Neighbourhood Care Network Integrated Medium Term Plan 2020-2023

Monmouthshire South

Table of Contents

Executive Summary

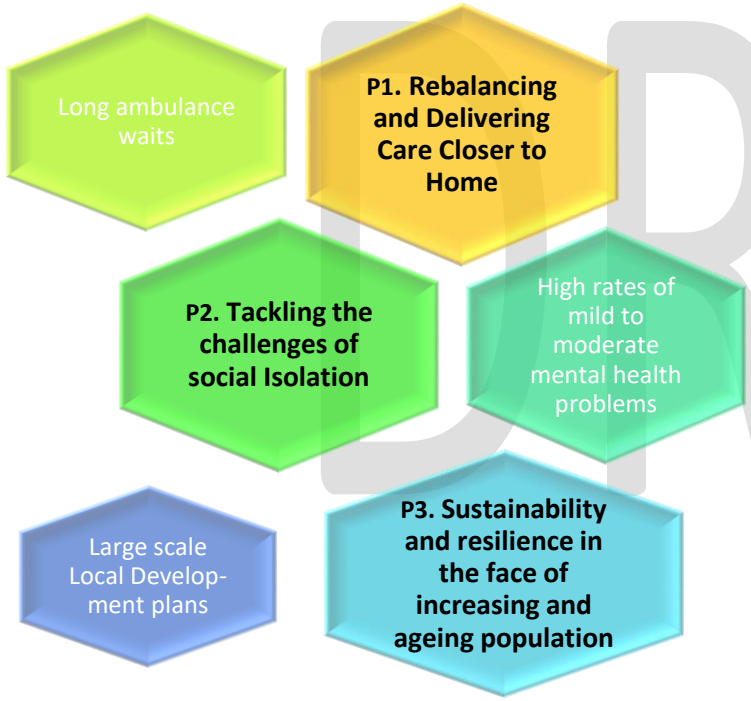
2019-20 was a busy year in South Monmouthshire NCN with Dr. Andrew Gray leaving the role of NCN Clinical Lead, to work with the Aneurin Bevan University Health Board, clinical futures team. I would like to take this opportunity to thank him for all he has done for local communities, within South Monmouthshire, and wish him well for the future.

Monmouthshire South is a semi-rural Neighbourhood Care Network (NCN), which brings with it a number of challenges as confirmed by our local needs assessment, which led us to focus our delivery plan on three key objectives (as detailed on the next page).

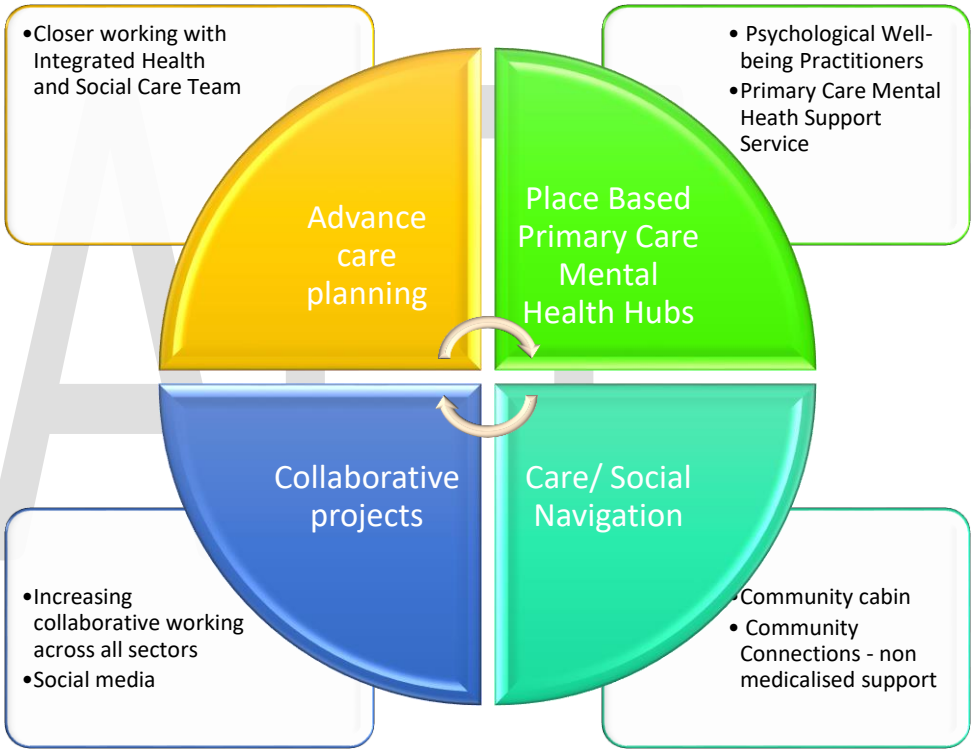
We know patients, carers and families in Monmouthshire cannot always travel easily to community and hospital based services, so with the Primary Care Plan for Wales in mind, we will take forward the three broad themes of **1)** Rebalancing and delivering care closer to home for people of all ages where appropriate, **2)** Tackling the challenge of social isolation by supporting people and communities, working with Third Sector colleagues to increase the range of non-medical support, information and advice available to help maintain well-being and self-care, and **3),** we recognise that we need to continue to grow Resilient and Sustainable services and communities in the face of an increasing and ageing population. Our estate plans as detailed within this IMTP, must be robust enough to meet the challenges of new housing developments, a growing population, and therefore greater demand on already stretched public services. We also recognise the value in maintaining positive relationships with County Council colleagues, the Third Sector and the people of South Monmouthshire, recognising also the approximately 10,000 people living in England and registered with a Monmouthshire GP. The Regional Partnership Board's integrated system of health, care and Well-Being for Gwent underpins the development of our Integrated Health, Social Care and Well-Being Centres (or Hubs), which are recognised as a way to focus a range of multi-agency support, and Monmouthshire has led the way in driving this agenda with its 'person centred, one front door' approach via Place Based communities, for example the Raglan Project.

This plan will demonstrate how the NCN will continue to build on the valuable work already undertaken over the past 5 years, and continue to test new initiatives where possible, and financial constraints allowing. Having an almost fully committed budget has led us as an NCN to look at other funding streams for example, Social Enterprise schemes plus other options already being taken forward in other parts of Wales. We have had some success in accessing Integrated Care and Transformational funding to support delivery of schemes aligned to our three key priorities, but as NCNs are now widely understood to play a key role in the planning and development of local services, a more fluid financial framework would enhance our opportunity to drive change and test new ideas. To close, we hope this plan goes someway to demonstrate how we will take forward our three key objectives for South Monmouthshire, and show how local people contribute to, and benefit from the work we are doing.

The diagram below shows six themes relating to key risks in Monmouthshire. The NCN has agreed on three interrelated priorities for the next three years, which are also aligned with A Healthier Wales and the Primary Care Plan for Wales:



What we want the South Monmouthshire NCN plans/infrastructure to look like in 3 years' time aligned with our three key priorities:



Neighbourhood Care Networks
Integrated Medium Term Plan 2020 - 2023

Plan on a Page

Aneurin Bevan University Health Board: **Delivering Care Closer to Home**

Monmouthshire South Neighbourhood Care Network Plan – 2018/19

"Enablers"

Technology
Skilled Workforce
Partnership Working
Financial Resource
Fit for Purpose Estate

Our aims are to:-

- P3: Improve the health and wellbeing of the local population
- P2,3: Support people to stay well, lead healthier lifestyles and live independently
- P1: Reduce health inequalities
- P1: Support the Clinical Futures Strategy in primary and community care by delivering Care Closer to Home:-
- P1,2,3: Ensure that services have the flexibility to meet individual needs
- P1,3: Improve access to specialist expertise
- P2: Provide a positive experience for patients and carers
- P1,3: Ensure a supportive working environment and career development opportunities for our staff

What are we doing?

- P1,2,3: Regularly reviewing local needs to identify priorities and develop effective solutions
- P3: Developing primary care teams using the SCR/ CC2H: Primary Care Model for Wales built around traditional GP, District Nurse and Health Visitor roles
- P3: Exploring new primary care roles to provide easier access to local services including: Care/Social Navigators, practice based physiotherapists, mental health workers, primary care audiologists, paramedics, occupational therapists and social workers.
- P1: Increasing access to specialist nursing roles in the community including Diabetes, Heart Failure and Palliative Care Nurses.
- P3: Working to increase uptake of preventative services to keep citizens well including influenza immunization / childhood immunization / smoking cessation services / weight management services / exercise schemes
- P1&3: Developing clinical pathways to improve patient experience and service quality
- P1,2,3: Building strong processes to support community engagement

How are we delivering change?

P1,3: Making best use of health and social care estate to support CC2H

P1,2,3: Work with partners to establish wrap around health and wellbeing services

P1,2,3: Use of preventative, early opportunity and self-management approaches

Understanding local needs and developing effective solutions

P3: Use prudent healthcare pathways to improve planned care

P1,2,3: Use Multidisciplinary Team to undertake active signposting

P1,2,3: Recruit, train & educate our workforce to ensure needs of population met

How will we know if we have made a difference?

Progress will be tracked via the IMTP Delivery Plan

1 Introduction to the 2020-2023 Plan

Why work with South Monmouthshire NCN?

There is no single model for community health services across the NHS, local authority and third sector. The range and configuration of services varies depending on local population, geography, nature of local services, and local legacy in terms of how services have developed and evolved, and there exists pockets of good practice within Monmouthshire. However, this is inconsistent across the locality resulting in a lack of best practice. Evidence has identified that to ensure our services can meet our local population needs, we need to adapt our current model of care. Our aim is to provide a foundation for early intervention and prevention services to reduce loneliness and social isolation, which can lead to a high number of GP consultations for social problems such as housing, debt management and benefits concerns, which can all exacerbate the feeling of isolation and loneliness. Care or Social Navigators/ Community Connectors via face to face contact, new technology or social media etc. and regardless of agency, can link people to established community support hubs across the locality.

The South NCN seeks to embed services and provide an integrated approach, intervening as early as possible to improve outcomes for our population through engagement with across all ages, to better understand the most effective support mechanisms and delivery methods.

The NCN priority of delivering Care Closer to Home will allow it to support and deliver a range of priorities in response to the needs of local people. This includes improving access to local support for people with mild to moderate mental health and well-being issues, as well as information and advice as close to home as possible for example via the Chepstow Community Cabin. Our third priority is to continue to work with partners to build resilient and sustainable services and communities, which are equipped to support each other over the next three years and beyond. This plan talks about the important engagement work already started to gauge the views of local people, and how what we learn is being used to improve the experience of patients, carers and families in South Monmouthshire. We look forward to the continued support of the Health Board in developing a robust financial framework, which will allow the NCN to continue to grow, test new ideas and respond to the needs of people in South Monmouthshire. Our overriding aim is for this NCN to become a beacon site for Wales.
Examples of our achievements aligned to our three priorities and 'wish list':

Training for individuals within our GP practice and Integrated Health and Social Care team to become 'Community Connectors', and who will link in with the Chepstow Community Cabin to offer local people Information, Advice and Assistance and therefore building more resilient and sustainable communities and services.

Information Technology will be further explored to support new initiatives to help tackle the impact of social isolation, increasing awareness of available support, how to access services.

Underpinning our three priorities, the Care Closer to Home strategy supports our continued development of sustainable and resilient services and communities for the future. Our wish list includes a range of professionals with specialist skills including Psychological Well-Being Officers who can work in GP practices, linking with Integrated Services, Community Connectors, Care Navigators and the Chepstow Community Cabin to identify people who may suffer from loneliness and isolation, and improve access to a range of information and support.

Care Close to Home as a driver will also help us secure funding in support of Advanced Care Planning, allowing GPs to undertake holistic patient reviews, regularly conducted across our most frail patients who will be given an opportunity to discuss their personal wishes for their future care. Plans to introduce a frailty Consultant-led team have been developed over a number of years and will support keeping unwell patients at home where appropriate and when this is the patient's wish. To further develop and build resilient and sustainable community, adopting a place based approach, we will further encourage collaborative working across GP practices, community health and social care services and continue to build our relationship with the third sector to identify community assets. We also are working together on building resilient continuity planning.

Potential obstacles to achieving our plans and how we aim to overcome them:

- **Finance:** Annual time limited budgets to be spent in focused time-frames: We have partially mitigated this by preparing clear budget forecasts with high and low budget items that fit in with our overarching priorities and plans, agreed according to circumstance. A key challenge is 'budget-paralysis', not having flexibility to support recurrent posts, which are evidence based, tested and meet our priorities. A number of 'top-sliced' schemes are in place with some yet to be tested in terms of value and benefit.
- **Joint working:** We will continue to work across organisational boundaries to find collective solutions and deliver the IMTP.
- **Sustainability:** New housing developments planned for the short and long term are already putting pressure on our systems and plans. Despite having good links with partner agencies, , we need to fully understand the impact on our infrastructure, services and local population of all ages, if we are going to be able to deliver our ambitious plans, especially building resilient and sustainable services and communities.

2 Overview of the Neighbourhood Care Networks

2.1 Profile of the Neighbourhood Care Network

In April 2014 'primary care clusters' serving populations of 30,000-50,000 patients were introduced. With a total population of approximately 100,000 people residing across 850km^2, Monmouthshire was divided into two Neighbourhood Care Networks, South and North. South Monmouthshire has a population of 47,301 (01.04.19 capitation report), 5 GP Practices, 4 branch surgeries & an Integrated Health and Social Care team serving the populations of Chepstow, Caldicot and surrounding areas. The NCN borders Newport to the East and England to the West and as of 1st April 2019, there was a total of 6,206 people living in England registered with a South Monmouthshire GP.

The NCN has seen a 2.3% increase in population since 2017/18 and by 2036, it is projected that the number of people in Monmouthshire as a whole, aged 85 and over in Monmouthshire will increase by 147%, from approximately 13,000 in 2011, to 32,000[2]. Further population growth is anticipated with new housing developments planned in Monmouthshire and the Forest of Dean, enhanced by the removal of the Severn Bridge toll in December 2018.

Monmouthshire has for many years had a perceived affluence, which can mask differences within and between communities. Wages in 2017/18 were some 10% below the UK average and only marginally above the Wales average. Some 34% of our working population were commuting out of county to earn a living[1]. We face many challenges as highlighted previously, especially around building resilient and sustainable community and primary care services. Our Health and Social Care system is stretched with new challenges in terms of difficulties in recruiting staff. We rely on Third Sector services to offer a range of support and these relationships are key when trying to deliver our three key priorities.

In terms of organisational structure, local governance and strategic links, the NCN is aligned to Aneurin Bevan University Health Board's Clinical Futures and Care Closer to Home strategies, Monmouthshire Integrated Services Partnership Board (ISPB), the Greater Gwent Regional Partnership Board (GGRPB), and also The Well-being of Future Generations (Wales) and Health & Social Services Well-Being (Wales) Acts.

