Neighbourhood Care Network Integrated Medium Term Plan 2020-2023

Newport North

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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 Integrated Medium Term Plan (IMTP) 2020 to 2023 describes the vision for Newport North Neighbourhood Care Network (NCN), Newport County Borough Services and the Primary and Community Division (ABUHB). This plan seeks to address challenges facing the both the Borough and Division during this time, which include increasing demand from an aging population; significant health inequalities across Gwent; deficits in the current workforce; and the implications of commissioning a new specialist and critical care centre, the Grange University Hospital, in 2021. Care closer to home and sustainability of services remain as the emphasis along with the overarching goal of providing the best possible system of care for the local population and communities.

At a national and regional level, there remains continued emphasis on delivering quality health and care services fit for the future and promoting good health and well-being for everyone. Driven by the ambitions in recent documentation including *Healthier Wales.* This plan aims to outline how we will continue to build on strong relationships across statutory and non-statutory agencies, with a growing public facing agenda.

Sustainability of services within the NCN is the key factor for the aim of recruiting to our wider healthcare team, along with upskilling existing staff. To provide this prudent healthcare model, various funding routes will need to be explored to achieve these goals.

We also aim to expand on the good work already being undertaken within Newport North in the development of place based care models and hubs incorporating the medical element and the social wrap around services required to support sustainable services for the local population.

We aim to work closely with Public Health Wales, local services and voluntary sector organisations to develop an integrated wellbeing network and build resilient communities through partnership working with affiliated services across the NCN footprint.

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 surgeries
- GPs demonstrating leadership and best practice (e.g. Common Ailments, Flu Vaccination)
- 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 primary care cluster funding

During 2020-2023, opportunities ahead for Newport include;

- Development of the Newport East Health and Wellbeing Centre in Ringland
- Reorganisation of the District Nursing Team in line with CNO District Nurses Principles
- Implementation of graduated care
- Establishment of a hub and spoke 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.

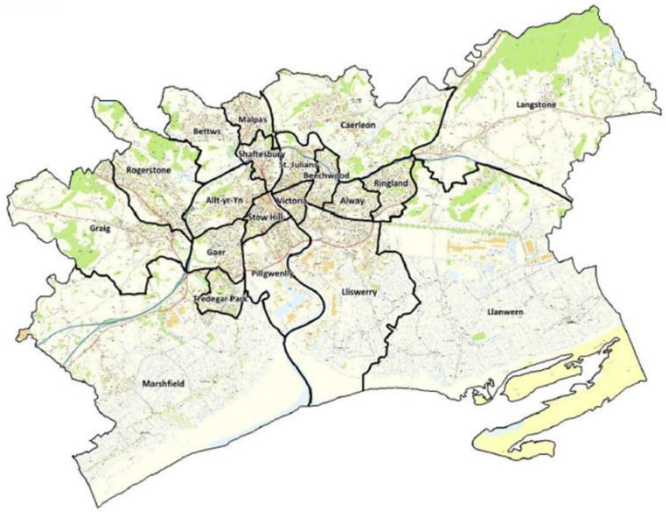
2 Overview of the Neighbourhood Care Networks

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.

2.1.3 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.

The city has undergone a radical transformation with entire new communities on former industrial sites, new landmark buildings, award winning developments and modern infrastructure. This city wide programme of regeneration has earned Newport recent acclaim along with international recognition as hosts of the Ryder Cup, the NATO Summit and prestige sports events. Newport is home to a cluster of cutting edge technology businesses, major public service employers and is regarded as a hotspot for business growth.

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.

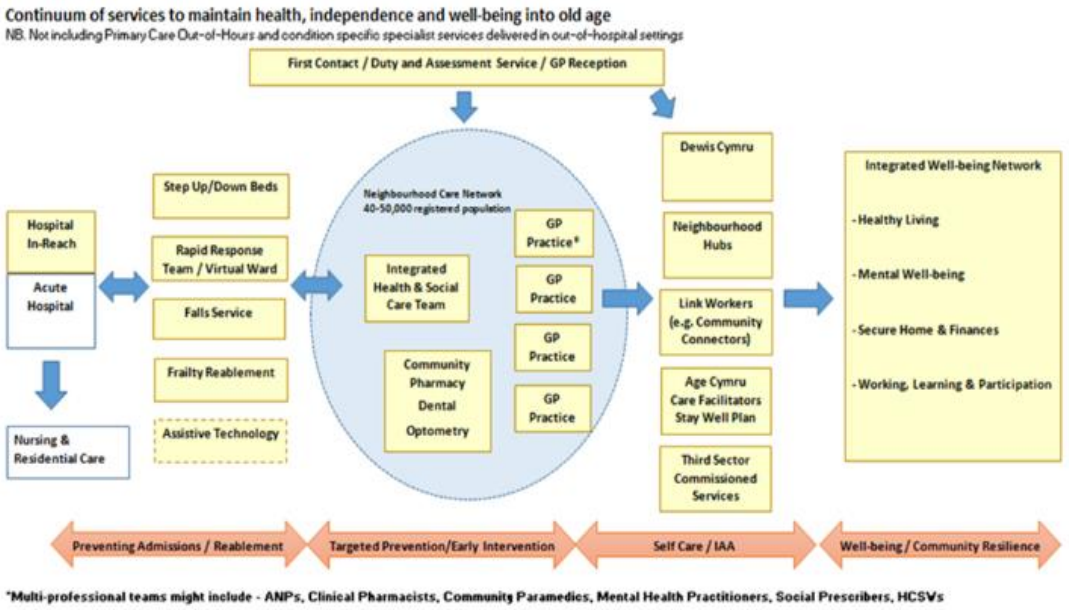
The Newport North NCN is led by Dr Graeme Yule, Partner at St Julians Medical Practice. They are a network of 6 main practices which together have a combined registered population of 55,874.

There are 3 optometrists, 8 dental practices and 11 Community pharmacies based in Newport North.

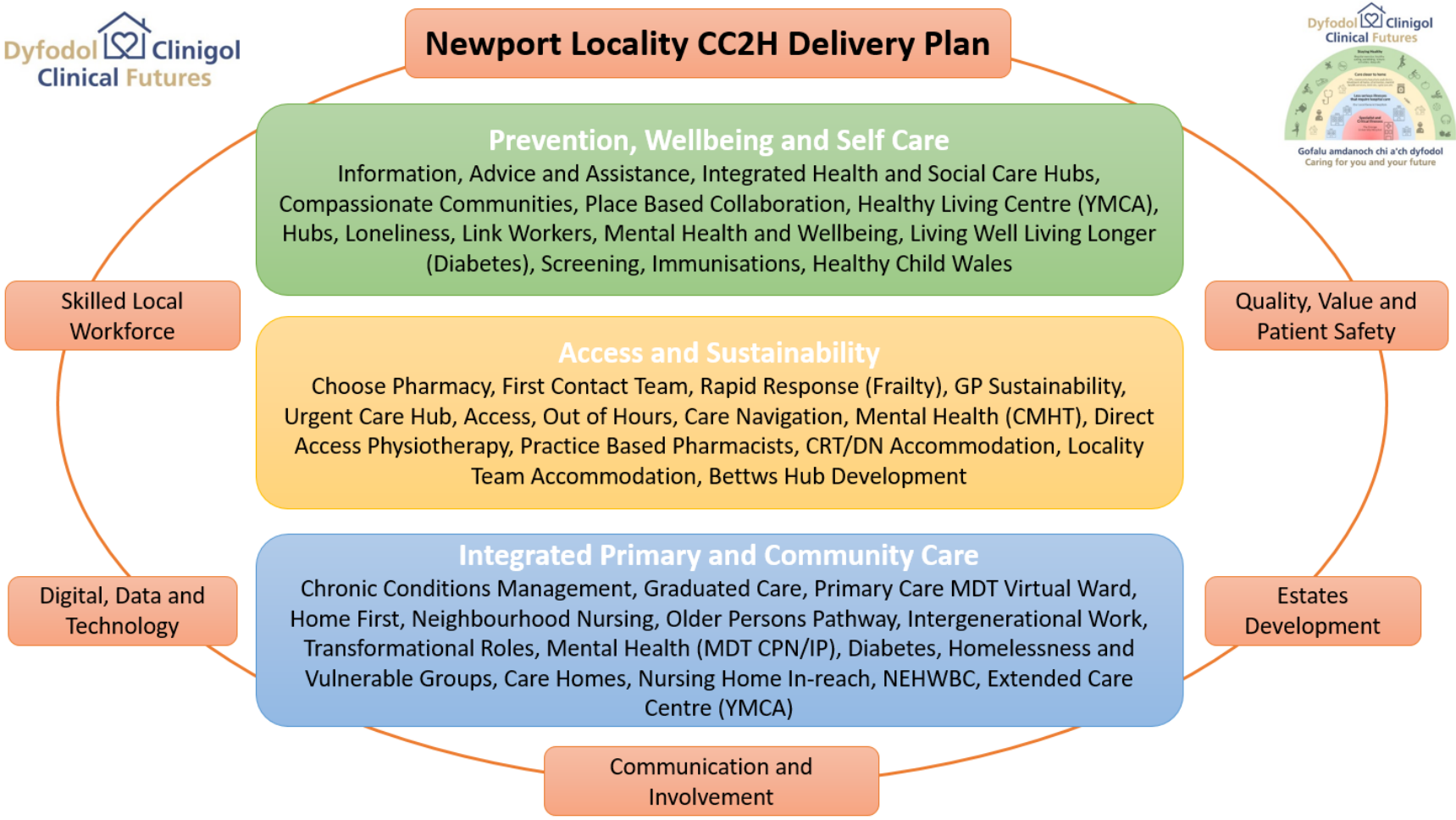
2.2.3 Vision Statement

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.



Newport will be delivering this through its three key Care Close to Home work streams (outlined below). These will feed into the Newport Integrated Partnership Board and priority sub work streams working within it that are closely managed and taken forward via NCN three year plans.



