Blaenau Gwent East Network Integrated Medium Term Plan 2020 -2023

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Executive Summary

This plan sets out our future vision for the Blaenau Gwent East Neighbourhood Care Network;

People in Blaenau Gwent East are empowered to nurture their own wellbeing and are able to access quality health and wellbeing services in the community when they need to.

Our vision for the service model for Blaenau Gwent is focussed upon 'place based care', aligned to Ebbw Vale and Tredegar as our two main 'places', with services operating on a local population basis but supported by more specialist expertise at a wider level.

In order to focus our efforts over the next 3 years towards delivering this vision, we undertook a population health needs assessment, to ensure that the services we plan and deliver have the biggest impact and address the greatest needs.

This assessment told us that:

- Our population has the highest rate of deprivation across all of the Health Board Clusters
- The gap in health inequalities persists
- We have an aging population and an increase in number of people predicted to live alone
- We have a high % of people who state they have a long-term health problem or illness
- We have high prevalence of chronic disease within our population
- Our borough has the highest rates of childhood tooth decay in Wales, poorer mental wellbeing that Wales as a whole and a high percentage of patients who do not participate in health behaviours
- We have a particularly high use of Tramadol, and an overall Opioid burden- driven by high tramadol and co-codamol use and our NCN is one of the highest users of 4Cs antibiotics, and antibiotics in general.
- Uptake of childhood immunisations and flu vaccination need to be improved

We also undertook a review of our assets which told us that we are fortunate to have a vast array of services in our area for the population to access, but that ensuring everyone is aware of them is a challenge.

In order to achieve our vision of place-based care, we need to develop a hub approach, both physical and virtual, at key locations in the Borough. This 'hub' approach will require our estates strategy to ensure that services, equipment and infrastructure are aligned to make best use of resources available.

Delivery of our plan relies on having a sustainable workforce that can meet the increasing demands upon primary care services.

Our NCN is not unique in that we have issues around GP recruitment and retention. The Health Board acknowledges these issues and is supporting the implementation of the Primary Care Model, where core GPs are supported by larger multi-

disciplinary teams of extended roles. We have taken the opportunity to test a number of roles across the NCN using transformation and NCN funding, including

Based upon our assessment of our population health needs, assets, estates and workforce, we have identified 8 priorities to work upon collaboratively;

1. To work together to improve **GP training, recruitment and retention** across the NCN.
2. To improve oral health
3. To improve the management of patients with chronic disease
4. To build capacity of individuals, **,** to be independent, **maintain good health and well-being** by building on **community development principles** and harness assets readily available in local communities and beyond (including roll out of compassionate communities and Integrated Well-being Network).
5. To better support people who may feel **social isolated** and **lonely** to include 1) those who are **'hard to reach'** and 2) those who **frequently access health services for social reasons.**
6. To improve the **experience of people with cancer,** from prevention to diagnosis, living with the impact of cancer and end of life care.
7. To improve childhood **immunisation and vaccination uptake**
8. To improve prescribing practices and reduce prescribing rates in line with best practice

We will ensure the principles of prudent and value based healthcare underpin our work, so that our population receive maximum benefit and highest quality from the least interventions.

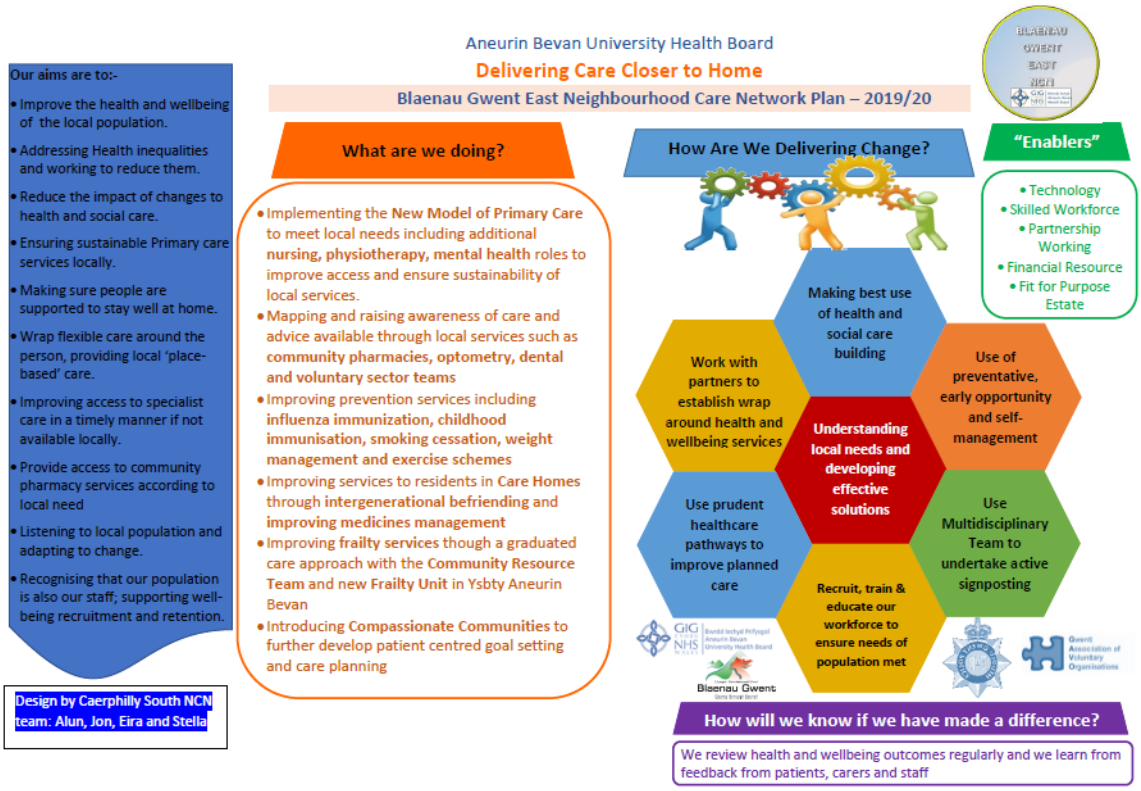
We have an annual budget of **£110,907** funded from cluster monies. This, combined with transformation funding gives us opportunity to test new models of care and new extended roles including mental health practitioners and advanced nurse practitioners with proposals being developed for direct access physiotherapy and a home visiting occupational therapist service.

However, the short term nature of the funding means that practices may be reluctant to commit to new roles until they have tested them in practice, and sustainable funding streams are identified. There can also be delays in recruitment when we are testing new ideas within NCN budgets- and that is challenging when we are working on annual budgets.

Dr Isolde Shore-Nye

Cluster Lead

Blaenau Gwent East NCN Plan On A Page



1 Introduction to the 2020-2023 Plan

Our Primary and Community Care Division's Integrated Medium Term Plan sets out the ambition to create a new system of primary care and community services which, in partnership with local government and the independent / third sectors, strives to improve wellbeing across Gwent.

It describes a place based model of care whereby, through our 12 Neighbourhood Care Networks, people access the care they need in their own resilient community and homes wherever appropriate and avoid any unnecessary harm, be it from injury at home, medication errors, and unnecessary admissions to hospital or from delayed diagnosis or access to treatment. In our vision, services are designed to provide more co-ordinated care, with fewer handoffs and reduced complexity.

This plan describes the steps which the Blaenau Gwent East Neighbourhood Care Network will take over the next three years to take us closer to achieving our vision.

It clearly sets our key priorities, milestones and implementation plans, and analyses the challenges, opportunities and risks associated with delivery.

Our NCN plan will also describe what it will take to 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 priorities, for the benefit of the communities we serve.

Our role as an NCN is to improve the population health and wellbeing of our local population, supporting people to stay well, lead healthy, independent lifestyles and reduce inequalities, utilising an asset based community development approach.

To achieve this, we need to shift from a traditional medical model of care to a social one, whereby communities empowered to nurture their own wellbeing and are able to access quality health and wellbeing services in the community when they need to.

This we require us, as a multi-disciplinary team of professionals in health services, local authorities and the third sector, to work together and work differently, across organisational boundaries.

It will require us to change ways of working and traditional relationships that have become embedded over many years; this will not be easy.

However, standing still is not an option because:

- **Blaenau Gwent has statistically significantly lower healthy life expectancy than Wales as a whole,** which is unsurprising given the link between socio-economic deprivation and poor health:
  - 82% of the population in Blaenau Gwent East are living in the most two most deprived fifth of areas in Wales
  - there are above average mortality rates for persons aged under 75 and all ages in Blaenau Gwent

- Blaenau Gwent has the highest rates of smoking, the lowest compliance with 'healthy behaviours' in Gwent and;
- Blaenau Gwent has the 2nd highest % of people who state they have a long-term health problem or illness in Wales

- **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 in turn leads to increased demand for a whole range of services.

- **Primary and community services in our area are unsustainable;** as an NCN, we have historic difficulties in the recruitment and retention of staff, particularly GPs, medical staff in the Community Resource Team (CRT) and within domiciliary care.

- **Some of our estate is not fit to provide primary care services fit for now and the future;** we have venues that present issues for citizens who are unable to walk up stairways to access services, venues that are seeking to renovate to provide more consulting and administration areas, and new builds with outstanding snag lists to be resolved before ownership is transferred to the Health Board.

Put simply, within our traditional service model, our demand is quickly outstripping our capacity. We need to move at pace in delivering a new model of care to ensure sustainability of services for our population.

We have been fortunate in Blaenau Gwent West NCN to have received funding to enable us to test components of the new place based model including;

- Appointment of *extended roles* to include practice based pharmacist, direct access physiotherapy, community phlebotomy services, mental health practitioners and CRT nurse.
- Involvement within the *Compassionate Communities* initiative , through the establishment of MDTs and involvement of community connectors to sign post to community resources and services
- Mapping of community resources and assets through the Integrated Wellbeing Network project

Our main challenge will be to implement and embed new ways of working, whilst at the same time coping with increased demand and day to day pressures, GP sustainability issues and difficulties in recruitment.

We are fortunate to have short term funding available to introduce new extended roles, whereby practices are planning to pick up long term funding. However practices may be reluctant to commit to new roles until they have tested them in practice. There can also be delays in recruitment when we are testing new ideas within NCN budgets- and that is challenging when we are working on annual budgets.It is within this context, and in the face of these challenges, that the Blaenau Gwent West NCN will work together to deliver place based care to our citizens.

2 Overview of the Neighbourhood Care Networks

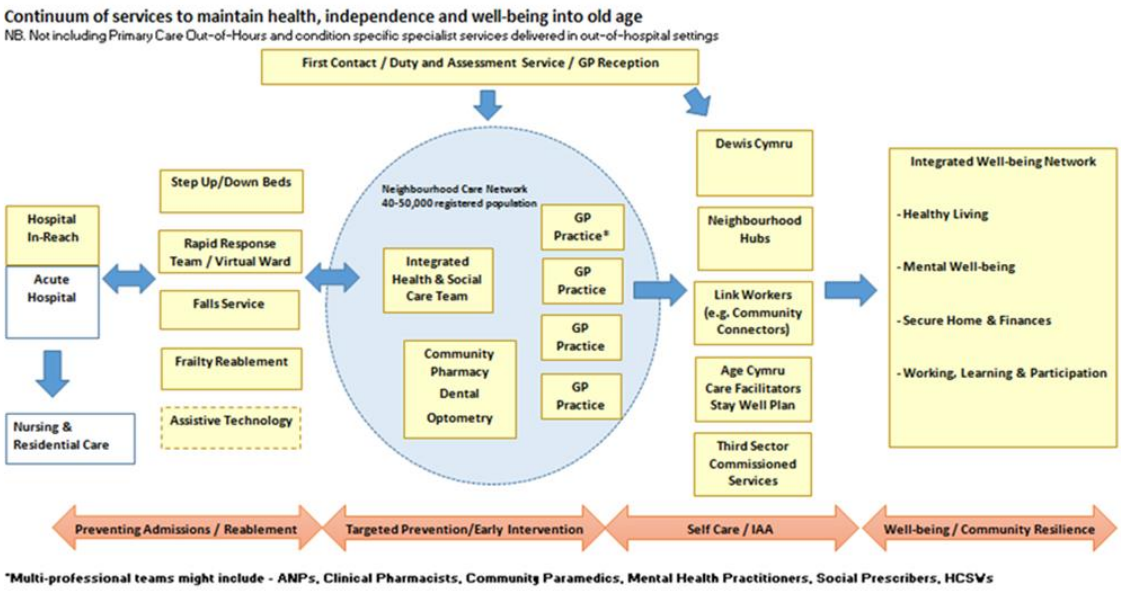
2.1 Profile of the Neighbourhood Care Network

2.1.1 Introducing the NCN Model in Blaenau Gwent

The borough of Blaenau Gwent is divided in to two NCNs; Blaenau Gwent West and Blaenau Gwent East.

Neighbourhood Care Networks (NCN) have been set up as drivers of change across Aneurin Bevan University Health Board (ABUHB), bringing together a network of professionals from different disciplines and agencies to implement local solutions to resolve local issues. The NCNs have the opportunity to employ an 'asset-based community development' approach, considering local strengths / resources and harnessing them to achieve the greatest benefit to their population.

This aspirational service model, as outlined within our ABHB Primary and Community Care Divisional IMTP, describes the continuum of services planned in the future, from low-cost community resilience activities through to accessing acute hospital care.



2.1.2 The Blaenau Gwent East NCN

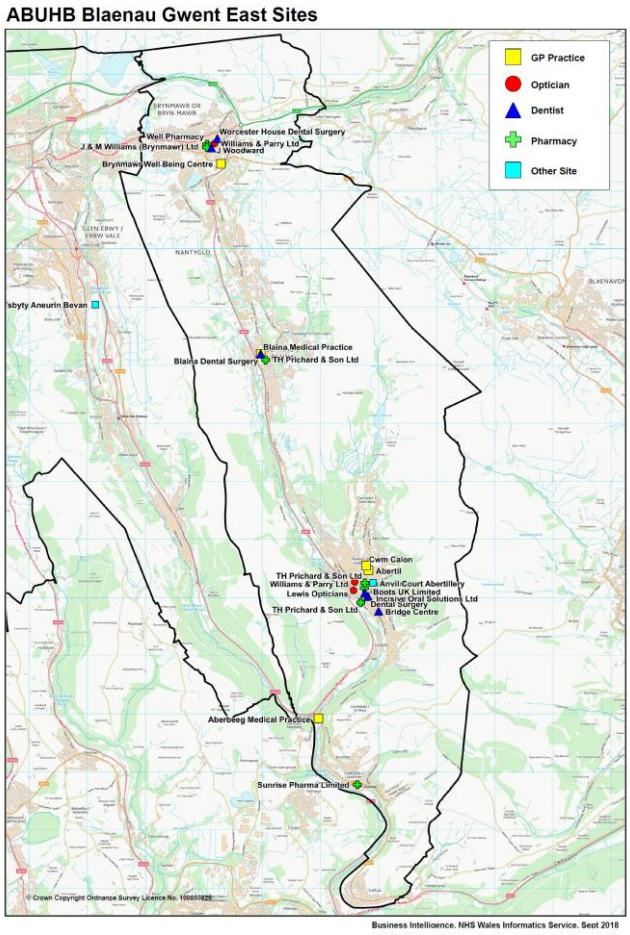
Our NCN brings together all the services for our local population. These are summarised below:

Primary Care

Primary Care is the first point of contact that patients have with the National Health Service; the day-to-day care given by a health care provider such as a Doctor, Nurse, Dentist, Optician or Pharmacist which are supported by Aneurin Bevan University Health Board.

The Blaenau Gwent East NCN has a practice based population of 33,604.

The map below outlines the NCN Footprint.



Primary Care Services

The NCN has a Practices based population of 33,604 across five Practices, two of which are Health Board Managed Practices.

Practice	Practice Population	Population >65 years	%age
Abertillery Group Practice	7,476	1,505	20.13
Aberbeeg Medical Practice (Managed)	4,528	844	18.64
Blaina Surgery	6,351	1,232	19.40
Brynmawr Wellbeing Centre (Managed)	10,321	2,048	19.84
Cwm Calon Surgery	4,928	997	20.23
Totals	**33,604**	**6,626**	**19.72**

Dr Isolde Shore-Nye is the NCN / GP Cluster Lead and is a Partner at Cwm Calon Surgery. She has the Clinical Lead for Children's Services, including CAHMS, for the Gwent NCNs / GP Clusters.

Brynmawr and Aberbeeg became Health Board managed practices in April 2017 and April 2018 respectively.

There are **six Dental Practices** located within the East NCN footprint:

Dental Practices			
Main Surgery Name	Branch Name	Branch Address	Branch Postcode
The Bridge Centre	Abertillery	The Bridge Centre Health Centre,Foundry Bridge,Abertillery,Gwent,	NP13 1BQ
HASTINGS KR MR	Abertillery	24 King Street,Abertillery,Gwent,	NP13 1AD
Inclusive Oral Solutions Ltd	Abertillery	Abertillery Dental Practice,3a Somerset Street,Abertillery,Gwent,	NP13 1DJ
Abertillery Community Clinic	Abertillery	Abertillery Community Clinic, Resource Centre, Foundry Bridge, Abertillery,	NP13 1BQ
N Malik & K Partridge	Brynmawr	Blaina Dental Surgery,Blaina Medical Practice,Rear Of,High Street, Blaina, Abertillery,	NP13 3AT
Brynmawr Community Clinic	Brynmawr	Brynmawr Community Clinic, Lower Bailey Street, Brynmawr,	NP23 4DL

Within the East Blaenau Gwent NCN, there are **three Optometry Practices**:

Optometry Practices			
Name	Place	Address	Postcode
Lewis Opticians	Abertillery	Lewis Opticians, 7 Church Street, Abertillery, NP13 1DA	NP13 1DA
Williams & Parry Ltd	Abertillery	Williams & Parry Ltd, 50 Church Street, Abertillery, NP13 1DB	NP13 1DB
Williams & Parry Ltd	Brynmawr	Williams & Parry Ltd, 16 Beaufort Street, Brynmawr, NP23 4AG	NP23 4AG

Blaenau Gwent East NCN also has **seven Community Pharmacies** for its residents to access:

Community Pharmacies			
Name	Place	Address	Postcode
Prichard T.h. & Son Ltd.	Abertillery	48 Church St	NP13 1DB
Prichard T.h. & Son Ltd.	Abertillery	31 Somerset Street Medical Hall	NP13 1XT
Sunrise Pharma Ltd	Abertillery	21/23 Commercial Rd, Llanhileth	NP13 2JA
Boots Uk Ltd	Abertillery	9 Church St	NP13 1DA
Prichard T.h. & Sons Ltd.	Brynmawr	103 High St, Blaina	NP13 3AE
J & M Williams (brynmawr) Ltd	Brynmawr	41 Beaufort Street	NP23 4AQ
Well Pharmacy	Brynmawr	Brynmawr Well Being Centre, Blaenavon Rd (Minor Relocation)	NP23 4AG

There is **one shared base** within Blaina Gwent East NCN:

Other Sites (e.g. Health Centres, Team Bases)			
Name / Description	Place	Address	Postcode
Anvil Court	Abertillery	Church St, Abertillery NP13 1DB	NP13 1DB

Community services

Hospital Services

Ysbyty Aneurin Bevan (YAB) is our community hospital and is a key component of our model, ensuring that patients can remain as close to home as possible by either direct admission or by repatriation. YAB has 80 funded beds which flex to 94 in the winter. The Outpatient service is also important in providing opportunity for patients to be seen as close to home as possible.

Community Resource Team

Our community resource team provides service including Reablement, Community OT, Community Physio, Falls, Assistive Technology, VI support, CARIAD, Rapid Medical and Rapid other to citizens in BG in order to minimise admissions and promote independent living. In the Blaenau Gwent East NCN, CRT staff are based at a shared, integrated services base in Anvil Court, Abertillery.

District Nursing

Our District Nurses provide skilled nursing care to patients who are predominantly housebound.

Blaenau Gwent Adult Social Services

Blaenau Gwent Adult Services Department is configured on an NCN West and East footprint and provides supports to adults aged 18 or over who require care and support as a result of their vulnerabilities. The department provides support across its 5 main teams of:

- IAA (Information, Advice and Assistance)
- Community Long Term Care (West and East) which is integrated with the CRT and District Nursing Teams
- Adult Mental Health and Substance Misuse Team – collocated with Health at Cwm Coch Hospital - YAB Ebbw Vale and
- Disability Team which is collocated with colleagues from the ABUHB Learning Disability Team but supports both children and adults with complex health conditions.

Our IAA or prevention team provides preventative support to enable citizens to maintain their independence for as long as possible and support offered includes the provision of our Community Connector (social prescribing) team, third sector support and care managers who undertake preventative assessments. In addition to these teams we have a Safeguarding Team providing support following allegations of abuse/ neglect, our Supporting People Team who commission our supported housing schemes, Direct Payments Team and Domiciliary Care Brokerage Unit.

Our Commissioning Team are responsible for the commissioning and quality monitoring of our external providers including local Care Homes both residential

and nursing, Domiciliary Care agencies, Supported Living Projects and our Third Sector agencies. We also have a specific team that support unpaid family carers. We have recently developed bespoke telecare facilities within our intermediate care (CARIAD) facilities and work closely with colleagues in our integrated Community Resource Team to provide seamless reablement support and have hospital discharge staff based at both YAB and Nevill Hall Hospitals.

In addition to our statutory care management structure we also provide in house services. We provide specialist residential care dementia support at Cwrt Mytton Care Home Abertillery with specific respite beds to support family carers and have an in-house domiciliary care team that in addition to providing traditional domiciliary care provides support at our two Extra Care facilities in Ebbw Vale and Nantyglo and emergency (DASH) care at home.

Augusta House Respite Centre in Ebbw Vale provides bespoke respite for adults with a Learning Disability and we have 5 supported Living Bungalows offering independent living to adults with complex needs. Our Community Options (Day Services) provision spans many ages and disabilities and includes a specialist Dementia facility, work and training programmes including catering and horticulture, outreach activities and a purpose built Bert Denning centre for people with complex health needs in Brynmawr.

Third Sector Partners

We are extremely fortunate to have the support of a number of third sector organisations who provide services within the community.

- Aneurin Leisure Trust
- Job Centre
- Learning Action Centre
- Credit Union
- Supporting People
- Tai Calon
- Gwent Police
- Community Connectors
- Coal Fields Regeneration
- 50+ Forum
- Age Cymru
- GAVO
- Groundworks
- NET Team
- Digital Communities
- Living Well Living Longer
- Mental Health Services
- Expert Patient Programme
- Carers Project
- Citizens Advice Bureau
- National Exercise Referral Service
- Bryn Bach Park
- Blaenau Gwent Partnerships Team

- DEWIS

The collaboration between all of these organisations and the NCN forms the foundation of the Blaenau Gwent Integrated Wellbeing Network.