Sources: [1]The Well-Being of Future Generations (Wales) Act – Monmouthshire County Council Well-Being Assessment 2017/ [2]Monmouthshire SS&WBA Needs Assessment https://www.monmouthshire.gov.uk/app/uploads/2017/10/Population_Needs_Assessment_Final.pdf

2.2 Vision Statement

It is our vision that everyone is able to live longer healthier lives at home and will receive the majority of their care either at home or in their local community, where it is safe, effective and efficient to do so. This will be achieved through our work, for example, on sustainable Primary Care and Integrated Health and Social Care. Our Care Closer to Home strategy is an integrated plan for strengthening communities outside of hospital settings, based on a number of integrated working themes including person centred, workforce sustainability, shared resources/pooled budgets, community resilience and early intervention & prevention. Care Closer to Home is being delivered through the NCN and forms the foundation of our future service model.

2.3 Neighbourhood Care Network Governance

The NCN itself is a collaborative network, led by an NCN Clinical Lead, and features a wide range of professionals delivering care within South Monmouthshire. The NCN meets bi-monthly to share best practice and discuss/ plan local developments against the three key priorities. This section outlines these arrangements.

2.3.1 Membership

Name	Role	Organisation / Designation
Dr Annabelle Holtam	NCN Clinical Lead South/ Chair	Mount Pleasant Practice
Alison Marshall	Senor Nurse – Mental Health	ABUHB
Amanda Dalley	District Nursing Team Leader	ABUHB
Angela Lewis	Health Programme Manager	ABUHB
Anna Burke	Midwifery	ABUHB
Anna Morgan	Senior Health Promotion Practitioner	Public Health Wales
Annette Brady	Integrated Services Manager South	ABUHB
Bronwen John	Head of Service	ABUHB
Caldicot Medical Centre, Mount Pleasant, Town Gate, Vauxhall Surgery, Wye Dean	GPs/ Practice Managers	Independent Contractors
Chris Phillips	Public Health Nursing Team Manager	Public Health Wales
Deborah Saunders/Kim Sparrey/Susan Dryburgh	Carers Information and Support Worker	Monmouthshire County Council
Hannah Hutchison	Independent Dental Advisor	ABUHB
Hywel Jones	Prescribing Lead	ABUHB
Joanne Hook	Senior Nurse	ABUHB

Joe Brown/ Gemma Mainwaring	Finance	ABUHB
Johnathan Russ	Integrated Team Manager South	Monmouthshire County Council
Karen Gully	Clinical Director	ABUHB
Kate Edwards	Primary Care Mental Health Service	ABUHB
Katie Molumby	Network & Community Services Support Officer	ABUHB
Linda Berry	Health & Social Care Facilitator	GAVO
Lorraine Hicks	Assistant Head of Service	ABUHB
Mariam Elmirghani	Well-Being Support Manager	Monmouthshire Housing Association
Melanie Hatch	Primary Care Service Development Manager	ABUHB
Nairn Powell	Canisc User	St Davids Foundation
Nicola Maggs	Flying Start Operational Health Manager	ABUHB
Paul Richards	Primary Care Manager	ABUHB
Sharon Hooker	Primary Care Pharmacy technician	ABUHB
Shona Martin	Melin Homes	Melin Homes
Stephanie Campbell	Independent Optometry Advisor	ABUHB
Steve McDonagh	Network & Community Services Manager	ABUHB
Susanne Jones	Borough Manager - Midwifery,	ABUHB
Thomas Willgoss	Practice Based Pharmacist	ABUHB
Tracy Morgan	Divisional General Manager	ABUHB
Virginia Morgan	Primary Care Mental Health Service Manager	ABUHB

2.3.2 NCN Leadership and Support Teams

Within each borough, NCNs have a support structure consisting of fellow NCN Leads and members of the Primary Care & 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	Role in Borough/NCN
Bronwen John	Head of Service
Lorraine Hicks	Assistant Head of Service
Dr Annabelle Holtam	NCN Lead (South)
Dr Brian Harries	NCN Lead (North)

Steve McDonagh	Network & Community Services Manager
Katie Molumby	Network & Community Services Support Officer
Melanie Jones	Primary Care Service Development Manager

2.3.3 Frequency of Meetings

In line with the 2019-20 Quality Assurance and Improvement Framework (QAIF), GMS colleagues are mandated to attend 5 NCN meetings per annum. The NCN meets on approximately a bi-monthly basis avoiding where possible the period of Winter Pressures. The NCN management team also meets on a bi-monthly basis.

2.3.4 Secretariat Support

The annual NCN meeting schedule and agendas are co-ordinated by the NCN clinical lead, NCN manager and support officer.

2.3.5 Quorum

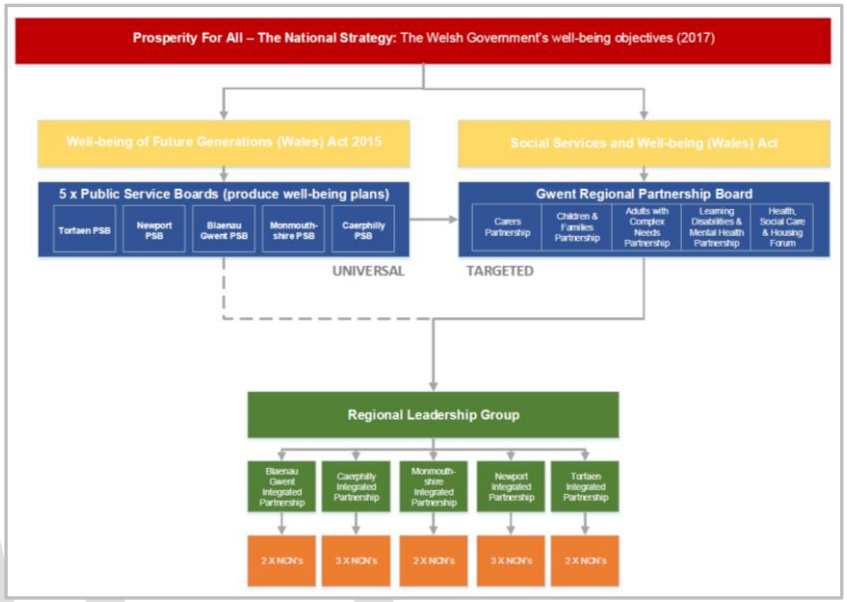
To be quorate, the NCN would need to have two thirds of the membership by profession, either primary membership or nominated deputies, as per the list of members at 2.3.1 above. Where voting is necessary it will be along the lines of a vote per professional entity. Where no majority is achieved, the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

2.3.6 Communication

The NCN lead has one dedicated NCN day per week, working directly with the locality management team in order to progress meeting planning, NCN budget, implementation of NCN plans and objectives. This is enhanced outside of this time by email correspondence as required to facilitate local resolution of queries linked to the NCN plan. The NCN Team has developed a Monmouthshire NCN public facing newsletter which shares good news stories from the work of the NCN. The NCN leads provide annual written updates to the LMC with details of their specialist lead role, specific work streams within their role, an action log on work stream progress, proposed LMC consultations as required and the end of year NCN report on successful work. There is a fluid line of communication between NCN teams, the Divisional Senior Leadership team and Integrated Services Partnership Board.

2.3.7 Reporting Framework

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

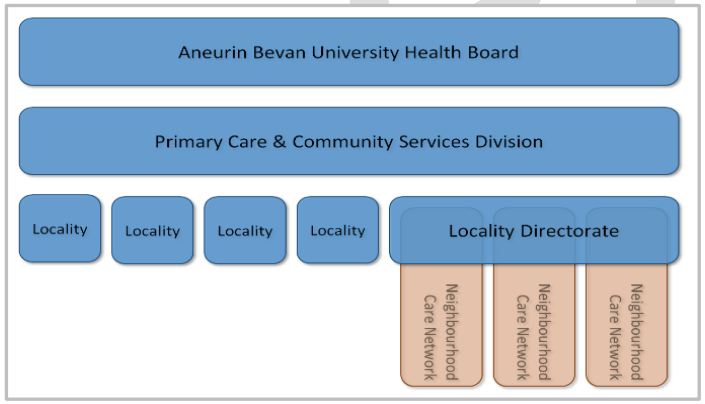


The NCNs are a key component of the Integrated Services Partnership Boards (ISPBs) in each of Gwent's five boroughs, which report to the Regional Leadership Group and onwards to the Public Service Boards and Gwent Regional Partnership Board.

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

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

2.3.8 Organisational Alignment within Aneurin Bevan University Health Board



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

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

3 Planning Context

3.1 A Healthier Wales

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

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

The context in which these aims will be delivered is through regional planning of health and social care services, for people with a care and support need. This is done via the Regional Partnership Board, and the publication of an 'Area Plan' detailing the agreed 'partnership activity'. The plan sets out how services will be planned, delivered and designed on a regional, local authority and NCN footprint to provide more integrated care closer to home.

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

As such the NCN IMTPs are developed within the context of the agreed regional partnership planning framework (the Area Plan) and in alignment with five Well-Being Plans, published in May 2018, by Public Service Boards. On a local authority footprint Integrated Services Partnership Boards will translate the regional vision into local delivery and support NCN to develop more integrated services closer to home, the NCN IMTP sets out this activity in detail and will align with both the Health Board IMTP and Gwent Area Plan.

3.2 Clinical Futures Strategy

Within the Health Board, the need for clinical modernisation has been recognised in the context of the delivery of the new model of primary and community care. The *Clinical Futures Strategy* sets out the strategic direction for modernising clinical services and forms part of the Health Boards response to delivering '*A Healthier Wales'*. Clinical Futures is a clinically owned and led programme that seeks to rebalance the provision of care in Gwent. The programme aims to:

- Improve citizen well-being and patient outcomes (including patient experience) for people of all ages, by designing and delivering new models of care for the population of Aneurin Bevan University Health Board across the whole health and well-being 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:-

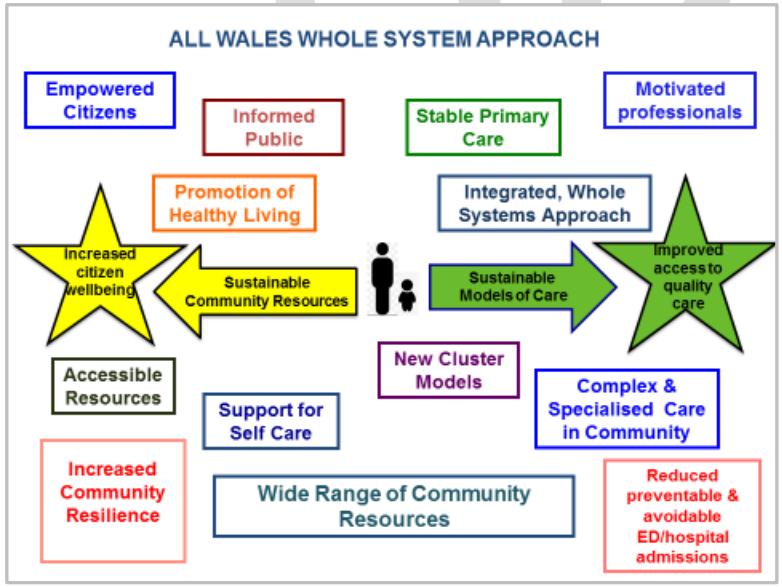
- ***Patient centred***, concentrating on safety, quality and experience.
- ***Home to home***: integrated services in the community to prevent illness and improve well-being, and providing care closer to home where appropriate
- ***Data*** and ***evidence*** driven, patient ***outcome*** focussed.
- ***Innovative*** and transformative, considering new ways of organising and delivering care around the patient and their careers.

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

3.3 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, NCN, integrated care fund). The model seeks to address the well-established challenges facing primary care, which includes increasing workload from a growing, ageing 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 Well-Being
- 24/7 Primary Care Model
- Data & Digital Technology
- Workforce & Organisation Development
- Communication & Engagement
- Transformation and the Vision for Clusters

3.4 Primary Care & Community Services Integrated Medium Term Plan

The Division's IMTP is intended to provide an overarching 3 year plan, based on an assessment of both strategic priorities and operational risks. The IMTP has been broadly divided into 9 work-streams. It is intended that NCN plans will feed into these work-stream areas for support and decision-making.

Strategic Work-stream	Delivery Committees	Work-steam Description	Example of Priority Areas
1) Prevention, Well-Being & 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 Well-Being 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 ageing 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

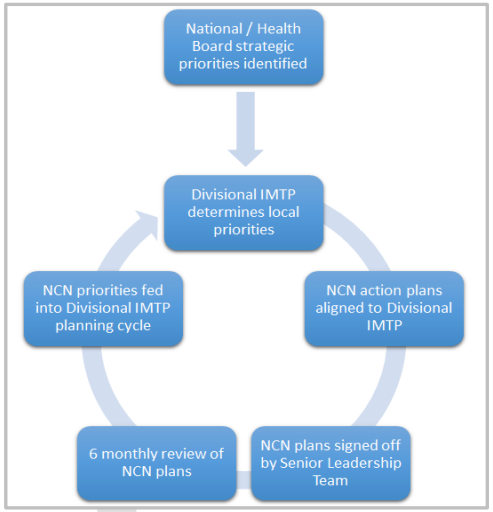
6) Digital, Data & Technology	Digital Technology Group	Utilising new developments in technology to improve communication between professionals, reduce workload for staff and enhance care and the experience of patients.	WCCIS, GP System Migration, electronic referrals, virtual consultations, electronic 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 work-stream 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 & well-being 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 & well-being hub developments, discretionary capital programme
9) Communication & Involvement	Senior Leadership Team	Involving both local practitioners, patients and the general public in the planning of services is key to their success. Particularly with the changing face of primary care, an awareness of the new options for care is essential to change behaviours.	Health talks, public engagement, social media campaigns
10) Quality, Value & Patient Safety	Quality & Patient Safety Committee	All services should be continually seeking opportunities to improve the way that care is delivered, making it more effective, of higher quality and safe. A quality / continuous improvement programme	Medicines management, Strategy for Falls & Bone Health, management of wounds & pressure damage, infection prevention and control, healthcare needs assessments, peer reviews, Primary Care QI Programme, advance care planning

3.5 NCN IMTP Process

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

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

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



4 Key Achievements from the 2017-2020 NCN Plan

Examples of NCN funded local pilot schemes and workshops held over the last 3 years in line with the key strategic aims of the NCN plan:

Key Priority	Key Achievements	Benefits/ Outcomes
Sustainability and resilience/ Delivering Care Closer to Home	• 1.64WTE GP Practice Based Pharmacists - prescribing budget reviews, audits and appropriate switches/ substitutions.	• Pharmacists have taken on medication reviews and prescribing issues therefore reducing the burden on GP time. • Regular feedback on performance is provided at NCN meetings by the dedicated ABUHB prescribing team. Prescribing efficiencies have been allocated to NCN budget on a non-recurrent basis. • 2018-19: 241 GP hours replaced and 1,203 face to face or telephone contacts made
	• Dedicated cross-practice sustainability workshop and NCN level discussions	• Open forum for Practice representatives to share issues and opportunities for inter practice working. • Access to ABUHB Divisional Leadership team.