Prevention, Wellbeing 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.

A vital component of offering appropriate level support and care within each community is the development of 'hubs', which will co-locate services and offer one front door and a model to navigate people to appropriate professionals based on their needs. Newport East has been identified for the first Health and Wellbeing Hub subject to Welsh Government funding approval. The hub will contain an Integrated Services Team with greater emphasis on collaborative working so that handoffs between team members are minimised to ensure greater continuity of care. The hub will also provide an opportunity to amalgamate local services such as debt advice, housing services, community pharmacies, mental health services, GP practices, dental practices, among many others. Newport partners are also exploring the possibility of replicating this model and establishing an extended care hub in the West of the city, to enable a greater emphasis on place-based care.

Access and Sustainability

Maintaining timely access to service and ensuring long term sustainability of primary and community care provision in the face of growing demand and an aging workforce. Creating new roles in Primary Care to support a sustainable workforce e.g. direct access physiotherapy, mental health crisis support and choose pharmacy. Supporting additional roles within GP practice to make it easier for patients to access the most appropriate services and support available to them.

Integrated Primary and Community Care

Changing the way we provide short term patient centred care to ensure that support increases independence and enables people with complex needs to be supported in the community. Developing integrated place based teams which reduce hand offs and increase continuity of care, resulting in quicker hospital discharge and less re-admissions. Managing demand for Primary Care services through a multi-disciplinary approach.

Delivery of the 3 workstreams will be underpinned by a series of enablers:

- A skilled local workforce

- Digital, Data & Technology
- Communication and Involvement
- Quality, Value & Patient Safety
- Estates

Further detail in relation to the aims, actions and aspirations of the workstreams, along with the enablers can be found within the NCN delivery plan.

2.3.3 Neighbourhood Care Network Governance

The NCN itself is a collaborative network, led by an NCN Lead but featuring a wide range of individuals from different disciplines and agencies who deliver care within the local area. The group are required to meet on a monthly basis to share information and discuss / plan local developments. This section outlines these arrangements.

2.3.1.1 Membership

Newport North Neighbourhood Care Network

Name	Title	Organisation / Designation
Dr Graeme Yule	Newport North NCN Lead/Clinical Futures Clinical Lead	Primary Care & Community
Stacey Clarke	Practice Manager	Westfield Clinic
Dr Michael Redmore	General Practitioner	Westfield Clinic
Sian Moore	Practice Manager	Isca Medical Centre
Dr Rebecca Davies	General Practitioner	Isca Medical Centre
Helen Rossiter	Practice Manager	Malpas Brook Health Centre
Dr Rebecca Moore	General Practitioner	Malpas Brook Health Centre
Nichola Tayler	Practice Manager	Richmond Clinic
Dr Matt Dexter	General Practitioner	Richmond Clinic
Lynne Barry	Practice Manager	St Julians Medical Centre
Dr Rhodri Evans	General Practitioner	St Julians Medical Centre
David Harris	Practice Manager	The Rogerstone Practice
Dr T B Gallagher	General Practitioner	The Rogerstone Practice

Aimee Clement-Rees	Service Development Manager	Primary Care Unit
Ann Owen	Senior Nurse	Community Division
Sian Price	Public Health Operational Manager	Families & Therapies Division
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
Dawn Pridham	Service Manager	Newport Local Authority
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
Mike Curson	Senior Primary Care Pharmacist	Newport Locality
Marietta Evans	Integrated Wellbeing Network Service Development Lead	Public Health Wales
Penny Gordon	Head of Nursing	Primary Care & Community Division
Patricia Bartley	Community Resource Team Manager	Frailty
Sandra Trimarco	Community Strategy & Partnership Manager	Newport Local Authority
Sarah Halliday	Community Dietician	Community Dieticians
Susan Waters	Diabetes Specialist Nurse	Diabetes
Sian Davies	Team Leader	Primary Care Mental Health Support Service
Newport Carers Forum	Newport Carers Forum	Newport Carers Forum
Lucy Higgins	Prescribing Advisor	Pharmacy

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

2.3.2.1 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

2.3.3.1 Frequency of Meetings

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

2.3.4.1 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.

2.3.5.1 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.

2.3.6.1 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.

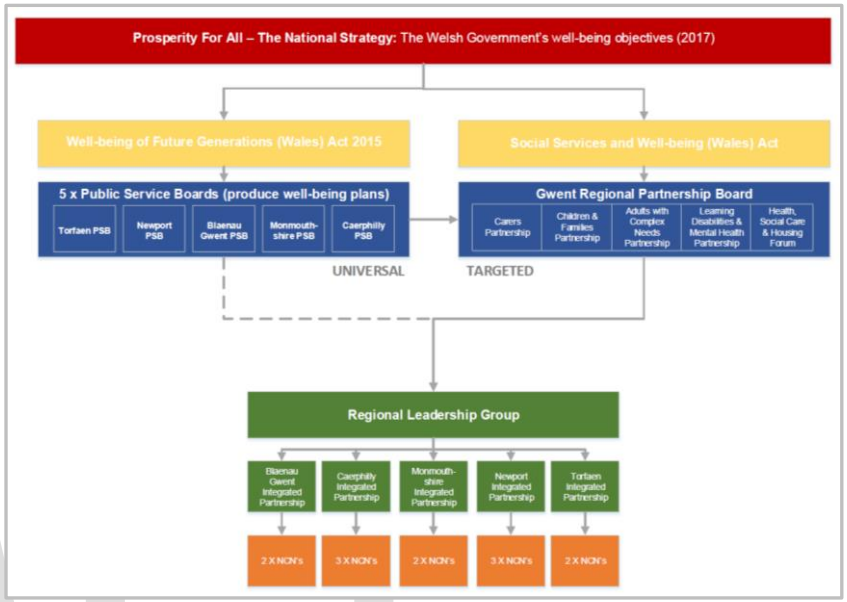
There is Regular email contact with the NCN and partners as and when applicable to circulate information.

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.

2.3.7.1 *Reporting Framework*

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

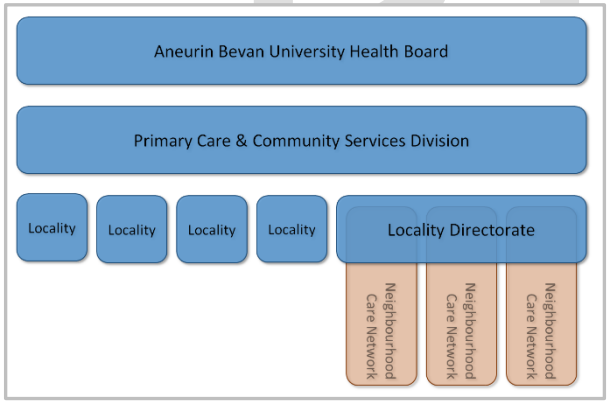


The NCNs are a key component of the Integrated Services Partnership Boards (ISPBs) in each of Gwent's five boroughs, which report to the Regional Leadership Group and onwards to the Public Service Boards and Gwent Regional Partnership Board.

The NCNs are an operational arm of this framework, and as such have the responsibility of implementing national and regional strategy through local actions. However, the NCNs are also crucial in prioritising the implementation of these strategies depending on local circumstances.

Where need is identified that is not currently being addressed, NCN plans must seek to address these issues and, via the ISPBs, influence regional planning as required.

2.3.8.1 *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)

3.1.3 A Healthier Wales

Integration across Health and Social Care is the driving force for reform and service modernisation, set out in both the *Parliamentary Review of Health and Social Care* (January 2018) and Welsh Government's long term plan, *'A Healthier Wales'*. These documents describe four interlocking aims – described together as the Quadruple Aim – which create a shared commitment to how the system will develop and prioritise change over the coming years. These aims consist of:

- Improved population health and wellbeing;
- Better quality and more accessible health and social care services;
- Higher value health and social care; and;
- A motivated and sustainable health and social care workforce

The context in which these aims will be delivered is through regional planning of health and social care services, for people with a care and support need. This is done via the Regional Partnership Board, and the publication of an 'Area Plan' detailing the agreed 'partnership activity'.

As such the NCN IMTPs are developed within the context of the agreed regional partnership planning framework (the Area Plan) and in alignment with five Wellbeing Plans, published in May 2018, by Public Service Boards.

3.2.3 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:-

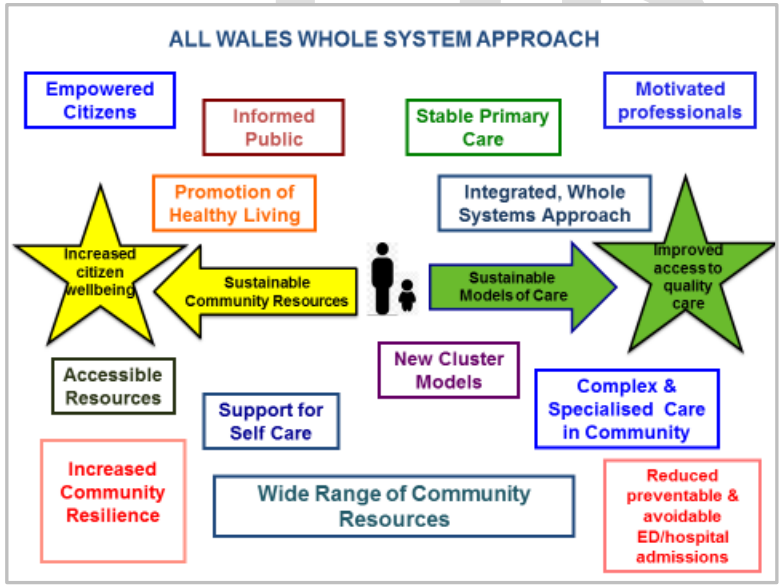
- ***Patient centred***, concentrating on safety, quality and experience.
- ***Home to home***: integrated services in the community to prevent illness and improve wellbeing, and providing care closer to home where appropriate
- ***Data*** and ***evidence*** driven, patient ***outcome*** focussed.