There is a unique relationship between the NCN and Hospice of the Valleys, who provide community based holistic specialist palliative care services in people's homes and care homes across Blaenau Gwent.

Services have developed over recent years to offer a Day Centre and outpatients clinic for patients with palliative care needs. All staff have honorary contracts with ABUHB and can support patients transition from community into hospital for step up and end of life care. They also provide a dementia specific service (CARIAD) to support families across Blaenau Gwent.

2.2 Vision Statements

People in Blaenau Gwent East are empowered to nurture their own wellbeing and are able to access quality health and wellbeing services in the community when they need to.

If we achieve our vision, this will mean:

- The health and wellbeing of the local population will improve
- Services will be provided equitably across the NCN
- Everyone will feel part of, and contribute to, the community
- Our community will be resilient , with citizens empowered to stay well, lead healthier lifestyles and live independently
- When our citizens need to access services, they will know who to ask for to signpost them to the most appropriate service for their needs
- Access to services will be easy, close to home and will have the flexibility to meet individuals needs
- Services are sustainable and fit for the future
- Should specialist expertise be required, these will be accessed in a timely manner
- Blaenau Gwent NCN remains a supportive working environment, with many career development opportunities for the staff who work within it

2.2.1 Achieving our vision

To achieve this vision in Blaenau Gwent East NCN we aim to achieve the following outcomes:

1) Better quality, more accessible services
2) Higher value care
3) Motivated and sustainable workforce

In order to achieve outcomes, we have developed the following aims:

- Improve the health and wellbeing of the local population
- Support people to stay well, lead healthier lifestyles and live independently
- Reduce health inequalities
- Deliver the Clinical Futures Strategy in primary and community care to:
    - Provide more joined up services in community settings
    - Ensure that services have the flexibility to meet individual needs
    - Improve access to specialist expertise
    - Provide a positive experience for patients and carers
    - Ensure a supportive working environment and career development opportunities for our staff

The following principles, highlighted in our Plan on a Page will underpin our plan delivery:

The prioritised action plan at section 10 describes the specific objectives and actions we will take over the next 3 years to deliver our vision and aims, supported by our principles.

2.3 Neighbourhood Care Network Governance

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

2.3.1 Membership

Name	Designation	Organisation
Dr Isolde Shore-Nye	GP and NCN Lead	ABUHB
Aimee Goulding	Health, Social Care and Wellbeing Officer	GAVO Wales
Angela Jarrett	Deputy Practice Manager	Cwm Calon Surgery
Ashleigh O'Callaghan	Assistant Head of Services	Aneurin Bevan UHB – Primary Care and Community Services
Beth McDermott	Practice Manager	Blaina Practice
Claire Davies		
Claire Edmunds	Deputy Practice Manager	Blaina Practice
Emily Davies	Occupational Therapist	Brynmawr Practice
Grant Usmar	Manager	Hospice of the Valleys
Dr Helen Davey	GP	Blaina
Ian Fido	Network and Community Services Manager	ABUHB
Ian Haywood	Network and Community Services Support Officer	ABUHB
Ian Stuart	Primary Care GMS Contract Manager	ABUHB
Jason Davies	Information, Assistance and Advice (IAA) Manager	Blaenau Gwent LA
Dr Jayendra Chouhan	GP	Abertillery Group Practice
Dr Jo Rudling	GP	Abertillery Group Practice
Joanna Watts-Jane	Practice Manager	Aberbeeg Medical Practice
Joanne Burchell	Community Resource Team (CRT) Manager	Blaenau Gwent LA
Jo Moreno	Practice Manager	Abertillery Group Practice
Dr Karen Gully	Clinical Director	ABUHB

Name	Designation	Organisation
Kath Thomas	Primary Care GMS Contract Support Officer	ABUHB
Kathryn Cross	Integrated Well-Being Networks Manager	Public Health Wales
Kelly Love (IAA)	Information, Assistance and Advice Manager	Blaenau Gwent LA
Dr Lakshmi Rani	GP	Aberbeeg Medical Practice
Linda Griffiths	Practice Manager	Brynmawr Practice
Lissa Friel	Community Connector	Blaenau Gwent LA
Louise Tovey	Health Social Care & Wellbeing Coordinator	GAVO
Lynwen Law	District Nursing – Senior Nurse	ABUHB
Mary Ann Morgan	Pharmacist	ABUHB
Michele Zeraschi	District Nurse Manager	ABUHB
Nichola Maggs	Health Visitor	ABUHB
Philip Hackling	Housing Manager	Tai Calon
Rachel Price	Social Worker	Blaenau Gwent LA
Rhiann Mainwaring	Deputy Practice Manager	Abertillery Group Practice
Richard Pryce	Head of Services, Blaenau Gwent	ABUHB
Sharon Whittaker	Primary Care Mental Health Support Services Manager	ABUHB
Sian Price	Public Health Operational Manager	ABUHB
Sue Scully	Health Visitor	ABUHB
Sue Hitchman	Deputy Practice Manager	Brynmawr Practice
Dr Tom Evans	GP	Blaina Surgery
Tom Kivell	Fitness Development Manager	Aneurin Leisure
Dr Victoria Whitbread	GP	Brynmawr Practice
Wayne Turner	Older Adult Mental Health Manager	Social Services

2.3.2 NCN Leadership and Support Teams

Within each borough, NCNs have a support structure consisting of fellow NCN Leads and members of the Primary Care & 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
Dr David Minton	NCN Lead (West)
Dr Isolde Shore-Nye	NCN Lead (East)
Richard Pryce	Head of Service
Ashleigh O'Callaghan	Assistant Head of Service
Ian Fido	Network and Community Services Manager
Claire Evans (Secondment)	Network and Community Services Support Officer
Ian Stuart	Primary Care Contracting Manager

2.3.3 Frequency of Meetings

The Blaenau Gwent East meetings take place every two months.

2.3.4 Secretariat Support

The Network and Community Services Support Officer provides this function.

2.3.5 Quorum

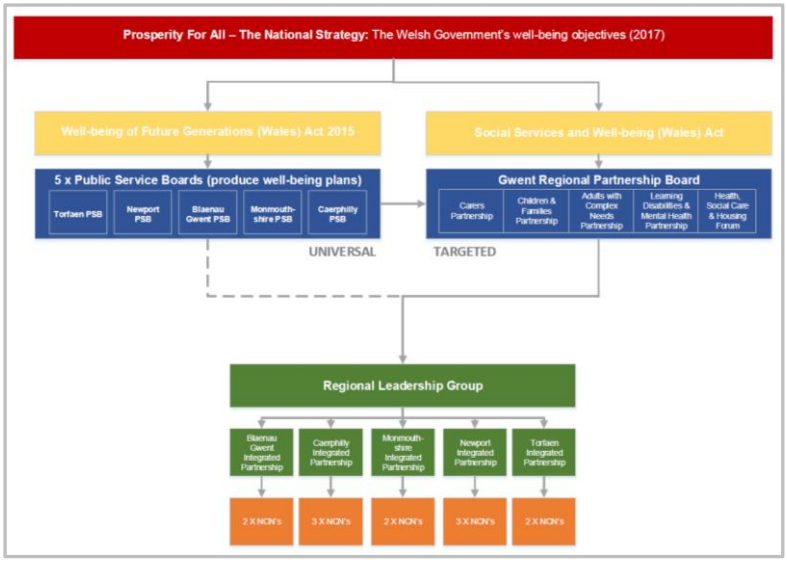
To be quorate, the NCN would need to have two thirds of the membership by profession, either primary membership or nominated deputies, as per the list of members at 2.3.1 above. Where voting is necessary it will be along the lines of a vote per professional entity. Where no majority is achieved, the Chair will have the casting vote.

2.3.6 Communication

The NCN maintains regular communication via e-mail, telephone calls, newsletter and ad hoc meetings at events.

2.3.7 Reporting Framework

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

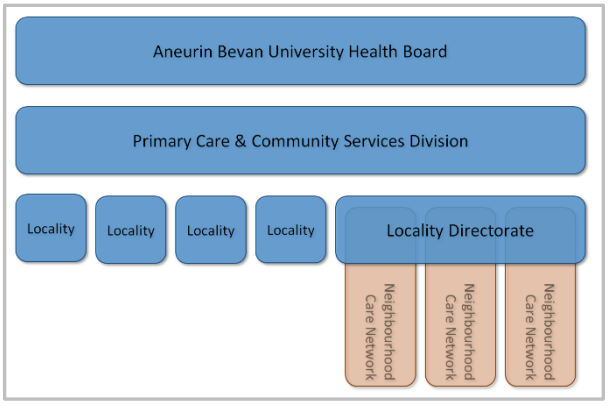


The NCNs are a key component of the Integrated Services Partnership Boards (ISPBs) in each of Gwent's five boroughs, which report to the Regional Leadership Group and onwards to the Public Service Boards and Gwent Regional Partnership Board.

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

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

2.3.8 Organisational Alignment within Aneurin Bevan University Health Board



Although the NCNs consist of representatives from a wide range of services, both within and outside Aneurin Bevan University Health Board, the NCN function is organisationally aligned to the Primary Care & Community Services Division of the Health.

This alignment ensures that the resources of the Division can be utilised to support the NCN function as a whole (including support for consistent governance between NCNs) and support individual NCNs with planning and implementation of prioritised developments, as and when required. The NCN Leadership & Support Teams, described earlier, provide the key link between NCNs and the wider Health Board.

3 Planning Context

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.

3.1 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.

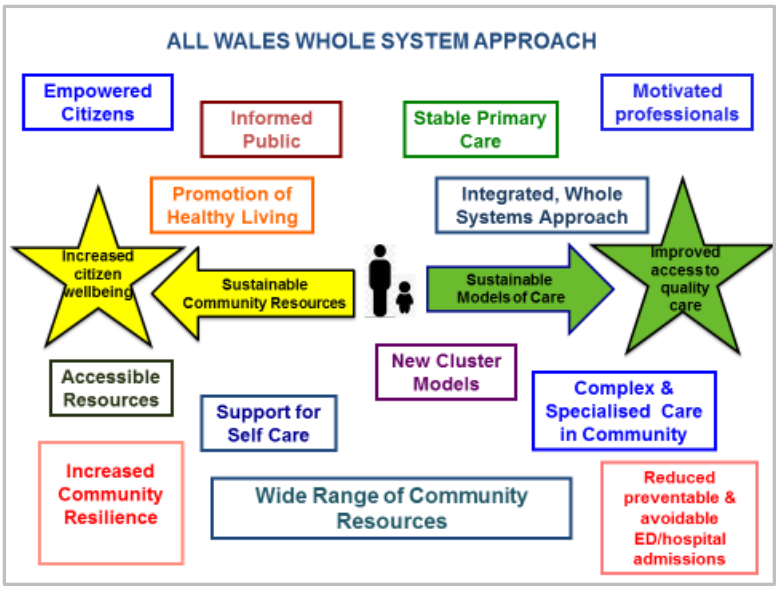
The design principles of Clinical Futures are:-

- ***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.

3.2 Strategic Programme for Primary Care

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

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



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

As a result, on a national basis, 6 key work streams have been established to oversee this work, these include:

- Prevention and wellbeing
- 24/7 Primary Care Model
- Data & Digital Technology
- Workforce & Organisation Development
- Communication & Engagement
- Transformation and the Vision for Clusters

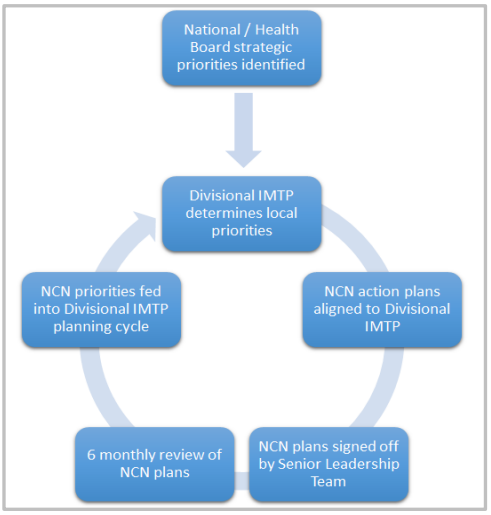
3.3 Primary Care & Community Services Integrated Medium Term Plan

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

3.4 NCN IMTP Process



The NCNs are a pivotal part of providing more care closer to home and must be supported by a robust process which aligns their actions with the Health Board's IMTP and the Gwent Area Plan. In doing so, this will ensure that priorities are both fed up from the local teams delivering services, as well as ensuring a co-ordinated approach to planning on a wider scale.

Beginning in 2019, a new approach will be implemented to provide a seamless link between these previous separate planning processes.

The template for the NCN IMTPs will be more closely aligned to IMTP for the Primary Care & Community Services Division. Following development of the first NCN IMTPs, a cycle of six monthly reviews will be implemented by the Senior Leadership Team. This new approach is designed to provide a more robust framework to the local planning process and ensure a strategic join-up from intent to delivery, supported by oversight from Senior Leaders within the Health Board.

4 Key Achievements from the 2017-2020 Plan

The table below highlights key achievements delivered during the previous planning cycle.

Strategic Workstream	Key Achievements	Benefits/outcomes
Prevention, Well-being and Self-Care	• **Established Smoking Cessation Champions in each Practice.** • **Support for Living Well Living Longer Programme.** • **Established annual flu planning process, including identification of Flu Champions.** • **Early stage implementation of the Compassionate Communities programme.** • **Established Care Navigation principles in Practices and community settings to enable access to services without seeing a GP.** • **Recruitment to the Information, Assistance and Advice (IAA) Team.** • **Community Connectors have been appointed to each Practice in the West NCN.** • **Development of the Period Equity**	• Identified member of staff on site to direct residents to services. • Pilot for programme was launched in Blaenau Gwent. • Effective process operating over past three years to ensure readiness for flu season. • Programme building local community networks to develop resilience and self-care management. All 5 Practices signed up to the Programme. • Six pathways (Physiotherapy, Minor Injuries, Mental Health, Eye Services, Emergency Dental, Pharmacy) in operation in 80% of the East NCN Practices. • Strengthened the preventative services provided through the CRT via the IAA Team. • Eleven Local Authority employed Connectors attend Practices on a rota basis to offer advice and support on services availability to residents. • Sanitary products are freely available at Health and Local Authority venues, Sports Centres, Schools

	Programme in Blaenau Gwent. • **Trialled the provision of a National Exercise Referral Scheme Pregnancy Pathway.**	and Food Banks via this sustainable scheme. • Inconclusive results from the trial Pathway. Activity levels for scheme were low. No longer supported following review.
Rebalancing Care Closer to Home	• **Dedicated session at NCN meeting to discuss Care Closer to Home.**	• ABUHB Programme was outlined and discussed with NCN members. CC2H is now a regular agenda item at NCN meetings.
Access & Sustainability	• **Direct Access Physiotherapy funding** • **Sustainability workshop held for Practices.** • **Dedicated sessions held to specifically discuss the Access LES.** • **Provision of QR Information Boards across the West NCN Stakeholder membership.** • **Securing Transformation Funding to support Primary Care Services.** • **Successfully maintained Locality based services during inclement weather.**	• Funded 15 slots per day, per week at YAB which reduce demand on GP time. 75% uptake of available slots by Blaenau Gwent residents. • Open forum for Practices enabled shared issues and potential inter practice working to be discussed. • Practices were enabled to better understand the LES and apply for the funding available to support its implementation. • Immediate Patient access, by mobile phone, to information and resources about locally available services provision. • Practices are able to trial extended staff roles, funded short term by ABUHB, with a view to employing staff once HB funding has ceased. • Services have been available to residents throughout the Borough during inclement weather.

Redesigning Community Services	• **Employment of HCSW to take bloods instead of District Nurses.** • **Establishment of Graduated Care Services at Ysbyty Aneurin Bevan.** • **Development of an emergency care at home team – Direct Access Support at Home (DASH).** • **Establishment of Collaborative Assessment Reducing Interventions, Admissions and Delayed transfers of care (CARIAD) beds in Blaenau Gwent.** • **Successful submission of ICF bids.**	• District Nurses enabled to deliver services to more complex cases. • Ward based, CRT Assessment and Treatment Units, Nurse Led Wards, Virtual Home Beds and DN led Weekend Wound Clinics established at YAB. • Development of an emergency care at home service providing a 'bridging' service for citizens to cover the gap between hospital discharge and a care package commencing. • Step Up / Step Down Beds established as a viable discharge destination as opposed to remaining in a hospital bed. Community Resource Team and Information, Assistance and Advice Team bids successful for: • Regional Advocacy initiative • Resilient Provider Services • BG Health and Social Care social media project • BG Community Meals and Catering enterprise • BG Integrated senior practitioner post CRT/ IAA • BG Young Persons project • BG Artificial intelligence project
Effective Medicines Management	• **Reviewed prescribing budgets and made appropriate switches and substitutions.**	• Enabled CEPP savings and awards to be made to the NCN and Practices, respectively.
Improving Quality, Value and Patient Safety	• **Completed National Audits for EOLC, USC and Polypharmacy.** • **Provision of Defibrillators and ECG**	• Open discussion between peers to review practice, issues and outcomes – shared learning. • Lifesaving equipment readily available at

	machines for use at Practices.	Practices for immediate use.
Developing a skilled workforce	• **Provided top sliced funding to support Independent Contractor attendance at NCN Leads meetings.** • **Safe Sleep and Constipation Pathways training for Health Visitors.**	• Strategic development, support and guidance being driven at a Divisional level. • Updated and innovative skills for staff.
Digital Technology	• **Introduction of text message reminders at East NCN Practices.** • **Purchase of Dopplers for District Nursing Teams.** • **Laptops provided for Practices to support mobile working for staff.** • **Installation of patient calling systems in Practices.** • **Upgraded Network connectivity at Anvil Court for the East Health Visitor Team.**	• Patient attendances have been shown to be more consistent with fewer DNAs. • Resources readily available for Teams to review patients. • Portable equipment enabling on the spot testing to be delivered to residents. • Improved patient experience when attending appointments at Practices. • Increased access speed to operational systems. Slow access had seen the Team relocate to Brynmawr until work was completed.
Estates Development	• **Brynmawr Health and Well-being Resource Centre opened in 2018.** • **Room upgrades to Abertillery Group Practice.** • **Lift replacement planning for the Bridge Centre.**	• Fit for purpose, multi-agency facility for local community to access. • Improved facilities, two refurbished treatment rooms, for Practice to deliver services from. • Planning process has secured Capital funding for lift replacement at the Centre which will be undertaken in Q3 + Q4 2019-20.

5 Population Health Needs Assessment

In order for us to plan services appropriately, it is important that we as an NCN understand the population we serve. Understanding the population of an area and how this might change can provide an insight into both the assets and challenges that are likely to exist or arise.

We have undertaken a full population health needs assessment, which can be found at Section 14, however, below, we have summarised the key points that our plans will aim to address.

5.1 Population and Future Projections

We know that:

- The population of Blaenau Gwent is declining over time
- Blaenau Gwent has an aging population which is predicted to increase
- Blaenau Gwent East NCN has the highest rate of deprivation of all the Health Board Clusters
- The gap in health inequalities does not appear to be reducing in Blaenau Gwent
- The annual premature mortality rate in Blaenau Gwent from all causes, standardised for age, whilst declining slightly, is higher than Wales as a whole
- By 2035, the number of people aged 65 and over predicted to be living alone will increase
- Data from the 2011 survey shows that more than one third of unpaid carers in Blaenau Gwent aged over 65 provide 50 or more hours of care per week to people who are disabled or infirm
- Blaenau Gwent has the 2nd highest % of people who state they have a long-term health problem or illness in Wales; this leads to a high proportion of people claiming disability—related benefits

Our NCN plan needs to consider:

- Ensuring we are managing chronic conditions
- Ensuring that we have services in place to support patients who are living alone and who are isolated
- Providing support for carers
- Implementation of different service models to ensure equitable access of services across the footprint

5.2 Health and Wellbeing

We know that:

- Hypertension, obesity and depression combined accounts for 54% of the disease prevalence within Blaenau Gwent East NCN
- Cardiovascular disease and Cancer are the biggest causes of premature mortality in Blaenau Gwent
- The % of people who are overweight, obese, who do eat 5 portions of fruit and vegetables a day and who are active for less than 30 minutes a week in Blaenau Gwent is significantly higher than Wales
- Blaenau Gwent citizens have poorer mental wellbeing than for Wales as a whole, often associated with multiple comorbidities
- Blaenau Gwent has the highest rates of childhood tooth decay in Wales

Our NCN plan needs to consider:

- Targeted intervention to address the disease areas above; from self-management, prevention, early diagnosis, treatment, living with the impact of disease and end of life care.
- Building community resilience through the development of Integrated Wellbeing Networks
- Maximising the use of practice based MDTs to improve signposting and holistic support
- Increasing social prescribing
- Implementing best practice community/prevention initiatives that are proven to work, and testing new and innovative approaches to meet the specific needs of our NCN

5.3 Incidents & Concerns

We know that:

Primary Care- Independent Contractors

Since September 2018, there have been 10 complaints received by the Primary Care directorate in relation to practices within the Blaenau Gwent East NCN.

- 5 were in relation to staff attitude, 3 of the complaints were in relation to 1 GP practice
- 2 complaints were regarding attitudes of staff (GP and receptionist)
- 1 was in relation to a delay in dispensing of medication
- 1 was in relation to a change in medication
- 1 was in relation to the GPs choice of medication given the side effects
- 1 was in relation to access to opiods
- 1 was due to a misdiagnosis

Community

We are unable to break down our complaints to NCN level for community services as the majority are attributed to services provided on a borough wide basis (i.e. YAB). Since September 2018, in Blaenau Gwent Borough as a whole:

- 16 complaints were received
- 9 of these were concerns- expression of patient dissatisfaction
- 5 were informal complaints
- 2 were early resolution (resolved within 24 hours)

In terms of the speciality:

- 10 were care of the elderly (admitted to YAB)
- 6 were district nursing
- When looking at the themes:
- 5 were concerns from family members in regards to care and treatment of their relatives
- 3 were patient concerns regarding delays in receiving treatment
- 3 were concerns regarding disjointed care
- 2 were from family in regards to attitude of staff
- 1 was a complaint from a family member regarding discharge arrangements
- 1 was a complaint from a patient in regards to treatment administration
- 1 was due to provision of gluten free food
- 1 was managed through the serious incident process.

All concerns are managed under the All Wales Putting Things Right Framework.

Complaints and concerns are an essential indicator for us and we take each one as a learning opportunity to reflect upon what we could do differently to improve our patient experience.

This process is multi-layered, and includes discussions and de-briefs through 1:1s and also through our Borough and Divisional Quality and Patient Safety meeting structure.