	• NCN funding for GP Practice Dermatoscopes and training	• GPs upskilled to improve the quality of referrals to secondary care dermatology improving the patient experience.
Delivering Care Closer to Home	• Childhood constipation pathway implemented	• Monmouthshire South NCN funding led to a pilot pathway for children aged between 0-5 years with delayed continence, or who are constipated, has now been rolled-out across Gwent. The NCN supported the Flying Start service to develop pathway, raise awareness, identify suitable clinic venues and funded the ERIC training for local staff to deliver the service.
Delivering Care Closer to Home/ Tackling the challenges of social isolation	• Implemented a Pulmonary Rehabilitation Programme	• Over 200 participants to-date - patients and carers no longer undertaking long journeys to Newport Velodrome • Patients and carers able to access local NERS • Patients and carers able to socialise and share experiences with people in similar situation • Patient receive dedicated education session with appropriate professional from statutory and non-statutory agency
Care Closer to Home/ Building resilient and sustainable services and communities/ Tackling the challenges of social isolation	• Implemented Care Navigation & Active Sign-Posting training for GP reception staff to enable access to a range of non-medicalised community based services.	• Patients, carers and families have access to seven pathways introduced for Minor Injuries, Eye Services, Emergency Dental Care, Minor Ailments, Housing and Well-Being problems, Mental Health Consortium and Primary Care Mental Health Support. This work is aligned with the new 111 service.
Building resilient and sustainable services/ Tackling the challenges of social isolation	• Established annual flu planning process.	• Continues to support the high achievement for flu up-take across all three cohorts
Delivering Care Closer to Home/ Tackling the challenges of social isolation/ Building resilient and sustainable services	• Dedicated weekly drop-in phlebotomy and ECG clinic	• Patients no longer travelling to Newport • Patients able to drop-in at any time during the day • Highly regarded and dedicated service • ECGs undertaken in support of the Older Adult mental Health Service to aid diagnosis

The NCN is delivering improvements for local people in other ways also:

- **Increased cross-practice and NCN working: - GP led Safeguarding Forum (Bevan Exemplar – North and South)** The forum evolved in North Monmouthshire as a result of a significant event and complies with Healthcare Inspectorate Wales' recommendation to build a greater understanding of safeguarding in Primary Care. Examples of excellent practice within the NCN cluster: Reviewing records of children not brought to same day booked appointments (marker for vulnerability); Practice review of non-attendance for immunisations, or chronic disease reviews such as asthma or epilepsy as part of their safeguarding work; 'Flagging' of potentially vulnerable families to be given same day appointments when they call - including families where parent has mental health or alcohol problems, or financial stresses such as recent redundancy, GPs can follow up if necessary; The variation in how different practices address this issue is marked and the group would promote best practice for the whole area. The forum is open to and attended by GPs from South Monmouthshire.
- Dedicated sessions to benchmark prescribing across all 12 NCNs with efficiencies reinvested in delivering the NCN plan
- On-going support to the development of Integrated Well-Being Centres to help tackle isolation
- Dementia Roadmap funding commitment
- DEWIS Cymru co-ordinator role
- Improved links with Council planning/ housing team
- Dedicated sustainability/ workforce planning discussions
- Increased opportunities for cross-practice working
- On-going development of an Integrated Child & Family Centre in Caldicot

The NCN will continue to monitor its 'business as usual', performing consistently well in respect of flu up-take and smoking cessation, and will continue working with NCN partners to ensure key targets remain an objective for the NCN over the 3 year span of this IMTP. The NCN's intention in responding to needs of a growing older population is clearly stated within this plan, however, the NCN also has a commitment to improving local access to Integrated Health and Social Services for Children and Young People (CYP).

5 Population Health Needs Assessment

5.1 Population and Future Projections

The total population of Monmouthshire for all ages in 2017 was 92,100, with an additional approximately 10,000 people resident in England who chose to register with a Monmouthshire GP[1]. As of 1st April 2019, there was a total of 100,390 people (including those resident in England) registered with a Monmouthshire GP (Primary Care capitation report). It is predicted that the

population structure will change and that by 2025, there will be 4% drop in 0-17 year olds, 40% increase in 75-79 year olds, 31% increase in 80-84 year olds and 38% increase in those aged 85 years and over[1].

There is a small black and minority ethnic population (from the 2011 census)

- Total population: 91,323
- BME 0-17 years: 601 (0.7%)
- BME 18+ years: 1,196 (1.3%)
- White (all years): 89,526 (98%)

When broken down by age, approximately 18.8% (17,390) were aged 0-17 years and 24.7% (22,760) aged 65 and over. The number of those residing in our Residential Care Homes was 159 (0.7%), and the number receiving Reablement services was 1,394 (6.5%).

1. **Rebalancing and Delivering Care Closer to Home:** There is a predicted change to population structure between 2017 and 2025 when it is anticipated there will be a 40% increase in 75-79 year olds, a 31% increase in 80-84 year olds and 38% increase in those aged 85 years and over[1]. Aneurin Bevan University Health Board has been working in partnership with local authorities and the third sector to deliver improved citizen outcomes for many years. Earlier strategies like Wanless, Setting the Direction and Neighbourhood Plans had also foreseen the need to enable people to live safely and independently at home through a multi-disciplinary/ agency approach to early intervention and preventative support and help reduce the demand for costly secondary services and lead to improved well-being for the citizens of Gwent. Care Closer to Home builds on this, providing an overarching, forward thinking strategy for Gwent. Care Closer to Home builds on this, providing an overarching, forward thinking strategy for Gwent. This agenda, a cornerstone of the clinical futures model, is considered highly important to our NCN. We need to be able to care for our patients at home wherever possible and practical, where not appropriate then as close to home as possible, for example local health and social care facilities. We, as an NCN, recognise the need to further strengthen our already strong foundation, in order to grow the provision of health and social care at home. The important work around reducing avoidable hospital admissions could have a positive impact on ambulance response times, which have been highlighted as an issue in Monmouthshire. It has been identified by the Welsh Ambulance Service Trust (WAST), ambulance response team, that capacity is compromised by frequent call outs to care homes therefore this will form part of our work-plan.
   ([1]Daffodil).

2. **Tackling the challenges of Social Isolation:** The number of people aged 16 and over predicted to be living alone in Monmouthshire in 2017 was 21,087, with a projected increase to 23,496 (11.4%) by 2035, the third highest in Gwent[1].

The challenge is how we respond as a network with 44% of people living in rural and semi-rural areas and the challenge that brings. Loneliness and isolation can lead to mental health & well-being problems, a reliance on alcohol with evidence suggesting 46% of adults in Monmouthshire drinking above national guidelines, the highest in Gwent. These interventions would work with and alongside Local Authority and Third Sector partners, to try and meet the challenge of providing Information, Advice and Assistance as locally as possible, not only within the 5 key towns in Monmouthshire but also the surrounding areas.
([1]Daffodil)

3. **Sustainability and Resilience in the face of an increasing and ageing population:** Understanding the whole system and importance of maintaining a sustainable integrated health and social care approach across primary/ community teams including GMS and Integrated Services Teams is a priority for the NCN. In terms of maintaining a robust and responsive 'whole-team' approach, we need to understand the challenges locally with available data predicting, for example, a 71.6% increase of people aged 65 and over unable to manage at least one domestic task on their own, a 97.1% increase of people aged 65 and above living with dementia, a 14% increase in sight impaired people aged 65 years and over and a 58.9% increase of people aged 65 and over providing 50 hours or more unpaid care (2013 to 2035).

Our population needs assessment considered service utilisation for urgent care such as Emergency Department and Out Of Hours use influenced by access to local services/geography and rurality/ age profiling etc. This told us the following:

New housing and population growth: Implications of Local Development Plans (LDPs)
Monmouthshire County Council has developed an ambitious replacement Local Development Plan, which is currently out to consultation. If ratified by full council, there are very significant population growth implications, which will impact on South Monmouthshire NCN services. GP practices in Monmouthshire, via NCN meetings, have been directly involved in discussions with Monmouthshire County Council (MCC) housing planning colleagues in relation to the impact of proposed new housing developments across Monmouthshire (please see table below). The anticipation is that these developments will create an influx of middle and older aged people, therefore, we need to continue working with partners including third sector organisations, to meet increasing new challenges and build resilient services and communities.

PROJECTED NUMBER OF HOMES PER SITE AS INDICATED BY MONMOUTHSHIRE COUNTY COUNCIL

Main Town area	Number of hectares	Potential houses*	Number of people
Chepstow	254.8	8,917	23,187
Caldicot	135.93	4,757	12,278
Severnside**	79.45	589	1,533
'New settlement': Portskewett	371.1	12,985	33,761
'New settlement': Magor & Undy	860	30,100	78,260
Projected Population Increase based on LDP			**149,019**

Sources: Number of hectares and proposed use taken from Monmouthshire County Council maps – *includes some mixed use (residential and/or commercial) sites. Number of houses per hectare taken from Swansea 2014 paper (30-40 considered best practice) therefore 35 hph used for this purpose, multiplied by 2.6 heads per household (Aneurin Bevan University Health Board Primary Care team). **Magor, Undy, Rogiet, Caerwent, Sedbury.

Population profile:

- According to 2017-18 disease registers data, 9% of the population were living in the two most deprived fifths of South Monmouthshire, the lowest in Gwent[1]
- In 2011, 1.42% (1,042) of people aged 16 and over in Monmouthshire, were living in a dwelling with no central heating, the highest in Gwent[1]
- The number of people predicted to be providing unpaid care (all ages) in Monmouthshire in 2017, equated to 12,084, anticipated to drop by 1.8% (221) by 2035[1]
- The total number of people claiming Disability Living Allowance or Personal Independence Payments across all age bands at May 2015 equated to 3,025, the lowest in Gwent[1]
- The total number of people aged 18 and over, receiving Employment & support allowance, Incapacity Benefit, or Severe Disablement Allowance in Monmouthshire at May 2015, equated to 5,252, the lowest in Gwent[1]

([1]Daffodil).

5.2 Health & Physical Disabilities

- In terms of dementia, there were 27 people aged between 30 and 64 were predicted to have early onset dementia, reducing to 22 in 2035. There were 1,593 people aged 65 and above reported as having dementia in 2017, rising to 2,825 in 2035, a shift of 76%[1]
- The number of people aged 5 years and above in 2017, predicted as having a mental health problem was 19,935 remaining consistent with 19,936 predicted in 2035[1]
- Quality Outcomes Framework (QOF) data identifies 221 people per 10,000 population with Atrial Fibrillation (3rd highest in Gwent), 310 with Cancer (2nd highest in Gwent), 73 with dementia (joint 2nd highest), 153 with COPD (lowest in Gwent), 556 with diabetes, 62 with epilepsy and 29 people with a Learning Disability (29)[1]
- Smoking rates in South Monmouthshire have decreased from 22% to 19% in 2003 to 2014. Noticeably the overall percentage decrease in smoking rates is greater across Wales than within South Monmouthshire.
- The percentage of overweight or obese patients remains steady from 2003 to 2014 at approximately 51%. Whilst numbers are not increasing, obesity has a significant impact on both health and well-being, and measures need to continue to help reduce obesity across the generations.
- For people with a Limiting Long Term Illness, there is a predicted decline from 871 in 2017 to 737 in 2035 in 0-15 year olds, and a rise of 18.7% over the same period in people aged 18 and above[1]
- Between 2017 and 2025 there is predicted to be a 22.7% rise in the number of people unable to carry out at least one domestic task on their own (highest in Gwent and higher than Wales)[1]
- Between 2017 and 2025 there is predicted to be a 23.6% rise in the number of people unable to carry out at least one activity on their own (highest in Gwent and higher than Wales)[1]

([1]Daffodil)

In conclusion, available data suggests that significant issues identified by the needs assessment, align with the three key priorities detailed across this IMTP:

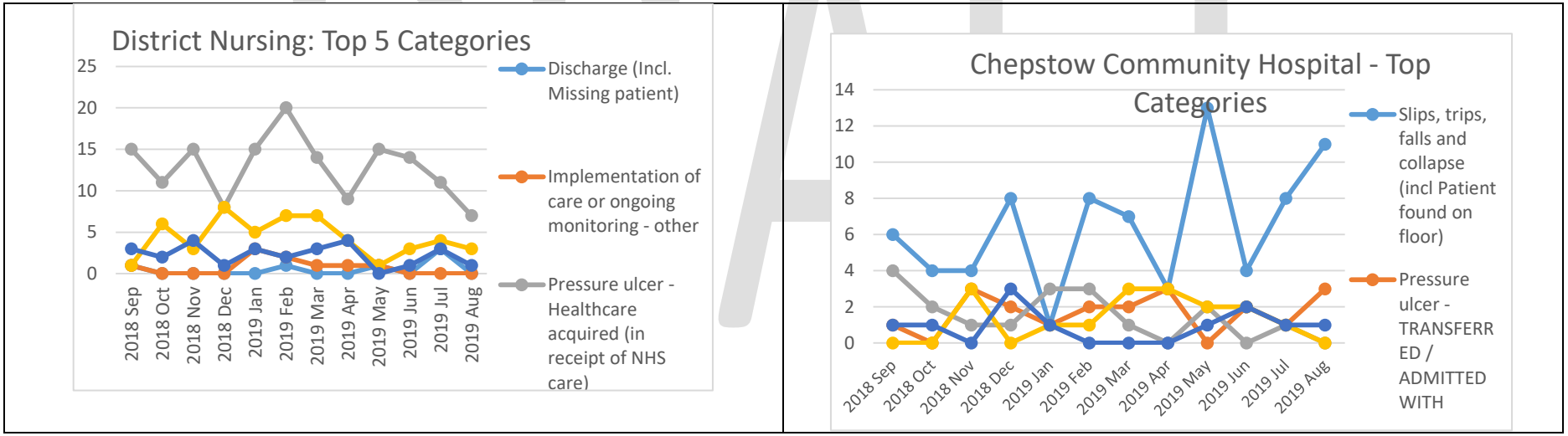
- A growing and ageing population with increased demand on community and primary care services
- Rurality, social isolation and loneliness with implications for service delivery/ access and urgent care response – associated with high levels of alcohol use.

5.3 Incidents & Concerns

The Monmouthshire Quality & Patient Safety Group [QPS] is an established health and social care forum which provides Divisional assurance for all quality and patient safety issues to include current and future related initiatives across

Monmouthshire. This platform enables escalation of significant clinical risks to the Divisional Quality and Patient Safety Group (QPSG) as well as assurance in relation to safeguarding, health and safety and improving the quality and safety of patient-centred healthcare for both staff and citizens. A number of serious incidents took place at Chepstow Community hospital during this financial period. Interim guidance relating to patient falls in community hospitals has been provided by Unscheduled Care Division, pending formal guidance which is under development.