- ***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.

3.3.3 Strategic Programme for Primary Care

Following on from Welsh Government's '*Plan for a Primary Care Services for Wales up to March 2018*', published in February 2015, a new '*Strategic Programme for Primary Care'* was released in November 2018. This strategy builds on the work gone before and provides a direct response to '*A Healthier Wales'* from a primary care perspective.

The Transformation Model for Primary Care features heavily within this strategy, following a period of testing each component via national funding sources (i.e. pacesetter / pathfinder, cluster, integrated care fund). The model seeks to address the well-established challenges facing primary care, which includes increasing workload from a growing, aging and increasing complex population and a shortage of GP numbers to deliver the traditional model of primary care.



As a result, the model depicts a different approach to delivering services, featuring a renewed emphasis on early intervention; a focus on signposting, direct-access and social prescribing services; implementation of a new multidisciplinary workforce model; and greater utilisation of technological developments.

As a result, on a national basis, 6 key 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

3.4.3 Primary Care & Community Services' Integrated Medium Term Plan

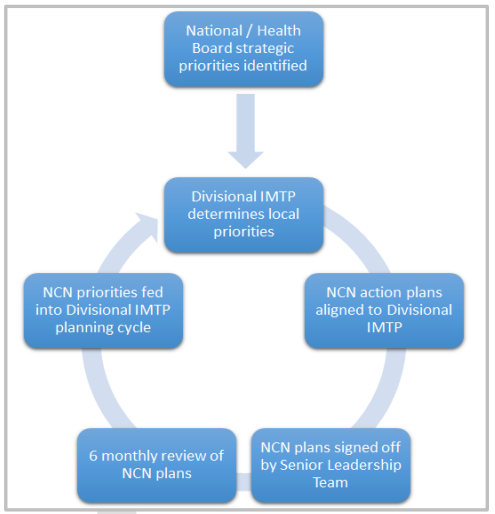
The Division's IMTP is intended to provide an overarching 3 year plan, based on an assessment of both strategic priorities and operational risks. The IMTP has been broadly divided into 10 workstreams. It is intended that NCN plans will feed into these workstream areas for support and decision-making.

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

3.5.3 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.

Workstream	Key Achievements	Benefits/outcomes
Community Wellbeing	**Choose Pharmacy Common Ailments Service** - Community pharmacies in each NCN have 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 requiring more specialist/complex care. Newport pharmacies have documented 2253 direct 'choose pharmacy' attendances from April – June 2019, with 50% for hay fever remedies in June.
	Involvement in national Public Health Programmes designed to prevent ill health - influenza and childhood immunisation, smoking cessation services, and screening services.	Increased uptake recorded for each programme.
	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 frequent users of high cost care	To date, 3229 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, 2577 have had an interaction with a Care Facilitator with 1742 undertaking support resulting in 1184 active stay well plans. An evaluation undertaken in 2017 demonstrated a reduction in the number of A&E attendances, emergency admissions and Frailty episodes in those who took up the offer of a Stay Well Plan compared with those who were offered a Stay Well plan but declined.

	Care Navigation- The introduction of 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, WECCS Eye Service, Emergency Dental Service and minor injuries. It is envisaged to save 23% reduction on GP demand.
	Provision of QR Boards (Quick Response) –in GP practices, Royal Gwent and St Woolos Hospitals	Immediate patient access to information about local services and support. Supporting Care Navigation across Newport City
	Provision of DEWIS Support - the NCNs have contributed towards the funding for a pan-Gwent post to assist with the roll out of DEWIS across the Health Board	Newport has the highest usage of DEWIS within Gwent
	Newport East Health and Wellbeing Centre- Provision of a community campus in Ringland following £4m allocation from Welsh Government capital funding.	The relocation of two practices and integration of community services will result in closer MDT working, providing community services in one place. The anticipated completion for the programme is early 2021
	Neighbourhood Nursing - District nursing in East Newport have adopted the Buurtzog Principles of neighbourhood Nursing.	Teams are more aligned with the Community Resource Team and support MDT working in Primary Care and discharge MDT planning on the community wards. Care Aims training has improved patient experience by providing care in a more holistic way.
	Compassionate Communities - Compassionate Communities will be rolling out across Newport in the autumn of 2019.	Preparatory work with the GP practices, CRT and district nursing has been undertaken. The focus is upon prevention and self-care Communities by working together to reduce individual isolation that can lead to depression and loneliness resulting in the need for clinical intervention.
Extended/ Urgent Care	**Direct Access Physiotherapy -** A direct access service for patients with a muscular skeletal problem	Current data has indicated that the service demand is increasing and will continue to do so with the

	commenced in Newport in June 2018, with the aim of reducing the demand upon the GP.	implementation of care navigation. An additional 1wte is being recruited to 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 funds 1 practice based pharmacist with each of the NCN's. The 1wte is split amongst the practices within each NCN.	The aim was to reduce to need for some patients to visit the GP if the pharmacist could accommodate the patients need. The role has been so successful that Beechwood, Westfield and Bellevue practices have since recruited their own pharmacist.
	Workflow Optimisation - The NCN funded the accredited Workflow Optimisation service.	Administrators safely and efficiently process clinical correspondence and release time for GPs to provide clinical care.
	Primary Care Mental Health Support Services - Pilot area for the collaborative PCMHSS model to strengthen integration, reduce duplication across agencies for referrals, assessments and interventions.	Work progressed to develop a transformational model for service provision based on the 'iceberg' model. The model builds on the 'single point of access' providing mental health 'in reach' to schools, perinatal mental health provision for infants and parents, community embedded, family-based early interventions for vulnerable families, community Psychology and supporting frontline staff to make changes in Health, Education and the Local Authority.
	Gwent Drug and Alcohol In-reach Service – funding for a GDAS In-Reach Worker to provide 4 x 2 hour dedicated clinics a week in GP surgeries.	Provided support with harm reduction, promotion of alcohol awareness and educated patients who wanted to reduce alcohol intake. In future, this service will be provided from the NCN hubs when they are established.
	Provision of an NCN Phlebotomist – appointment of a HCSW to undertake phlebotomy	Enabled District Nursing to provide care for patients with more complex needs

	Equipment for CRT – purchase of small aids for frail older people who were unable to purchase the pieces of equipment to aid their independence.	Portable equipment enabling teams to support patients in their own homes.
	Oximeters for District Nursing	
	Doppler Machines for District Nursing	
	Managed laptops for GPs	To support agile working for GP practices
MDT/ Intermediate Care	**Ambulatory Community Frailty Unit** established in St Woolos Hospital	Community patients are able to receive appropriate interventions in a clinic environment
	Inpatient Community Frailty Unit – established on Gwanwyn Ward, St Woolos Hospital	Community patients can be stepped up or stepped down depending on their clinical need
	Integrated Reablement Care Team - A pilot in-reach programme was to identify frail older patients whose mobility and independence were at risk of de-conditioning whilst they were waiting for packages of care	The in-reach pilot highlighted the importance of continued rehabilitation for patients, up until their date of discharge, to improve confidence and maintain a level of independence. A Reablement carers programme is being developed to embed the reablement ethos within the hospital, from the point of admission to hospital to discharge and beyond. To be rolled out in December 2019
Sustainability	**Lexacom Digital Dictation System**	Reduction in administrative time for GPs and supports workflow optimisation.
	Dementia Roadmap – Funding to support the roll out of the online resource	
	IM&T Guidance – Funded support from Vision in Primary Care	Support to develop templates to ensure continuity across NCN GP Practices

	Patient Check In System	Improved patient experience when attending practice appointments
	Patient Record Scan and Store	Enables GP Practices to access patient records electronically and free up space within the practice to offer additional patient services.
	Training and Professional Education AMSPAR Certificate and Diploma qualification for Practice Managers CIPD Level 3 in Practice Management – part funded for two practices Wound Management, ECG and Phlebotomy **–** for Health Care Support Workers Annual subscription for First Practice Management – for Practice Managers Funded attendance at the GP Workforce Planning workshop and All Wales Practice Managers forum. GDPR Seminar – delivered by Insight for GPs and Practice Manager to aid compliance. Lunch and Learn Sessions – venues and speakers for NCN members to attend sessions about Care Navigation, NHS111/DEWIS, Flu immunisations, winter preparedness	Developing a skilled workforce to support GP sustainability and extended roles.

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)

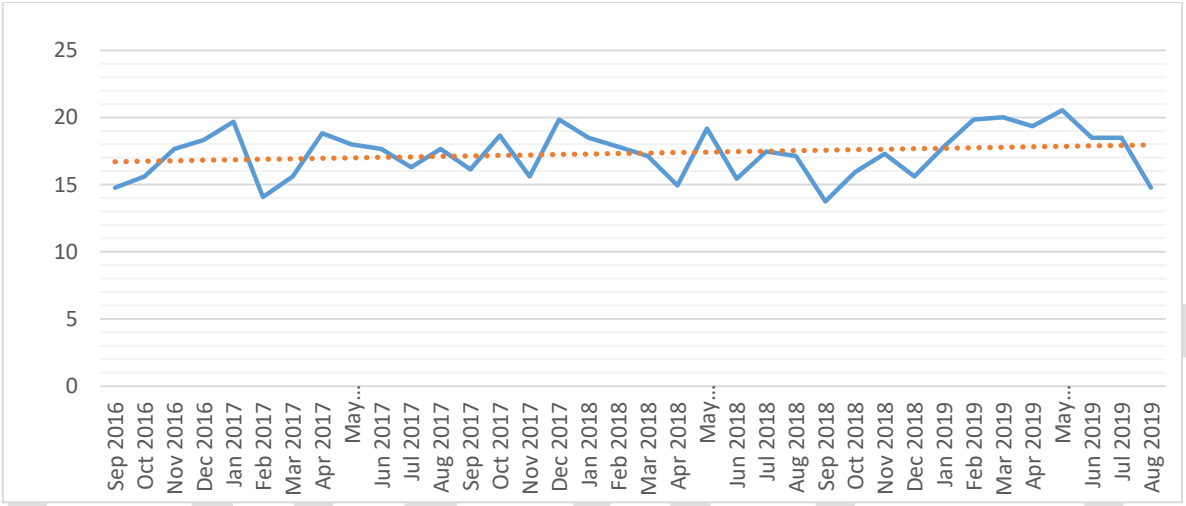
5.1.3 Population and Future Projections

We have conducted a local needs assessment by reviewing data from various sources including The Public Health Observatory, (health behaviours wales document) – Newport City Borough Council Area Assessment of Local Wellbeing 2017, the Primary Care Information Portal and local data sources relating to access, prescribing and referrals. We have discussed local issues with members of the NCN (including all GP practices) and given all partners an opportunity to contribute to the plan. *We have considered national issues and tier 1 WAG priorities.*

Included as Section 14 - Appendix 1 is a copy of data analysis that and was used to inform the key needs identified in paragraphs above.

