Blaenau Gwent West Network Integrated Medium Term Plan 2020 -2023

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Executive Summary

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

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

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

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

This assessment told us that:

- Our population has the 2nd highest rate of deprivation across all of the Health Board Clusters
- The gap in health inequalities persists
- We have an aging population and an increase in number of people predicted to live alone
- We have a high % of people who state they have a long-term health problem or illness
- We have high prevalence of chronic disease within our population
- Our borough has the highest rates of childhood tooth decay in Wales, poorer mental wellbeing that Wales as a whole and a high percentage of patients who do not participate in health behaviours
- We have a particularly high use of Tramadol, and an overall Opioid burden- driven by high tramadol and co-codamol use and our NCN is one of the highest users of 4Cs antibiotics, and antibiotics in general.
- Uptake of childhood immunisations need to be improved

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

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

New hubs within the Blaenau Gwent West NCN are either under construction (Tredegar) or in the process of having plans developed (Ebbw Vale) for discussion, agreement and implementation.

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

Our NCN is not unique in that we have issues around GP recruitment and retention. The Health Board acknowledges these issues and is supporting the implementation of the Primary Care Model, where core GPs are supported by larger multi-disciplinary teams of extended roles. We have taken the opportunity to test a number of roles across the NCN using transformation and NCN funding, including

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

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

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

We have an annual budget of **£122,340** funded from cluster monies. This, combined with transformation funding gives us opportunity to test new models of care and new extended roles including mental health practitioners and advanced nurse practitioners with proposals being developed for direct access physiotherapy and a home visiting occupational therapist service.

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

Dr David Minton

Cluster Lead

Plan on a Page

Our aims are to:-

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

Design by Caerphilly South NCN team: Alun, Jon, Eira and Stella

Aneurin Bevan University Health Board

Delivering Care Closer to Home

Blaenau Gwent West- Neighbourhood Care Network Plan – 2019/20

What are we doing?

- Ensuring sustainable local services by introducing new primary care roles including:- practice based pharmacists, physiotherapists, mental health workers and primary care audiologists.
- Strengthening local professional networks to support collaboration for service improvement
- Improving uptake of the care and advice available through community pharmacies and voluntary sector teams
- Increasing the population coverage of preventative services to keep citizens well including influenza and childhood immunisation
- Working to reduce the local health burden of heart disease and cancers by strengthening smoking cessation and weight management services and increasing participation in exercise schemes
- Providing assessments and advice through a re- visit of the Living Well Living Longer programme
- Tackling inequalities – including:-
  - The launch of the Period Equity Scheme
  - Analysis of late presentation of disease to understand causes and to identify opportunities for earlier diagnosis
- Improving services to residents in Care homes through intergenerational befriending, personalised care planning and improved medicines management
- Focussing future work on the needs of housebound residents
- Improving frailty services and establishing a new frailty unit in Ysbty Aneurin Bevan
- Supporting the implementation of the Compassionate Communities programme

How Are We Delivering Change?

- Making best use of health and social care building
- Work with partners to establish wrap around health and wellbeing services
- Use of preventative, early opportunity and self-management
- Understanding local needs and developing effective solutions
- Use prudent healthcare pathways to improve planned care
- Use Multidisciplinary Team to undertake active signposting
- Recruit, train & educate our workforce to ensure needs of population met

"Enablers"

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

How will we know if we have made a difference?

We review health and wellbeing outcomes regularly and we learn from feedback from patients, carers and staff

1 Introduction to the 2020-2023 Plan

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

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

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

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

Our NCN plan will also describe what it will take to deliver these actions, in terms of workforce configuration and financial implications.

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

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

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

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

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

However, standing still is not an option because:

- **Blaenau Gwent has statistically significantly lower healthy life expectancy than Wales as a whole,** which is unsurprising given the link between socio-economic deprivation and poor health:

- 66% of the population in Blaenau Gwent West are living in the most two most deprived fifth of areas in Wales
- there are above average mortality rates for persons aged under 75 and all ages in Blaenau Gwent
- Blaenau Gwent has the highest rates of smoking, the lowest compliance with 'healthy behaviours' in Gwent and;
- Blaenau Gwent has the 2nd highest % of people who state they have a long-term health problem or illness in Wales
-

- **Demand for healthcare is growing and will continue to grow;** we have an ageing population, with people living longer and with more complex needs, which in turn leads to increased demand for a whole range of services.