Across Gwent the top reported incidents consistently reported are patient falls followed by Healthcare acquired pressure damage. The graph below provides the most prevalent incidents across Monmouthshire for the District Nursing and our community hospital sites, showing a peak at Chepstow Community Hospital in August 2019 and staffing related incidents in July 2019 at Monnow Vale.



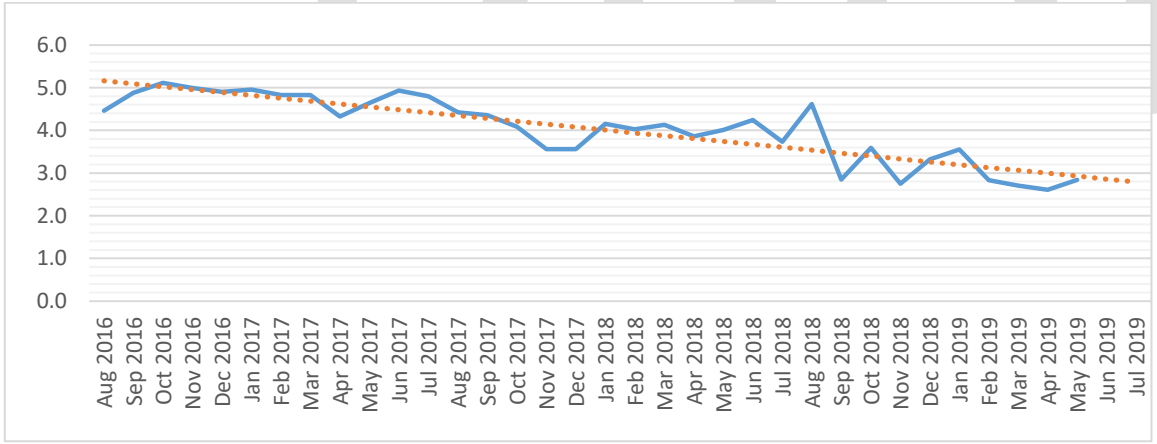
- *Summary of AM letters or patient/population surveys*

The Monmouthshire Management Team has been undertaking public engagement and feedback gathering sessions in relation to the general public's views about Chepstow Hospital, Clinical Futures and Care Closer to Home, with a view to extending this in the future to all Monmouthshire Health Board sites. To-date the team has received approximately 70 responses via suggestion slips and face to face contact since April 2019. Key messages from the sessions focus heavily on people accessing services locally providing an opportunity to discuss the on-going work around Clinical Futures and delivering Care Closer to Home.

In terms of Assembly Member (AM) letters specific to Monmouthshire, 44 letters were received between 1st September 2018 and 31st August 2019, 9 of which related to accessing primary care community services (Dental, Pharmacy and General Medical Services). The team also monitors social media sites and will factor findings from AM letters, engagement sessions, social media and suggestion slips into a report that will go to the Integrated Services Partnership Board.

5.4 Patient Safety Indicators

NCN Area		BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newp East	Newp North	Newp West	Torf North	Torf South
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*
No. of 4C Antimicrobials items	*Mar 19 - May 19*	10.2	10.4	10.2	9.3	8.7	11.2	8.2	7.8	7.9	6.8	10.8	9.7
Tramadol DDDs	*Mar 19 - May 19*	421.7	638.2	689.7	607.9	664.3	408.8	403.9	586.7	346.1	328.9	604.8	406.4
Gabapentin and Pregabalin DDDs	*Mar 19 - May 19*	2148.5	2093.3	1858.9	1815.8	1813.4	1370.6	1272.0	1378.9	1480.7	1732.6	2534.3	2245.7



Monmouthshire South is the 4th lowest of the 12 NCNs in terms of 4C antimicrobial prescribing per 1,000 patients, but continues to remain an area of focus for the NCN and NCN prescribing team. Antimicrobial Stewardship Strategy in Primary Care:

- Monitor prescribing data
- Support an audit and feedback model for targeted practices
- Identify antibiotic champions within settings
- Ensure an NCN approach to promote good practice
- Provide education and training
- Engage the public

- Monitor HCAIs
- Support the uptake of AMR diagnostics

- *USC and conversation rates*

NCN Area		Blaenau Gwent East	Blaenau Gwent West	Caerphilly East	Caerphilly North	Caerphilly South	Mon North	Mon South	Newport East	Newport North	Newport West	Torfaen North	Torfaen South
Urgent Suspected Cancer refs per 10,000 population	*May 19 - Jul 19*	111.73	100.25	88.33	73.98	85.19	105.62	101.40	72.37	89.07	87.66	103.10	91.90

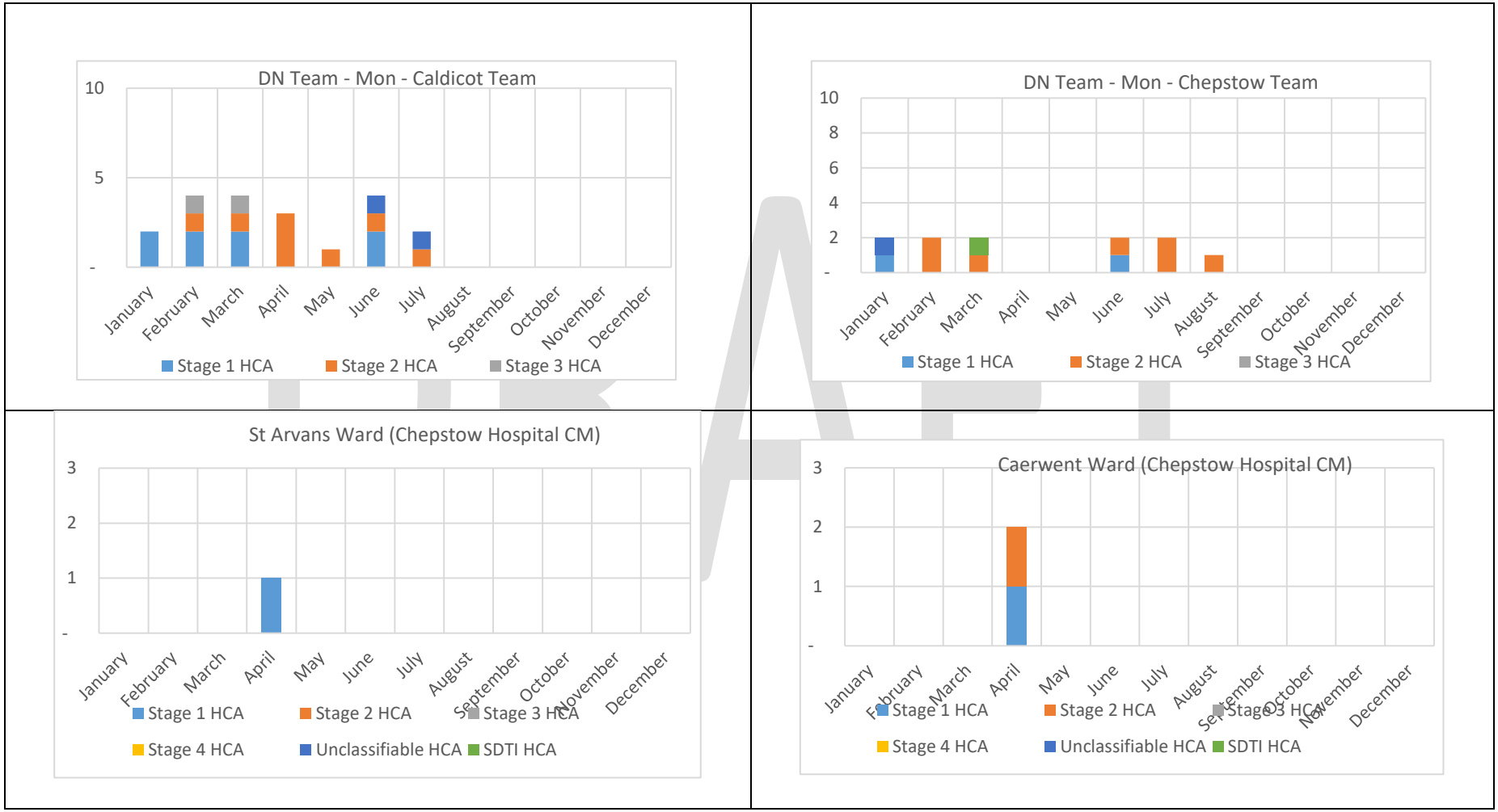
We are committed to ensuring that delays in diagnosis are minimised and that all patients, and their carers, have appropriate support and advice through treatment and beyond. We recognise the importance of involving the MDT in supporting people affected by cancer, and integrating cancer care into holistic chronic disease management in Primary Care. Our NCN has participation in the Macmillan Cancer Quality Toolkit to explore how we deliver care and to develop actions to improve our services. Four practices are using the Toolkit and the learning will be shared at our NCN meetings to inform our ongoing plans.

Our areas of focus will be Module 1: Detecting cancer earlier, Module two: Prompt recognition and early referral and Module four: Cancer care reviews and long-term consequences of cancer and its treatment.

As clinical pathways are shared through the Single Cancer Pathway programme we will review local experience to inform implementation. This will include ensuring that the multidisciplinary primary care team has the necessary skills and knowledge to support the SCP and detection and diagnosis of cancer. Embedding anticipatory care planning as routine practice will be a priority for our partnership.

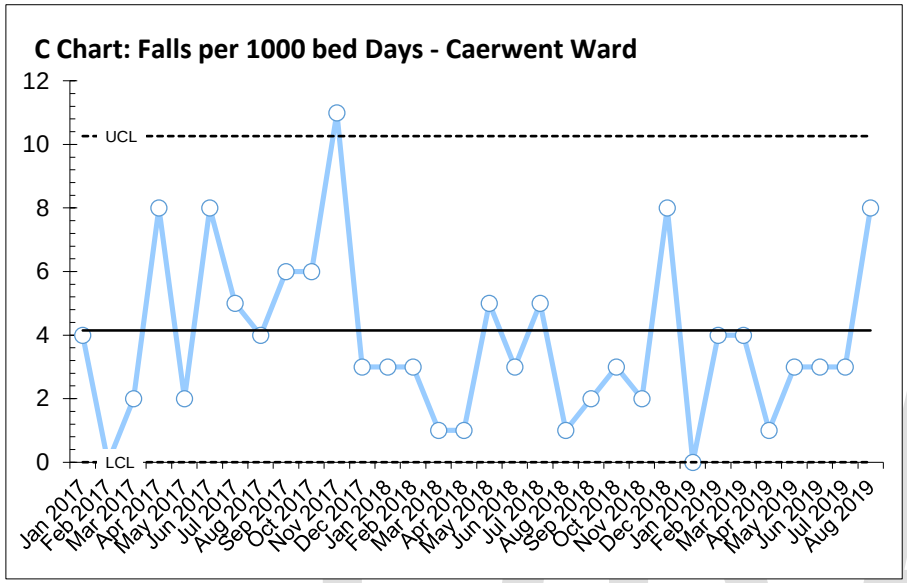
- *Hospital Acquired Pressure Ulcers*

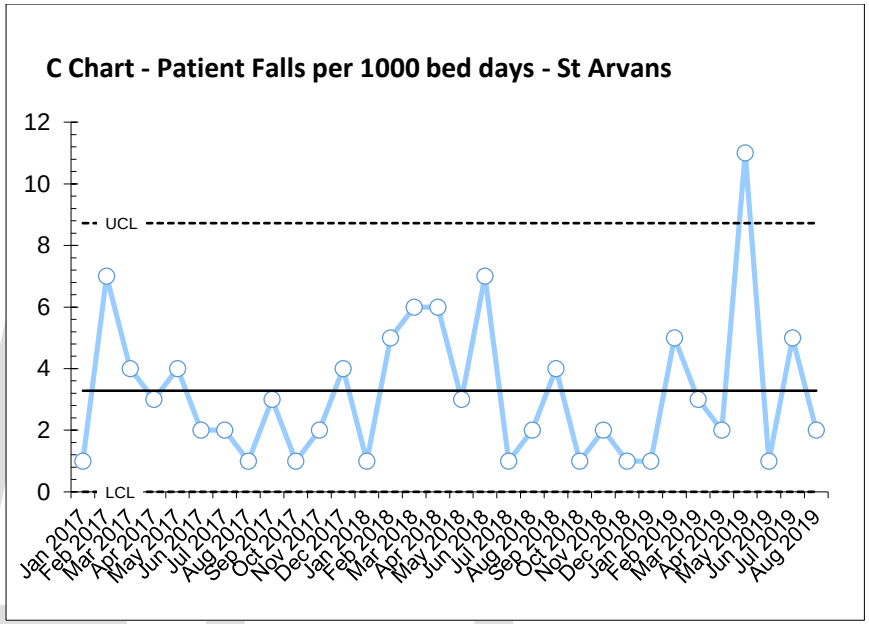
The following charts provides an overview of the most prevalent incidents of health care acquired pressure ulcers Across Gwent the top reported incidents consistently reported are patient falls followed by Healthcare acquired pressure damage across Monmouthshire for the District Nursing and community hospital sites.



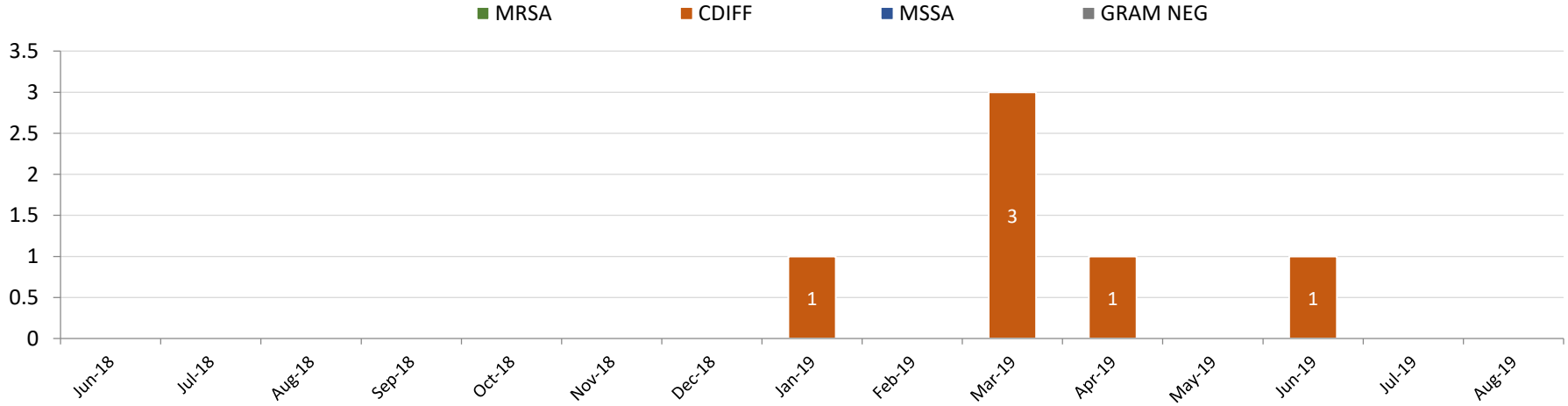
- *Falls per 1000 occupied bed days Chepstow Hospital*

Across Gwent Falls have remained above average since January 2019, although no significant increase has been seen in Monmouthshire. Caerwent Ward saw a peak of 8 falls in August 2019.