Incidents

- There has been a significant increase in the number of incidents classified as 'abusive incidents', this is driven by the need to record all incidents in YAB that involve violence and aggression from patients with limited capacity towards staff.

Our NCN plan needs to consider:

- Embedding a process of continuous learning from complaints and concerns through our NCN meetings

- Implementation of Care Navigation, Care Aims training and compassionate communities to support improvements to our care processes, making accessing our complex systems easier for our patients to navigate.

5.4 Patient Safety Indicators

We know that:

- Blaenau Gwent East has a particularly high use of: Proton pump inhibitors (PPIs) prescribing, Opioid burden- driven by high tramadol and co-codamol use, Pregabalin /gabapentin prescribing, and antibiotics.
- The NCN quality dashboard highlights that Blaenau Gwent East NCN are outliers in terms of:
    - number of emergency admissions where RIP less than 2 days
    - low levels of reablement referrals remaining at home on discharge
    - low rapid response referrals assessed in less than 4 hours
    - low uptake of childhood immunisations and flu immunisation.
- Ysbyty Aneurin Bevan (YAB) is an outlier in comparison with others in ABUHB in terms of falls per 1,000 patients; We believe this is due in part to the patient cohort in YAB; ongoing orthopaedic rehabilitation, General medical rehabilitation, Dementia Patients. Statistically, patients at most risk of an inpatient fall are generally within one of the three cohorts above.

Our NCN plan needs to consider:

- Working with pharmacist colleagues to review how we can improve our prescribing rates and consider wider partnership working that may help to address the underlying causes that can lead to high dependence on medication.
- Pilot areas for trialling the use of CRP point of care testing equipment in general practice, starting in late 2019. The ability to rapidly ascertain a CRP result from a patient will provide a primary care clinician with previously unavailable information, which will aid decision making when considering whether antibiotics should be prescribed or not.
- Targeted action to improve our immunisation rates
- Working with CRT to improve uptake of reablement referrals
- Review of emergency admissions where RIP less than 2 days to identify whether there are opportunities for learning
- Targeted action to improve rapid referral rate less than 4 hours

5.5 Clinical Audits

In summary:

- All practices within the NCN participated in the national diabetes audit
- All practices within the NCN participated in the National COPD Audit Programme; Compared to ABUHB, Blaenau Gwent West NCN and All Wales Comparators, Blaenau Gwent East NCN shows:
    - A higher percentage of patients with Asthma;
    - A lower percentage of patients with Bronchiectasis;
    - A lower rate of reported Lung Cancer.

- Stop a stroke project: the high level summary information for Blaenau Gwent East NCN, against comparator data for All Wales, ABUHB and Blaenau Gwent is as follows:

    - The percentage of patients with Atrial Fibrillation, treated with Warfarin, is higher;
    - The percentage of patients with Atrial Fibrillation, treated with NOAC, is lower.

We discuss the findings of audits at our NCN meetings and develop action plans to address any recommendations.

5.6 Enhanced Services

The NCN has to ensure that there is equitable access across the area- particularly where these services meet the additional needs of vulnerable groups. The NCN will develop different service models to ensure equitable access to all enhanced services across the NCN footprint. This will be achieved through collaborative working across practices as a pre cursor to delivering the community wellbeing hub model in Blaenau Gwent.

5.7 Activity Benchmarking

The areas that Blaenau Gwent East are identified as outliers in comparison with others are which require focused effort in order to make improvements are:

- High use of lab tests
- GP referrals to non-surgical specialities per 10,000 population
- GP referrals for chest x-ray per 10,000 population
- Referrals accepted by Rapid Response Services per 10,000 population

5.8 Engagement Events

A review of Winter Planning processes that were adopted in the previous Financial Year was held at Bedwellty House, Tredegar in July 2019. The event was attended by members of Public Services Organisations, Third Sector and local interest groups. Task and finish group work took place on each table with concerns and potential solutions recorded for consideration for the 2019/20 Winter Planning process.

In August 2019 the Locality Team headed up a 'Talk Health' event at the Tabor Centre in Brynmawr. The event was well attended by approximately 60 residents and local councillors. Items discussed included the development of the Primary Care Transformation Programme for the Borough as a whole and the Health Board's Clinical Futures Programme which overarches the modernisation of Health services provision across Gwent. Both items were well received and questions and discussion for the topics were positive and supportive of the intent and progress with the respective Programmes.

An Engage4Change event was held in Blaina Library in September 2019. Delegates discussed progress with the Grange University Hospital, the 111 system, access to GP surgeries, flu vaccinations and the Choose Well Minor Ailments Scheme. Feedback from the event has been provided to the NCN Management Team.

5.9 Access

Primary Care - GPs

On 20 March 2019, the Minister for Health and Social Services announced the Access to In-Hours GMS Services Standards.
https://gov.wales/written-statement-access-general-medical-services

The standards are:

- People receive a prompt response to their contact with a GP practice via telephone.
- Practices have the appropriate telephony systems in place to support the needs of people avoiding the need to call back multiple times and will check that they are handling calls in this way.
- People receive bilingual information on local and emergency services when contacting a practice.
- People are able to access information on how to get help and advice.
- People receive the right care at the right time in a joined up way which is based on their needs.
- People can use a range of options to contact their GP practice.
- People are able to email a practice to request a non-urgent consultation or a call back.

- Practices understand the needs of people within their practice and use this information to anticipate the demand on its services

These are underpinned by clear contractual guidance issued in September 2019: http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=99340

The access standards sets out the requirements on practices in terms of minimum expectations and will build public awareness of what people can expect from their practice.

Support will be available through the GMS Contract and via the Health Board to enable practices to make these changes, including;

- Demand and capacity analysis
- Telephone systems
- Use of IT technology
- Patient information
- Patient survey/feedback

The Health Board will be undertaking a baseline review of the current service quality, in which developments and improvements can be made over time.

Prior to these standards being issued,the Health Board has introduced an 'A is for Access Scheme', 5As, whereby practices are encouraged to ensure:

- They open on or before 8am with a first appointment at 8.30am or earlier.
- Their doors are open during the lunchtime period.
- The last routine doctor appointment is 17.50pm or later.
- There is telephone access to a 'live person', available from 8.00am - 6.30pm.
- Patients can book an appointment and 'Sort in one call' or by the internet.

40% of Blaenau Gwent East practices deliver on the 5As.

General Dental Services (GDS)

The current dental contract was introduced in 2006 and Health Boards in Wales are responsible for the provision of dental services to their local population.

There are 79 dental practices across the Health Board area with 10 in the Blaenau Gwent area providing general dental services (GDS). 5 of these practices are in Blaenau Gwent West.

Since 2013 the Health Board has invested additional monies into dental services in order to increase NHS dental provision; approximately £246k has been invested in general dental services in the Blaenau Gwent area.

Current Access

Since 2006, patients are no longer 'registered' with a NHS Dental Practice and can receive NHS dental treatment from any dental practice with an 'open' list.

Emergency appointments can be obtained via the Dental Helpline on 01633 744387, which is open Monday – Friday, 9:00am-12:15pm and 1:15pm-4:00pm. Patients contacting the Dental Helpline during weekday evenings, 6:30pm – 8:00am, will receive an advisory service only.

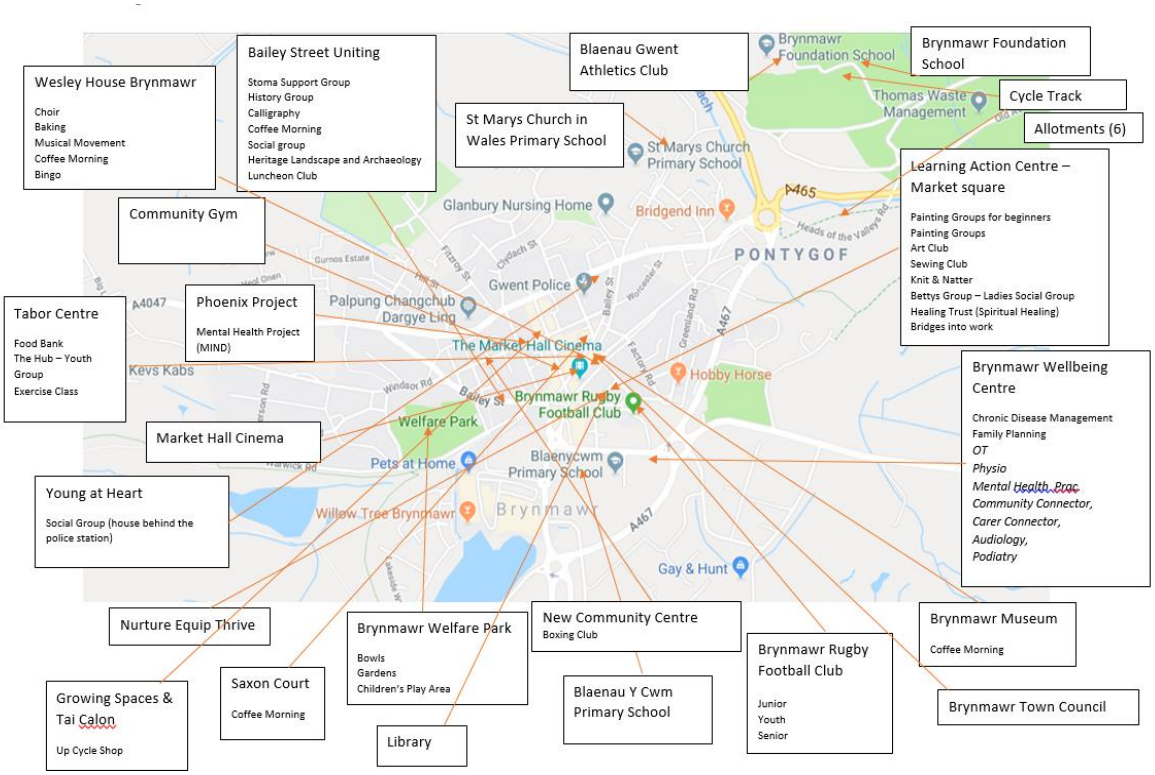
Contract Reform

The new Contract Reform programme was first introduced in September 2017. Since this date, 3 Practices from Blaenau Gwent have successfully applied to join the programme. Abertillery Community Dental Service joined the programme in October 2018 and successfully applied for an Innovation Fund bid which was granted for £11,560, which was used to provide an additional nurse. J Woodward (Brynmawr) both joined the programme from April 2019. One of the stipulations of the programme more latterly has been the issue that no practice should have a Unit of Dental Activity (UDA) value of less than £25. Both the latest Practices to join the programme have benefitted from this criteria with an investment of almost £99,000. All the above Practices have also benefitted from a 10% reduction in their annual UDA target as part of the programme. The Health Board is currently in the process of collating expressions of interest from practices to join the programme from October 2019.

~~7~~6 Assets Profile

Blaenau Gwent East NCN are fortunate to have many assets available for the population to access, from a number of health and local authority provided services (as outlined within Section 2- Overview of NCNs and Section 7- Estates Profile) to services run by the community themselves and the third sector.

Through the Integrated Well-being Network (IWN) project, the service lead has undertaken initial mapping of services in Brynmawr, below;



Initial observations are that whilst there appears to be a lot of support and services available in these areas, one of the big challenges is ensuring that everyone is aware of them of aware of the mechanism (DEWIS) to be able to search for them.

In order to maximise our assets, it is important that individuals and groups are aware of DEWIS and are entering details about the support they offer on to the database.

This is also the case for the Social Services Information Advice Assistance (IAA) function. There is a need to ensure that professionals and members of the public are aware that there is one front door to use for information, advice and assistance.

The IWN service lead is working closely with the IAA manager to get promotional information produced.

The IWN will commence proper in September 2019, as a network of communities and professionals, to better coordinate and align services to the needs of the population and to identify and address gaps.

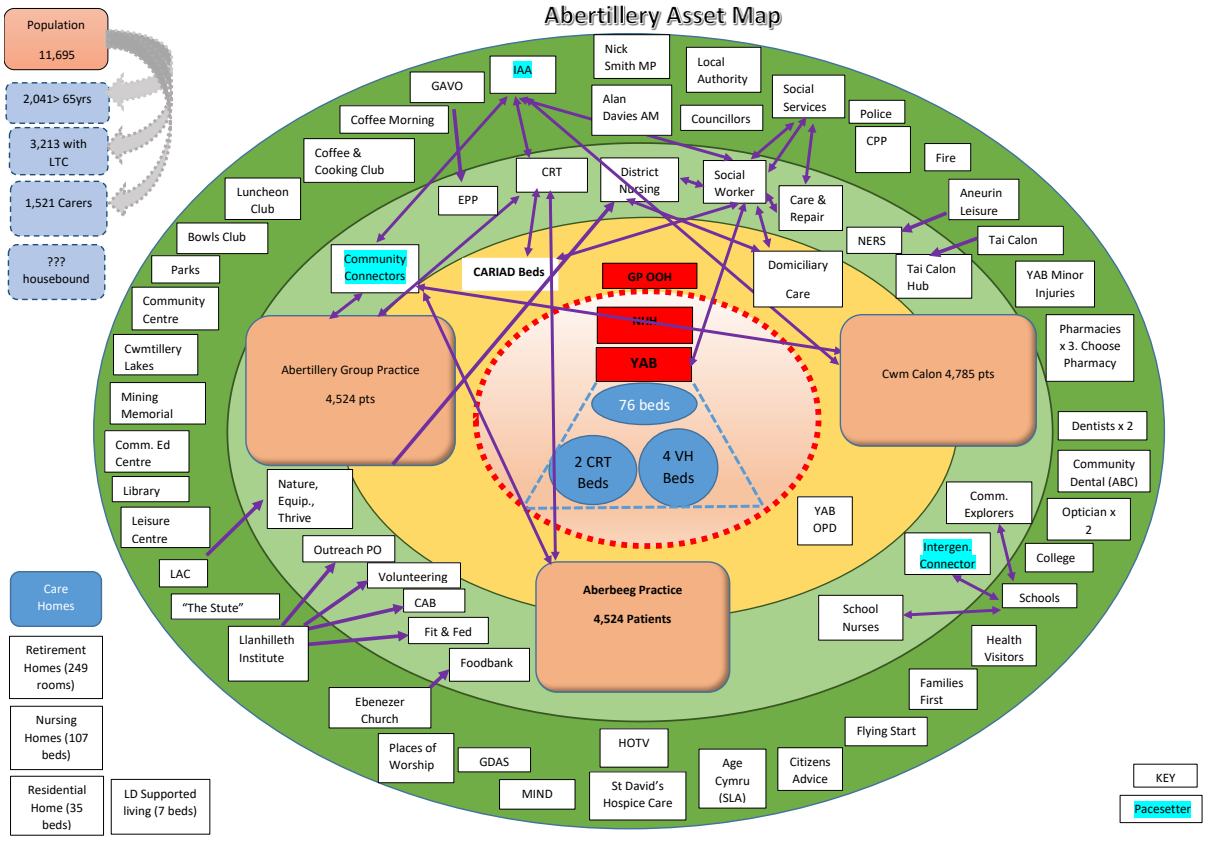
However, some early gaps that have been identified anecdotally whilst scoping are;

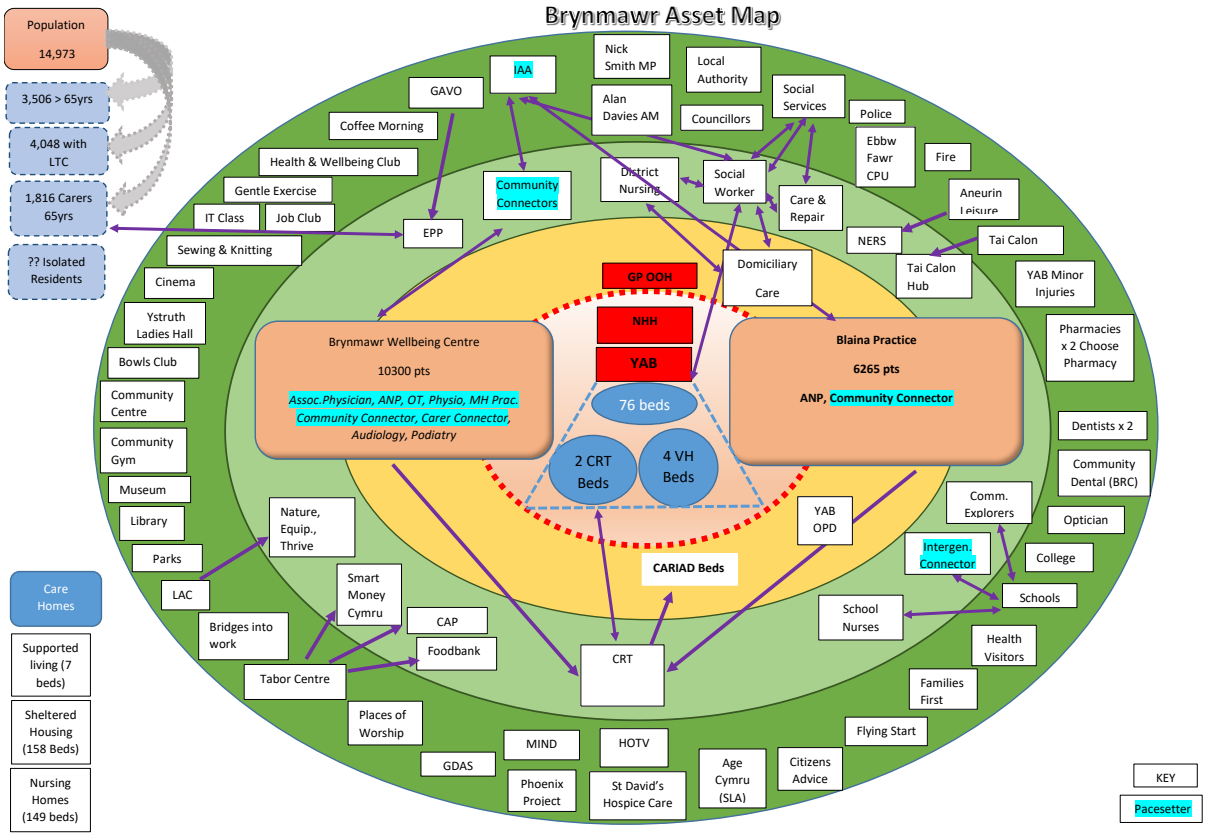
- Lack of support for those suffering with effects of the menopause
- Lack of befrienders
- No suitable venue Brynmawr (within budget)
    - Baby Yoga
    - Baby Massage
- Support for fibromyalgia

The IWN will be a resource support the NCN in identifying and addressing these gaps and maximising resources.

The IWN project is funded to focus on Tredegar initially, but if successful, will take the learning and apply to Ebbw Vale.

Below is mapping previously undertaken for both Ebbw Vale and Tredegar, which similarly highlights the amount of services available but also, from a patient perspective, the complexity in navigating the vast range of services available in these areas.


Abertillery Asset Map
Population 11,695
2,041> 65yrs
3,213 with LTC
1,521 Carers
??? housebound
Nick Smith MP
Local Authority
IAA
GAVO
Alan Davies AM
Councillors
Social Services
Police
CPP
Fire
Coffee Morning
Coffee & Cooking Club
Luncheon Club
Bowls Club
Parks
Community Centre
Cwmtillery Lakes
Mining Memorial
Comm. Ed Centre
Library
Leisure Centre
LAC
"The Stute"
Llanhilleth Institute
Nature, Equip., Thrive
Outreach PO
Volunteering
CAB
Fit & Fed
Foodbank
Ebenezer Church
Places of Worship
GDAS
MIND
HOTV
St David's Hospice Care
Age Cymru (SLA)
Citizens Advice
Flying Start
Families First
Health Visitors
School Nurses
Schools
College
Intergen. Connector
Comm. Explorers
Optician x 2
Community Dental (ABC)
Dentists x 2
Pharmacies x 3. Choose Pharmacy
YAB Minor Injuries
Tai Calon Hub
Tai Calon
Aneurin Leisure
NERS
Care & Repair
Social Worker
District Nursing
CRT
EPP
Community Connectors
CARIAD Beds
GP OOH
NWH
YAB
76 beds
2 CRT Beds
4 VH Beds
YAB OPD
Domiciliary Care
Abertillery Group Practice
4,524 pts
Aberbeeg Practice
4,524 Patients
Cwm Calon 4,785 pts
Care Homes
Retirement Homes (249 rooms)
Nursing Homes (107 beds)
Residential Home (35 beds)
LD Supported living (7 beds)
KEY
Pacesetter


Brynmawr Asset Map
Population 14,973
3,506 > 65yrs
4,048 with LTC
1,816 Carers 65yrs
?? Isolated Residents
Nick Smith MP
Local Authority
IAA
GAVO
Alan Davies AM
Councillors
Social Services
Police
Coffee Morning
Ebbw Fawr CPU
Fire
Health & Wellbeing Club
Gentle Exercise
Community Connectors
District Nursing
Social Worker
Care & Repair
Aneurin Leisure
IT Class
Job Club
EPP
NERS
Tai Calon
Sewing & Knitting
Domiciliary Care
Tai Calon Hub
YAB Minor Injuries
Cinema
GP OOH
NHH
YAB
Ystruth Ladies Hall
Brynmawr Wellbeing Centre
10300 pts
Assoc.Physician, ANP, OT, Physio, MH Prac. Community Connector, Carer Connector, Audiology, Podiatry
Blaina Practice
6265 pts
ANP, Community Connector
Pharmacies x 2 Choose Pharmacy
Bowls Club
76 beds
Community Centre
2 CRT Beds
4 VH Beds
Dentists x 2
Community Gym
Community Dental (BRC)
Museum
Comm. Explorers
Optician
Library
Nature, Equip., Thrive
YAB OPD
Intergen. Connector
College
Parks
CARIAD Beds
Smart Money Cymru
LAC
Schools
School Nurses
CAP
Bridges into work
Foodbank
Health Visitors
CRT
Tabor Centre
Families First
Places of Worship
Flying Start
MIND
HOTV
GDAS
Age Cymru (SLA)
Citizens Advice
Phoenix Project
St David's Hospice Care
Care Homes
Supported living (7 beds)
Sheltered Housing (158 Beds)
Nursing Homes (149 beds)
KEY
Pacesetter

~~10~~7 Estates Profile

~~10.1~~7.1 Estate Profile

The table below illustrates the estates venues within the Blaenau Gwent East NCN footprint. They comprise:

- Five GP Practices (Three Independent Practices and two Health Board Managed Practices);
- Six Dental Practices;
- Three Optometry Practices;
- Seven Community Pharmacies;
- One shared Team Base in Anvil Court.

