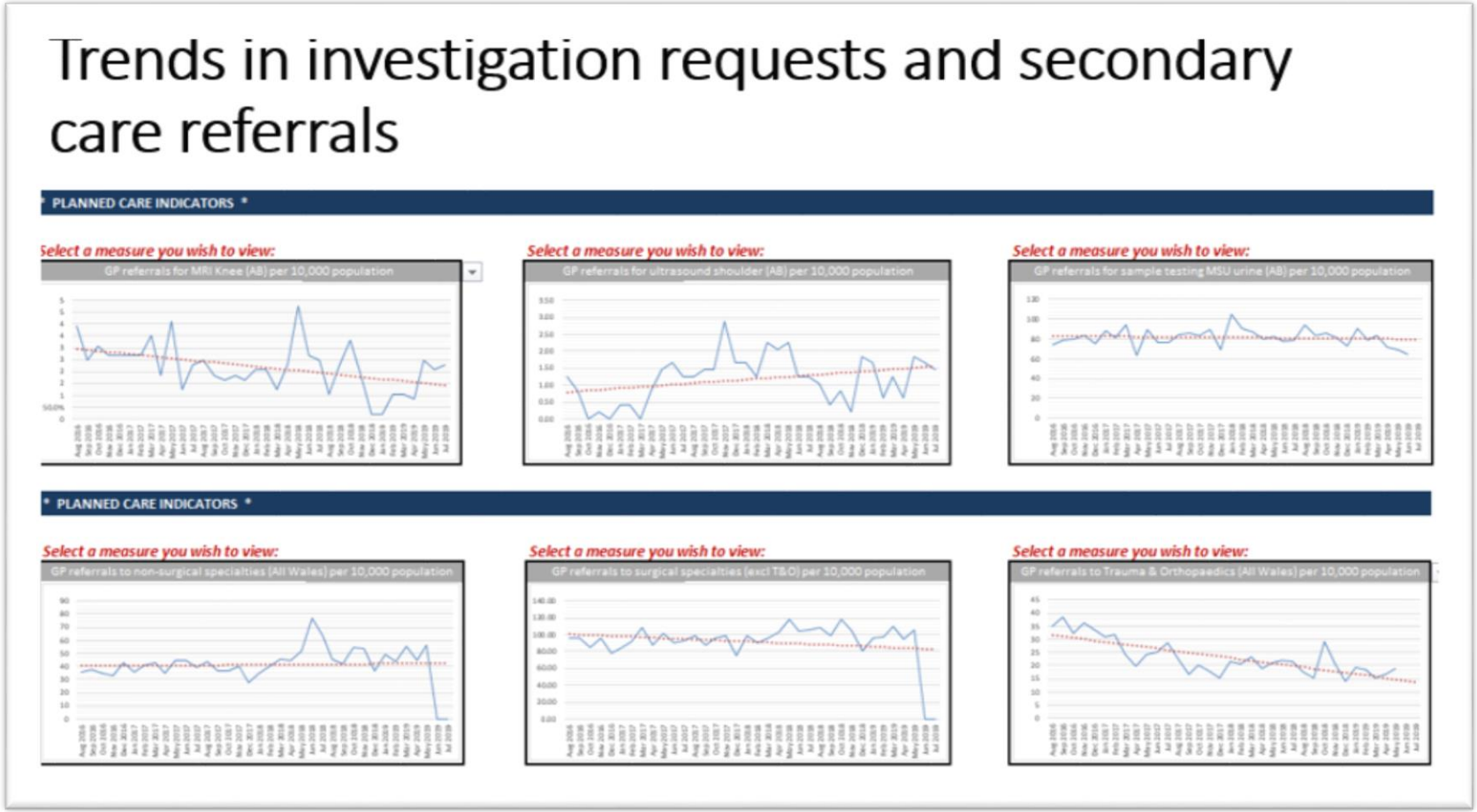
- Average days medically fit prior to discharge where complex needs identified
- ALOS in Community Hospital
- Average hours from referral to assessment reablement and falls services
- GP referrals to assessment units
- Referrals to non-surgical specialties
- GP referrals for Chest X-Ray

Decreased compared to 2018:

- EMAs for ambulatory care sensitive conditions
- Referrals accepted by reablement and falls service
- Percentage of Frailty referrals remaining at home on discharge
- Referrals accepted by Rapid Frailty Services
- Referrals to surgical specialities and T&O

Trends and benchmark for urgent care indicators




Trends in investigation requests and secondary care referrals
* PLANNED CARE INDICATORS *
Select a measure you wish to view:
GP referrals for MRI Knee (AB) per 10,000 population
Select a measure you wish to view:
GP referrals for ultrasound shoulder (AB) per 10,000 population
Select a measure you wish to view:
GP referrals for sample testing MSU urine (AB) per 10,000 population
* PLANNED CARE INDICATORS *
Select a measure you wish to view:
GP referrals to non-surgical specialties (All Wales) per 10,000 population
Select a measure you wish to view:
GP referrals to surgical specialties (excl T&O) per 10,000 population
Select a measure you wish to view:
GP referrals to Trauma & Orthopaedics (All Wales) per 10,000 population

The NCN are also about to commence a demand and capacity exercise, through which baseline activity and demand profiles will be established for all practices across the NCN.

15 Appendix 2 – Care Closer to Home Communication Plan

A full copy of the East Newport NCN Care Closer to Home Communications plan is available below.

11 Newport CCTH Communications Pla