- *Hospital Acquired Infections: Cas-Gwent Unit - Chepstow*



- *Immunisation rates, etc.*

Immunisation rates are regularly reviewed at NCN cluster meetings and individual practices data shared. This promotes sharing of best practice and offers support and advice to practices where uptake is lower. It has been noted that as immunisation rates have decreased nationally, the incidence of measles has increased. The NCN is mindful of this and will develop plans to maintain immunisation rates. There is an on-going issue with up-dating the child health IT system resulting in incomplete immunisation documentation.

- *Age Group - 2 Years:* Monmouthshire South NCN has performed well in all three elements achieving the national target.

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

- *Age Group - 5 Years:*

The NCN achieved fourth highest up-take of MMR2 and highest in Gwent for the pre-school booster.

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

- *Age Group - 16 Years:*

MMR1 and 2 are below the national target and the second lowest of all 12 NCNs. The NCN also had the lowest up-take of the 3 in 1 pre-teen booster and therefore an area where compliance needs to be improved.

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

- *Flu immunisation*

The NCN routinely performs well in all three categories on an annual basis with a robust flu immunisations plan in place.

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

Screening uptake:

The NCN recorded the second highest up-take for bowel screening, and highest of all 12 NCNs for breast and cancer screening.

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

- *Ambulance response times*

There is some evidence which suggests the high number of ambulance call-outs to Monmouthshire Care Homes, is impacting negatively on emergency response times. For example, a study undertaken by the 5 GP Practices in South Monmouthshire between May and July 2019 identified waiting times of between 40 minutes and 5 hours. The NCN is working with the Welsh Ambulance Service Trust to understand the reasons for the high Care Home demand and ways of reducing this in order to improve emergency response times, and also considering potential funding options to support a Care Home liaison nurse role in the future.

5.5 Clinical Audits

- *Outcome of national clinical audits (Diabetes, Respiratory, stroke)*

We are currently collecting the results of the national diabetic audit for South Monmouthshire GP cluster and will be meeting to discuss. However, results show well controlled Hba1c figures with patients receiving regular reviews. We look to participate in further audit reviews as data become available. Learning and action points will be taken forward via the NCN IMTP Delivery Plan.

- *Outcome of local clinical audits / QI projects*

Our main focus this year has been on demand and capacity projects, which are detailed in this report. We look forward to working on GMS contract proposed Quality Improvement projects as further details become available. We also plan to do QI work around our planned interventions as listed in the IMTP. Learning and action points will be taken forward via the NCN IMTP Delivery Plan.

5.6 Enhanced Services

	DES																			LES																
Practice Name	**Pneumococcal**	**Childhood Imms**	**Asylum Seeker**	**Learning Disability**	**Violent Patients**	**Minor surgery - Fee A**	**Minor surgery - Fee B**	**Diabetes Gateway DES**	**Mental Health**	**CARE HOME**	**Anti-coagulation Level A**	**Anti-coagulation Level B**	**Homeless**	**GLP1 Monitoring**	**Flu Immunisation**	**Unscheduled**	**Non-Routine Imms**	**Substance Misuse**	**Shingles**	**Rota virus**	**Meningitis**	**Minor Surgery non-Registered patients**	**DOAC**	**DOAC Monitoring**	**Depo-Provera**	**Depo/Sayana Press**	**Contraceptive Implants (Nexplanon)**	**Depression/Lithium**	**IUCD Registered**	**IUCD - Non registered**	**Near Patient Testing**	**Extended Hrs**	**Denusomab**	**Pertussis**	**Gonadorelin/Zoladex**	**Extended Skin Surgery**
Vauxhall	Y	Y		Y		Y	Y	Y	Y	Y	Y			Y	Y	Y			Y	Y	Y		Y		Y		Y	Y	?	Y	Y	Y	Y	Y	Y	
Mount Pleasant	Y	Y		Y		Y	Y	Y	Y	Y	Y			Y	Y	Y			Y	Y			Y		Y		Y	Y	Y	Y	Y		Y	Y	Y	
Town Gate	Y	Y				Y	Y	Y		y	Y			Y	Y	Y			Y	Y		Y	Y	?	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gray Hill	Y	Y		Y		Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wye Dean	Y	Y				Y	Y	Y			Y				Y	Y			Y	Y	Y		Y		Y			Y			Y		Y	Y	Y	

- *Are there any inequalities in access due to shortfall in delivery of enhanced services?*

Enhanced services are delivered by GP practices in addition to their core service provision. This provides enhanced care for groups with particular clinical needs and supports the delivery of additional services in the community. Practices in Monmouthshire participate in most of the available enhancements but we plan to review local provision to ensure patient needs are met as close to home as possible. This builds upon co-operative work already undertaken between practices. A review is currently being undertaken to identify where there are gaps in delivery. Practices are encouraged to take up enhanced services to ensure all patients can access services. Where not possible, we look at how we can deliver these services to patients.

We are awaiting the delivery of a Directed Enhanced Service for Transgender patients and will be ensuring that this service is available for all local patients through network arrangements.

The Local Development Plan has identified a number of proposed/planned housing developments which will result in a need for additional access to dental services in the next couple of years. It is anticipated that this will also have an impact on GP access.

The Dental Contract Reform is being pushed and there are currently 5 practices across Monmouthshire taking part. As practices progress through the stages of the programme, pathways will be developed and the expectation is for greater links to be developed with GP's, Out Of Hours, Designed 2 Smile and the wider integrated team.

5.7 Activity Benchmarking

The table below outlines GP referrals for specialist consultation with any Welsh provider and also to radiology within Aneurin Bevan University Health Board. Monmouthshire South is performing relatively well in most elements when comparing to other NCNs. However, the NCN has the highest number of referrals for knee MRIs and is joint 4th highest for MSU testing, therefore, the NCN will continue to monitor this.

NCN AREA		BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon 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*
GP refs to non-surgical specialties	*Mar 19 - May 19*	211	208	168	172	139	186	164	156	162	171	211	171
GP refs to Trauma & Orthopaedics	*Mar 19 - May 19*	88	103	72	63	55	81	56	51	65	67	90	78
GP refs to surgical specialties excluding T&O)	*Mar 19 - May 19*	379	378	376	339	294	348	337	309	333	337	393	329
GP refs for MRI Knee (AB)	*May 19 - Jul 19*	11.02	7.55	7.74	6.32	6.91	9.74	13.73	6.80	5.60	8.29	8.86	10.31
GP refs for ultrasound shoulder (AB)	*May 19 - Jul 19*	3	3	3	2	2	3	3	5	1	3	2	3

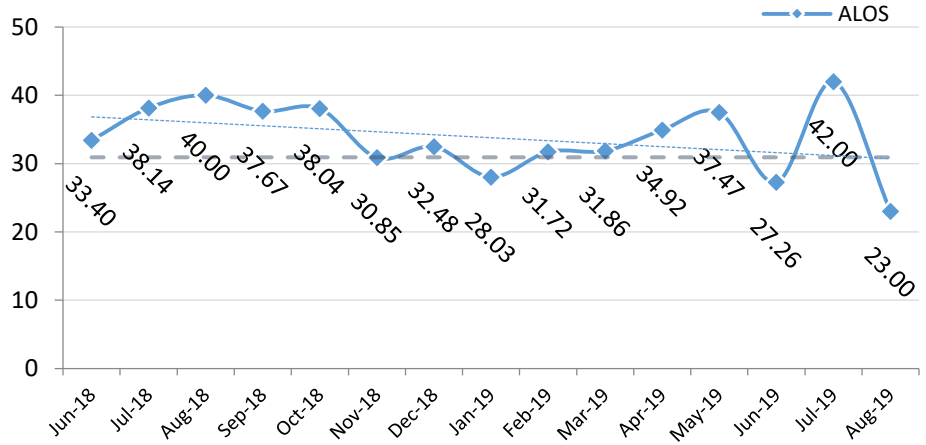
GP refs for chest x-ray (AB)	*May 19 - Jul 19*	141	122	98	86	113	111	101	84	92	90	149	104
GP refs for sample testing MSU urine (AB)	*Apr 19 - Jun 19*	262	222	254	258	207	275	254	207	215	211	248	195

Benchmarking in relation to urgent care shows Monmouthshire South as having the lowest number of inappropriate Emergency Department attendances per 10,000 population. The NCN will monitor the number of occupied bed days following an emergency admission for adults aged over 65 years (per 10,000 population), despite being the 3rd lowest in Gwent.

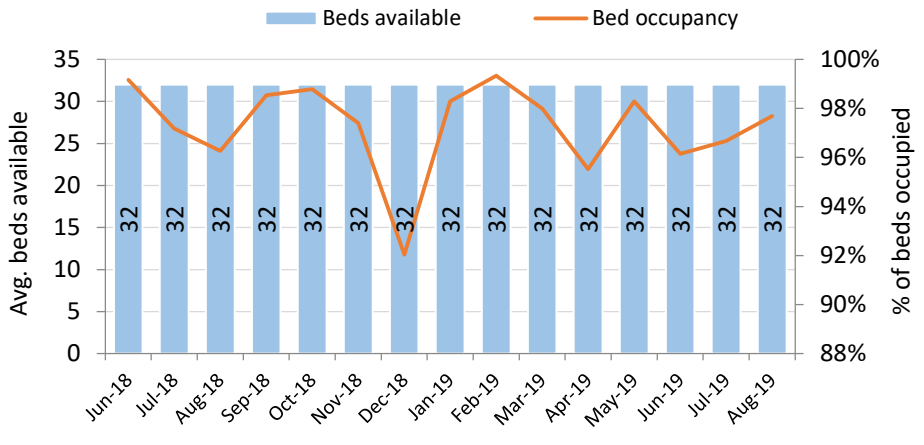
NCN AREA		BG East	BG West	Caer East	Caer North	Caer South	Mon North	Mon South	Newport East	Newport North	Newport West	Torfaen North	Torfaen South
NCN List Size		*33,563*	*38,404*	*65,889*	*64,886*	*56,463*	*53,399*	*47,335*	*48,499*	*58,942*	*50,651*	*49,661*	*46,571*
Refs accepted Rapid Response Services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

community hospitals													
Occupied bed days > 65 years of age following EMA	*May 2019 - Jul 2019*	7368	9144	6197	3535	7920	5031	5912	7325	7988	9156	7649	7837
Inappropriate ED Attendances	*May 2019 - Jul 2019*	59	54	59	57	62	8	7	25	22	30	25	20

- *Average length of Stay: Cas-Gwent Unit (Chepstow)*

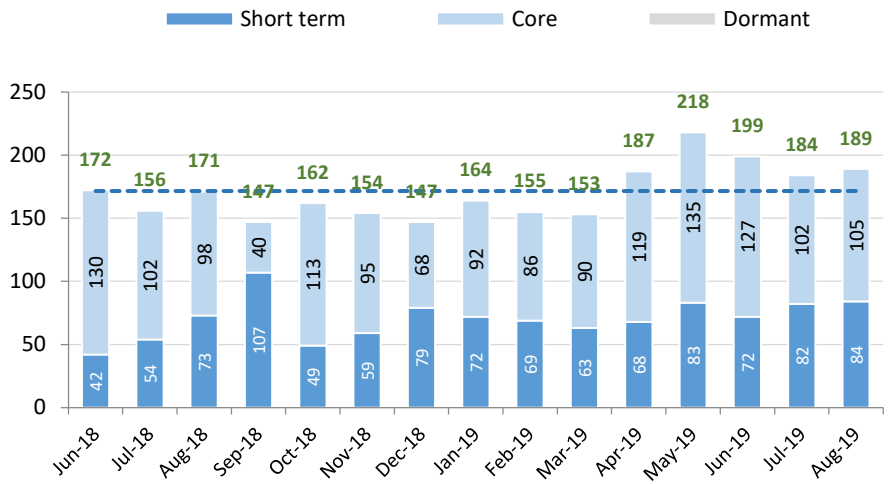


- *Occupied bed days: Cas-Gwent Unit (Chepstow)*

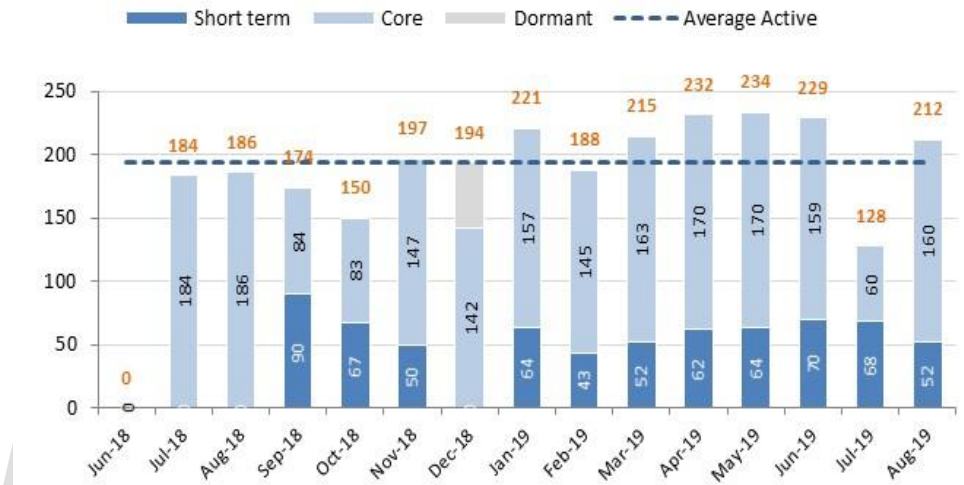


- *District Nursing referrals*

Chepstow



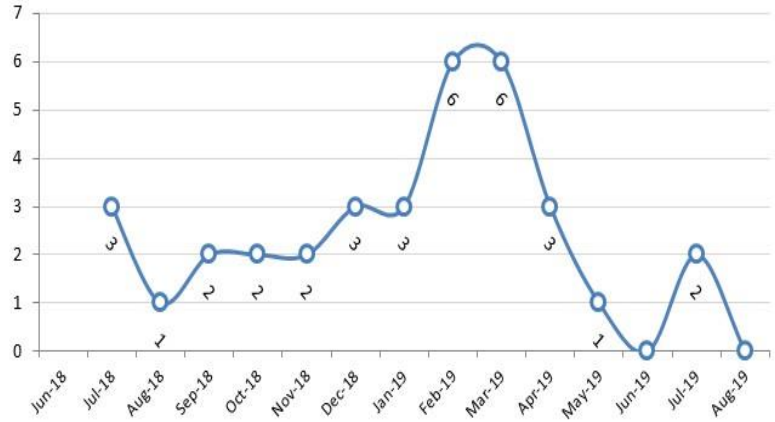
Caldicot



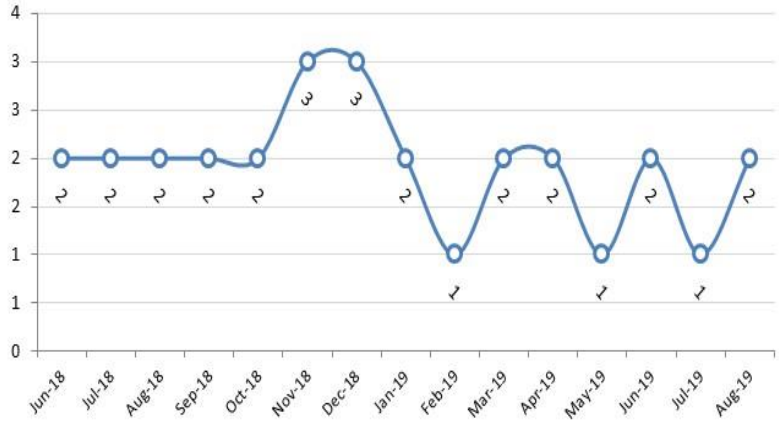
- *Referrals to secondary care services*