Blaenau Gwent East NCN - Estates Mapping

GP Practices			
Name	Place	Address	Postcode
Abertillery Group Practice	Abertillery	Abertillery Group Practice Abernant Surgery Bridge Centre, Foundry Bridge Abertillery	NP13 1BQ
Cwm Calon Surgery	Abertillery	Cwm Calon The Bridge Centre Foundry Bridge Abertillery	NP13 1BQ
Aberbeeg Medical Practice	Abertillery	Aberbeeg Medical Practice, Aberbeeg Medical Centre, The Square, Abertillery, Gwent,	NP13 2AB
Blaina Medical Practice	Brynmawr	Blaina Medical Centre,High Street,Blaina,Gwent,	NP13 3AE
Brynmawr Medical Practice	Brynmawr	Brynmwar Medical Practice, Brynmawr Wellbeing Centre, Blaenavon Road, Brynmawr,	NP23 4BR

Dental Practices			
Main Surgery Name	Branch Name	Branch Address	Branch Postcode
The Bridge Centre	Abertillery	The Bridge Centre Health Centre,Foundry Bridge,Abertillery,Gwent,	NP13 1BQ
HASTINGS KR MR	Abertillery	24 King Street,Abertillery,Gwent,	NP13 1AD
Inclusive Oral Solutions Ltd	Abertillery	Abertillery Dental Practice,3a Somerset Street,Abertillery,Gwent,	NP13 1DJ
Abertillery Community Clinic	Abertillery	Abertillery Community Clinic, Resource Centre, Foundry Bridge, Abertillery,	NP13 1BQ
N Malik & K Partridge	Brynmawr	Blaina Dental Surgery,Blaina Medical Practice,Rear Of,High Street, Blaina, Abertillery,	NP13 3AT
Brynmawr Community Clinic	Brynmawr	Brynmawr Community Clinic, Lower Bailey Street, Brynmawr,	NP23 4DL

Optometry Practices			
Name	Place	Address	Postcode
Lewis Opticians	Abertillery	Lewis Opticians, 7 Church Street, Abertillery, NP13 1DA	NP13 1DA
Williams & Parry Ltd	Abertillery	Williams & Parry Ltd, 50 Church Street, Abertillery, NP13 1DB	NP13 1DB
Williams & Parry Ltd	Brynmawr	Williams & Parry Ltd, 16 Beaufort Street, Brynmawr, NP23 4AG	NP23 4AG

Community Pharmacies			
Name	Place	Address	Postcode
Prichard T.h. & Son Ltd.	Abertillery	48 Church St	NP13 1DB
Prichard T.h. & Son Ltd.	Abertillery	31 Somerset Street Medical Hall	NP13 1XT
Sunrise Pharma Ltd	Abertillery	21/23 Commercial Rd, Llanhileth	NP13 2JA
Boots Uk Ltd	Abertillery	9 Church St	NP13 1DA
Prichard T.h. & Sons Ltd.	Brynmawr	103 High St, Blaina	NP13 3AE
J & M Williams (brynmawr) Ltd	Brynmawr	41 Beaufort Street	NP23 4AQ
Well Pharmacy	Brynmawr	Brynmawr Well Being Centre, Blaenavon Rd (Minor Relocation)	NP23 4AG

Other Sites (e.g. Health Centres, Team Bases)			
Name / Description	Place	Address	Postcode
Anvil Court	Abertillery	Church St, Abertillery NP13 1DB	NP13 1DB

~~10.2~~7.2 Vision for Estates within the NCN

~~10.2.1~~7.2.1 *Place Based Care and the Hub model*

The services provision model for Blaenau Gwent will focus on 'place based care', with services operating on a local population basis but supported by more specialist expertise at a wider level.

The model of service provision will require the development of 'hubs', both physical and virtual, at key locations in the Borough. This 'hub' approach will require our estates strategy to ensure that services, equipment and infrastructure are aligned to make the best use of resources available in the Locality.

The Hubs within Blaenau Gwent East will be based in Brynmawr and Abertillery.

~~10.3~~7.3 Priority Developments

~~10.3.1~~7.3.1 *Major Improvement Grants*

~~10.3.2~~7.3.2 *Minor Improvement Grants*

There are potential applications being developed for consideration for Improvement Grant funding within the East Blaenau Gwent NCN area.

1. Aberbeeg is considering the conversion of existing storage space on ground floor to accommodate cleaner's resources and access to appropriate water and drainage facilities for cleaning purposes. To include painting and decorating works;
2. Blaina Surgery have a vision to convert accommodation that was previously used as a waiting area and storage to be used as administration offices and a consulting room. To include painting and decorating works;
3. Cwm Calon intend to convert a room previously used as a coffee room in to a clinical room. To include painting and decorating works;
4. Cwm Calon will apply for grant funding to replace blinds in the Practice;
5. Cwm Calon will also apply for a grant to be used to replace windows in the Practices that are no longer fit for purpose.

~~10.3.3~~7.3.3 *Capital Pipeline Funding*

There are no pipeline developments planned for the East Blaenau Gwent NCN area at the time of compiling this Plan.

~~10.3.4~~7.3.4 *Other Developments*

Capital funding has been secured during 2019/20 for the replacement of the lift at the Bridge Centre in Aberbeeg. The value of this funding is £185,000. Work on replacing the lift will begin in September 2019 and will take four months to complete.

Capital funding, totalling £30,600 has also been secured by Abertillery Group Practice to convert a storage room in to a Clinical Room and to

refurbish a second Clinical Room that has become non-Health and Safety Compliant. The work on the refurbishments began in the Summer of 2019 and is expected to be completed by the end of September 2019.

Brynmawr Well-being Centre has a snag list that will require completion by the Third Party Developer before final handover to ABUHB.

The Six Facet Estates Survey returned the following high level summary of the Primary Care Estate in Blaenau Gwent East. The summary reveals that:

- There are building works that individual Practices within the NCN require:
    - Two Practices are reported as having tired décor;
    - External paved areas are cracked and uneven at one Practice;
    - Carpets / vinyl flooring beyond design life and in need of replacing;
- Environmental works in respect of internal and external fixtures and fittings, including mechanical and electrical systems, are required within two Practices within the NCN;
- Two premises within the NCN do not have separate Male and Female W/Cs;
- One Practice has a fire door that needs to be replaced;
- One Practice has insufficient Clinical Rooms;
- One Practice has non-clinical rooms on its first floor that are not used;
- One Practice reported as having insufficient signage;
- One Practice does not have adequate facilities for disabled patients;
- One practice has potholes in its car park;
- Premises' building condition ratings will be lower if the above remedial works are not undertaken.

~~11~~8 Workforce Profile

Our Divisional Plan describes how Health and social care in Wales aims to shift care away from hospital toward community based services. These services will support people to live well and die well, independently in their own homes and on their own terms, wherever possible. While Wales' ageing population and workforce poses continued challenges for the medium to longer term, there are also opportunities because the workforce is at the forefront of the shift to the community, directly involved in improving patient care and outcomes.

Primary Care sits at the heart of an integrated health and social care system, offering GP and community services including district and community nursing, dentistry, community pharmacy, and optometry, as well as social care services, third and independent sector provision.

As new services are developed in response to changing demand, they must also keep pace with further change within ABUHB this includes the implications of Clinical Futures Strategy and the wider integration agenda. Though many people are now living longer lives, they often do so with multiple long-term conditions which require long-term reactive treatment and care which requires adjustments to the supply of our health and care workforce, and requires staff to develop new skills, combining them in different ways.

For GPs, this means a significantly enhanced role in caring for people with complex conditions, with support from multi-disciplinary teams. For medical and nursing staff, it may mean providing much more flexible and complex care outside hospital settings.

It is mainly in the areas above where workforce demand will increase in the future.

~~11.1~~8.1 Current Workforce Profile

There are 125.47 WTE in Blaenau Gwent East, broken down as follows:

	Post	WTE
Primary Care Staff in Post	General Practitioners	11.88
	Extended Roles *(employed by practice)*	3.15
	General Dental Practices	8
	Optometry Practices	3

	Community Pharmacy Practices	7
	Total	**33**

	Post	**WTE**
Community Nursing Staff in Post	Rapid Response Nursing *	4.19
	Out of Hours Nursing ^	1.49
	Primary Care Specialist Nursing	1.26
	Chronic Conditions Nursing *	0.00
	District Nursing	20.24
	Healthcare Support Workers	**3.23**
	Total	**30.41**

	Post	**WTE**
CRT Staff in Post	Medical *	0.93
	Social, Therapy & Other Profs *	4.39
	Support Workers / Carers *	12.22
	Total	**17.54**

	Post	**WTE**
Community Hospital	Medical *	1.58
	Nursing *	22.92
	Therapy *	-
	Pharmacy *	0.47

	Healthcare Support Worker *	19.53
	Total	**44.49**

~~11.2~~8.2 Workforce Risks & Drivers for Change

We want to ensure that we have the right staff, with the right skills, delivering the right care in the right place to the right people. This gives us the best chance of providing the excellent care that our population deserves.

We believe that there are opportunities for:

- services to further integrate rather than just collocate
- development of extended roles
- strengthening of the graduated care model and;
- formalisation of the integrated well-being networks around the agreed hubs

The key drivers for change are:

- **Legislation**, including A Healthier Wales
- Development of **Integrated Wellbeing Networks**
- **Sustainability** issues across primary care including three managed practices
- Implementation of **Clinical Futures**

8.3 Sustainability

The data below demonstrates that there is a significant shortfall in the number of sessions provided within the practices in Blaenau Gwent East.

Practice	Practice List Size 01.10.2018	Pts per session	GP sessions provided	Required GP	NER Hrs	NERE sessions	combined sessions	Shortfall	% shortfall
ABERBEEG MEDICAL PRACTICE	4526.0	175.0	8.0	25.9	0.0	0.0	8.0	17.9	69.1
ABERTILLERY GROUP PRACTICE	7411.0	175.0	16.0	42.3	80.5	10.1	26.1	16.3	38.5
BLAINA MEDICAL PRACTICE	6328.0	175.0	28.0	36.2	0.0	0.0	28.0	8.2	22.6
BRYNMAWR MEDICAL PRACTICE	10360.0	175.0	23.0	59.2	73.5	9.2	32.2	27.0	45.6
CWM CALON SURGERY	4916.0	175.0	16.0	28.1	0.0	0.0	16.0	12.1	43.0

8.3.1 General Practice Skill Mix

In recent times, general practice has evolved from small local GP practices to larger Health and Well Being centres with average list sizes in excess of 10,000 patients. It is on this scale that a wider skill mix can be explored, and prudent health care embraced. With a larger critical mass of patients economies of scale can be achieved.

The Health Board acknowledges the current issues around GP recruitment and retention and is supporting the implementation of the Primary Care Model, where core GPs are supported by larger multi-disciplinary teams of extended roles such as Advanced Nurse Practitioners, Pharmacists, Physiotherapist, Paramedics, Mental Health Practitioners and Occupational Therapists. These extended roles help to bridge the gap where there are GP shortages and ease pressure on existing GP resource, ensuring that they are free to see the most complex of cases.

These roles are explained below with a description of how they can provide care as part of the GP Practice Team:

- Advanced Nurse Practitioners, with Independent Prescriber qualification, are able to fully support the GPs by undertaking telephone triage where appropriate and by supporting with acute on the day minor illness presentations, as well as offering routine appointments.

- Advanced Practice Paramedics are able to support the General Practice team by carrying out home visits, Care Home ward rounds and also assisting with on the day acute presentations at the practice.

- Practice Based Clinical Pharmacists conduct medication reviews with patients, reconciling medications, hospital discharges, repeat reauthorisations and audit work. If the Pharmacist also has an Independent Prescriber qualification they are able to support with chronic disease management by holding relevant clinics.

- Physiotherapists work within the practice team to offer appointments to patients presenting with musculoskeletal problems, aches and pains. They may offer a one off treatment but are then able to refer on to the GP or secondary care physiotherapy services as appropriate.

- Mental Health Practitioners working in Primary Care are on hand to offer same day or pre-booked appointments to those patients that would have previously presented to the GP with low grade Mental Health Problems.

- Occupational Therapists work a little differently in that they don’t necessarily redirect first contacts from the GP. However they are able to work with patients that are living with chronic conditions, such as fibromyalgia.

8.3.2 Funding of the Primary Care Model in Independent Contractors

Some of the practices in Blaenau Gwent East are experiencing difficulties in relation to GP recruitment/retention and impending retirements.

This scheme is aimed at supporting practices with the implementation of the Primary Care Model, as detailed above, via the Transformational Bid monies. This will allow practices to test the extended roles and wider skill mix, with financial support.

8.3.3 Primary Care Academy

As part of the transformational work being undertaken across Aneurin Bevan, the health board has established Primary Care Training Sites to deliver training for non-GP professionals new to Primary care. The scheme aims to replicate the GP Registrar training scheme.

In partnership with the NCN leads and independent contractor practices we have 16 training sites vetted and approved. 10 supporting the training of Nurses new to primary care and 6 supporting Pharmacists new to General Practice. There is Health Board funding for their full employment costs and a training bursary for the practices.

- **Nursing scheme.**
  10 placements, each 6 months long with a described training curriculum supported by in practice mentorship. Additionally supported by a 4 nurse primary care support team from the Health Board. The Training curriculum is delivered on a whole day Multidisciplinary training session weekly with consolidation back at practice. By the completion of the 6 month programme the post holders will have a full complement of competencies to work as a Practice Nurse and it is envisaged they will find employment within independent contractors. This first cohort completes end of August 2019.

- **Pharmacy scheme.**
  Is similar in many respects to the nurse training scheme but is delivered over 2 years with a recognised curriculum via Bath University with a mix of distance learning and on-site training. By the completion of the project the pharmacists will hold an Independent Prescriber Qualification and should become directly employed by independent contractors. This cohort completes March 2021.

8.3.4 Sustainability Framework

The Welsh Government and BMA Cymru Wales published the *GP Sustainability Assessment Framework in 2015.* This programme is designed to identify practices at risk of collapse within 12 months and/or sudden service reduction. Practices can submit an application form which is then considered by a Panel to determine

if support is required. Recognising the limited availability of direct staff support the Health Board is able to provide, a sustainability financial calculator has been developed, in conjunction with Gwent Local Medical Committee.

8.3.5 Placed Based Care

The Blaenau Gwent Borough team are working with the NCN infrastructure and the wider community teams to develop a robust placed based care model that focuses on integration. This includes developing an ambitious NCN plan that strengthens community based care for the Borough population utilising the community estates assets within the area to deliver care closer to home.

8.3.6 Care Navigation

Care Navigation is being implemented across the Borough and has been met with the full engagement of the practices. Work is ongoing to successfully implement the scheme and is also supported by NCN investment in QR Boards to support the education and appropriate access of patients to a range of health and local authority services.

8.3.7 Workflow optimisation

This is an effective and efficient processes for dealing with patient correspondence. Workflow optimisation has been implemented across the Borough with the majority of practices having access training and support available. Work is ongoing to ensure maximum uptake and use.

8.3.8 Social prescribing

Local sign-up and support through the NCNs for the development of Integrated Well-Being Networks, establishing a place-based approach to improving well-being for the whole population. Fundamental to the network is the use of link worker roles such as Community Connectors, with relationships enhanced at a local level through a number of NCN programmes of work.

~~11.2.9~~8.2.9 Funding for other directly accessible services

Support for a number of national and locally developed directly accessible services such as Choose Pharmacy, Welsh Eye Care Service (WECS) and with full engagement and use of services across the Borough. The Health Board recognises that further work is required to raise public awareness of these alternative services and as Mr Cooke has highlighted, patients do not always need to see a GP.

8.3 Workforce vision

Our vision in Blaenau Gwent West is that services are aligned with the following places:

- Abertillery
- Brynmawr

The summary of the service changes required to achieve our vision are:

GP practices

Develop Place Based Care – enable citizens to receive as much of their care as possible within either their GP practice or a hub which is close to their home. This will be achieved by

- Developing an MDT approach within each surgery which provides support for patients to remain home rather than being admitted to hospital. This will include additional nursing and admin hours and support from GP's.
- Increasing opportunities for citizens to access support from community connector staff to reduce impact on health services
- Using new extended roles to mitigate reduction in GP hours which will include; physiotherapy, mental health, advanced nursing practice etc
- Continuing to develop strategies to recruit GP's in order to both increase sustainability and to reduce reliance on locums
- Development of home visiting scenarios

Community Resource Team

Support the development of a place based care approach by ensuring that the CRT resource is based locally and has good links with both LA and GP colleagues

- Continue to develop and evaluate the IAA 'front door' approach supported by the WG Transformation Fund.
- Ensure the development of the clinical team to include a substantive consultant and staff grade, and review the hours of operation of the service to ensure balance between demand and clinical capacity. Ensure the opportunities of enhanced clinical roles are maximise, providing opportunity for GP's to refer more patients in to the service and prevent patients being sent to an acute hospital by default.
- Develop a robust MDT approach to Rapid Medical/ Rapid other referrals incorporating Advanced Nurse Practitioners, Occupational Therapists, Physiotherapists and DASH.
- The nursing team capacity will be increased through Q3 & Q4 2019/20 in line with service demand. The ANP model will be developed, and the potential for the recruitment of additional Band 3 and Band 5 will be explored to release leadership capacity for more senior staff.
- The DASH team will continue to integrate more fully with CRT to enhance the offer to GP's of providing urgent care at short notice. A review will take place to understand if overnight support will be beneficial utilising short term pacesetter funding.

- The Therapy Enhanced Enablement Model (TEEM) on Tyleri ward will be developed in tandem with the Reablement team, proposing staff work rotationally between both services.
- Continue to develop the Community Treatment Unit and CRT beds on Sirhowy to prevent admission and provide care closer to home and include the development of a virtual ward round
- Support the development of the CRT pharmacy role as part of the Transformation bid.
- Developing an enhanced service provision for people with a diagnosis of Dementia.
- BetterCare - Working in collaboration with the local authority to develop a modernised approach to care handling, promoting people's choice, creating a sustainable social care workforce and enhance training around care provision.

District Nursing

The DN teams are structured so they are coterminous with the NCN footprint and currently work across six geographical zones which are located or close to GP surgeries in line with the place based care approach.

- The teams do not currently adhere to the All Wales District Nursing Staffing Principles in that the teams exceed the recommended number of staff, however the structure supports a unit approach where three units of approximately 8-10 staff work under the direction of a Band 6 SpQ nurse as part of a larger team managed by a B7 also with a recordable qualification (SpQ). Each unit is collated or close to one or two surgeries. If it is necessary to interpret the staffing principles differently there will be the need for additional senior staff.
- HCSW staff are not currently working to the full potential of their job description as part of a long running issue, BG has no B4 staff currently.
- District nurses need to become an active part of the hub approach that that is being developed in GP practice and currently there is no resource for this.
- WCCIS is due to roll out to BG shortly and there will be an impact on DN services however at the moment this is difficult to quantify. Blaenau Gwent District Nursing Service is piloting the implementation of e-referrals and very early indication is that some time is saved by not needing to visit every practice every day to obtain referrals, however it is vitally important to ensure that key links and communication with practices are not affected.
- Development of a District Nursing Weekend Wound Clinic, based in YAB, has released capacity within the DN team, through efficiency the centralisation has provided more time to care for other patients within the Borough.
- Development of wound services within Blaenau Gwent provide opportunity as part of the pacesetter initiative to evaluate the effect on staffing.
- Development of catheter and HIC/PIC pathways to provide a clinic on Sirhowy ward to improve patient experience
- Consider whether District Nursing ANP role is the appropriate way forward or should this be achieved by integration with CRT
- Development of the neighbourhood nursing model in line with the work currently carried out in Newport

Ysbyty Aneurin Bevan

Ysbyty Aneurin Bevan (YAB) is a key part of the borough in ensuring that patients can remain as close to home as possible by either direct admission or by repatriation. The Outpatient service is also important in providing opportunity for patients to be seen as close to home as possible

- Further develop Graduated Care to include the TEEM model (Therapy Enhanced Enablement Model) to provide care for level one/two patients and enhance the use of the Virtually Home beds particularly as a step up option.
- Develop a direct admission pathway to allow further options for patients to come into YAB rather than going to NH first
- Enhance the palliative care CWTCH approach to ensure that patients in Blaenau Gwent have a full choice for management of symptoms and for end of life care.
- Further develop use of the Community Treatment Unit on Sirhowy working both with CRT and District Nursing.
- Continue to improve patient experience by reducing length of stay.
- Consider wider divisional work around the development of a rotational programme between hospital and community services
- Continue to develop the ANP model across both in hours and out of hours services using a training model including Band 6 and Band 7 staff however an 8a may become necessary to provide senior level leadership as the team expands.
- Consider development of a B4 HCSW role as part of the Nurse Led and Therapy Led models.
- Across all areas the following needs to be considered
- Development of rotational programmes
- Impact of an ageing population on both retirement and sickness management
- Risk of at least two Ward Managers reaching retirement age in the next three years.
- Improve the communication between senior management and ground level staff as currently this sits primarily with middle management
- Consider any impact of Brexit on both NHS staff and wider agencies
- Many initiatives have short term funding attached with no plan beyond March 2020

To achieve this vision we need to:

Develop prudent approach to maximising roles across all staff groups

- GP practice – development of new roles, use of connectors, development of community structures

- Nursing – development of Band 3 and Band 4 HCSW roles to include therapy skills, enablement model and non-complex patient management.

- Development of ANP model between areas i.e. hospital/CRT/District nursing to provide advanced practice in a synergistic way across all services.

- Working with LA and third sector ensure that integration across all services is maximised to prevent handoffs and poor patient experience. Reduce barriers between services by strong management and leadership and development of robust pathways.

- Consider how the planned integration of therapy staff from YAB into the CRT team is developed.

- Consider the impact of introducing District Nursing Staffing Principles on staff and patients, i.e. each team having a staffing complement of no greater than 15 staff/12 WTE. On current team size this will require increasing the teams from two to four, an additional Band 3 Patient Scheduler, two additional Band 7's appointed within existing Band 6 posts.