Access to services

Access to primary care services and primary care sustainability are national issues and the NCN is keen to develop plans to address these issues. It is noted that Newport North mainly has a lower than average OOH contacts between 6.30pm and 8.00pm to hospital from Residential and Nursing Homes.



Data and discussion at public consultation events indicates that use of the common ailments scheme could be improved. The aim is to continue to drive improvements in quality of care, sustainability and care closer to home by exploring/introducing methods of improving access to primary care. Introducing and utilising extended roles and social prescribing/care navigation to provide a prudent healthcare model. Maximising the potential of estates for better health and social care provision via hubs and GMS sites across the NCN. Understanding the whole system and importance of maintaining a sustainable integrated health and social care approach across primary/ community teams including GMS and Integrated Services Teams. In terms of maintaining a robust and responsive 'whole-team' approach, we need to understand the challenges locally.

Healthy lifestyles and Preventative Services

Unhealthy behaviours are predictors of mortality and morbidity. Newport North NCN, has medium levels of ill health across the board generally. Whilst the prevalence of asthma, Cancer and hypertension areas of concern, as are all the determinants of poor health such as smoking, obesity, poor diet, and lack of exercise and high levels of alcohol intake, these do not score highly compared to the rest of Gwent. Following discussion at NCN meetings, members of the NCN continue to be keen to address smoking cessation rates, diabetes, self-care through health literature and also to address rates of obesity through the next phase of the Living Well, Living Longer Service.

Newport North NCN has always tried to maximize uptake of preventative services. Uptake of childhood immunizations, influenza immunizations and screening services has scope for improvement and all partners are keen to try to maximize uptake where possible. Increasing Flu Uptake for 2-3 year olds is a key target and the NCN will promote ideas to form plans involving all partners to improve the uptake of flu immunisation in this age group.

Quality of care

Prescribing data indicates that opiate prescribing could be improved and we will develop plans which all members of the NCN can participate in to try to improve prescribing rates.

Key implementations for Newport North will be incorporating the Compassionate Community initiative work and the pilot of the Chronic Conditions Home Management Service.

Compassionate Communities will be rolling out across Newport Cluster in 2019. Preparatory work with the GP practices, CRT and district nursing will be taking place in the New Year of 2020. The focus is upon prevention and self-care Communities by working together to reduce individual isolation that can lead to depression and loneliness resulting in the need for clinical intervention.

Mental health provision continues to be an area where all partners feel that there is a disparity in services across the NCN footprint despite previous investment. Partners feel that services are not always joined up and easy to access. This will be addressed as a priority area for the NCN.

The Newport North NCN Team will continue to attend local engagement events and local estate/service development meetings. Events are also organise by the ABUHB Engagement Team where subjects such as access to services and 'Building a Healthier Gwent' are worked through with members of the public. Feedback should feed into future planning for the NCN and wider localities.

- Estimated adult population in 2017 (18+) in Newport is 117,640 with an anticipated increase of 13% to 132,530 by 2035.
- Estimated child population in 2017 (0-17) in Newport is 34,100 with an anticipated increase of 10% to 37,480 by 2035.
- The projected increase in population growth for Newport is estimated to be around 7.9% to 158,492 people in 2039.

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. With the introduction of more localised connector services there will be an opportunity to complete more detailed community asset profiles that can be used to inform and connect organisations. This will enable services to work better together to meet the needs of their community and also potentially reduce duplication of services.

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.

7.1.3 Estate Profile

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

Main Surgeries

- None 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.
- There is potential for one practice to move as part of a planned housing development, conversations ongoing.

Branch Surgeries

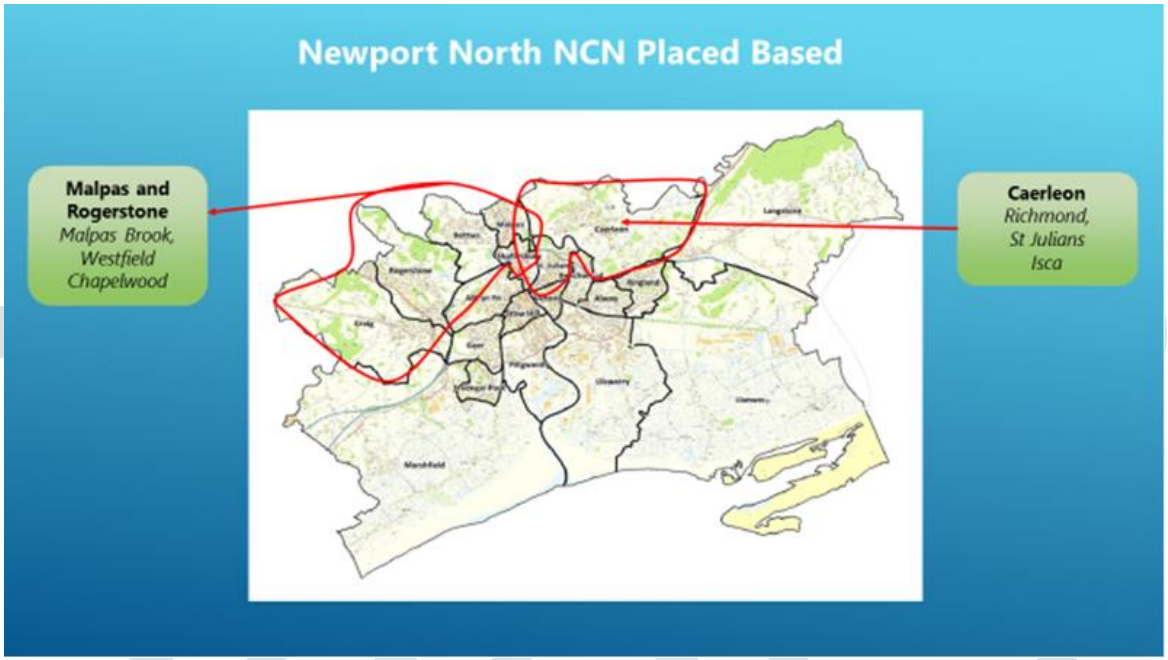
- The branch surgery is a relatively modern facility, however is it need of some refurbishment

Place	Practice	NCN	Practice Population	Code	Year 1-4	Year 5-9	Year 10+
Caerleon	Isca Medical Centre	Newport North	9,460	W93018 -			
	Candwr Brook, Isca Medical Centre (Ponthir)	Newport North	Branch	W93018a			
	Richmond Clinic	Newport North	6,417	W93043			
	St Julians Medical Centre	Newport North	12,106	W93049			
Malpas & Rogerstone	Westfield Clinic	Newport North	8,167	W93045			
	Malpas Brook Health Centre	Newport North	9,267	W93051			
	The Rogerstone Practice (Chapelwood)	Newport North	11,612	W93061 -			

7.2.3 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 North 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).

7.3.3 Priority Developments

7.3.1.1 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.

7.3.2.1 Minor Improvement Grants

As at September 2019 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.

7.3.3.1 Capital Pipeline Funding

There are plans within the Bettws area to develop a Healthy Living Centre. Discussions are ongoing in relation to the location of this build with multiple sites being explored along with the potential for pipeline funding. This is being progressed as per the pan Newport Health, Local Authority, Third Sector and Housing Association estates plan, facilitated by the Newport Integrated Partnership Board.

8 Workforce Profile

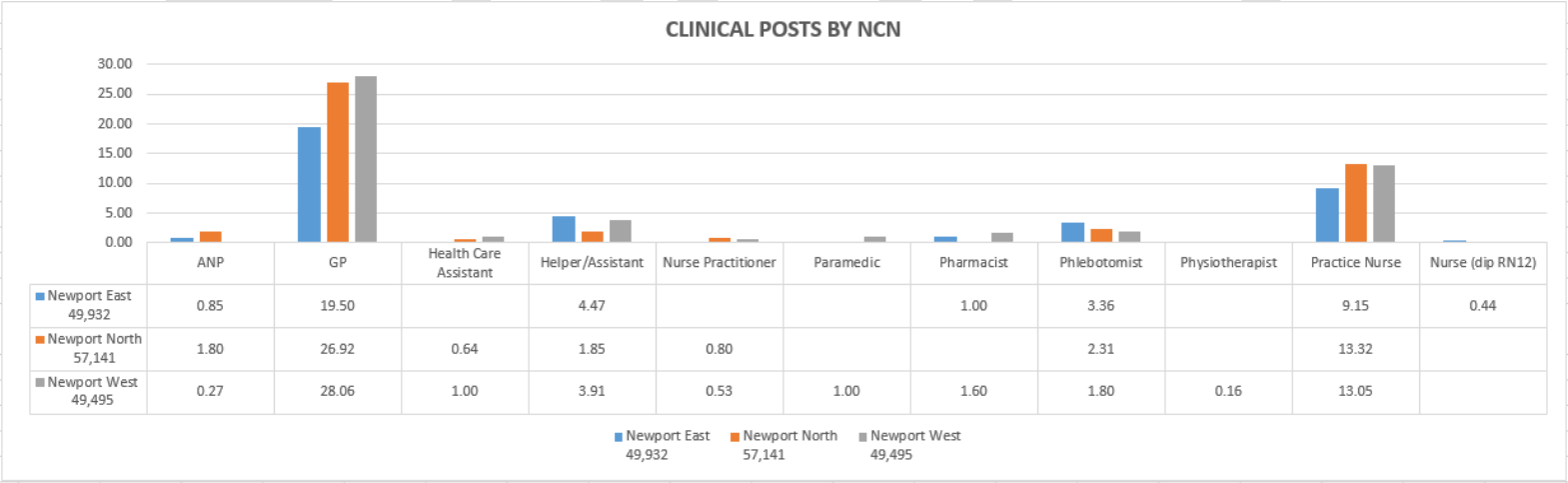
What is this section for?