	Per 10,000 List Size						
GP Practice	Outpatient Referrals (Elective)	Day Cases (Elective)	Hospital Admissions (Elective)	Hospital Bed Days (Elective)	Hospital Assess. (Emergency)	Hospital Admissions (Emergency)	Hospital Bed Days (Emergency)
Mount Pleasant Practice	5,376	910	192	576	550	930	7,853
Gray Hill Surgery	3,335	734	169	550	386	700	7,327
Vauxhall Surgery	2,944	525	127	398	328	608	6,359
Town Gate Practice	3,338	602	116	284	321	594	6,265
Wye Dean Practice	2,924	583	94	199	210	409	3,916

- *% of population in receipt of CHC/ FNC: Caldicot*



- *% of population in receipt of CHC/ FNC: Chepstow*



5.8 Engagement Events

The 25th June 2019 saw the launch of a new 'Community Cabin' at Chepstow Community Hospital. The cabin was officially opened by County Councillor Penny Jones, Cabinet Member for Social Services, Health & Safeguarding, a drop-in space which offers Information, Advice and Assistance to members of the public. Councillor Jones provided context for the Cabin and welcomed the 'place-based' approach for older and vulnerable people, provided by the Monmouthshire Integrated Services teams. Skilled professionals can 'triage' people to appropriate colleagues or community based services based on their needs. The first visible change towards a social care and well-being centre is the re-designation of the former shop into an information point and community 'hub', aimed at supporting local people. Integrated Care Funding, via Welsh Government, enabled the Community Cabin to be set up offering opportunities for the community to receive person-centred support from the following range of organisations:

- Communities for work plus offering support to Monmouthshire residents looking for employment or volunteering.
- ELITE supported employment (JobSense - Project for people with sight loss)
- Volunteering for Well-Being supporting people to access volunteering opportunities in partnership with MCC
- Community Connections befriending and Car Scheme helping people to live independently
- Building Bridges (young people with disabilities)

- MIND (Mental Health mentoring and opportunities)
- Gwent Police (Drop-in session)
- Gwalia housing and Well-Being session
- PACE (Volunteering and child care support)
- Monmouthshire Housing Association (Social Inclusion)

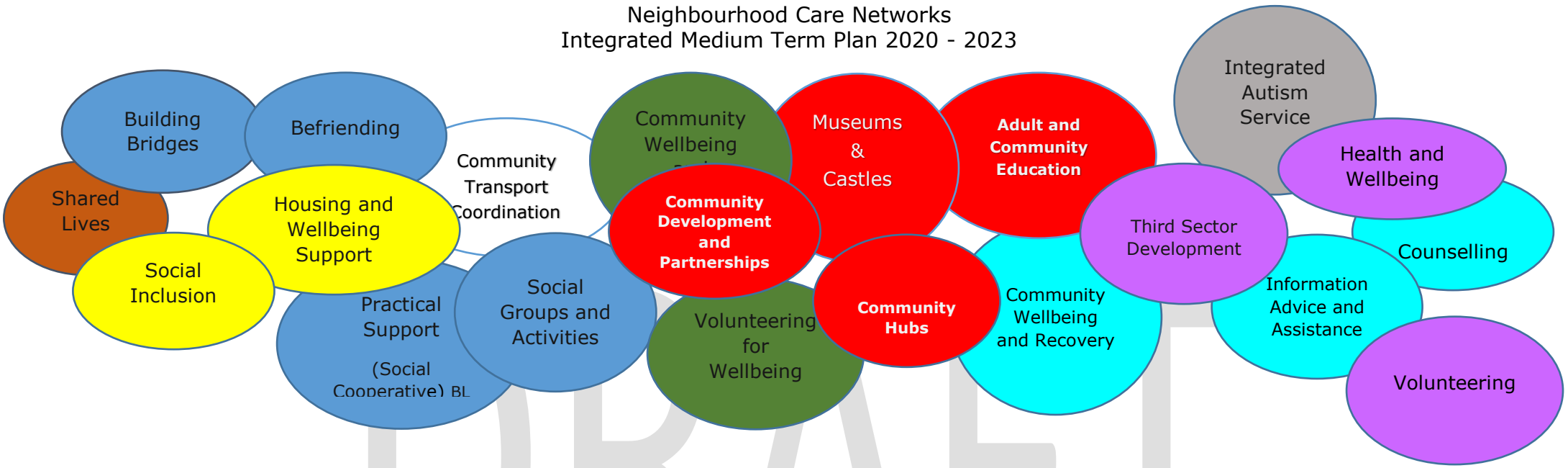
The NCN support team has recently started a programme of public engagement sessions allowing local people the opportunity to discuss issues relating to the delivery of health and social care in Monmouthshire. This provides the team the opportunity to hear what is important to local people first hand, and also a chance to discuss key strategic initiatives for the Health Board e.g. the delivery of Clinical Futures and Care Closer to Home strategies. Learning from these sessions will be reported to the Integrated Services Partnership Board (ISPB). Since April 2019, 19 contact sessions have been held by the team.

6 Assets Profile

'A Healthier Wales' sets out the Welsh Government's long term plan for the seamless delivery of health and social care in Wales. Its narrative focuses on a 'whole' system approach across organisational boundaries, seamless care and new integrated models of services, providing care and support. An integrated system of delivery for health, Well-Being and social care services is embedded within Monmouthshire, and there is an underpinning intent to improve care through working in a more efficient and effective way in line with the Transforming Primary Care model. The diagram below visualises the system of community connections that are in place across South Monmouthshire, work is now at pace to explore opportunities to build a team of 'community connectors' based within primary care to enhance the existing services within the Integrated Service Teams, to further support and direct local residents by bringing together the existing community, integrated service, Primary Care and NCN at hub level to provide all the resources required to enable staff and individuals to focus on empowering our communities to be resilient and take ownership of their health and Well-Being through early intervention, prudent healthcare, the provision of level 1 at home which removes pressure from secondary care and GP's, through supporting early intervention/prevention to help strengthen the community response for integrated service delivery.

We aim to build stronger partnerships with care homes, encouraging robust advanced care planning to support better understanding of the issues facing the care home community. We are looking to establish a working group across South Monmouthshire where care homes and NCNs can work collaboratively to optimise care home services, whist reducing demand on GPs and Integrated teams.

Neighbourhood Care Networks
Integrated Medium Term Plan 2020 - 2023



Population and Community Assets:

- 2 Leisure Centres
- 2 Community Hubs (former libraries now Information, Advice and Assistance centres based in Chepstow & Caldicot)
- Chepstow Community Cabin
- 8 Dental Practices
- 4 Optometrists
- 7 Community Pharmacies

Please refer to map in appendices

7 Estates Profile

7.1 Estate Profile

As more services are being moved to and provided in the primary care and community setting, a key challenge is the availability of the estate to respond to the need to hold and deliver more services. As such, estate is seen as a priority area for investment and development in order for it to be utilised for more services, which have traditionally been delivered elsewhere. There has been a shift beyond buildings being used for their traditional use only and potential recognised with a move towards a concept of community assets across organisations, which can be used for multiple purposes regardless of ownership.

General Medical Services: All 5 Practices are GP owned and considered to be in a reasonable state of repair. Two of the 5 are situated side by side within Chepstow Hospital (Mount Pleasant and Town Gate) and therefore covered by the PFI as previously mentioned, and Vauxhall Practice is located within half a mile of the Hospital also. The branch of Mount Pleasant Practice is situated in Portskewett, near Caldicot and near a proposed new 'Care Village' for people with dementia, and new housing developments are also proposed for the area. GP partners are considering options in terms of their professional and estate capacity to meet any increased demand, including recruitment implications to enhance the skill-mix associated with population growth. There is a large GP Practice in Caldicot, which is in a good state of repair and recently received a major improvement grant to extend their access options. We are currently discussing an option to refurbish its branch surgery via the improvement grant process. Our smallest practice, a GP owned single handed practice in Tintern has a registered population of around 1,900 people and is situated on the outskirts of Chepstow. The current estate is considered incapable of supporting the new clinical model and requires considerable investment, development and time investment. A number of challenges lay ahead if the estate is fit for purpose to support the clinical model in the coming years:

(a) Demographic Challenge:

- Local population increase with parts of the Division likely to be more than originally anticipated.
- Elderly patients 65 & over will increase significantly - Monmouthshire and Torfaen to be hardest hit.
- Frail & vulnerable people living with complex needs significantly increase over the next 10 years.
- Housing developments will further significantly increase resident population by 2030 which could further increase the registered patient to GP ratio.

(b) Workforce Challenge:

- Ever decreasing Clinical and Social care professional workforce.
- Retaining existing work force - recruitment, retention, revalidation & re-entry particularly challenging for deprived areas.

- Demand for more flexible working patterns will increase part time working and could potentially further reduce clinical workforce capacity.
- New skill mix model could increase headcount in primary care by circa 30%.

(c) Patient Challenge:

- Demand for consultations in general practice continues to grow
- Demand for flexible extended hours, seven day service, and same day urgent care.
- Demand for greater choice in the way patients can access primary care, to include digital - remote & virtual access
- Demand for care closer to home with a wider range of services offered through general practice and out of hospital settings.
- Quality & Equality of outcomes: significant variation across practices & benchmark to other Health Boards.

(d) Estate & IT infrastructure Challenge:

- Premises location: meet predicted population growth and new housing developments.
- Economy of scale must ensure estate is distributed accordingly.
- Premises Standards: Ageing estate not capable of meeting new regulations & requirements.
- Premises Inflexibility: to offer wider range of service and provide multiple functional use.
- Inability to support Digital Infrastructure: Inability to increase use of digital innovation and technology to maximise efficiency and access, including inability to access other healthcare systems.
- Consequences of lack of communication requires the Division sets out to engage member practices patients, providers and other key stakeholders to inform all of the Divisional vision for primary care and developing general practice with a sustainability plan.

- *Where is major maintenance required?*

It is considered that no major maintenance is required.

7.2 Vision for Estates within the NCN

- *How can the estate be adjusted to better align with local service models?*

The strategic vision for primary care estate has been designed to meet the following priorities:

- Deliver a 'place-based' model of service delivery which enables integration and / or co-location with local coterminous services wherever possible
- Ability to accommodate changes in the GP list sizes and the vision for delivery of primary care at a larger scale either virtually or physically.
- Ensure appropriate capacity available to support the local population with all clinical and social needs.
- Support practices to ensure Health Board requirements and statutory compliance standards are met.
- To proactively understand lease status, terminations and review dates, to ensure practices are contractually secure and patient care protected.
- Proactively support and facilitate partnership working with local authority, public sector and third sector to maximise the potential to be derived from the one public estate agenda.
- Greater focus on keeping people healthy, with more health screening and better management of long-term conditions.

- *Are there opportunities to develop Health & Well-Being Hubs?*
  - Health and Well-Being Centres have been identified as a positive way to support delivery of the Care Closer to Home and new Clinical team models. Extensive statutory and non-statutory service mapping has been undertaken by the Public Health team and this information has been used to underpin the roll-out of Care Navigation and Active Signposting in GP Practices, and will also support the development of Integrated Well-Being Networks, and Information, Advice and Assistance centres such as the new Chepstow Community Cabin.

In the next 15 years it is proposed that a new purpose-built Health, Social Care and Well-Being hub will be developed to serve the Caldicot/ Magor/ Rogiet/ Portskewett and Caerwent areas as anticipated population growth gathers pace.

7.3 Priority Developments

7.3.1 Major Improvement Grants

- Magor Surgery refurbishment (2 years)
- Development of clinical facilities at Sedbury branch surgery

7.3.2 Minor Improvement Grants

- None identified: Letter seeking bids sent 19.09 2019, will also depend on feedback from estates surveys

7.3.3 Capital Pipeline Funding

- Exploring the potential for a new Health, Social Care and Well-Being Centre to serve Caldicot/ Magor/ Rogiet/ Caerwent populations (15 years), so outside timescale of table above.