- Development of rotational posts both to attract and retain staff but more importantly to ensure skills are appropriate for changing models, this must be underpinned by a robust training mechanism

- ANP – developing hospital ANP staff to be able to work confidently in and out of hours providing support to both the site and to the nurse led ward

- Consider the development of a more generic role across hospital and CRT with the potential implementation of a model that includes district nursing

- B5 nurses – develop a robust training programme that develops generalist skills across CRT, DNS and ward and a model of pool staffing that reflects this. Consider how this links to practice nursing

- HCSW – further develop the enablement model by staff working in hospital and across CRT

~~11.3~~8.3 Training Requirements

Training opportunities include:

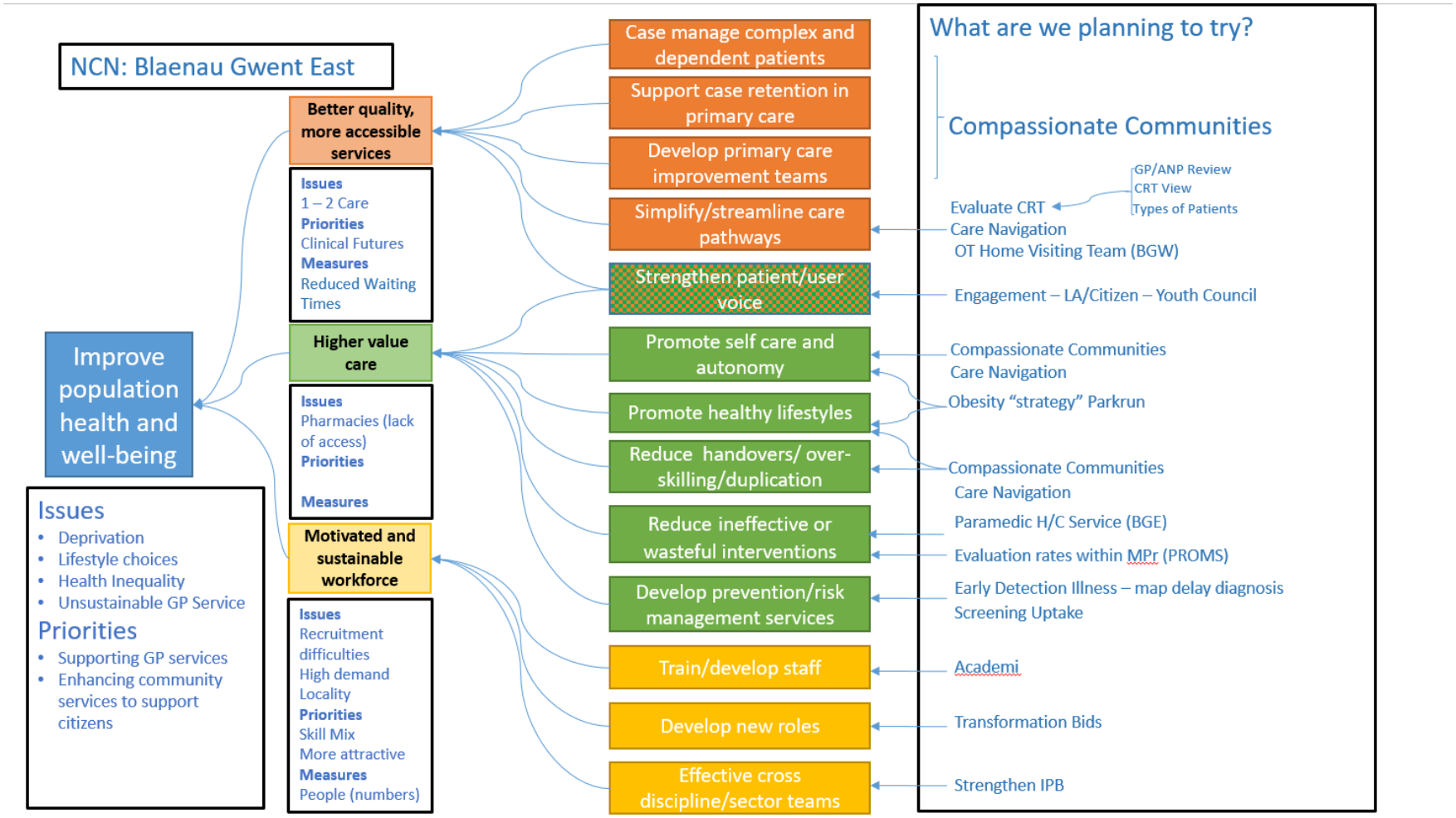
- Making Every Contact Count (MECC) Training for GP practice and partnership organisations staff
- Care Aims training
- Care navigation
- Compassionate Communities mentoring
- Quality improvement training
- Mentorship for Practice Based Pharmacists
- Various training opportunities that arise for upskilling GP practice staff both clinical and non-clinical will be supported via NCN funding if deemed appropriate
- Organisational Development programme for practice managers

~~12~~9 Opportunities and Challenges for 2020-2023

~~12.1~~9.1 SWOT Analysis

Strengths	Weaknesses
Low levels of DTOC / patient flow. Robust process is in place to ensure that patients are supported to move expediently across the system.	Age profile of nursing staff risks long term sustainability of ward staffing
The ability to develop innovative programmes of work such as Graduated Care / Frailty Team / Prevention Services provision.	High level of antibiotic and opioid prescribing and usage
Positive workforce culture across all disciplines of staff.	Long term sustainability of primary care
Strong, resilient Nursing and Healthcare Support Team across the Borough.	Perceived duplication of services within the Locality - will resolve through Integrated Wellbeing Networks activities.
Relationships with Local Authority and Third Sector	Introduction of WCCIS in 2020 - staff unfamiliarity with new system.
Opportunities	**Threats**
Integrated Well Being Networks.	Prevalence of long term chronic disease across the NCN
Compassionate Communities / Place Based Services.	Workforce issues at YAB and in Primary Care provision.
Transformational Modelling.	Low uptake of childhood immunisation.
Partnership Working with Local Authority and Third Sector Stakeholders.	Transfer of secondary services to community and primary care settings without the release of funding from secondary care budgets.
Development of Pipeline Health and Wellbeing Centres at Tredegar and Ebbw Vale.	Three managed Practices are concentrated within the Blaenau Gwent Locality.
Introduction of WCCIS in 2020. Improved information sharing.	Delays implementing initiatives such as Compassionate Communities, Integrated Well Being Networks, Graduated Care.

~~12.2~~9.2 Driver Diagrams



~~13~~10 Prioritised Actions 2020-2023

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
1.	To work together to improve **GP training, recruitment and retention** across the NCN.	- Identify how other primary care services or regions with a similar demographic sustainability issues and have successfully addressed this challenge. - Work with current GPs to understand how the job could be more appealing, including tackling system/process issues. - Set up a 'think tank' to focus on testing new ideas. - Implementation of transformation model including extended roles	**Direct benefits** - Improved access to the right care, at the right place, at the right time - Increase number of GP trainees - Increased recruitment of GP - Improved sustainability - Improved access to GP services - Increase in number of GP partners **Wider benefits** - Improved work-life balance for staff - Improved work satisfaction and morale	- Sustainability issues in Primary Care - Access standards - Inverse Care Law	Access & Sustainability

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		- Roll out of MDT working via compassionate communities - Increase uptake of direct access services			
2.	To improve **oral health** in Blaenau Gwent West	- Consider a pilot pop up service for varnish and case finding of early decay for referral onto regular services	- **Direct benefits** Evidence from Public Health England suggests that targeted community fluoride varnish programmes can result in an extra 3,049 school days gained per 5,000 children and that after 5 years, the return on investment for this intervention is £2.29 for every £1 spent and £2.74 after 10 years for every £1 spent	- BG has the highest rates of tooth decay in children in Wales	Prevention, Wellbeing & Self-care
3.	To **improve the management of patients with chronic disease**	- Target areas identified in our needs assessment including Hypertension, obesity, COPD, cardiovascular, asthma	**Direct benefits** - Reduced demand on health service	- High prevalence of chronic disease	Prevention, Well-being and Self-Care

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		- Involvement in developing phase 2 of Living Well Living Longer Programme - Pilot home visiting service for pre-emptive and proactive management of frailty and chronic conditions -	- Avoid emergency admissions - Improved community resilience - Improved signposting to services **Wider benefits** - Improved wellbeing of population - Improved health activation - Improved sustainability of services		
4.	To build **capacity of individuals,** to be independent, **maintain good health and well-being** by building on **community development principles** and harness assets readily available in	- Target areas identified in our needs assessment including Hypertension, obesity and asthma - Involvement in developing phase 2 of Living Well Living Longer Programme	**Direct benefits** - Reduced demand on health service - Improved community resilience - Improved signposting to services	- Unhealthy behaviours - Health inequalities	Re-designing Community Services

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
	local communities and beyond	- Use the IWN methodology to consult with the community regarding support for Fibromyalgia and Menopause to understand what support they need from the community and to develop a support system around the needs - Roll out of MDT working via Compassionate Communities programme - Implement proven evidence based interventions and self-management techniques - Work closely with our partners/the IWN to develop practice based schemes and communities specific to	**Wider benefits** - Improved wellbeing of population - Improved health activation - Improved sustainability of services		

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		local needs, such as free weight loss clubs run community volunteers for areas whereby payment for privately run schemes are a barrier			
5.	To better support people who may feel **social isolated** and **lonely** to include 1) those who are **'hard to reach'** and 2) those who **frequently access health services for social reasons.**	- Routinely identify patients through the compassionate communities MDT model - Analyse data on those patients who frequently access services (including unscheduled care, ambulance services) services to understand their reasons/identify demand - Mapping of services in the community (linking in with Integrated Wellbeing Network programme).	**Direct benefits** - Reduced demand on GP services - Reduced emergency admissions **Wider benefits** - Improved health and wellbeing - Improved social connectedness	- Aging population -Increase in number of people living alone in BG	Prevention, Wellbeing & Self-care

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		- Undertake gap analysis - Develop proposal to address gap			
6.	To improve the **experience of people with cancer,** from prevention to diagnosis, living with the impact of cancer and end of life care.	- Review screening campaigns and involvement - Undertake the Macmillan Quality Toolkit for General Practice as an NCN - Undertake cold reviews of previous cancer diagnoses to identify themes for change and actively assess where delay in diagnosis is happening. - Identify patients with changing care needs towards the end of life at an early stage, through the use of palliative care registers	**Direct benefits** - Increased uptake in screening - Appropriate USC referral rates - Earlier diagnosis - Earlier presentation to the GP - Improved cancer outcomes **Wider benefits** - Improved awareness of healthy lifestyle factors which impact upon other conditions - Reduction in advanced cancer rates - Reduction in inequalities	- Low uptake of screening - Link with cancer incidence and levels of social depravation - Late presentation - Poor outcomes	Quality, Value & Patient Safety

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		and regular multidisciplinary team meetings involving primary and social care. - Utilise standardised templates across the NCN to support sharing of information.			
7.	To improve childhood **immunisation and flu vaccination uptake**	- Understand the barriers to uptake in BG West - Review of communication and dialogue between contacting professional and patient to see if there are areas for improvement - Review the reasons for variation between practices in terms of high exception codes - Consider drop in clinics; evaluate the evidence	**Direct benefits** - Improved uptake in immunisation rates - **Wider benefits** - Reduced disease burden - Improved population health	- Low immunisation and vaccination rates	Prevention, Wellbeing & Self-care

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		- Learn from other clusters who have improved their uptake - Co-produce a targeted action plan			
8.	To improve prescribing practices and reduce prescribing rates in line with best practice	- Implement point of care testing	**Direct impact** - Improved compliance with national targets	Blaenau Gwent East has a particularly high use of: Proton pump inhibitors (PPIs) prescribing, Opioid burden-driven by high tramadol and co-codamol use, Pregabalin /gabapentin prescribing, and antibiotics	Quality, Value & Patient Safety

~~14~~11 Communication & Engagement Mechanisms

Effective, inclusive engagement is imperative to ensuring that all people have all the things they need to keep well and are living healthier lives for longer in the place they live. Using the unique strengths and assets that exist in the community, the aim is to bring people together to build a resilient community.

Stakeholders' engagement needs to involve a range of citizens who reside and work in the local community. Community members are undoubtedly the most important people that need to be engaged alongside the statutory and third sector, from senior leaders to frontline staff and volunteers.

Engagement regularly takes place with many organisations, groups and citizens within the community, including those that deliver support services and provide information to others as part of their roles. The stakeholder list for the borough engagement includes:

- Blaenau Gwent County Borough Council
- Aneurin Leisure Trust
- Job Centre
- Learning Action Centre
- Credit Union
- Supporting People
- Tai Calon
- Gwent Police
- Community Connectors
- Coal Fields Regeneration
- 50+ Forum
- Age Cymru
- GAVO
- Groundworks
- NET Team
- Digital Communities
- Living Well Living Longer
- Mental Health Services
- Expert Patient Programme
- Carers Project
- Citizens Advice Bureau
- National Exercise Referral Service
- Bryn Bach Park
- Blaenau Gwent Partnerships Team
- DEWIS

1.2 Engagement Plan

We recognise the need to communicate more effectively at grass roots level, we have good networks by which senior teams are fully sighted and engaged with developing plans but it is acknowledged that the onus for sharing these sits with this level rather than the senior team

As the management structure changes and develops in Blaenau Gwent there are opportunities to build stakeholder events across all HB teams and wider to include LA and third sector. A regular newsletter or mail shot would be helpful in ensuring that staff are sighted and engaged. We are good at making sure that the public is engaged but less effective at ensure that very senior managers work with staff on the ground to hear their ideas and concerns.

Regular meetings are in place to meet with county and town councils, public engagement events occur but primarily around change initiatives like THWBC and we will build a more proactive stance utilising local networks including supermarkets, clubs etc to provide information in relation to clinical futures. This will be done in partnership with the Engagement Team.

~~15~~12 Financial Profile

Cluster Funding

Blaenau Gwent East NCN Cluster Funding - Annual Budget £110,907.

Currently supports:

Role / Initiative	Recurrent Cost
Independent Contractors (Top Sliced across all ABUHB NCNs)	£2,092.00
Physiotherapist Band 6 (Direct Access Service at Yybyty Aneurin Bevan)	£17,220.00
Nursing HCA/HCSW Band 3 (Top Sliced across all ABUHB NCNs)	£9,229.00
Pharmacist Band 8A	£50,715.00
DEWIS Co-ordinator (Top Sliced across all ABUHB NCNs)	£1,291.00
Room Hire	£772.00
Dementia Road Map (Top Sliced across all ABUHB NCNs)	£582.00
Pharmacist Training	£1,699.00
NEWT Annual Subscription (Top Sliced across all ABUHB NCNs)	£23.00
Total Costs	**£83,881.00**

Since 2016-17 the Blaenau Gwent East NCN has invested around £160,800 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 Ysbyty Aneurin Bevan for all Practices to be able to refer to. Investment in the service since 2016 amounts to £61,751. At the end of Quarter 1 2019/20, the uptake of the available service was 64% of available slots.

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

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

The introduction of innovative use of digital and clinical technology and equipment has also been supported to enable Primary Care services to provide a wider range of options for patients.

The NCN continues to horizon scan with the aim of developing a portfolio of existing and proven schemes, and potential new pilot projects.

Transformation Programme Funding

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

1 x WTE Clinical Pharmacist

1 x WTE Clinical Physiotherapist
2 x WTE Mental Health Practitioners
1 x WTE CRT Nurse
1 x Clinical Paramedic led Home Visiting Service

Integrated Care Fund

ICF funding has been secured through joint applications, with Blaenau Gwent Local Authority, for the following initiatives:

- Resilient In House Provision (adults)
- Advocacy Access
- Health and Social Care Changing Culture - Social Media
- Social Value Project - Catering and Community Meals
- Integrated Prevention Senior Practitioner Lead
- Discretionary Accommodation Support for Young People
- Artificial Intelligence, Digital and Mobile Assistive Technical Solutions

~~16~~13 Actions to Support Cluster Working and Maturity

As part of the IMTP process, NCNs were asked to consider actions to aid their development and implementation of increasingly ambitious plans. Below is a summary of the key themes emerging from the exercise:

- Support to release NCN / primary care funds for new developments by converting services that have demonstrated positive impact into 'core' service provision
- Seek potential changes to the short-term allocation of grant funding, which is resulting in an ever-changing landscape of services and high levels of bureaucracy
- Development of a Communication and Engagement Strategy, aligning capacity and expertise across NCNs, borough teams and Corporate Services
- Strengthening of term of reference and governance / accountability between ISPBs and NCNs
- Help to manage the data requirements of population needs assessments and planning on a 'whole system' basis, with input from the Division, Corporate Information Services, Local Authorities and Public Health Wales
- Expectations on NCNs to plan, influence and assess impact across the system are growing and more expertise in service planning, performance management and business support would be hugely beneficial
- Issues with the capacity of NCN Leads and support teams to meet the growing expectations of detailed planning at an NCN level, which incorporates all operational divisions and public service organisations

Appendices

~~16.1~~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**

~~16.2~~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**

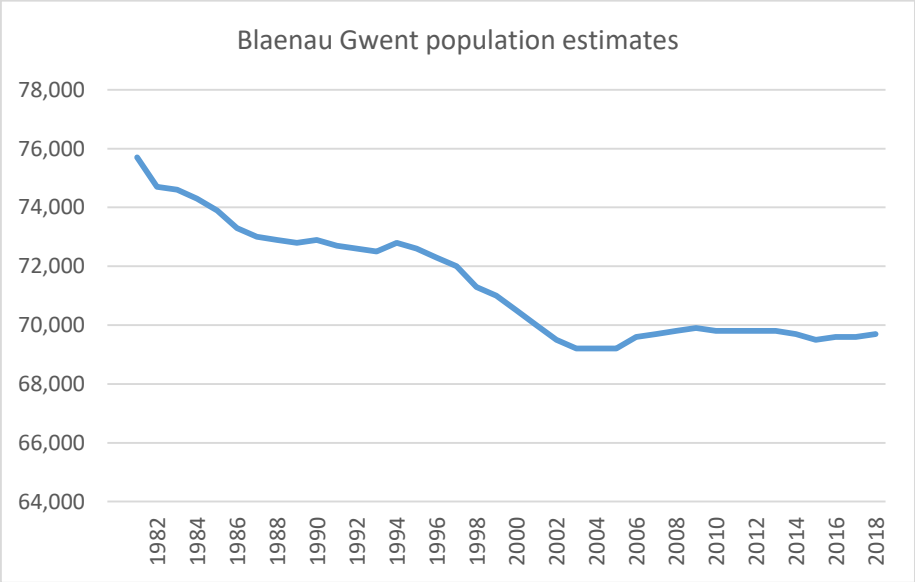
Baseline Data per 10,000 Population

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**

Summary of key points from this section:

- The population of Blaenau Gwent is declining over time
- Blaenau Gwent has an aging population which is predicted to increase
- Blaenau Gwent East NCN has the highest rate of deprivation of all the Health Board Clusters
- The gap in health inequalities does not appear to be reducing in Blaenau Gwent
- The annual premature mortality rate in Blaenau Gwent from all causes, standardised for age, whilst declining slightly, is higher than Wales as a whole
- By 2035, the number of people aged 65 and over predicted to be living alone will increase
- Data from the 2011 survey shows that more than one third of unpaid carers in Blaenau Gwent aged over 65 provide 50 or more hours of care per week to people who are disabled or infirm
- Blaenau Gwent has the 2nd highest % of people who state they have a long-term health problem or illness in Wales

The population of Blaenau Gwent is declining over time;



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In Wales, the population is predicted to rise by around 200,000 from3.1m to 3.3m by around 2033.

The population of Blaenau Gwent has declined overtime, with the ONS estimating a population of 69,700 in 2018, which has remained reasonably static since 2006 (Ref- Future Trends Report).

Blaenau Gwent is predicted to buck this national population trend, with the overall population expected to decrease. Current population projections **(2014 base)** suggest the population of Blaenau Gwent is projected to decrease by 1.2% by

2026 and 4.9% by 2039 (66,258), although projections become less reliable over more extensive time periods **(PSB needs assessment).**

Blaenau Gwent has an aging population which is predicted to increase;

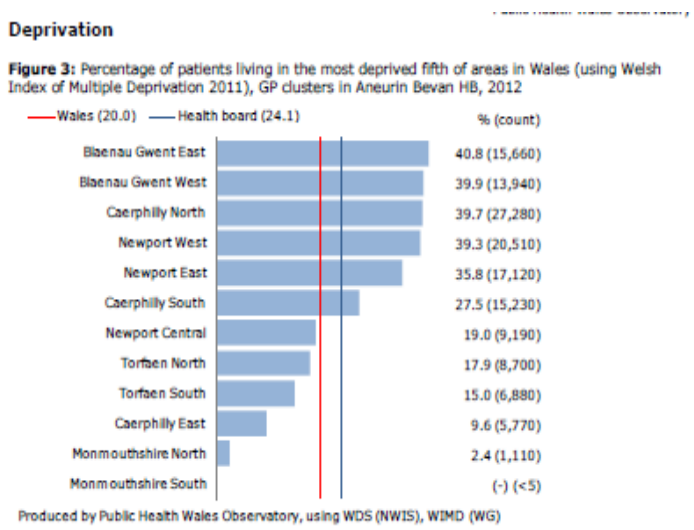
Blaenau Gwent, like the majority of places in the UK, has an overall population which is ageing. Generally, this is because less people are being born than before, and those people that are alive are living longer.

The information below shows key trends in population projections by three distinct age groups (0-15, 16 to 64 and 65 and over):

- The projected percentage of the population aged 0 – 15 years over the period 2014 to 2039 is expected to decrease by 2% in Blaenau Gwent to 10,726 people. This decrease is in contrast to the expected increase across Wales overall.
- The projected percentage of the population aged 16 – 64 years over the period 2014 to 2039 is to significantly decrease by 16% in Blaenau
- Gwent to 36,913 people.
- The projected percentage of the population aged over 65 years over the period 2014 to 2039 is to significantly increase by 39% in Blaenau to 18,619 people. This is in-line with expectation across Wales overall **(Taken directly from PSB needs assessment).**

The aging population will have an impact on the Blaenau Gwent East NCN, as our population is living longer, with more complex care needs, meaning demand on primary and community services will grow. The support our population will require will be multi-faceted because of this.

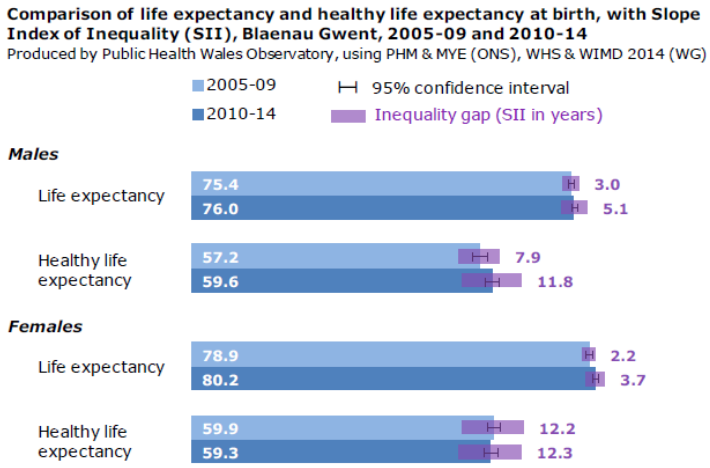
Blaenau Gwent East NCN has the highest rate of depravation of all the Health Board Clusters



82% of the population in Blaenau Gwent East are living in the 2 most deprived fifths.