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.

8.1.3 Current Workforce Profile

Primary Care

WTE per 10,000 NCN practice population			
Staff Role	**Newport North**	**Staff Role**	**Newport North**
ANP	0.32	Paramedic	0
GP	4.71	Pharmacist	0
Health Care Assistant	0.11	Phlebotomist	0.4
Helper/Assistant	0.32	Physiotherapist	0
Nurse Practitioner	0.14	Practice Nurse	2.33
Nurse (dip RN12)	0	**Total**	**8.34**



District Nursing

North Team

Band	WTE	Hours
7.00	2.00	75.00
6.00	2.00	75.00
5.00	11.79	441.99
4.00	1.51	56.63
3.00	0.00	0.00
3.0	0.97	36.37 Phlebotomy
2.00	0.80	30.00 Admin

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**

8.2.3 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

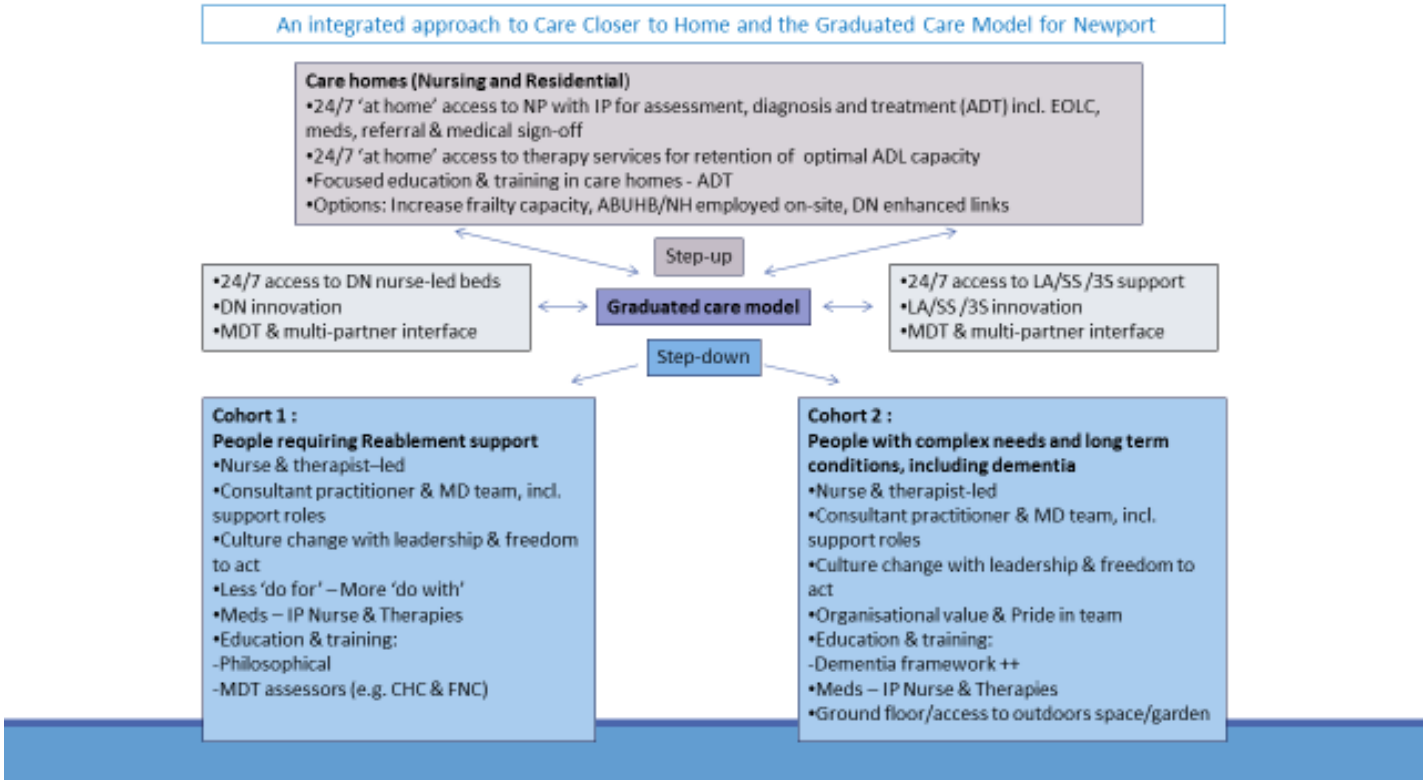
It is proposed that a vital component of offering appropriate level support and care within each community is the development of 'hubs', which will not only co-locate services and but also offer one front door and a model to 'screen' people to appropriate professionals based on their needs. This is currently 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 stages 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

Aims

1. To show a true representation of integrated working across primary, secondary and social care, whilst incorporating valuable third sector input.
2. To provide proactive & prudent care that focuses on prevention and early intervention.
3. To enable the person to be seen by the most appropriate person at first contact.
4. To enhance the capacity in general practice through direct connections to MDT members who offer a variety of approaches to addressing the broader determinants of health and their effects on a person's health, well-being and risk of deterioration.
5. To avoid and reduce unnecessary handoffs that can result in delayed support for individuals needing assistance.
6. To make a real difference to the wellbeing and quality of life for people living within a 'place', by harnessing collective resources efficiently and effectively.

By working to identify patients through anticipatory care planning, with the aim to reduce:

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

Current Progress

There are 5 practices within Newport West that are trialling this concept.

- Belle Vue Medical Centre commenced March 2019
- St Brides Medical Centre commenced March 2019

- St David's Medical Centre commenced July 2019
- Bryngwyn Surgery commenced April 2019
- St Pauls in initial stages July 2019

An evaluation of the approach is also being considered. 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.

Outcomes of the MDT

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

It has been agreed that the MDT concept will focus on 4 key areas:

- De-prescribing
- Falls
- Most significant change
- Staff experience

Working alongside CRT/Public Health/Pharmacy and GP's, outcomes of these 4 areas will be evaluated as part of the MDT process.

The ultimate aim for Newport locality is to continue to evaluate and promote the MDT concept throughout Newport as much as possible and further, however to do this will require additional resource within the following areas in order for there to be available resource without pulling upon the existing workforce:

- Nursing
- OT
- Physiotherapy

A business plan will be worked up to identify the required roles and banding to support this.

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 have 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

8.3.3 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

9 Opportunities and Challenges for 2020-2023

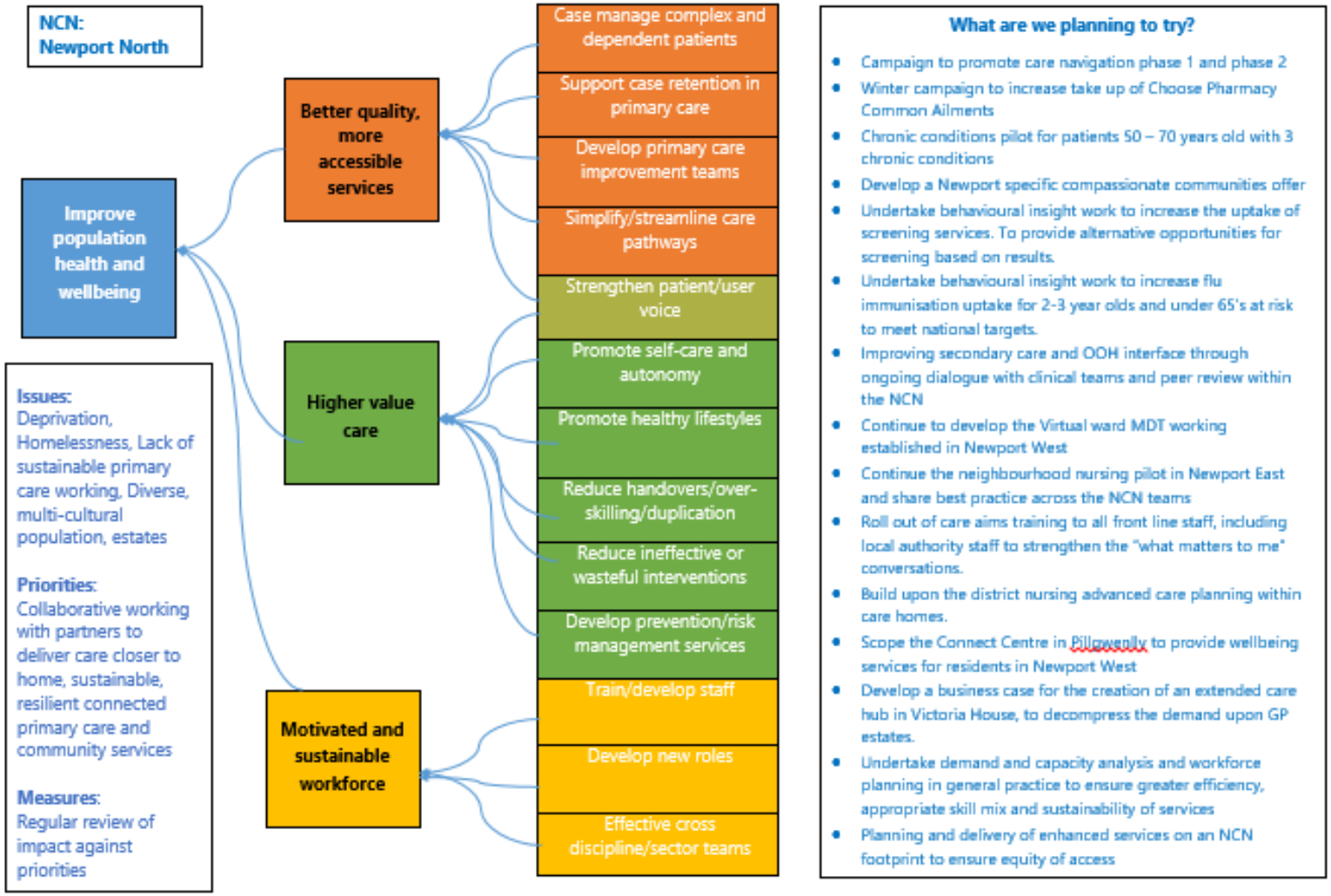
What is this section for?