7.3.4 Other Developments

- Replacement of Portskewett branch surgery with new purpose build facility, likely to be GP funded (4 years).
- The table below is the result of a 6 facet survey and identifies key areas for potential investment and forms an important part of the estate prioritisation process:

NCN area	Building	Practice Name	Planned Hub Development or Colocation	New Build	Building Work Required	HB Discretionary Capital	ICF Capital Funding	Major Improve-ment Grant	Minor Improve-ment Grant	Revenue Impli-cations
Chepstow	In Chepstow Community Hospital: PFI Leased	Town Gate	practice within HSCWB hub							
	branch surgery (England)	Sedbury Road, branch of Town Gate	not planned	N	Y	N	N	TBC	TBC	Y
	In Chepstow Community Hospital: PFI Leased	Mount Pleasant	practice within HSCWB hub							
	branch surgery	Portskewett, branch of Mount Pleasant	not planned	N	Y	N	N	TBC	TBC	Y
	GP Surgery stand-alone	Vauxhall	not planned	N	Y	N	N	TBC	TBC	Y
	branch surgery (in England)	Tutshill, branch of Vauxhall	not planned	N	Y	N	N	TBC	TBC	Y
Caldicot	GP Surgery stand-alone	Caldicot Medical Centre	not planned	N	Y	N	N	TBC	TBC	Y
	branch	Magor, branch of caldicot	not planned	Y	Y	TBC	TBC	TBC	TBC	TBC
Tintern	GP Surgery stand-alone	Wye Dean	not planned	N	Y	N	N	TBC	TBC	Y
Chepstow	PFI	Chepstow Hospital	Established HSCWB hub	No	Yes	Y	Y			Y

Chepstow	Health building	Hywel Dda	under consideration							
Caldicot	Health building	Caldicot Health Centre	Established HSCWB Sub Hub	No	Yes	Y	Y			Y

8 Workforce Profile

8.1 Current Workforce Profile

Age Group	No. Staff	WTE	Ave Age
Total	**158**	**123.96**	**51**
21 - 25	1	1.00	21
26 - 30	2	1.24	30
31 - 35	13	11.64	33
36 - 40	12	10.41	38
41 - 45	14	10.77	43
46 - 50	14	11.36	48
51 - 55	43	35.61	53
56 - 60	34	26.47	58
61 - 65	21	13.09	63
66 and Over	4	2.36	68

As mentioned previously, the Monmouthshire Primary Care workforce is facing significant challenges derived from a number of causal factors not least increasing workloads as a result of an increasing and ageing population, a growing dementia population and a continuing drive to shift the balance of care from acute to primary and community settings. This increases the risk factors for maintaining staff sustainability, ensuring premises can accommodate the growing demand remains a significant risk for the NCN.

Generally recruitment of GP's is not an issue and we need to make sure that Monmouthshire remains an attractive place to work across all of our locality and not purely in pockets of excellence. The cluster works innovatively to support service sustainability through the development of new roles and new ways of working as well as maximising the talents and skills of our existing workforce to support the further shift of services closer to home through developing stronger links with community connectors to develop a more socially centred model of care through removing barriers between hospital, GP, community, health and social care. We will continue to use opportunities arising from new technologies and new facilities to streamline and modernise working practices. Our innovative model will seek greater and closer alignment with NCN's through extending the role of the GP admin staff in signposting and delivering compassionate communities and strengthening the presence of integrated Well-Being networks across Monmouthshire through collaborative communication.

The professional workforce is a significant factor impacting on the delivery of services in the community in Monmouthshire, due to the rurality and relative distance from major towns and cities. The Primary Care Plan for Wales provides direction on developing the primary care workforce in Wales and the actions that need to be taken by everyone involved in health services to make sure that care, where we can, takes place locally and is delivered by professionally trained staff. The wider domiciliary

care workforce is seriously challenged, with outsourced care in the community being a particular local issue due to low pay rates, lack of local workforce, and the geography of Monmouthshire resulting in long travelling times and distances for carers.

Designing new models of care requires a workforce strategy that provides staff with the right skills to suit the needs of our population. The data shows that *116* including Primary Care staff are aged over *46*, we need to start now to future proof our services and ensure we have sufficient staffing resource to deliver our new model of care. We also have a range of part time staff working varying hours and this makes it difficult when managing staff rotas, alongside some inconsistencies across the teams which requires streamlining and clarity.

General Medical Services

Detailed work is on-going to understand the primary care workforce profile and development needs at a Neighbourhood Care Network level and it is recognised that two GP Practices are at potential risk due to staffing shortages. The context for this work is best summarised as:

- An ageing GP workforce
- Challenges to recruitment and retention
- Changing profile (in gender and contractual status) of the GP workforce
- Changing skill mix and the development of Nurse Practitioner and Health Care Support Worker roles
- Limited training numbers in the future

Beyond the core workforce required to deliver primary care services, there is a need to ensure that the workforce of the future have the skill to respond to a wider profile of services. As such, workforce plans will be developed at a Neighbourhood Care Network level, they will have at their core, principles of team working and team based competencies, enabling the growth of a general set of skills supported by specialist roles and training as required. There is a commitment through this plan to see teams and professions that have traditionally delivered services in the hospital setting to begin to deliver the same (where safe and acceptable) in a primary and community setting.

Community Nursing

It is a priority for us to ensure District Nursing alignment with GP practices and inclusion of the District Nursing team in Virtual wards/ Multi-Disciplinary Team meetings to ensure effective communication and shared priorities. To that end we are progressing work to develop the IT infrastructure to enable access to the patient (GP) record via Vision for District Nursing teams. This will allow service improvements including virtual INR clinics with real time dosing / communication and improved Diabetes care. We will also consider the development of an NCN wound service to release capacity in General Practice, improve wound healing, reduce cost and improve patient outcomes / experience.

8.2 Workforce Risks & Drivers for Change (Please refer to page 62)

Demand in general practice has risen faster than capacity and estimates for the period 2017/8 to 2018/19 indicate that the number of consultations has grown compared with the average annual growth in general practice workforce. This is in part attributable to demographic changes, for example, more people living longer with one or more complex long term condition. This has led to unprecedented pressure in general practice. This situation is exacerbated by difficulties in both recruitment and retention of staff with more people retiring from the professions than are being recruited and trends within the workforce to seek reduced hours or more flexible work patterns. Between 2017 and 2018 the proportion of GPs aged between 55 and 64 who left GMS, out proportioned the number of younger GPs joining. In recent years the number of training places has increased but not all places filled. The proportion of GPs working on a salaried or locum basis is rising whilst the proportion of GP Partnerships, whilst still in the majority, is gradually declining. The Aneurin Bevan University Health Board IMTP uses the findings from the Nuffield report (2016), which emphasises the urgent need to reshape our workforce to find a sustainable balance between available funding, patient and staff needs. It is the vision of the Integrated Services Partnership Board to incorporate these findings to identify opportunities and challenges specific to Monmouthshire to drive workforce development that ensures local sustainability in the delivery of our services.
Although historically General Practice within Monmouthshire has benefited from full recruitment, the Monmouthshire Primary Care workforce is facing significant challenges through increased workloads due to an increasing and ageing population and continuing drive to shift the balance of care from acute to primary and community settings. This increases the risk to maintaining staff sustainability and ensuring premises can accommodate the growing demand.

Our innovative model will seek greater and closer alignment with NCN's through extending the role of the GP admin staff in signposting and delivering compassionate communities, strengthening the presence of integrated Well-Being networks across Monmouthshire through collaborative communication. We will diversify the existing skill mix within our NCN both to reduce pressures on GP time and to meet the changing demand and population needs, making the best use of assisted technology to protect GP consultation time and improve patient care. The introduction of GP and Community based paramedics aligned to the NCN footprint could target a reduction in the average 7000 monthly calls received to Welsh Ambulance Service Trust from Monmouthshire, noting that of the 66% received, only 4.5% are red, this scheme will provide targeted support to those 61.5% non-urgent calls.

The anticipated implementation of Clinical Futures and opportunities to create a graduated care model within Monmouthshire remain our key drivers for change. Increasing demands for our services and a lack of skillset to meet acuity needs associated with the growing demand impacts on our ability to deliver services sustainably. There is a growing culture shift within the leadership of Monmouthshire to embed a social model of health based on based on relationships as opposed to transactions

which supports the health and well-being of all individuals and communities. Compassionate Communities training is currently being delivered to support and implement this cultural change.

8.3 Training Requirements

- Development of a generic Band 4 role bridging Aneurin Bevan University Health Board and Monmouthshire Local authority as part of the wider 'Place Based' model of care.
- Development of new roles to support the Primary Care Transformation Model across the 5 Monmouthshire hubs - Physician Associates , advanced nurse practitioners, practice based pharmacists, further collaboration and integration with the IST social workers and OT/Physio staff to support place based working.
- Increasing access and take up of the training and educational opportunities made available through the PCCS Training Academy
- Implementation of District Nursing Principles to ensure greater sustainability / safer staffing levels and more prudent use of resources including through consolidating services, improving skill mix, and education.
- Designing health and social care pathways which focus on people staying well in their own homes and communities.

Discussions have taken place with Integrated Services Managers to propose a 40% increase in staff across a 10 year period based on population growth, improving life expectancy, growing complexity and needs of our population. Specific mention was made relating to the growing life expectancy for people with a learning disability, increases with a dementia diagnosis resulting in additional resources across health and social care sectors. If realised, this will increase caseload numbers across the range of services within the locality from approximately 3,000 to 6,000.

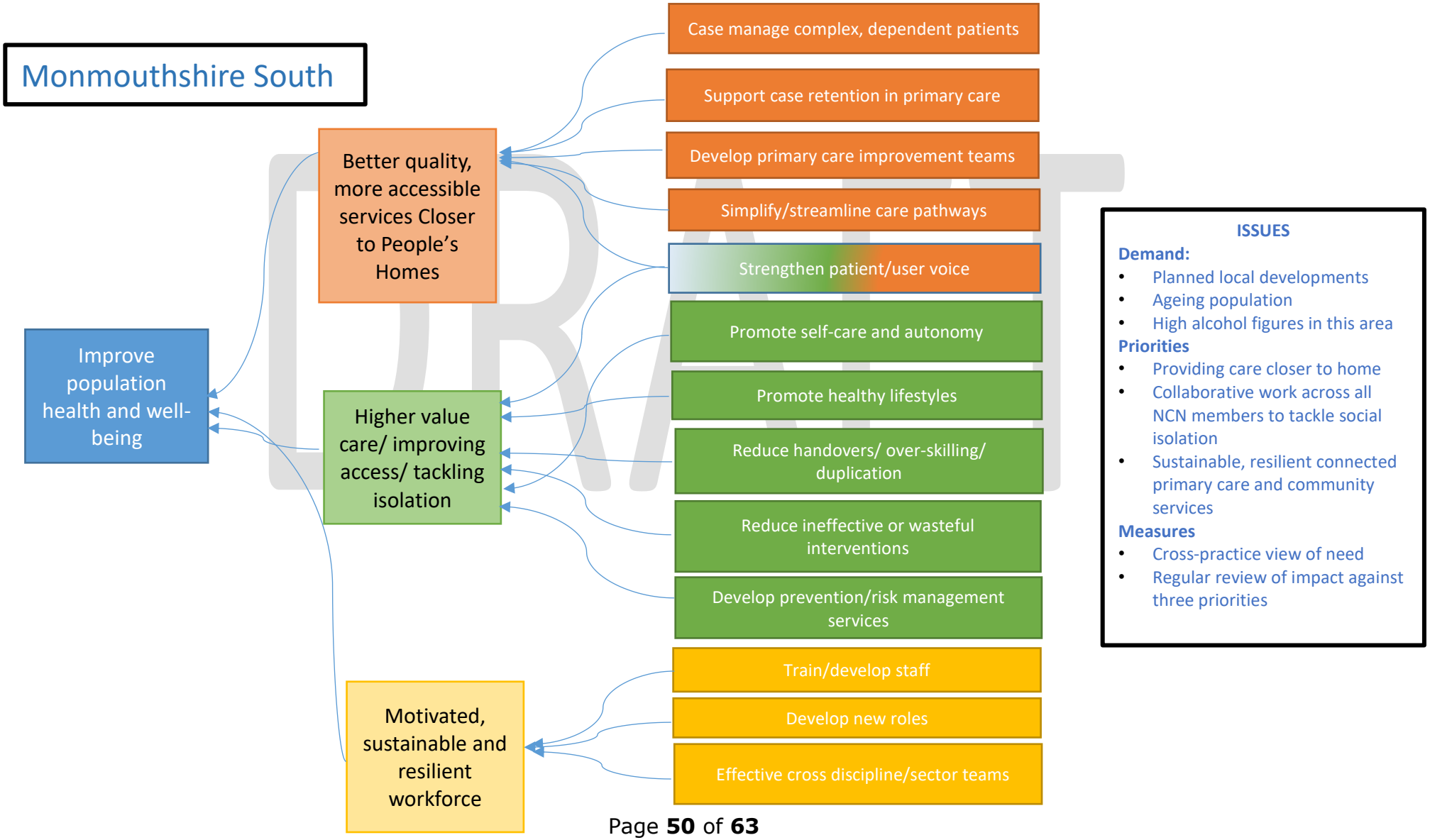
Historically, General Practice within Monmouthshire has benefited from full recruitment, the Monmouthshire Primary Care workforce is facing significant challenges through increased workloads due to an increasing and ageing population and continuing drive to shift the balance of care from acute to primary and community settings. This increases the risk to maintaining staff sustainability and ensuring premises can accommodate the growing demand. Our innovative model will seek greater and closer alignment with NCN's through extending the role of the GP admin staff in signposting and delivering compassionate communities, strengthening the presence of integrated wellbeing networks across Monmouthshire through collaborative communication. We will diversify the existing skill mix within our NCN both to reduce pressures on GP time and to meet the changing demand and population needs, making the best use of assisted technology to protect GP consultation time and improve patient care.