This factor is critical to the planning and delivery of our services, due to the strong link between deprivation and poor health. People in the most deprived areas have higher levels of mental illness, hearing and sight problems, and long-term conditions, particularly chronic respiratory diseases, cardiovascular diseases and arthritis.

The gap in health inequalities does not appear to be reducing in Blaenau Gwent



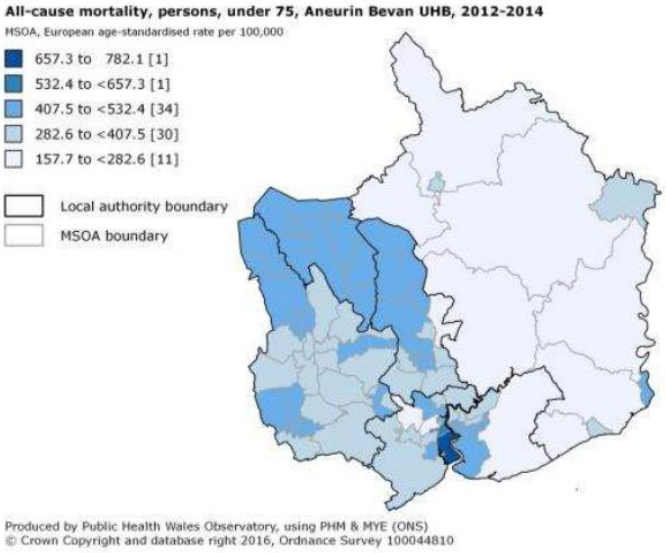
Blaenau Gwent males born today can expect approximately 60 healthy years of life and females about 59 years. For both males and females, Blaenau Gwent has statistically significantly lower healthy life expectancy than Wales as a whole (males, 65.3 years; females, 66.7 years).

There has been little change in the last decade with estimates suggesting healthy life expectancy is increasing only slightly.

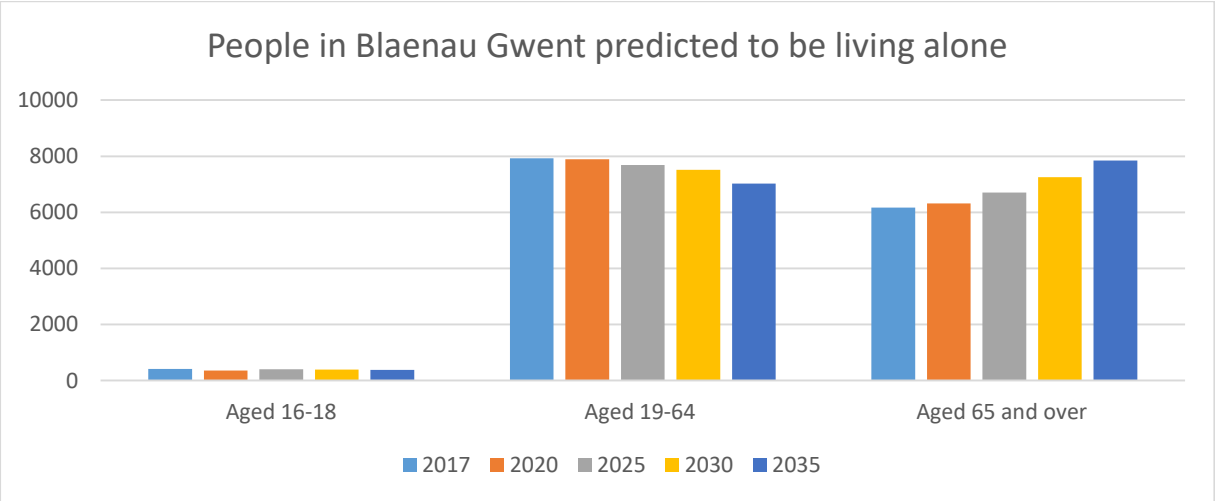
In essence, this means that not only are the most deprived likely to live shorter lives they are likely to enjoy fewer years in good health and for a smaller proportion of their lives. This negatively impacts quality of life, ability to work and the need for health and social services **(PSB Wellbeing assessment)**

The annual premature mortality rate in Blaenau Gwent from all causes, standardised for age, whilst declining slightly, is higher than Wales as a whole

Death rates amongst those aged under 75 years are an important indicator for the wellbeing of citizens. Whilst gradually improving over time, in 2012-14, Blaenau Gwent had the highest all-cause mortality rate for persons aged under 75 and all ages, compared to its neighbour Monmouthshire which had the lowest all-cause mortality rate for persons aged under 75 and all ages in the Gwent area. **(PSB Wellbeing assessment)**



By 2035, the number of people living alone in Blaenau Gwent between the ages of 19-64 years old is predicted to decrease whilst the people aged 65 and over predicted to be living alone will increase



(Source BG needs assess data- performance team)

This changing demographic will have an impact upon demand for care in the community, across all providers.

Research demonstrates that lacking social connections is bad for our mental and physical health and that loneliness increases the likelihood of premature mortality by 26%. **(DOPH report).**

Therefore, an increase in loneliness linked to living alone will have a negative impact upon the population of Blaenau Gwent East, and will lead to increased demand upon our services if we don't take a proactive approach to preventing this.

Unpaid Care

Data from the 2011 survey shows that more than one third of unpaid carers in Blaenau Gwent aged over 65 provide 50 or more hours of care per week to people who are disabled or infirm;

- There are increasing numbers of people in their 80s caring for spouses / others who require support;
- Many people aged 50 and over now have additional caring responsibilities, with working families increasingly relying on grandparents to care for younger children whilst at the same time caring for elderly relatives. **(PSB needs assessment).**

Blaenau Gwent has the 2nd highest % of people who state they have a long-term health problem or illness in Wales

The 2011 Census showed that 28% of all people who live within Blaenau Gwent stated they had a limiting long-term health problem or illnesses, where day-to-day activities were limited. This was higher than Wales overall (23%), and was the 2nd highest level in Wales (behind Neath Port Talbot with 28%).

More recent statistics from the Annual Population Survey (June 2016) shows that Blaenau Gwent continues to have significantly above average levels of disability with a total of 31.6% of working age people being defined as disabled (economically active core or work-limiting disabled) compared to 22.8% for Wales.

These comparatively high levels of disability in Blaenau Gwent leads to a high proportion of people claiming disability-related benefits, with 12.0% of working aged people in Blaenau Gwent claimed EAS or Incapacity Benefit, compared to 8.4% across Wales (May 2016). **(PSB needs assessment).**

~~16.3~~13.3 Health and Wellbeing

Summary of key points from this section:

- Hypertension, obesity and depression combined accounts for 54% of the disease prevalence within Blaenau Gwent East NCN

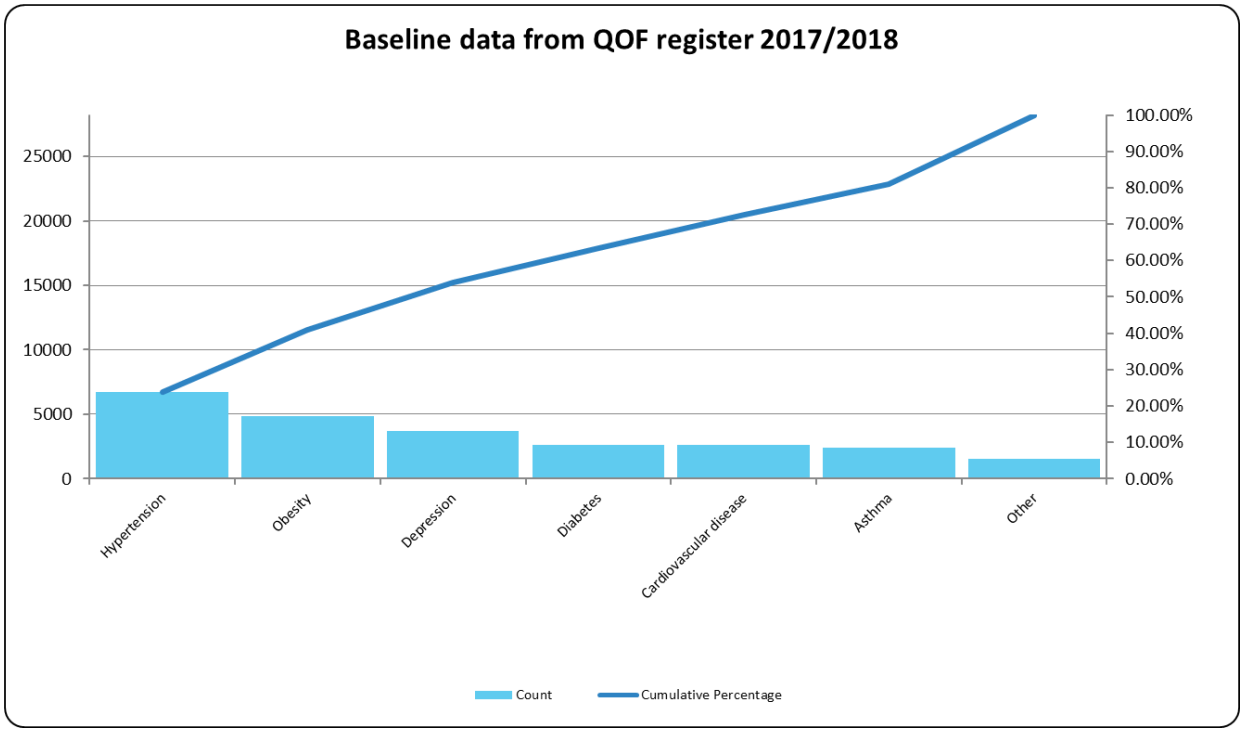
- Cardiovascular disease and Cancer are the biggest causes of premature mortality in Blaenau Gwent
- The % of people who are overweight, obese, who do eat 5 portions of fruit and vegetables a day and who are active for less than 30 minutes a week in Blaenau Gwent is significantly higher than Wales
- Blaenau Gwent citizens have poorer mental wellbeing than for Wales as a whole, often associated with multiple comorbidities
- Blaenau Gwent has the highest rates of childhood tooth decay in Wales

Disease Prevalence in Blaenau Gwent East

Baseline Data per 10,000 Population

Borough		Practice List Size			% of pop. living in the 2 most	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	1,389	2,524	47	1,437
	West	38,377	7,566	20%	66%	734	273	156	256	506	334	66	722	637	87	124	1,678	2,420	50	1,156
Caerphilly	East	65,790	12,754	19%	40%	606	193	161	220	330	334	40	734	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**

Data from the QOF disease register indicates that there is a comparatively high prevalence of asthma, COPD, diabetes, hypertension, epilepsy, heart failure, influenza, learning disabilities and obesity.



**NB the above reflects the raw data (not adjusted to per 10,000 per population).*

Hypertension, obesity and depression combined account for 54% of the disease prevalence in BG East.

Cardiovascular disease and Cancer are the biggest causes of premature mortality in Blaenau Gwent.

The two major cause of premature death in Blaenau Gwent West are cancer and cardiovascular disease.

Reducing overall mortality from circulatory disease to levels seen in the least deprived areas of Wales would increase life expectancy in the most deprived areas by 1.5 years in males and 1.3 years in females with greater potential gains in the more deprived areas. Similar gains could be made if cancer mortality rates were reduced to the same level (1.3 years in males, 1.2 in females).

A significant proportion of circulatory disease and some types of cancer is attributable to unhealthy health behaviours (diet, physical activity, smoking). For many types of cancer, more positive outcomes are associated with early detection and diagnosis. This depends on health services, but also on patient's awareness of cancer signs and symptoms of cancer and whether they seek treatment promptly **(PSB assessment).**

The QOF register for Blaenau Gwent East indicates a low disease prevalence of cancer (as demonstrated in the section above), however, we know that Blaenau

Gwent has the highest cancer mortality rate of all the local authorities in Wales.; 12% higher than the Wales rate **(PSB assessment).**

This is therefore an indication that cancers are not being detected at an early stage.

Uptake of Bowel Screening is low in Blaenau Gwent East as benchmarked below:

BOWEL SCREENING UPTAKE 2017/18 **Source: Bowel Screening Wales**

GP Cluster Name	Eligible / Invited	Tested	Uptake %
Newport West	3293	1612	49.0
Blaenau Gwent East	2904	1455	50.1
Newport East	3414	1724	50.5
Torfaen South	3997	2133	53.4
Blaenau Gwent West	3418	1839	53.8
Caerphilly North	5830	3235	55.5
Caerphilly East	5594	3107	55.5
Torfaen North	4318	2400	55.6
Newport North	4770	2764	57.9
Caerphilly South	4887	2895	59.2
Monmouthshire South	3831	2302	60.1
Monmouthshire North	5193	3192	61.5

In addition Blaenau Gwent east have a higher % of patients diagnosed at stages 3 and 4 in comparison with the ABUHB average.

INCIDENCE Staging – cases diagnosed of colorectal cancer 2011-15

Characteristic of stage	Nos of cases- Blaenau Gwent East NCN	% of total	ABUHB average
Stage 1	12	9.3%	11.5%
Stage 2	19	14.7%	22.6%
Stage 3	44	34.1%	32.0%

Stage 4	32	24.8%	20.9%
Unknown Stage	22	17.1%	13.1%
	129 78 men, 51 women		

Source : https://public.tableau.com (PHW wcisu) www.wcisu.wales.nhs.uk

This later diagnosis is reflected in the fact that Blaenau Gwent has a higher mortality rate than the Wales average given the link between later diagnosis and poor survival outcomes.

MORTALITY

Colorectal Cancer Death rates 2015-2017: 3 year average per 100,000 population.

Wales average	**28.9**
ABUHB	29.6
Blaenau Gwent (LA)	39
Blaenau Gwent U002 (post codes NP13 1BQ, NP13 2AB)	40.5
Blaenau Gwent U001 (post codes NP23 4BR, NP13 3AT)	38.1

Source: Health Maps for Wales:
https://www.healthmapswales.wales.nhs.uk/IAS/ (NHS Wales Informatics)

As an NCN, we believe the reasons for low screening and late presentation to be multi- factorial to including attitudes to cancer within our population.

The International Cancer Benchmarking (ICB) Study Phase 1 (2013) explored whether the general public's awareness and attitudes towards cancer to see if cultural differences could help explain variation in survival between jurisdictions. It was acknowledged that individuals with low awareness of cancer symptoms or negative beliefs about cancer outcomes may delay going to the doctor when they have symptoms.

We believe that this explanation is relevant to parts of our population in Blaenau Gwent West, where there can be a lack of awareness, a fear of being told bad news or an acceptance of one's 'lot' in life, which might result in late attendance to GP.

1) Access to primary care services

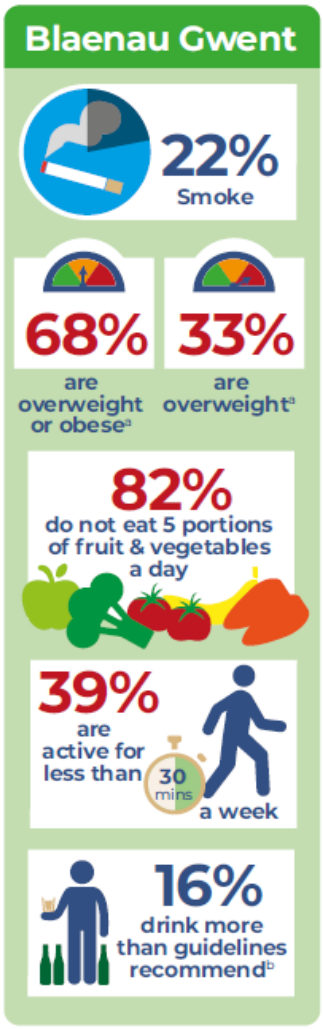
Access to primary care services, whether real or perceived (i.e. "I don't want to burden the Doctors as they are busy") has also been highlighted as a barrier within the literature around variation in cancer outcomes (ICB, 2013). We also believe this to be a key characteristic within our community.

2) Demands on GPs

Whilst there are clear red flags indicating suspicion of cancer within clinical guidelines, early symptoms of cancer can be vague and require more nuanced questioning by a practitioner to inform whether there is a suspicion of cancer or otherwise.

The fact that individual GPs only see a small number of patients with suspected cancer per year, combined with increasing time demands upon GPs which constraints appointment times ,this creates a perfect storm for nuanced conversations to be missed.

The % of people who are overweight, obese, who do eat 5 portions of fruit and vegetables a day and who are active for less than 30 minutes a week in Blaenau Gwent is significantly higher than Wales.



As outlined within the Director of Public Health Annual Report 2019, *Building a Healthier Blaenau Gwent* "…..the development of a large percentage of these [prevalent] illnesses can be attributed to preventable risk factors including smoking, unhealthy diets and physical inactivity. The difference in preventable risk factors across Gwent (figure 1.4) explains the major part of the difference in the average number of years people live in good health and how long they live. People living in disadvantaged areas in Gwent have a greater number of unhealthy behaviours."

As the pictogram to the left indicates by highlighting in red, the % of overweight people who do eat 5 portions of fruit and vegetables a day and who are active for less than 30 minutes a week is significantly higher than Wales.

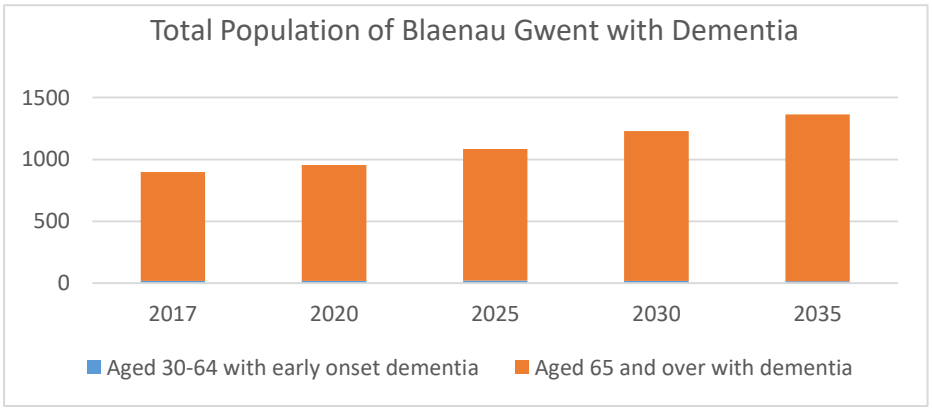
This poses a significant opportunity to Blaenau Gwent East NCN given that a significant proportion of the burden of ill health in Blaenau Gwent could be prevented, if:

- More people ate a healthier diet and maintained a healthy weight
- More people were physically active
- Fewer people used tobacco
- Fewer people took alcohol above the recommended amounts.

Equally, it poses a significant challenge in that ingrained behaviours are extremely difficult to change.

Blaenau Gwent has worse mental wellbeing than for Wales as a whole

Dementia



The number of people with dementia is predicted to increase over the coming years, in line with the aging population.

Mental Health

In the United Kingdom mental health issues are responsible for the largest burden of disease, 23% of the total burden, compared to 16% each for cancer and heart disease. Common mental health issues such as depression and anxiety are more prevalent among people experiencing greater economic disadvantage (Mental Health Foundation 2015).

Data regarding Welsh population mental well-being and trends over time is limited and not comparable with other countries due to differences in data collection. The main data sources available are outlined below **(Taken from PSB assessment)**

Mental health in children and young people

Data is not collected on prevalence of mental health problems in children and young people. Numbers of children and young people with any mental health problem can be predicted by applying estimated UK prevalence to ABUHB population projections (data extracted from the Daffodil system). Estimations of prevalence are based on the report 'Mental Health of Children and Young People in Great Britain 2004, National Statistics, 2005' as follows:

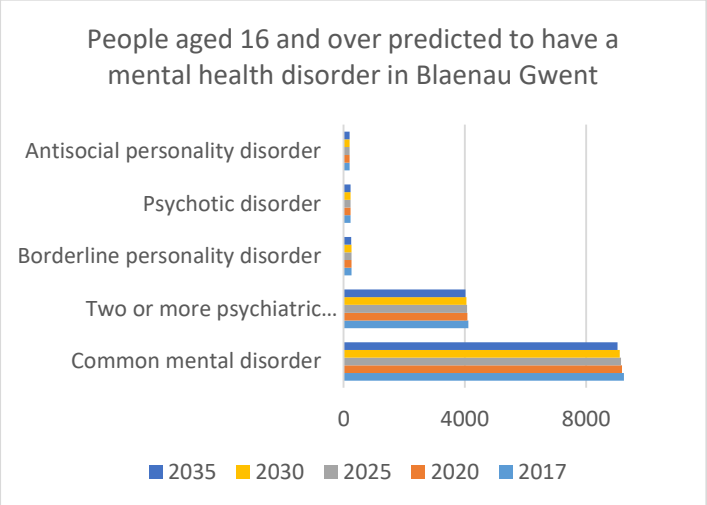
10% of children and young people aged 5-15 had at least one clinically diagnosed mental disorder. The most prevalent disorders included:

- Anxiety and depression: 4%
- Conduct disorder: 6%
- Hyperkinetic disorder- 2%
- Less common disorders (including autism, tics, eating disorders and mutism): 1%

This data reveals that prevalence of mental health problems appears to be greater in boys (11%) than girls (8%) and to increase with age.

Early life experiences, such as bullying or abuse, may have long-term consequences for the development of children and young people, with associated costs to society and public services. **(PSB assessment)**

Mental health in adults



There is a strong link between deprivation and poor well-being / being treated for a mental illness, with 8% of the people in the least deprived quintile reporting a mental health condition, compared with 20% in the most deprived quintile (Public Health Wales, 2016). This report also found that 24% of those who are long term unemployed or have never worked, report a mental health

condition compared to 9% of adults in managerial and professional groups in Wales. **(PSB assessment)**

Below, the Welsh Health Survey SF-36 scores have been transformed to give an indication of the number of cases of mental disorder. This indicates that there are a much greater proportion of people experiencing a common mental illness (anxiety and / or depression) than those seeking treatment (28% vs 14% in the Gwent area), and this is consistent with findings of psychiatric morbidity surveys in England. There are many reasons for this including: stigma of mental health problems, lack of accessible / acceptable help, and lack of awareness of the need to seek help.