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.

9.1.3 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?*
• Newport Older Persons Pathway • Skill Mix • Care Navigation • Practice Managers Forum • Direct Access Physiotherapy • New early intervention CAMHS model	• Screening uptake • Access • Estate • Integration of community teams towards a place based model • Communication and engagement – public and front line professionals
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.*
• Caerleon University Development • 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 • Strengthening the secondary care interface • Organisational development for practice managers • NCN footprint reconfiguration – reduction from 3 to 2, supporting place based approach	• Workforce stability • Maintaining outcomes from transformation • Demographic changes with increasing multiple-morbidities • Widening health inequalities • Engagement in the Clinical Futures service redesign programme

9.2.3 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	**Access & Sustainability** Ensure appropriate access to primary care services and sustainability of services	Implementation of the Newport CCTH communication and engagement strategy, to be delivered in accordance with and responding to local population needs (linked with behavioural insight work) Promote new model of primary care Continue to pilot and develop new roles in Newport North and maintain transformation outcomes Promote and monitor use of additional services such as common ailments scheme, WECS	Ensuring care is provided by the right person at the right time in the right place. Improved population wellbeing and resilient communities To improve access and enable better target achievement by recruiting the appropriate skills to meet demand Develop and support a common language between partners (care aims)	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

		Utilize use of extended services and 3rd sector Realignment of DN services Implement Compassionate Communities model Organisational development programme for practice managers Development and communication of Care Navigation Demand and capacity analysis and workforce planning in general practice Rollout of Care Aims training – all health teams and relevant partners			

2	**Pilot an integrated team to identify ways of improving the management of long term chronic conditions, complex and palliative care needs within the NCN**	Nurse practitioner, OT and Pharmacy technician Team –assessment Patient with Multiple Co-morbidities. Bio/psycho/social assessment of patient	Move towards anticipatory care planning Reduction in hospital admissions by identifying and supporting patients co-morbidities early on Improving/increasing independence More appropriate referrals to CRT More capacity for true district nursing care at home Separating clinical and non-clinical care so both are treated/ managed by the most appropriate person Medication review undertaken in a non-acute situation Longer appointment time/More detailed and worthwhile assessments	Appendix 14 – aging population high levels of chronic conditions within NCN	Primary Care and Community IMTP 2020-2023 - Redesigning community services workstream

3	**Work with NCN partners and local communities to understand perspectives and increase the uptake of childhood flu vaccination.**	Care aims training/MECC Flu Vaccination – pilot for 2/3 year olds & under 65 at risk Strengthening the contribution of community pharmacies for practices with a low uptake in under 65 at risk clinical groups Cluster plan for dealing with supply issues Arrangements for promoting vaccine uptake/access for pregnant women, housebound patients and care homes Pilot project funded through NCN with Flying Start to vaccinate children age 3 years in pre-school nursery settings follow-up patients by phone not letter - Underwood have the highest uptake Cluster audit the influenza vaccine call and recall	More pre-school age children vaccinated - Increase from current uptake of 36.8% Decrease in variance between practices	Flu uptake in under 65s varied from 51.7% to 40.3% across the 5 practices Flu uptake in 2 and 3 year olds varied between 54.3% to 20.9% across the 5 practices	Primary Care and Community IMTP 2020-2023 - Prevention, wellbeing and self-care workstream

		system for those with chronic respiratory disease and report on uptake with robust systems in place as evidenced by letter/telephone call or text Promote the contribution of Community Pharmacy to raising awareness of need for flu vaccination in those on repeat prescriptions for inhaled steroids			
4	**Promote the uptake of Immunisation and Screening programmes to ensure we are preventing infectious disease and detecting disease at an early stage**	Flu Vaccination – pilot for 2/3 year olds & under 65 at risk Meetings with individual practices to look at what support can be provided to improve uptake, particularly in under 65s Strengthening the contribution of community pharmacies for practices with a low uptake in under 65 at risk clinical groups	Increase AAA target from 76.5% to 80% Increase Bowel screening target from 57.9% to 60% Increase breast screening target from 72.8% to 70% Earlier detection of common cancers More pre-school age children vaccinated - Increase from current uptake of 52.7%	Flu uptake in under 65s varied from 64.8% to 40.4% across the 6 practices Flu uptake in 2 and 3 year olds varied between 66.1% to 41.8% across the 6 practices	Primary Care and Community IMTP 2020-2023 - Prevention, wellbeing and self-care workstream

		Cluster plan for dealing with supply issues Arrangements for promoting vaccine uptake/access for pregnant women, housebound patients and care homes Pilot project funded through NCN with Flying Start to vaccinate children age 3 years in pre-school nursery settings Follow-up patients by phone not letter - Underwood have the highest immunisation rate (best practice) Public Health are training champions in relation to uptake (Employee Screening Promotion Officers) and that a proposal will be put forward for a campaign Cluster audit the influenza vaccine call and recall system for those with	Increase flu imms uptake for 65+ from 71.3% Increase flu imms update for 2 and 3 year olds from 52.7% Increase flu imms for clinical risk patients <65 from 44.6% Standardise variance between practices		

		chronic respiratory disease and report on uptake with robust systems in place as evidenced by letter/telephone call or text Promote the contribution of Community Pharmacy to raising awareness of need for flu vaccination in those on repeat prescriptions for inhaled steroids			
5	**Compassionate Communities** Transform care through a Compassionate Communities approach	Alignment of the Newport Older Persons Pathway to Compassionate Communities Undertake Risk stratification / population segmentation to identify those with more complex needs Building on the MDTVW for improved partnership working and development of the Primary Care model	Reduced demand on health service Improved community resilience Improved signposting to services Improved wellbeing of population Improved health activation Improved sustainability of services	Appendix 14 – Health inequalities	Primary Care and Community IMTP 2020-2023 – Redesigning of community services and Prevention, Wellbeing & Self Care

		Linking patients to community assets within our Integrated Well-being Networks Discharge Liaison			
6	**Self Care & Health Literacy** Improve prevention, self care and well being offer for the citizens of Newport by identifying and addressing support required for patients at an earlier stage	Development of culturally appropriate services Structured patient education programmes (e.g. Diabetes) Implement Phase 2 of Living Well, Living Longer Supporting the delivery of the Integrated Wellbeing Networks Improved access to information, advice and assistance through a standardised front door model	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 Management Service Reduced demand on health service Improved signposting to services Improved wellbeing of population Improved health activation	Profile and population needs – 48+ different languages spoken within the NCN	Primary Care and Community IMTP 2020-2023 – Wellbeing & Self Care worksream

			Improved sustainability of services		
7	**Working with NCN partners and local communities to identify ways of improving the management of diabetes**	Participate in National Diabetes Clinical Audit and reflect on the findings. Living Well Living Longer – identifying patients with pre-diabetes reviewing capacity to deliver a wider ABUHB Prediabetes Management Service as another arm to the LWLL WBS National Diabetes Support Module - a practice level discussion to identify outcomes. Bring back to the NCN meeting to identify common themes/Shared learning Invited patients to give feedback Agreement for this to be scheduled for M2	Practice to review the effectiveness, efficiency and value of their practice services. Continuity of care for patients during annual reviews Effective call/recall systems Structured Diabetes programme Dedicated HCA role to arrange blood tests, reviews, foot care etc Better understanding of the psychological impact	Appendix 14 – higher than average levels of diabetes within the NCN	Primary Care and Community IMTP 2020-2023 - Prevention, wellbeing and self-care workstream

		Cluster Diabetic Specialist Nurse Multi-disciplinary virtual ward rounds Patient held record and educational materials			

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.

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.

12.1.3 Neighbourhood Care Network

Newport North NCN Cluster Funding – Annual Budget £160, 358

Currently Supports:

Role / Initiative	Recurrent Annual Cost
Practice Based Pharmacist	£ 56, 894
Direct Access Physiotherapy	£ 14, 952
Mental Health Practitioner	£ 32, 407
Community Phlebotomy Team	£ 13, 421
First Practice Management Subscription	£ 708
Independent Contractors (Top Sliced across all ABUHB NCNs)	£ 3, 065
DEWIS Coordinator (Top Sliced across all ABUHB NCNs)	£ 1, 190
Dementia Road Map (Top Sliced across all ABUHB NCNs)	£ 853
Total	**£ 123, 490**

Since 2016-17 the Newport North NCN has invested around £170, 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 North 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 West.

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 North 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.