9 Opportunities and Challenges for 2020-2023

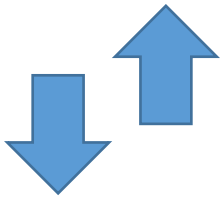
9.1 SWOT Analysis

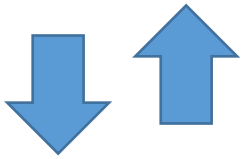
Strengths	Weaknesses
• Clear strategic drivers in place • Joint service vision re development of multi-disciplinary and integrated well-being 'hubs' to tackle social isolation and deliver localised services • Positive relationships across the NCN • Strong focus on innovation/development of new services • Clear direction via the NCN plan on a page of our priorities Clear governance and accountability lines via Aneurin Bevan University Health Board and ISPB	• Lack of capacity/ autonomy/ necessary skills for the NCN to recruit professionals aligned to three priorities • Inflexible budget when fully committed with established recurrent roles blocking new initiatives • Lack of capacity to backfill staff for skill development • Inaccessibility of Information Technology and social media
Opportunities	**Threats**
• Explore sources of external funding/ Social Enterprise • Horizon scan to develop business plans/ portfolio of schemes in event of budget release • Build on positive relationships and increase IT options to increase/ underpin cross-practice working Development of place based care models and hubs incorporating the medical element and the social wrap around services required to support sustainable services for the local population	• Risk of successful projects being taken down if tried and tested schemes not absorbed into core business or rolled out by the Health Board • Increasing regionalisation of Local Authorities • Brexit: Potential impact on NHS workforce pending clarification in terms of visas for migrant workers and access to medicines etc. Significant housing development plans both in Monmouthshire and across the border with England

9.2 Driver Diagrams



10 Prioritised Actions 2020-2023 aligned to 3 key themes

Objectives	Outcomes/ Anticipated Impact (against cross-cutting priorities)	Alignment to Population Needs Assessment *(Section 5)*	Alignment to Strategic Work-steam *(Section 3.4)*
P1. Rebalancing and Delivering Care Closer to Home 	• Improved access to Information, Advice and Assistance and local services within health & social care centres (hubs) - local plans and processes ensure new services in hubs reflect need e.g. weight management (child & adult), dietetics, cardiology, mental health etc. avoiding long journeys to Newport/ Abergavenny • Raised awareness of care closer to home via NCN public engagement programme • NCN clinical lead pathway reviews for dermatology, pathology and general surgery • Expansion of Integrated Health & Social Care teams responding to population growth and increasing complexity of need	• The percentage of overweight or obese people remains steady from 2003 to 2014 at approximately 51%. Whilst numbers are not increasing, obesity has a significant impact on both health and well-being, and measures need to continue to help reduce obesity across the generations. • Projected rise of 18.7% in number of people aged 18 + with a Limiting Long Term Illness[1] • Between 2017 and 2025 predicted 22.7% rise in number of people unable to carry out at least one domestic task (highest in Gwent and higher than Wales)[1] • Between 2017 and 2025 there predicted 23.6% rise in number of people unable to carry out at least one activity on their own (highest in Gwent and higher than Wales)[1] ([1]Daffodil)	• PC&CS IMTP Strategic Work-Stream 2
P2. Tackling the challenges of loneliness and social isolation	• More resilient communities - better understanding of individual and community level needs	• c21,000 16+ year olds living alone in 2017 expected to rise by 11.4%	• PC&CS IMTP Strategic Work-Streams 1,2,3,4,5,6,9

	• Improved access for people with dementia to local support via funded car schemes etc. • Improved ability to connect with lonely & isolated people via improved connectivity – use of social media and IT - signposting to local help & support initiatives via Care Navigation pathways • Reduced Primary Mental Health (PCMHSS) referrals with raised awareness of non-medical community based help e.g. Stress control measures • I.T. schemes improve direct patient access to GP advice e.g. new software in GP practices • Self-care sessions/ group work e.g. EPP, XPOD available locally		
P3. Sustainability and resilience (of communities and services) in the face of an increasing and ageing population	• General Medical Services new access standards • Estates Strategy in place/ prioritisation process • Reduced avoidable hospital admissions due to local wrap around services - increased ambulance capacity to reduce response times, Advanced Care Planning/ Holistic Review Pilot implemented & evaluated • Reduced demand on GP time, GPs released to see more complex patients • Reduced medicalisation of stressful life events • Increased cross-practice working – and building of relationships with other primary	• P1, 2 & 3. Increasing total population & proportion of >75 year olds - predicted change to population structure. By 2025 with 40% increase in 75-79 year olds, 31% increase in 80-84 year olds and 38% increase in those aged 85 years and over[1] - see predicted housing (5.1)	• PC&CS IMTP Strategic Work-Streams 1,2,3,4,5,6,7,8,9,10

	care services (GDS/GOS & Community Pharmacy) • Joint training workshops e.g. Advanced Care Planning, PCC training to build NCN maturity and responsiveness • Reduced individual practice workload via Care Navigation etc. • Opportunity to share best-practice - improved GP relations • Increased NCN maturity –NCN budgets directed to support IMTP priorities & Primary care model for Wales • Multi-agency working underpins impact of population growth through new housing developments • Tested & evaluated new roles in weight management, community connections, Mental Health trained Psychological well-being Officers etc. • I.T. schemes improve direct patient access to GP advice e.g. new software in GP practices		

11 Communication & Engagement Mechanisms

The NCN support team has developed a programme of public engagement to be extended across Monmouthshire in order to gauge the views of local people in response to our three key priorities and discuss key Health board strategies such as Clinical Futures and Care Closer to Home, and known issues in that particular area. This provides a vehicle also to discuss the impact of new housing developments and how the NCN is working with Monmouthshire County Council housing colleagues regarding local pressures and demands on GP practices and community services. Also, to raise awareness of our intent to provide other Information, Advice and Assistance 'Cabins' such as the one opened in Chepstow -Being centres. These centres will provide information on non-medical interventions provided by the Third Sector and thus support the NCN priority of developing resilient communities.

12 Financial Profile

12.1 Neighbourhood Care Network

- *Cluster Funding*

The NCN has an annual recurring budget of £126,456 which is almost fully committed. Prescribing efficiencies across the cluster achieved approximately £35,000 non-recurrent, which has led to the opportunity to explore training and clinical system software options in GP practices.

Funding Currently Supports:

Role / Initiative	Recurrent Annual Cost	Priority
1.64 WTE Practice Based Pharmacists	£105,293	Care Closer to Home/ resilient GMS
Community Phlebotomy Team	£10,044	Care Closer to Home
Independent Contractors (Top Sliced across all ABUHB NCNs)	£2,517	Resilient GMS
DEWIS Coordinator (Top Sliced across all ABUHB NCNs)	£1,465	Tackling social isolation
Dementia Road Map (Top Sliced across all ABUHB NCNs)	£ 661	Care Closer to Home/ Tackling social isolation
0.2 WTE Health Care Support Worker Phlebotomy drop-in clinic	£3,978	Care Closer to Home
Total investment	**£123,958**	

A range of support for GP practices and people in South Monmouthshire have been recurrently funded by the NCN. These include specialist advisor roles in Optometry, Dentistry and Pharmacy, investment in a Community Phlebotomy Service and Practice Based Pharmacists. Investment has also been made in training opportunities to 'upskill' Primary Care and allied staff across the NCN. The introduction of innovative use of 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 aligned to our three key priorities.

A key area the NCN will pursue is cross-practice working and broaden its range of expertise on a shared basis, looking at opportunities for future investment and cluster management.

- *Transformation Programme Funding*

Projects confirmed:

- Funding until March 2020 agreed for one practice to employ a Practice Nurse to release Nurse Practitioner capacity for patients with complex needs;
- Primary Care Commissioning (PCC) training, focused on financial and legal framework modelling for cross-practice employment.

Projects being considered:

- Funding of a physiotherapist employed on a cross-practice basis.
- An 18 month programme to employ Psychological Well-being Officers based in GP Practices linked to Care Navigation, Active Signposting and the Integrated Services Team, to better access housebound patients, children and young people etc.
- Transformation Funds will be fully utilised to support new ways of working if Welsh Government continues with it in future.

- *Integrated Care Fund*

Chepstow & Caldicot

Care Closer to Home: A range of schemes are underway as a result of successful Integrated Care Fund bids to improve facilities and local services at the two main sites of Chepstow Community Hospital and Caldicot Health Centre, which will continue to grow as local Integrated Health and Social Care centres offering Information, Advice and Assistance to local people e.g. Chepstow Community Cabin.

- *Other Funding Streams*

In 2018-19, Aneurin Bevan University Health Board allocated £200,000 to the Monmouthshire Integrated Services Partnership Board (ISPB) to oversee the introduction of new community based projects for people with dementia and carers, aimed at increasing support closer to home. The following schemes were approved by the ISPB:

- **Combined exercise and educational scheme:** Piloted from January to March 2019 in Chepstow and Caldicot with additional funding agreed by ISPB for full-year funding.
- **Bridges Community Car Scheme:** Volunteer drivers enable people with dementia to access health appointments and facilities.

- **Creative Lives/ Active Lives:** Provision of free sessions for a professionally led, local community based creative education programme for people with dementia and carers, to build new relationships and connections, increasing their well-being and reducing loneliness and social isolation.
- **Respite Bed:** Service Level Agreement in place to support respite options for people living with dementia/ functional mental health issues and carers.

The ISPB is monitoring the effectiveness and value of these schemes and will look for alternative funding streams to ensure continuity where appropriate.

- *Priority Unfunded Developments*

Community Connectors: Scoping plans with Local Authority and Third Sector colleagues to have a nominated Community Connector in each GP Practice and Integrated Services Team. This could also be extended to other patient facing services e.g. NCN funded Ante-Natal Mind and Body exercise classes. This would involve training being provided by year April 2020, with fully trained and established 'connectors' by April 2023. Connectors will be mobile to also link in with people who are housebound or in Care Homes, and liaising closely with the Chepstow Community Cabin team, psychological Well-Being officers, wider practice team and Integrated Services Team. Funding to support training needs to be identified from slippage funds for Community Connectors in GP Practices and across the wider community including Bridges Centre volunteers, local taxi firms etc. where possible.

Mild to Moderate Mental Health: Psychological Well-Being Officers to work across all GP practices seeing patients presenting with LLMH problems who could be given direct appointments via care navigators or the medical team. Able to link in with Community Connectors and the Community Cabin and see housebound patients and children and young people, as felt appropriate by the primary care team or Integrated Services Team. Officers would work alongside the Primary Care Mental Health Support Service. Funding would be needed from alternative sources e.g. the Welsh Government transformational project fund if appropriate – currently being considered but funding is time limited.

Cross-Practice working: There has been an increasing commitment to working on a collaborative basis and recent projects have involved data collection and analysis to identify issues, working together to identify relevant action to address issues, for example, the reasons for the high number of mild to moderate mental health contacts, and Advanced Care Planning (ACP). The NCN is currently considering how ACP can be taken forward in a more robust way within Primary Care exploring the potential for collective employment. Training for cross-practice employment modelling is due to be launched in 2021 and we would look to further increase communications regarding business and contingency planning between Practice Managers. This

would also allow cross-NCN working with North Monmouthshire via the Practice Manager's Forum. We continue to work with the Macmillan toolkit and hope to secure NCN wide Macmillan training with the aim of collective outcomes for this intervention. We plan to follow similar QAIF projects along the lines of the new 2019-20 GP contract. Support to develop collaborative projects as practices have largely worked independently before but as work becomes more integrated we will need to understand and explore models that will allow our business models to adapt successfully**.**

Advanced Care Planning (ACP): A GP Advanced Care Planning/ Holistic review scheme has been designed by the NCN Clinical Lead.We plan to identify all patients with a high electronic Frailty Index (eFI) score, to receive a holistic review including ACP, including documentation (with patient consent) and shared with other health and social care professionals. This intervention aims to better connect individuals with wider community services/ projects and the NCN will utilize qualitative improvement monitoring through external funding.

Frailty team: A Frailty Consultant and Advanced Nurse Practitioner (ANP) to support the Clinical Futures and Care Closer to Home agendas. The roles fit with the Integrated Health and Social Care model in Monmouthshire and would reinforce the team's ability to support people at home where appropriate, or at Chepstow Community Hospital. Our Advanced Care Planning scheme would also sit closely with this modelling. A working group has already been established to support this end.

Integrated Services Team – resource sharing: As part of the on-going work around NCN modelling and its role as part of the Health and Social Care system, from a resource sharing perspective, we will look at the value of working with the Integrated Services Team to identify gaps in necessary skills or equipment etc. with a view to allocating funding where possible.

Ante-Natal Mind and Body exercise classes: Poor evaluation of NCN funded aqua-fit (Pathway to Pregnancy) classes led to transition to ante-natal exercise classes in partnership with Monmouthshire County Council, National Exercise referral Scheme (NERS) colleagues to provide an opportunity for pregnant women to socialise with other women, to maintain their mental health and well-being, and in keeping with our priority of tackling loneliness. Maternity leave can be isolating therefore connecting mothers to be, we hope, will provide them with a support structure. Pilot phase has been received with excellent feedback therefore recurrent funding needed (not available from fully committed budget) in order to extend pilot phase to become not only a 'core' service in Chepstow, but also extended to other areas e.g. Caldicot.

- *Other proposals*
- Funding of Psychological Well-Being Officers in GP Practices aligned with Care Navigation and Active Signposting
- GP Practice based extended Physiotherapy role to release GP capacity

13 Actions to Support Cluster Working and Maturity

A robust financial framework is required to release hamstrung budgets and allow the NCN to test new initiatives. Failure to establish this could risk a rapid disengagement from the work of NCNs. Despite this, the NCN recognises there are alternative funding streams open to explore and is open to learning from other Health Board clusters. The NCN considers itself well established and mature enough to drive forward with its commitment to delivering the three key priorities outlined throughout this plan. The NCN will also continue to pursue the following to enhance its range and maturity:

- Public Health Wales – Improve engagement to utilise data
- Welsh Community Care Information System (WCCIS) – information shared quickly and securely enabling the Health Board and Social Services staff to work together to plan, co-ordinate, and deliver services and support for individuals, families and communities.
- Clarity and simplification and availability of data/ dashboards KISS
- Continued cross-practice working including shared training opportunities to improve sustainability and access
- Improved communication with other Health Boards cluster initiatives/schemes to help shared learning and outcomes
- Working closer with the Third Sector for wider delivery of initiatives

14 Appendix 1: Population Health Needs Assessment (Monmouthshire South)

14.1 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**

14.2 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**

Existing staffing establishments and structures covering South Monmouthshire team and GP surgeries. Please note this excludes the Monmouthshire Locality Management team.

Team	Current Staffing Establishment
Adult Disability Service	8.74 WTE X Social Workers including assessors
Adult Mental Health Team	5.09 WTE x Social Workers including assessors
Chepstow Integrated Services	8.20 WTE x Social Workers including assessors, 10.53 WTE x Occupational Therapists 1.98 WTE x Physiotherapists, 3.33 WTE x Reablement, 1.49 WTE x Falls 7.71 WTE x Direct care – Reablement, 23.43 WTE x Direct Care – Long term
Community Nursing Caldicot	1.0 WTE Team Leader B7, 8.00 WTE x RGN B5, 0.6 x Frailty, 1.0 x CCN 0.8 HCSW B3, 0.38 B2 Phlebotomist , 0.76 WTE Administrator
Community Nursing Chepstow	1.0 WTE Team Leader, 6.87 WTE x RGN, 2.0 x Frailty 1.0 x CCN, 0.80 HCSW B3, 0.58 B2 Phlebotomist 0.788 WTE Administrator
Older Adults Mental Health Team	4.41 WTE x Social Workers including assessors
CALDICOT MEDICAL GROUP	GP Principal x 10, Extended Role & Specialist Nurse x 3 Practice Nurse x 7, HCSW x 3, Phlebotomist x 2, Admin/Clerical x 22
MOUNT PLEASANT PRACTICE	GP Principal x 3, GP Salaried x 3, Practice Nurse x 4 HCSW x 2, Dispenser x 5, Dispenser Assistant, Admin/Clerical x 12
TOWN GATE PRACTICE	GP Principal x 6, GP Salaried x 1, GP Registrar x 1, Advanced Level Nurses x 1, Extended Role & Specialist Nurse x 2, Practice Nurse x 1, Phlebotomist x 1, Dispenser x 5, Admin/Clerical x 15 Cleaner/Gardener x 1
VAUXHALL PRACTICE	GP Principal x 5, GP Salaried x 2, Practice Nurse x 4, Clinical Pharmacist x 1, HCSW x 1, Phlebotomist x 4, Dispenser x 1, Admin/Clerical x 16, Cleaner/Gardener x 2
WYE DEAN	GP Principal x 1, Practice Nurse x 2, HCSW x 2, Dispenser x 1, Dispenser Assistant x 4 Admin/Clerical x 6, Cleaner/Gardener x 1

Monmouthshire Assets Profile