Percentage of adults free from a common mental disorder (2013-14)

Wales	74
Gwent	72
Blaenau Gwent	66
Caerphilly	70
Monmouthshire	78
Newport	74
Torfaen	69

Source: *Public Health Wales, Our Healthy Future Indicators (2015)*

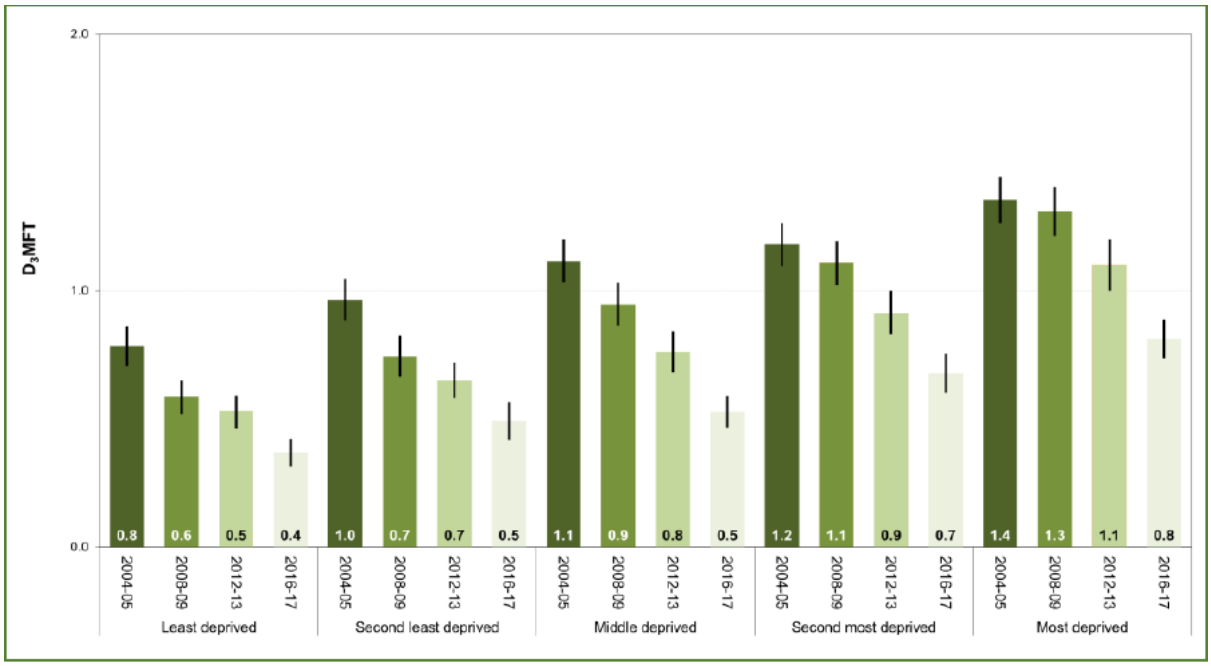
(Taken from PSB report)

Blaenau Gwent has the highest rates of childhood tooth decay in Wales

There remains a strong relationship between mean decay levels and quintile of deprivation, as demonstrated by the *Picture of Oral Health 2018- Dental Epidemiological Survey of 12 year olds 2016-17.*

The sum of Decayed, Missing and Filled teeth (D3MFT1) is a measure of the decay experience of the average child. It is therefore the burden of disease which theoretically could have been prevented and thus key data for evaluation of efforts to prevent decay.

Average D3MFT in Wales by quintile of deprivation (WIMD) for surveys of 12 year olds from 2004-2017



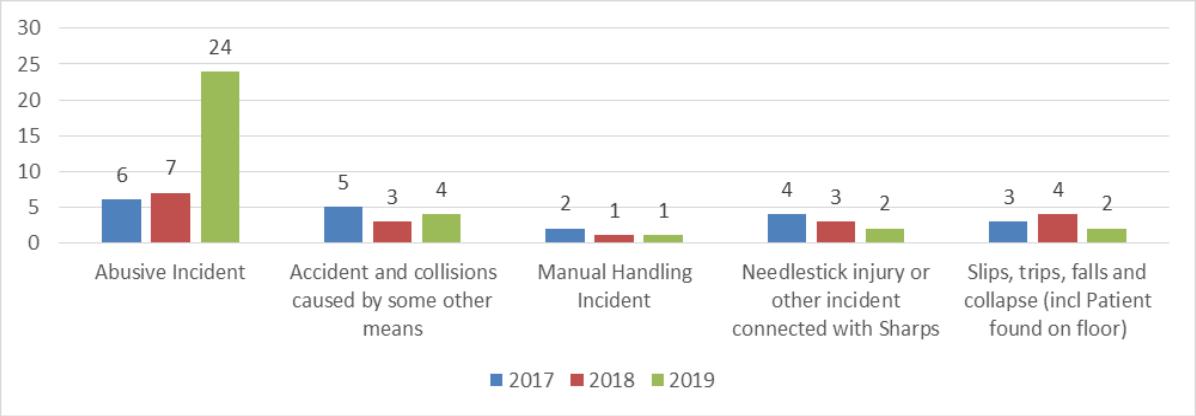
Blaenau Gwent has the highest rates of D3MFT1 in comparison with other boroughs in ABUHB, as demonstrated below, and indeed, of all the boroughs in Wales.

~~16.4~~13.4 Incidents & Concerns

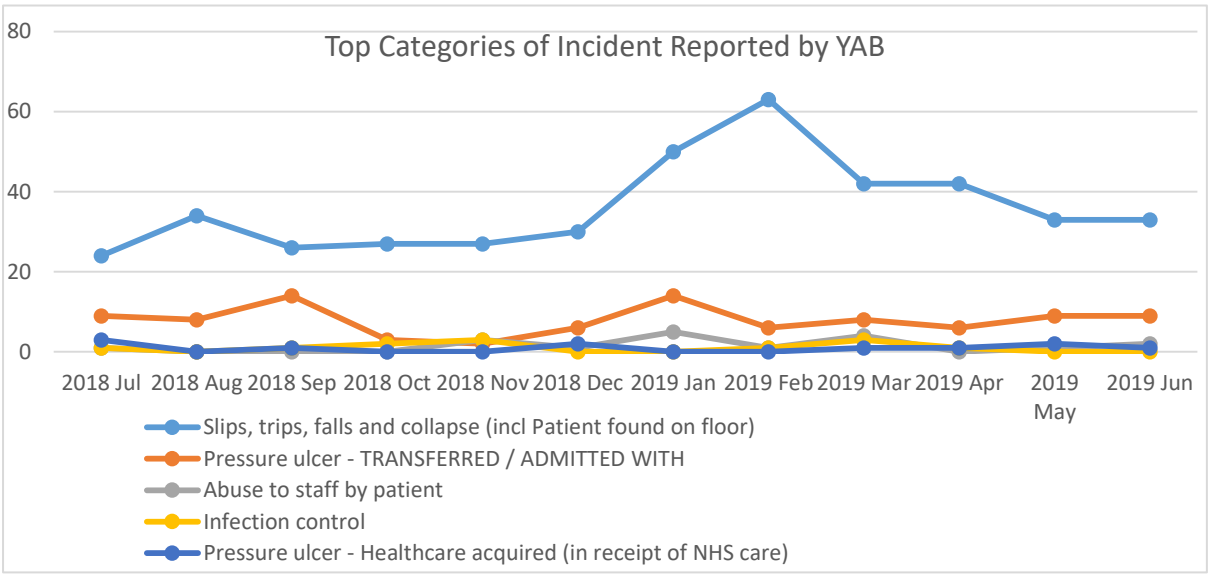
There has been a significant increase in the number of incidents classified as 'abusive incidents' during 2019 in Blaenau Gwent

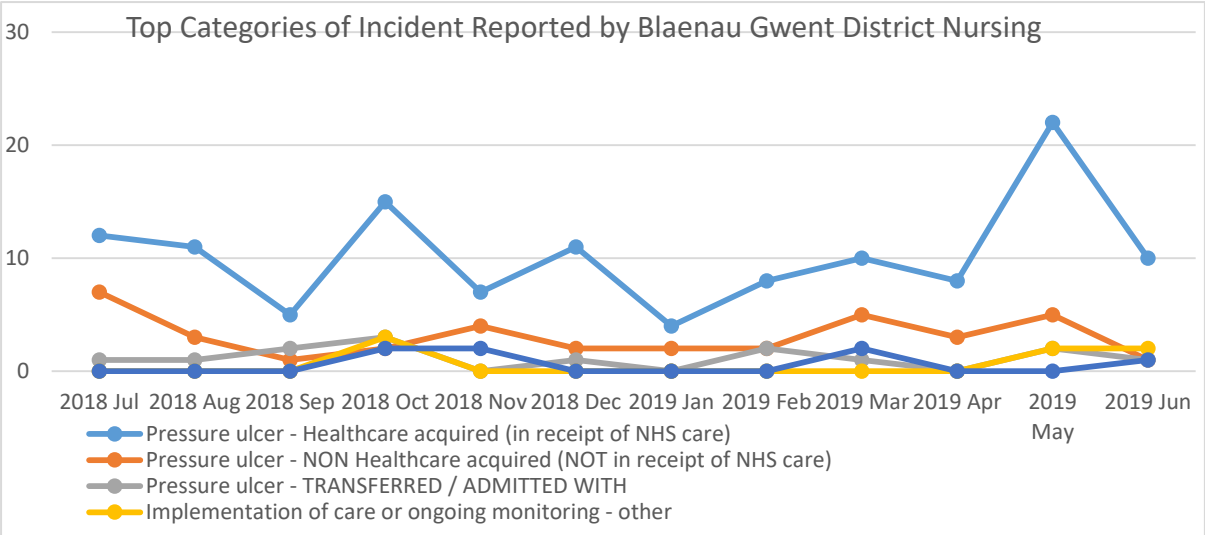
This charts illustrate all incidents affecting staff, visitors or contractors by category during a six month period between January and June for 2017, 2018 and 2019 within Blaenau Gwent Borough.

The number of incidents reported to be abusive has almost tripled in 2019 compared to the 2018 reported rate.



There has been a significant increase in the number of incidents classified as 'abusive incidents', this is driven by the need to record all incidents in YAB that involve violence and aggression from patients with limited capacity towards staff.





We know that:

Primary Care- Independent Contractors

Since September 2018, there have been 10 complaints received by the Primary Care directorate in relation to practices within the Blaenau Gwent East NCN.

- 5 were in relation to staff attitude, 3 of the complaints were in relation to 1 GP practice
- 2 complaints were regarding attitudes of staff (GP and receptionist)
- 1 was in relation to a delay in dispensing of medication
- 1 was in relation to a change in medication
- 1 was in relation to the GPs choice of medication given the side effects
- 1 was in relation to access to opiods
- 1 was due to a misdiagnosis

Community

We are unable to break down our complaints to NCN level for community services as the majority are attributed to services provided on a borough wide basis (i.e. YAB). Since September 2018, in Blaenau Gwent Borough as a whole:

- 16 complaints were received
- 9 of these were concerns- expression of patient dissatisfaction
- 5 were informal complaints
- 2 were early resolution (resolved within 24 hours)

In terms of the speciality:

- 10 were care of the elderly (admitted to YAB)
- 6 were district nursing
- When looking at the themes:
- 5 were concerns from family members in regards to care and treatment of their relatives
- 3 were patient concerns regarding delays in receiving treatment

- 3 were concerns regarding disjointed care
- 2 were from family in regards to attitude of staff
- 1 was a complaint from a family member regarding discharge arrangements
- 1 was a complaint from a patient in regards to treatment administration
- 1 was due to provision of gluten free food
- 1 was managed through the serious incident process.

All concerns are managed under the All Wales Putting Things Right Framework.

Complaints and concerns are an essential indicator for us and we take each one as a learning opportunity to reflect upon what we could do differently to improve our patient experience.

This process is multi-layered, and includes discussions and de-briefs through 1:1s and also through our Borough and Divisional Quality and Patient Safety meeting structure.

~~16.5~~13.5 Patient Safety Indicators

- Blaenau Gwent East has a particularly high use of: Proton pump inhibitors (PPIs) prescribing, Opioid burden- driven by high tramadol and co-codamol use, Pregabalin /gabapentin prescribing, Total antibiotics.
- When comparing with others, Blaenau Gwent East NCN are outliers in terms of number of emergency admissions where RIP less than 2 days, low levels of reablement referrals remaining at home on discharge and low rapid response referrals assessed in less than 4 hours and low uptake of childhood immunisations and flu immunisation
- Ysbyty Aneurin Bevan (YAB) is an outlier in comparison with others in ABUHB in terms of falls per 1,000 patients; We believe this is due in part to the patient cohort in YAB; ongoing orthopaedic rehabilitation, General medical rehabilitation, Dementia Patients. Statistically, patients at most risk of an inpatient fall are generally within one of the three cohorts above.

Prescribing Indicators

Priority areas

In developing our plans, we have linked in with our Senior Primary Care Pharmacist, who has analysed the March 19 and June 19 quarter national prescribing indicator by NCN.

Blaenau Gwent East has a particularly high use of:

- Proton pump inhibitors (PPIs) prescribing
- Opioid burden- driven by high tramadol and co-codamol use
- Pregabalin /gabapentin prescribing
- Total antibiotics

Therefore, we will work with our pharmacist colleagues to review how we can improve this and consider wider partnership working that may help to address the underlying causes that can lead to high dependence on medication.

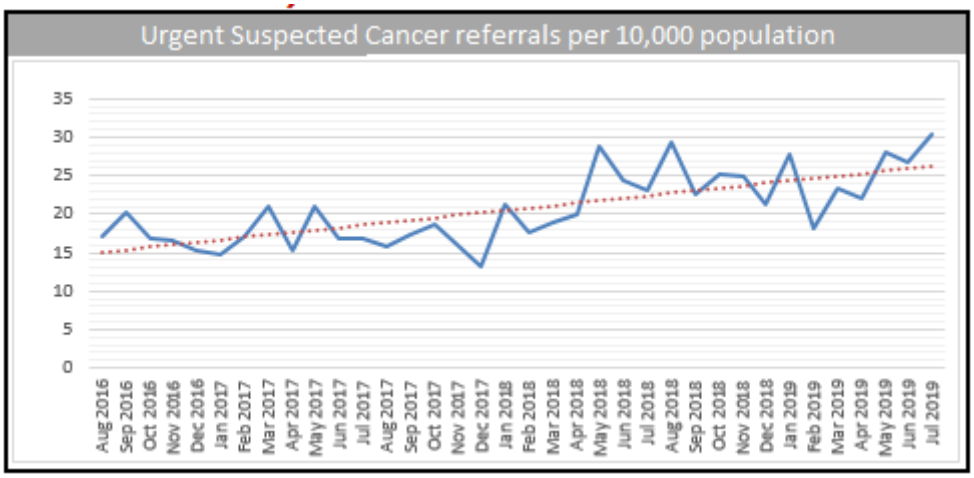
- The NCN is going to be one of the pilot areas for trialling the use of CRP point of care testing equipment in general practice, starting in late 2019. The ability to rapidly ascertain a CRP result from a patient will provide a primary care clinician with previously unavailable information, which will aid decision making when considering whether antibiotics should be prescribed or not.

Quality Indicators

NCN AREA		laenau Gwent East	Blaenau Gwent West	Caerphilly East	Caerphilly North	Caerphilly South	Monmouthshire North	Monmouthshire South	Newport East	Newport North	Newport West	Torfaen North	Torfaen South
NCN List Size		*33,563*	*38,404*	*65,889*	*64,886*	*56,463*	*53,399*	*47,335*	*48,499*	*58,942*	*50,651*	*49,661*	*46,571*
* QUALITY AND PATIENT SAFETY *	*Latest Time Period*												
Percentage of PCMH assessments undertaken within 28 days of referral	*Jul 2019*	85.71%	81.25%	94.53%	96.70%	94.94%	64.00%	71.67%	65.45%	72.55%	77.97%	82.09%	82.36%
Percentage of PCMH interventions started within 28 days of assessment	*Jul 2019*	87.50%	96.30%	92.86%	100.00%	60.00%	96.30%	94.12%	78.95%	83.33%	87.50%	81.48%	88.68%
Urgent Suspected Cancer referrals per 10,000 population	*May 2019 - Jul 2019*	111.73	100.25	88.33	73.98	85.19	105.62	101.40	72.37	89.07	87.66	103.10	91.90
EMAs where RIP less than 2 days	*Jul 2019*	5	3	4	3	2	1	2	2	1	5	5	3
Percentage of Reablement referrals remaining at home on discharge	*Jul 2019*	77.42%	87.50%	78.26%	67.50%	85.71%	0.00%	0.00%	78.26%	77.36%	75.00%	86.36%	88.89%
Rapid Response referrals assessed <4hrs (%)	*Jul 2019*	47.62%	56.60%	43.75%	36.36%	42.42%			60.87%	54.17%	31.82%	45.95%	40.00%
Average times from referral to assessment in Reablement (in hours)	*Jul 2019*	72.7	99.4	144.0	126.4	69.4			183.7	115.7	120.6	137.8	134.8
Delayed transfers of care per 10,000 population	*Jul 2019*	0.30	0.00	1.52	0.62	1.06	1.50	1.48	1.44	0.34	1.38	1.01	0.86
Delayed transfers of care bed days lost per 10,000 population	*Jul 2019*	2.68	0.00	27.62	10.33	19.13	18.17	24.93	15.26	5.94	18.76	12.69	12.45
Childhood Immunisations - MMR1 - Age 2 - Uptake %	*Mar 2019*	96.45%	97.49%	97.97%	96.04%	96.47%	94.52%	97.63%	96.33%	93.20%	93.88%	95.17%	96.51%
Childhood Immunisations - PCVf - Age 2 - Uptake %	*Mar 2019*	96.75%	97.74%	98.55%	96.59%	96.47%	94.78%	98.68%	96.19%	93.37%	93.73%	96.55%	96.95%
Childhood Immunisations - Hib/Men C - Age 2 - Uptake %	*Mar 2019*	95.27%	97.24%	97.39%	95.77%	96.01%	93.73%	98.68%	95.78%	91.38%	93.12%	95.17%	96.73%
Childhood Immunisations - MMR2 - Age 5 - Uptake %	*Mar 2019*	90.50%	91.01%	93.97%	92.32%	92.38%	86.96%	91.97%	89.15%	89.05%	86.00%	91.21%	91.56%
Childhood Immunisations - 4 in 1 Pre Sch Booster - Age 5 - Uptake %	*Mar 2019*	92.61%	92.63%	94.66%	94.79%	93.47%	93.26%	97.57%	90.66%	88.08%	89.13%	93.10%	92.50%
Childhood Immunisations - MMR1 - Age 16 - Uptake %	*Mar 2019*	94.61%	94.39%	96.91%	96.25%	97.51%	87.03%	88.84%	96.01%	94.28%	92.36%	97.44%	95.86%
Childhood Immunisations - MMR2 - Age 16 - Uptake %	*Mar 2019*	88.55%	91.71%	92.35%	92.94%	93.61%	78.24%	84.80%	90.80%	88.56%	87.60%	93.49%	91.72%
Childhood Immunisations - 3 in 1 Pre Teen Booster - Age 16 - Uptake %	*Mar 2019*	90.24%	86.63%	90.59%	87.24%	88.28%	85.56%	80.05%	88.50%	82.42%	81.20%	87.77%	90.63%
Flu Immunisation - ≥ 65 Years - Uptake %	*Apr 2019*	63.52%	69.21%	66.14%	67.61%	71.50%	73.85%	61.14%	65.18%	71.32%	65.91%	68.49%	73.54%
Flu Immunisation - < 65 Years "At Risk" - Uptake %	*Apr 2019*	38.12%	51.05%	43.79%	44.36%	48.48%	51.19%	54.94%	43.68%	48.44%	45.30%	44.65%	48.90%
Flu immunisation 2-3 years - Uptake %	*Apr 2019*	37.34%	43.65%	47.54%	37.59%	53.14%	56.31%	58.30%	41.16%	52.91%	36.86%	42.88%	63.40%

Areas where we are outliers are number of emergency admissions where RIP less than 2 days, low levels of reablement referrals remaining at home on discharge and low rapid response referrals assessed in less than 4 hours and low uptake of childhood immunisations and flu immunisation. These outliers will be the subject of investigation, analysis and, where possible, service improvements as part of the developing Work Programme for the Blaenau Gwent East NCN.

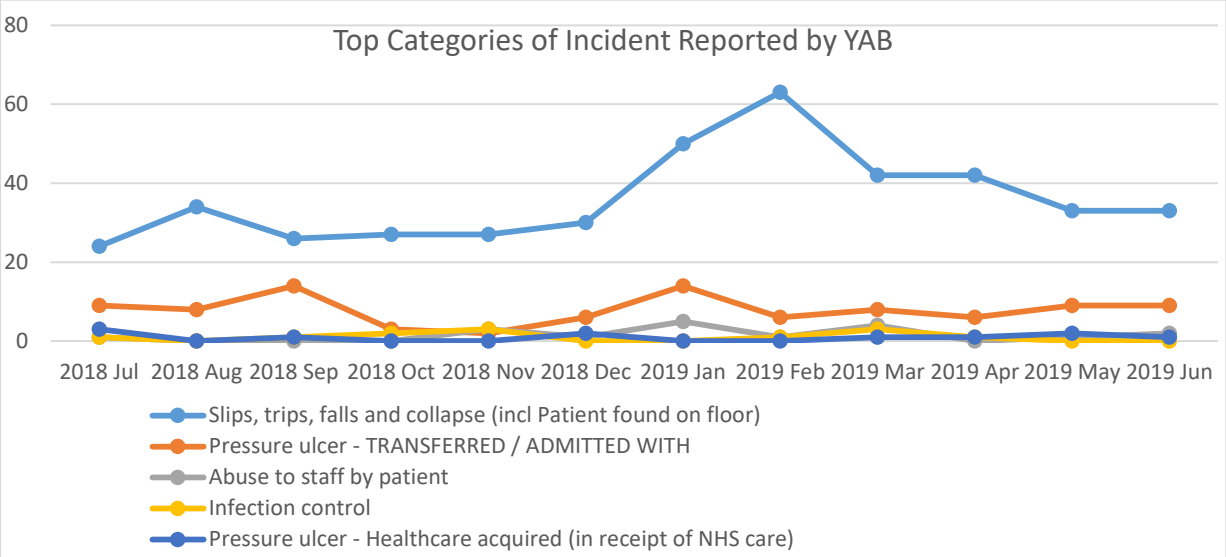
Urgent Suspected Cancer Referrals



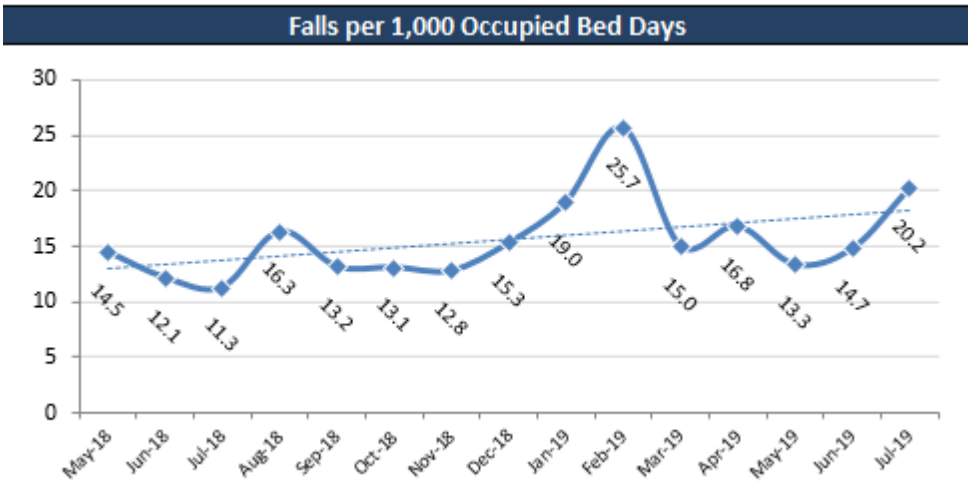
The Welsh Government Cancer Delivery Plan recognises that in order to improve early diagnosis, we need to encourage people to recognise the symptoms and signs of cancer, and seek advice from their doctor as soon as possible. We also need doctors to recognise these symptoms and (if appropriate) refer people urgently for specialist care.