1 x WTE Clinical Pharmacist
1 x WTE Mental Health Practitioners
3 x Advanced Nurse Practitioner

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

13.1 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**

13.2 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**

13.3 Baseline Data - Workforce

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 (Newport North)

14.1 Population and Future Projections

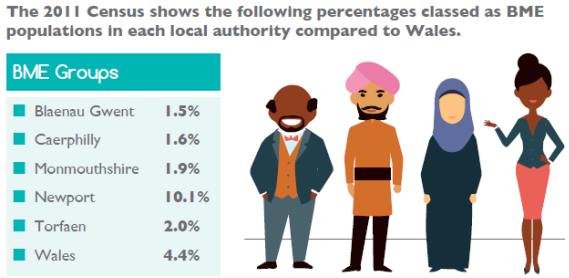
The total population of Newport North NCN for all ages is currently 57,150 (Source: ABUHB). As of 1st April 2019, a total of 576,200 people of all ages were registered with a GP in Newport Borough (Source: Public Health Observatory)

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.



The Newport North NCN area is divided into 33 Lower Super Output Areas (LSOAs). 56.8% of the LSOAs are within the top 50% most deprived LSOAs in Wales. Pillgwenlly 4 LSOA is currently ranked as the 10th most deprived LSOA in Wales and the 1st most deprived in Newport Borough.

The number of people aged 16 and over predicted to be living alone in Newport Borough in 2017 was 29,816, with a projected increase to 35,072 (TBC%) by 2035, the 2nd highest in Gwent. This compares with a predicted shift of (8.9%) in Torfaen, (5.2%) In Blaenau Gwent, (11.4%) in Monmouthshire and (12.4%) in Newport. (Source: Daffodil)

In 2011, 1.03% (180) of people aged 16 and over in Newport Borough, were living in a dwelling with no central heating, the second highest in Gwent. The highest was Monmouthshire with 1.42% (1,042), followed by Torfaen 631 (0.86%), Caerphilly with 0.66% (963) and the lowest was Blaenau Gwent with 370 (0.65%). (Source: Daffodil)

The number of people predicted to be providing unpaid care (all ages) in Newport in 2017, equated to 16,938, anticipated to rise by 11.9% (2,164) by 2035. This is the highest predicted rise after Caerphilly 1.8% (440). Blaenau Gwent is predicted to see the highest drop of 378 (4.1%) and Torfaen the lowest at 86 (1%) with Monmouthshire also predicted to drop by 1.8% (221). (Source Daffodil)

The total number of people claiming Disability Living Allowance or Personal Independence Payments across all age bands across Newport Borough at May 2014, equated to 6,794 the second highest in Gwent (Source: Daffodil)

The total number of people in Newport Borough aged 18 and over, receiving Employment & support allowance, Incapacity Benefit, or Severe Disablement Allowance at May 2014 equated in total to 12,820 the second highest in Gwent (Source: Daffodil).

In 2018-2019, Newport Borough's average of unemployment for Males was 5.7%, and Females was 2.9% (source Nomisweb)

GP practices in various areas within Newport North NCN will need to be aware of the implications of the Newport Local Development Plans (LDPs) – Key developments opportunities on brownfield sites with existing settlements as highlighted in the Newport Borough Council LDP are below:

- Jubilee Park, Rogerstone – 903
- Glan Usk/ Glebelands – 251
- Durham Road School - 57

14.2 Health & Physical Disabilities

14.2.1 QOF Disease registers

The table below gives an overview of a selection of key QOF disease registers (2017-18). In terms of comparison with the other 11 NCN clusters in Gwent, Newport North is mid to low ranging in all elements, however it is important to consider the all Wales and UK prevalence and it is also imperative that the change over time is considered. This is outlined on the following pages.

Prevalence *(QOF Registers 17-18)*	BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
Asthma	6.9%	7.5%	6.4%	7.0%	6.6%	6.9%	7.3%	6.3%	**7.0%**	6.5%	7.9%	7.0%
COPD	3.4%	2.8%	2.1%	2.6%	2.1%	2.0%	1.6%	1.8%	**1.7%**	2.2%	2.6%	2.3%
Cancer	2.4%	2.8%	2.4%	2.6%	3.0%	4.0%	3.4%	2.3%	**2.9%**	2.2%	2.7%	2.6%
CHD	4.4%	4.0%	3.4%	3.9%	3.7%	3.9%	3.5%	3.2%	**3.3%**	3.1%	4.1%	3.9%
Heart Failure	1.4%	1.3%	0.7%	0.9%	0.8%	1.6%	1.0%	0.7%	**0.8%**	0.8%	1.1%	1.0%
Hypertension	19.3%	17.5%	15.8%	16.6%	15.7%	17.5%	15.8%	13.3%	**15.4%**	14.1%	17.6%	16.1%
Atrial Fibrillation	1.9%	2.1%	1.8%	2.0%	2.0%	3.0%	2.4%	1.6%	**1.8%**	1.6%	2.4%	2.1%
Diabetes	7.7%	7.1%	6.1%	7.1%	6.1%	6.3%	5.8%	6.2%	**5.7%**	6.4%	7.2%	6.4%

14.2.2 Respiratory Conditions

Newport North has an asthma prevalence of 7.0% which is lower than the Wales average but higher than the ABUHB average prevalence, and also higher than the UK prevalence of 6%. The COPD prevalence is 1.7% which is lower than the UK position of 1.93% and also lower than the ABUHB and Welsh averages.

Prevalence *(QOF Registers 17-18)*	ABUHB	Wales	Newp North
Asthma	6.9%	7.1%	**7.0%**
COPD	2.2%	2.3%	**1.7%**

14.2.3 Hypertension & Heart Disease

At 15.4% prevalence of hypertension is lower than the Welsh average of 15.7% and the ABUHB average of 16.1%.

Atrial Fibrillation is 1.8% which is lower than the ABUHB and Welsh average. Anticoagulation of patients with AF has been identified as a national priority and should be considered for the IMTP.

Prevalence *(QOF Registers 17-18)*	ABUHB	Wales	Newp North
CHD	3.7%	3.7%	**3.3%**
Heart Failure	1.0%	1.0%	**0.8%**
Hypertension	16.1%	15.7%	**15.4%**
Atrial Fibrillation	2.1%	2.2%	**1.8%**

Coronary Heart Disease at 3.3% is lower than the ABUHB and Wales average of 3.7%, and slightly higher than the UK position of 3.2%.

At 0.8% Newport North is in line with the UK average of 0.8% in prevalence of people on the GP register with heart failure, this is better than ABUHB and Wales average.

14.2.4 Diabetes

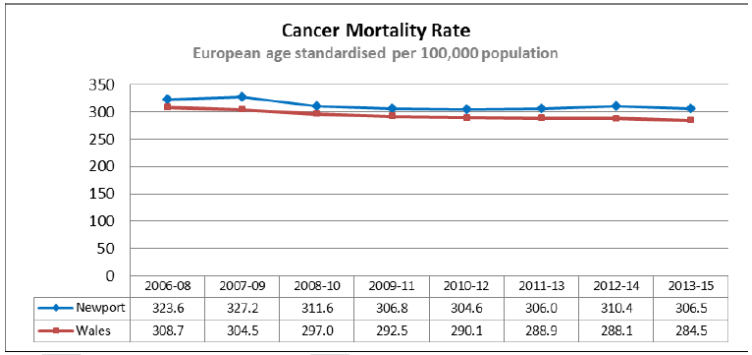
Although Newport North's latest prevalence position is lower than the ABUHB and Wales averages the NCN is continuing its support to the Living Well, Living Longer Programme for the prevention and detection of diabetes to help further prevent this.

Prevalence *(QOF Registers 17-18)*	**ABUHB**	**Wales**	**Newp North**
Diabetes	6.5%	6.0%	**5.7%**

14.2.5 Cancer

Prevalence *(QOF Registers 17-18)*	**ABUHB**	**Wales**	**Newp North**
Cancer	2.8%	3.0%	**2.9%**

The QOF register of all cancer patients defined as a 'patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 2007 has decreased year on year with a slight increase shown between 2012 and 2014 and now stands at 2.9% of the list size population. This is slightly more than the ABUHB position but less than the Wales average reported position of 3.0% and 2.8% respectively.



	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
Newport	323.6	327.2	311.6	306.8	304.6	306.0	310.4	306.5
Wales	308.7	304.5	297.0	292.5	290.1	288.9	288.1	284.5

14.2.6 Other Areas of Prevalence (source PC Needs Assessment for Wales)

The other areas of prevalence that could be considered contributory factors in the above are shown in the table below –

NCN GP LIST SIZE		*33,602*	*38,375*	*65,857*	*64,801*	*56,496*	*53,096*	*47,301*	*50,049*	*57,150*	*49,945*	*49,573*	*46,322*
NCN AREA		**BG East**	**BG West**	**Caer East**	**Caer North**	**Caer South**	**Mon North**	**Mon South**	**Newp East**	**Newp North**	**Newp West**	**Torf North**	**Torf South**
Smoking	*2013-14*	26%	24%	19%	23%	23%	15%	17%	25%	20%	25%	23%	23%
Healthy Eating	*2014*	30%	31%	33%	31%	32%	35%	35%	31%	33%	34%	32%	32%
Physical Activity	*2014*	29%	29%	30%	29%	29%	29%	29%	30%	29%	29%	29%	30%
Alcohol Misuse	*2014*	26%	26%	27%	27%	27%	26%	27%	27%	27%	27%	26%	27%
Obesity	*2017-18*	13%	12%	11%	12%	10%	11%	10%	11%	9%	11%	12%	10%

Smoking – the current NCN prevalence is 19.5%. The target is for 5% of population to attend stop smoking services. We should report against these targets and develop plans to meet or maintain attendance at stop smoking services and practices are actively encouraging 'champions' within own surgeries.

Mental Health - Following discussion with all NCN members and collating views from combined NCN events access to mental health services has been identified as an area of need by professionals and service users.

The number of people aged 5 years and above in 2017, predicted as having a common mental health problem as classified by Daffodil, was 21,496 with a rise predicted to 24,254 in 2035. In terms of dementia, Daffodil predicts that in 2017 there were 12 people aged between 30 and 64 with early onset dementia, increasing to 13 in 2035. There 1,824 people aged 65 and above reported as having dementia in 2017, rising to 2,806 in 2035.

Table 3: Smoking prevalence is 10.6 percentage points higher in the highest versus the lowest GP cluster in Aneurin Bevan

Cluster	Smoking Prevalence (%)	Rank out of 64 GP clusters[iii]
Monmouthshire North	15.3	6
Monmouthshire South	17.0	13
Caerphilly East	19.2	21
Newport Central	19.5	24
Torfaen North	22.6	42
Torfaen South	22.7	43
Caerphilly South	22.8	44
Caerphilly North	23.2	48
Blaenau Gwent West	23.7	52
Newport West	24.5	56
Newport East	25.4	60
Blaenau Gwent East	25.9	63

Source: Public Health Wales Observatory derived from Quality Outcomes Framework Data 2013/14 (QOF)
[iii] 1 = lowest smoking prevalence, 64 = highest smoking prevalence
Ordered by rank

People living with long term illness – (see 14.2.1). This has also been identified as an area of need by professionals and service users. We aim to develop plans to meet the needs of patients with long term illness by also utilising Social Prescribing to direct patients to the most appropriate source of care.

10,694 people over the age of 65 across Newport Borough are unable to manage at least one domestic task and 4,819 are unable to manage at least one activity on their own. (Source: Daffodil)

14.3 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

14.4.1 Prescribing rates

Newport North is the joint tenth highest prescriber of Tramadol in Gwent and compares mid-low across the Gwent clusters.

The NCN needs to develop plans to meet these areas of concern.

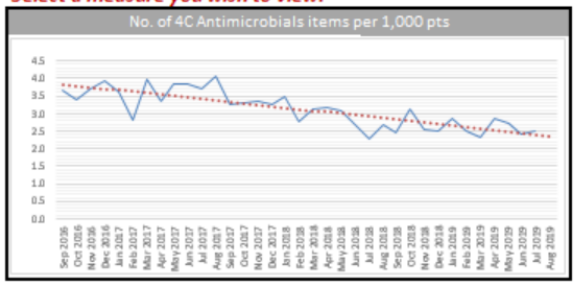
NCN GP LIST SIZE		33,602	38,375	65,857	64,801	56,496	53,096	47,301	50,049	57,150	49,945	49,573	46,322
	NCN AREA	BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
No. of 4C Antimicrobials items per 1,000 pts	*Feb 2019 - Apr 2019*	10.3	10.5	10.1	9.0	9.3	11.1	8.1	7.8	7.8	6.9	11.3	9.4
Tramadol DDDs per 1,000 pts	*Feb 2019 - Apr 2019*	397.6	597.7	647.3	580.8	637.2	399.5	392.3	571.1	325.8	321.8	581.2	398.4
Gabapentin and Pregabalin DDDs per 1,000 pts	*Feb 2019 - Apr 2019*	2044.1	1985.8	1789.8	1743.0	1731.9	1341.1	1252.3	1285.3	1461.7	1647.8	2435.4	2168.9

Antibiotic Prescribing **Tramadol Prescribing** **Gabapentin & Pregabilin Prescribing**

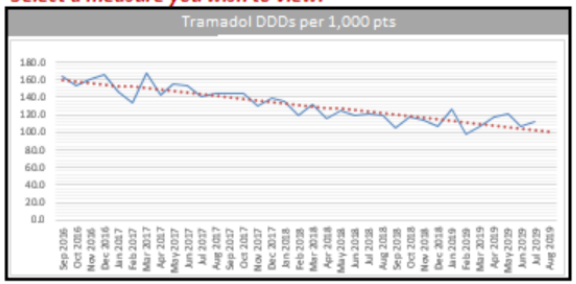
*** PRESCRIBING INDICATORS ***

**NB: Prescribing data has a two month data lag*

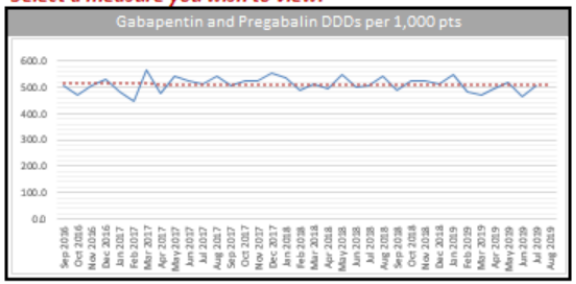
Select a measure you wish to view:



Select a measure you wish to view:



Select a measure you wish to view:



14.4.2 Immunisation rates, etc.

Immunisation rates are regularly reviewed at NCN cluster meetings and individual practices data shared. This promotes sharing of best practice and offers support and advice to practices where uptake is lower. It has been noted that as immunization rates have decreased nationally, the incidence of measles has increased. The NCN needs to be mindful of this and develop plans to maintain and increase immunization rates.

Age Group: 2 Years Newport North NCN does not achieve the national target of 95% for the Age 2 immunisation group.

NCN Area Childhood Immunisations - Age 2	BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
MMR1 Uptake % (March 2019)	96.4%	97.5%	98.0%	96.0%	96.5%	94.5%	97.6%	96.3%	**93.2%**	93.9%	95.2%	96.5%
PCVf Uptake % (March 2019)	96.7%	97.7%	98.5%	96.6%	96.5%	94.8%	98.7%	96.2%	**93.4.%**	93.7%	96.6%	96.9%
Hib/Men C Uptake % (March 2019)	95.3%	97.2%	97.4%	95.8%	96.0%	93.7%	98.7%	95.8%	**91.4%**	93.1%	95.2%	96.7%

Age Group: 5 Years Newport North is mid-low in relation to other cluster areas within Gwent, however is below the national target of 95%.

NCN Area Childhood Immunisations - Age 5	BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
MMR2 Uptake % (March 2019)	90.5%	91.0%	94.0%	92.3%	92.4%	87.0%	92.0%	89.1%	**89.0%**	86.0%	91.2%	91.6%
4 in 1 pre-school booster Uptake % (March 2019)	92.6%	92.6%	94.7%	94.8%	93.5%	93.3%	97.6%	90.7%	**88.1%**	89.1%	93.1%	92.5%

Age Group: 16 Years MMR2 is below target at 94.3% and the 3 in 1 pre-teen booster is the third lowest recorded uptake across Gwent of childhood immunisations at 82.4% and is an area where compliance could be improved.

NCN Area Childhood Immunisations - Age 16	BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
MMR 1 Uptake % (March 2019)	94.6%	94.4%	96.9%	96.2%	97.5%	87.0%	88.8%	96.0%	**94.3%**	92.4%	97.4%	95.9%
MMR 2 Uptake % (March 2019)	88.6%	91.7%	92.4%	92.9%	93.6%	78.2%	84.8%	90.8%	**88.6%**	87.6%	93.5%	91.7%

3 in 1 pre-teen booster Uptake % (March 2019)	90.2%	86.6%	90.6%	87.2%	88.3%	85.6%	80.0%	88.5%	**82.4%**	81.2%	87.8%	90.6%

Flu Immunisation

When compared to the rest of Gwent, Newport North appears to be comparing at mid to low-range. The uptake of flu immunisation is still below target and is an area that could be improved.

The flu immunization rates do not reach national targets and the NCN needs to continue to develop plans to improve uptake. Particular attention needs to be made to the 2-3yrs and 65 years at risk uptake.

NCN Area Flu Immunisations	BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
> 65 Years Uptake % (April 2019)	63.5%	69.2%	66.1%	67.6%	71.5%	73.9%	61.6%	65.2%	**71.3%**	65.9%	68.5%	73.5%
< 65 Years "At Risk" Uptake % (April 2019)	38.1%	51.0%	43.8%	44.4%	48.5%	51.2%	54.9%	43.7%	**48.4%**	45.3%	44.7%	48.9%
2-3 Years Uptake % (April 2019)	37.3%	43.6%	47.5%	37.6%	53.1%	56.3%	58.3%	41.2%	**52.9%**	36.9%	42.9%	63.4%

Screening uptake

Newport North NCN performs relatively well compared to other cluster areas in Gwent.
However, the NCN does not reach national targets and should continue to develop plans to meet these targets.

NCN AREA		BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
Screening Uptake													
Bowel Screening	*2017-18*	50%	54%	56%	55%	59%	62%	60%	51%	58%	49%	56%	53%
Breast Screening	*2017-18*	72%	73%	74%	71%	74%	76%	78%	68%	73%	63%	74%	74%
Cervical Screening	*2017-18*	76%	78%	79%	77%	79%	80%	82%	72%	80%	72%	77%	79%

Urgent Care
Urgent care remains a priority area for the Health Board. Although there are some large fluctuations due to small numbers, the conveyances to hospital from care homes has increased within the Newport North NCN area.

13.4 Clinical Audits

We are currently collecting the results of the national diabetic audit for Newport North 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.

13.5 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
Isca Medical Centre	North	Y	Y	Y	Y				Y		Y					Y	Y				Y	Y				Y		Y		Y	Y	Y	Y	Y	Y	Y	
Richmond Clinic	North	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	
Westfield Medical Centre	North	Y	Y	Y	Y		Y	Y	Y	N	Y	Y				Y	Y			Y	Y	Y		Y		Y		Y		N		Y	Y			Y	
The Rogerstone Practice	North	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y				Y	Y			Y	Y	Y		Y	Y	Y		Y	N	y	Y	Y	Y	Y	Y	Y	
St Julians Med Cent	North	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y				Y	Y	Y	Y	Y	Y	Y				Y				Y		Y	Y	Y	Y	Y	
Malpas Brook Health Centre	North	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	

13.6 Activity Benchmarking

The NCN are 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 North Newport NCN Care Closer to Home Communications plan is available below.