The upward trend in urgent suspected cancer referrals is a proxy indicator that patients are being referred when cancer is suspected, which should lead to earlier diagnosis and improved outcomes.

Falls Rates



Slips, trips and falls were the most common type of incident reported by Ysbyty Aneurin Bevan between 2018-2019.

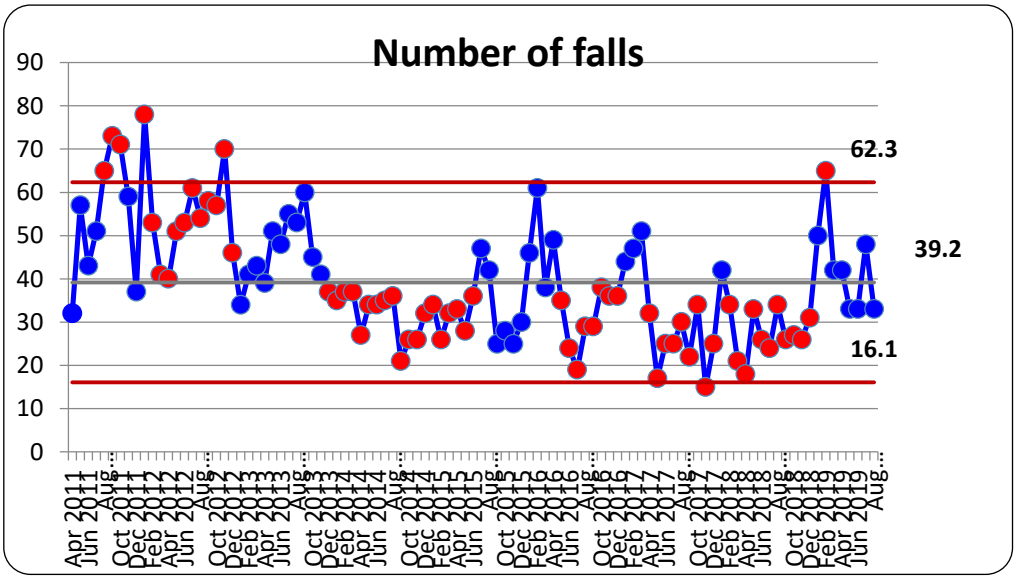


		Falls per 1,000 occupied bed days
		3 months rolling
Blaenau Gwent	Ebbw Ward (YAB)	18.12
	Sirhowy Ward (YAB)	10.05
	Tyleri Ward (YAB)	21.38
Caerphilly	Bargoed Ward (YYF)	12.94
	Oakdale Ward (YYF)	16.84
	Penallta Ward (YYF)	13.79
	Rhymney Suite (NRRC)	8.35
Monmouth-shire	Caerwent Ward (CCH)	9.96
	St Arvans Ward (CCH)	5.54
	Trefynwy Ward (MV)	7.64
Newport	Gwanwyn Ward (STW)	10.90
	Penhow Ward (STW)	5.03
	Ruperra Ward (STW)	7.45
Torfaen	Phoenix Ward (CO)	8.11
	Rowan Ward (CO)	3.68
	Usk Ward (CO)	5.19

BG (YAB) is an outlier in comparison with others in ABHB in terms of falls per 1,000 patients.

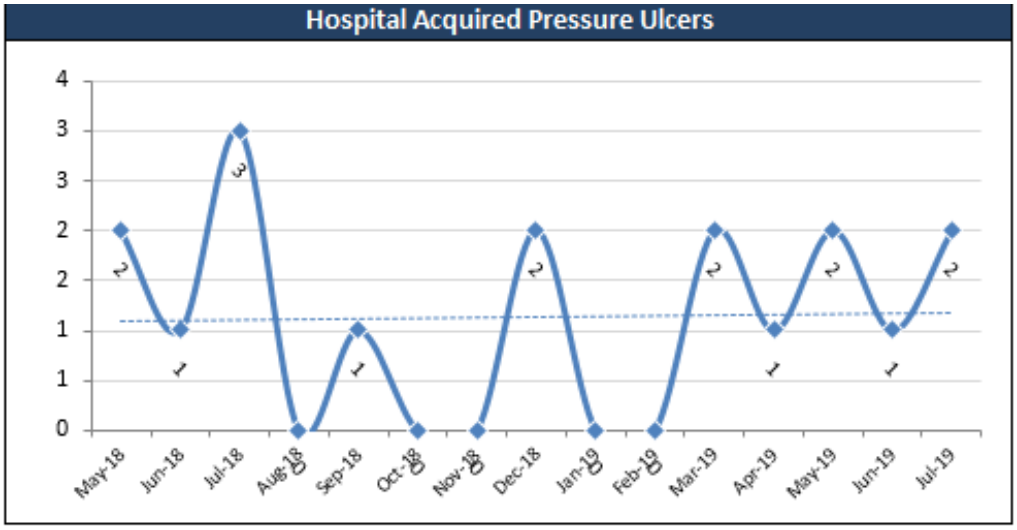
We believe this is due to the patient cohort in YAB; we have a high number of patients who are receiving orthopaedic and active rehab.

Tyleri, our nurse led ward, gradually promotes independence ahead of patients being discharged home. This service model therefore lends itself to a higher risk of controlled falls, however, we believe this to be an accepted risk given the quality of the service provided and the ethos of care in the right place at the right time, as demonstrated by our low length of stay.



Analysing the actual number of falls since the hospital opened in 2011, unless we make a targeted change to the service model or process, we can expect the number of falls to vary greatly from 16 falls to 62 falls each month, with a mean of 39.2.

Hospital Acquired Pressure Ulcers



~~16.6~~13.6 Clinical Audits

- All practices within the NCN participated in the national diabetes audit
- All practices within the NCN participated in the National COPD Audit Programme; Compared to ABUHB, Blaenau Gwent West NCN and All Wales Comparators, Blaenau Gwent East NCN shows:
    - A higher percentage of patients with Asthma;
    - A lower percentage of patients with Bronchiectasis;
    - A lower rate of reported Lung Cancer.

- Stop a stroke project; The high level summary information for Blaenau Gwent East NCN, against comparator data for All Wales, ABUHB and Blaenau Gwent is as follows:

    - The percentage of patients with Atrial Fibrillation, treated with Warfarin, is higher;
    - The percentage of patients with Atrial Fibrillation, treated with NOAC, is lower.

Information regarding outcomes for the National Clinical Audits for Diabetes, COPD and Stroke have been established from the Primary Care Information portal, supported by NWIS. The summary findings for Blaenau Gwent East NCN for each of these audits are shown below.

Diabetes.
The National Diabetes Audit (NDA) measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. It collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes.

The Audit provides a comprehensive view of Diabetes Care and measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. Reports are published for patients on practice diabetes registers.

NDA reports look at three main areas of diabetes services:

1. Care processes
2. Treatment targets
3. Structured education

1. The 8 care processes, which NICE recommend are undertaken once a year, are:

1.	HbA1c – blood test for glucose control.
2.	Blood pressure – measurement of cardiovascular risk.
3.	Serum Cholesterol – blood test for cardiovascular risk.
4.	Serum Creatinine – blood test for kidney function.
5.	Urine Albumin/Creatinine Ratio – urine test for kidney function.

6.	Foot risk surveillance – foot examination for foot ulcer risk.
7.	Body mass index – measurement for cardiovascular risk.
8.	Smoking history – question for cardiovascular risk.

2. The treatment targets are:

1.	HbA1c to reduce the risk of all diabetic complications.
2.	Blood pressure to reduce the risk of vascular complications and reduce the progression of eye disease and kidney failure.
3.	Cholesterol to reduce the risk of vascular complications.

3. Structured education measures the percentage of people newly diagnosed with diabetes being offered a structured education programme.

The high level summary for Blaenau Gwent East NCN, compared to Blaenau Gwent West NCN, Aneurin Bevan University Health Board and All Wales comparators, across three Financial Year periods between 2015 – 2018, is shown in the Table below.

	2015-16			2016-17			2017-18		
Wales / Health Board / NCN	Practice Count	Practices Submitted	Participation %	Practice Count	Practices Submitted	Participation %	Practice Count	Practices Submitted	Participation %
Wales	445	444	99.78	434	433	99.77	423	422	99.76
Aneurin Bevan University Local Health Board	83	82	98.80	80	79	98.75	78	77	**98.72**
Blaenau Gwent East	6	6	100.00	5	5	100.00	5	5	**100.00**
Blaenau Gwent West	6	6	100.00	6	6	100.00	6	6	**100.00**

The immediate reflection for Blaenau Gwent East NCN is that all of the Practices within the NCN have participated in the Audit. This compares favourably with ABUHB and All Wales compliance (<100% across the three yearly audits) and matches the 100% compliance for Blaenau Gwent West NCN based Practices.

The NDA does not specifically detail individual NCN results from the Audit, rather it gives summary recommendations for all Health Boards, Clusters and Practices to follow. Recommendations from the most recent Audit are as follow:

1. Develop and implement systems for GP practices that clarify who has attended patient education courses;
2. Seek new approaches to improving management for those Practices doing worse overall than others;
3. Serious mental health care providers should be aware of the higher risks of Type 2 diabetes at younger age onset in females;
4. Type 2 diabetes care providers should work with people who have serious mental illness to increase care process completion;
5. Support for people with a learning disability and Type 2 diabetes to complete all their annual checks;
6. Reduce variation between peer providers - select priorities for improvement in Service provision and outcomes.

Respiratory / COPD

The National COPD Audit Programme (commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and NHS Wales, as part of the National Clinical Audit Programme (NCA)) includes three workstreams that aim to drive improvements in the quality of care and services provided for COPD patients in England and Wales.

Data from the COPD Audit Programme does not provide any detail below NCN level. The summary of Practice participation on an All Wales, ABUHB and Blaenau Gwent East and West NCN basis is shown in the following table.

Health Board	Patients Registered with COPD who Participated	Number of Participating Practices per Health Board	Percentage of Practices that Participated
Aneurin Bevan Local Health Board	16,428	79	98.75
Wales	82,696	407	93.56
Cluster	**Patients Registered with COPD who Participated**	**Number of Participating Practices per Health Board**	**Percentage of Practices that Participated**
Blaenau Gwent East	1,342	5	100.00
Blaenau Gwent West	1,260	6	100.00

The high level participation message from the above table is that Blaenau Gwent East NCN, as well as Blaenau Gwent west NCN , both had 100% participation, which is above the overall levels achieved for All Wales and ABUHB, respectively.

The Programme also provides a specific summary of Respiratory Diseases for Practices, again it does not disaggregate results below NCN level. The Table below summaries results for patients with Asthma, Bronchiectasis and Lung Cancer on an All Wales, ABUHB and Blaenau Gwent NCN levels.

	Asthma			Bronchiectasis			Lung Cancer		
	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
Aneurin Bevan Local Health Board	6,705	16,428	40.81	796	16,428	4.85	346	16,428	2.11
Wales	34,622	82,696	41.87	3,946	82,696	4.77	1921	82,696	2.32
	Asthma			Bronchiectasis			Lung Cancer		
Cluster	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
Blaenau Gwent East	639	1,342	47.62	43	1,342	3.20	27	1,342	2.01
Blaenau Gwent West	407	1,260	32.30	46	1,260	3.65	31	1,260	2.46

Compared to ABUHB, Blaenau Gwent West NCN and All Wales Comparators, Blaenau Gwent East NCN shows:

- A higher percentage of patients with Asthma;
- A lower percentage of patients with Bronchiectasis;
- A lower rate of reported Lung Cancer.

Stop a Stroke Project

In June 2014, the National Institute for Health and Care Excellence (NICE) published Clinical Guideline 180 "AF: management" its aim was to "ensure that people receive the best management to help prevent harmful complications, in particular stroke and bleeding". In addition the NHS operating framework prioritised AF and stroke prevention as key areas for maintaining healthcare quality and improvements.

A key feature of both is the early identification of patients at risk of thromboembolic events and the prompt initiation of an oral anticoagulant as this has been shown to reduce the risk of stroke by two thirds. These recommendations

were supported by the All Wales Medicines Strategy Group and endorsed by Welsh Government.

The **Stop a Stroke project** aims to support every Health Board across Wales to initiate a sustainable approach to reviewing the treatment of patients with atrial fibrillation to reduce the risk of having a stroke. Practices use the Stop a Stroke Audit+ tool to identify patients with atrial fibrillation and their current anticoagulant medication.

Summary data for patients with Atrial Fibrillation who are either on Warfarin or NOAC treatment is shown in the Table below.

Stop A Stroke Project						
	Atrial Fibrilation with Warfarin			Atrial Fibrilation with NOAC		
Health Board	Numerator	Denominator	%	Numerator	Denominator	%
Aneurin Bevan Local Health Board	4,527	13,574	33.35	6,110	13,574	45.01
Blaenau Gwent East	269	715	37.62	311	715	43.50
Blaenau Gwent West	289	880	32.84	431	880	48.98
Wales	24,111	75,757	31.83	35,172	75,757	46.43

The choice of using Warfarin or NOACs for patient treatment is between GP and Patient. There is a cost implication to be considered when prescribing NOAC treatment, which is more expensive than Warfarin. The high level summary information for Blaenau Gwent East NCN, against comparator data for All Wales, ABUHB and Blaenau Gwent is as follows:

1. The percentage of patients with Atrial Fibrillation, treated with Warfarin, is higher;
2. The percentage of patients with Atrial Fibrillation, treated with NOAC, is lower.

Service Improvement Projects

At the time of compiling this report, information relating to individual Practice Projects were being analysed by the Primary Care Team and were not available for inclusion in the inaugural IMTP for Blaenau Gwent East NCN. The Plan will be updated as soon as the details are received.

~~16.7~~13.7 Enhanced Services

Shown below are three table which illustrate the uptake of DES, NES and LES schemes by Practices across the Blaenau Gwent East NCN. Enhanced Services are discussed as an agenda item for the Annual Contract Review meetings between Practices, NCN Lead and Locality Support Team.

The Table below shows the LES arrangements in Blaenau Gwent East NCN.

Blaenau Gwent East NCN - DES	W93007	W93009	W93068	W93075	W93115
	Cwm Calon Surgery	Aberbeeg Medical Practice	Brynmawr Medical Practice	Abertillery GP	Blaina Med Pract
Pneumococcal	Y	Y	Y	Y	Y
Childhood Imms	Y	Y	Y	Y	Y
Asylum Seeker					
Learning Disability	Y	Y	Y	Y	Y
Violent Patients					
Minor surgery - Fee A	Y	Y		Y	
Minor surgery - Fee B	Y	Y	Y	Y	Y
Diabetes Gateway DES		Y	Y	Y	Y
Mental Health		Y	Y	Y	
CARE HOME			Y	Y	
Anti-coagulation Level A	Y	Y	Y		Y
Anti-coagulation Level B		Y			
Homeless					

It is important to ensure that there is equitable access across the area- particularly where these services meet the additional needs of vulnerable groups. The following areas will be reviewed:

1. Asylum Seekers;
2. Violent patients;
3. Minor Surgery – Fee A
4. Diabetes Gateway DES;
5. Care Homes;
6. Mental Health;
7. Anti-coagulation Level A;
8. Anti-coagulation Level B;
9. Homeless.

The Table below shows the NES arrangements in Blaenau Gwent East NCN.

Blaenau Gwent East NCN - NES	W93007	W93009	W93068	W93075	W93115
	Cwm Calon Surgery	Aberbeeg Medical Practice	Brynmawr Medical Practice	Abertillery GP	Blaina Med Pract
GLP1 Monitoring			Y		
Flu Immunisation	Y	Y	Y	Y	Y
Unscheduled Immunisations	Y	Y	Y	Y	Y
Non-Routine Imms		Y	Y	Y	Y
Substance Misuse		Y	Y		
Shingles	Y	Y	Y	Y	Y
Rota virus	Y	Y	Y	Y	Y
Meningitis	Y	Y	Y	Y	Y

There is a potential requirement for the NCN to analyse the reasons why the following NES are not undertaken by Practices in the Blaenau Gwent East NCN:

1. GLP1 Monitoring;
2. Non-routine Imms;
3. Substance Misuse.

The Table below shows the LES arrangements in Blaenau Gwent East NCN.

Blaenau Gwent East NCN - LES	W93007	W93009	W93068	W93075	W93115
	Cwm Calon Surgery	Aberbeeg Medical Practice	Brynmawr Medical Practice	Abertillery GP	Blaina Med Pract
Minor Surgery non-Registered patients					
DOAC	Y	Y			Y
DOAC Monitoring		Y			
Depo-Provera	Y	Y	Y	Y	Y
Depo/Sayana Press					
Contraceptive Implants (Nexplanon)		Y	Y		Y
Depression/Lithium		Y			Y
IUCD Registered		Y	Y		y
IUCD - Non registered		**Y**	**Y**		**Y**
Near Patient Testing	**Y**	**Y1A**	**Y**	**Y1.1**	**Y**
Extended Hrs					
Denusomab	Y	Y	Y	Y	Y
Pertussis	Y	Y	Y	Y	Y
Gonadorelin/Zoladex	Y	Y	Y	Y	Y
Extended Skin Surgery			Y		

There is a potential requirement for the Locality Team to analyse the reasons why the following LES are not undertaken by Practices in the Blaenau Gwent East NCN:

1. Minor Surgery non-registered patients;
2. DOAC;
3. DOAC Monitoring;
4. Contraceptive Implants (Nexplanon);
5. Depression / Lithium;
6. IUCD - Registered;
7. IUCD – Non Registered;
8. Extended hours;
9. Extended Skin Surgery.

~~16.8~~13.8 Activity Benchmarking

We have a wide range of activity data that we are able to access, which helps us to understand how our services are performing.

The areas that Blaenau Gwent West are identified as outliers in comparison with others are which require focused effort in order to make improvements are:

- High use of lab tests
- GP referrals to non-surgical specialities per 10,000 population
- GP referrals for chest x-ray per 10,000 population
- Referrals accepted by Rapid Response Services per 10,000 population

NCN AREA		Blaenau Gwent East	Blaenau Gwent West
NCN List Size		*33,602*	*38,375*
*** PLANNED CARE ***			
GP referrals to non-surgical specialties (All Wales) per 10,000 population	-	200	199
GP referrals to Trauma & Orthopaedics (All Wales) per 10,000 population	*167.3939341*	96	102
GP referrals to surgical specialties (All Wales excluding T&O) per 10,000 population	*72.54716627*	355	380
GP referrals for MRI Knee (AB) per 10,000 population	*344.6316893*	7.74	7.56
GP referrals for ultrasound shoulder (AB) per 10,000 population	*7.264511474*	3	3
GP referrals for chest x-ray (AB) per 10,000 population	*2.69*	129	123
GP referrals for sample testing MSU urine (AB) per 10,000 population	*106.78*	261	223

NCN AREA		Blaenau Gwent East	Blaenau Gwent West
NCN List Size		*33,602*	*38,375*
* URGENT CARE *			
Referrals accepted by Rapid Response Services per 10,000 population	*0*	30.36	38.31
Conveyances to hospital from residential homes	*ü*	22	24
Conveyances to hospital from nursing homes	*ü*	28	40
GP referrals to assessment units per 10,000 population	*ü*	168.14	185.28
Average days medically fit prior to 'complex' discharge from RGH & NHH	*ü*	0.80	0.80
Average length of stay in community hospitals	*ü*	19	16
Occupied bed days > 65 years of age following EMA per 10,000 population	*ü*	7559	9052
Inappropriate ED Attendances per 10,000 population	*ü*	62	58

District Nursing

		Average days on active caseload	Active caseload per WTE	Visits per WTE each month	% of visits that are unplanned	% of active caseload that are CHC	% patient dying with EOL care	% venep'ture by HCSW	% active caseload on SKIN bundle	% active caseload with a pressure ulcer	Sickness	PADR compliance	Monthly spend per patient on active caseload	Monthly bank & agency per patient on caseload
		3 months rolling	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*3 months rolling*	*Jan-00*	*Jan-00*	*3 months rolling*	*3 months rolling*
Blaneau Gwent	East Blaneau Gwent	66	18.61	125	5.0%	1.6%	93.3%	64.8%	25.8%	3.4%	9.1%	76.0%	£187.00	£3.74
	West Blaenau Gwent	89	19.30	162	5.5%	1.6%	33.3%	79.9%	16.5%	2.6%	5.0%	95.8%	£184.95	£1.63

~~16.9~~13.9 Engagement Events

A review of Winter Planning processes that were adopted in the previous Financial Year was held at Bedwellty House, Tredegar in July 2019. The event was attended by members of Public Services Organisations, Third Sector and local interest groups. Task and finish group work took place on each table with concerns and potential solutions recorded for consideration for the 2019/20 Winter Planning process.

In August 2019 the Locality Team headed up a 'Talk Health' event at the Tabor Centre in Brynmawr. The event was well attended by approximately 60 residents and local councillors. Items discussed included the development of the Primary Care Transformation Programme for the Borough as a whole and the Health Board's Clinical Futures Programme which overarches the modernisation of Health services provision across Gwent. Both items were well received and questions and discussion for the topics were positive and supportive of the intent and progress with the respective Programmes.

An Engage4Change event was held in Blaina Library in September 2019. Delegates discussed progress with the Grange University Hospital, the 111 system, access to GP surgeries, flu vaccinations and the Choose Well Minor Ailments Scheme. Feedback from the event has been provided to the NCN Management Team.

13.10 Access

General Medical Services Access: The Health Board has introduced an 'A is for Access Scheme', 5As, whereby practices are encouraged to ensure:

- They open on or before 8am with a first appointment at 8.30am or earlier.
- Their doors are open during the lunchtime period.
- The last routine doctor appointment is 17.50pm or later.
- There is telephone access to a 'live person', available from 8.00am - 6.30pm.
- Patients can book an appointment and 'Sort in one call' or by the internet.

40% of Blaenau Gwent East practices deliver on the 5As.