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

- **Some of our estate is not fit to provide primary care services fit for now and the future;** we have venues that present issues for citizens who are unable to walk up stairways to access services, venues that are seeking to renovate to provide more consulting and administration areas.

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

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

- Appointment of *extended roles* including an advanced nurse practitioner within the Glanrhyd practice using transformation funds.
- Appointment of two Practice Based Pharmacists, covering practices within Blaenau Gwent West, establishment of a direct access physiotherapy service and a phlebotomy service utilising primary care cluster funding
- Involvement within the *Compassionate Communities* initiative , through the establishment of MDTs and involvement of community connectors to sign post to community resources and services
- Mapping of community resources and assets through the Integrated Wellbeing Network project
- Development of an outline business case for a new Tredegar Health and Wellbeing Centre, with plans to open in 2021 should approval be granted.

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

We are fortunate to have short term funding available to introduce new extended roles, whereby practices are planning to pick up long term funding. However practices may be reluctant to commit to new roles until they have tested them in

practice, and sustainable funding streams are identified. There can also be delays in recruitment when we are testing new ideas within NCN budgets- and that is challenging when we are working on annual budgets

It is within this context, and in the face of these challenges, that the Blaenau Gwent West NCN will work together to deliver place based care to our citizens.

2 Overview of the Neighbourhood Care Networks

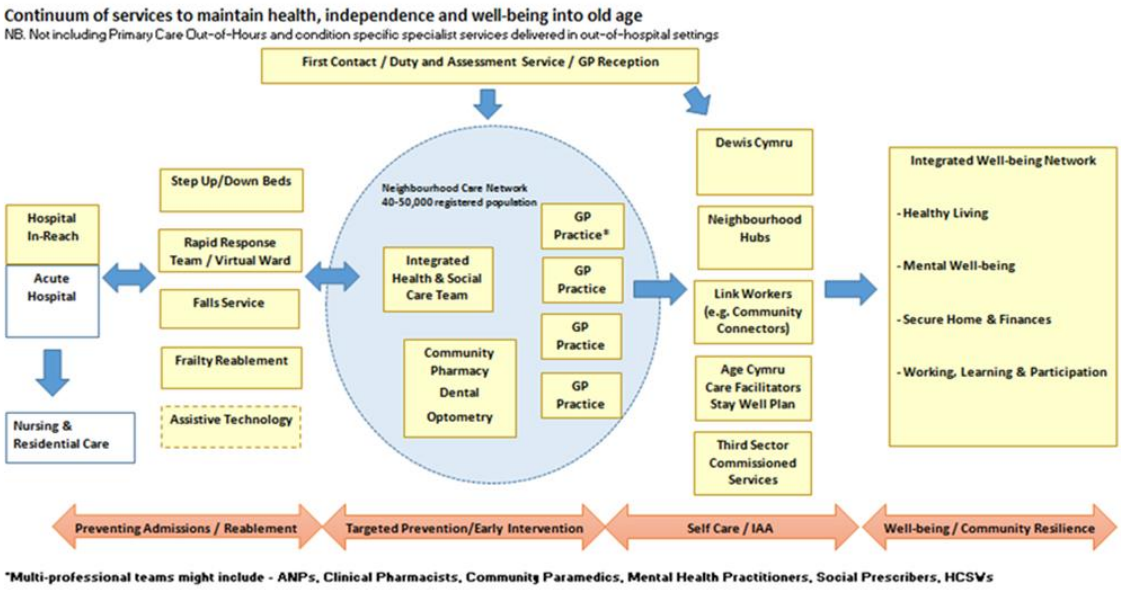
2.1 Profile of the Neighbourhood Care Network

2.1.1 Introducing the NCN Model in Blaenau Gwent

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

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

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



2.1.2 The Blaenau Gwent West NCN

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

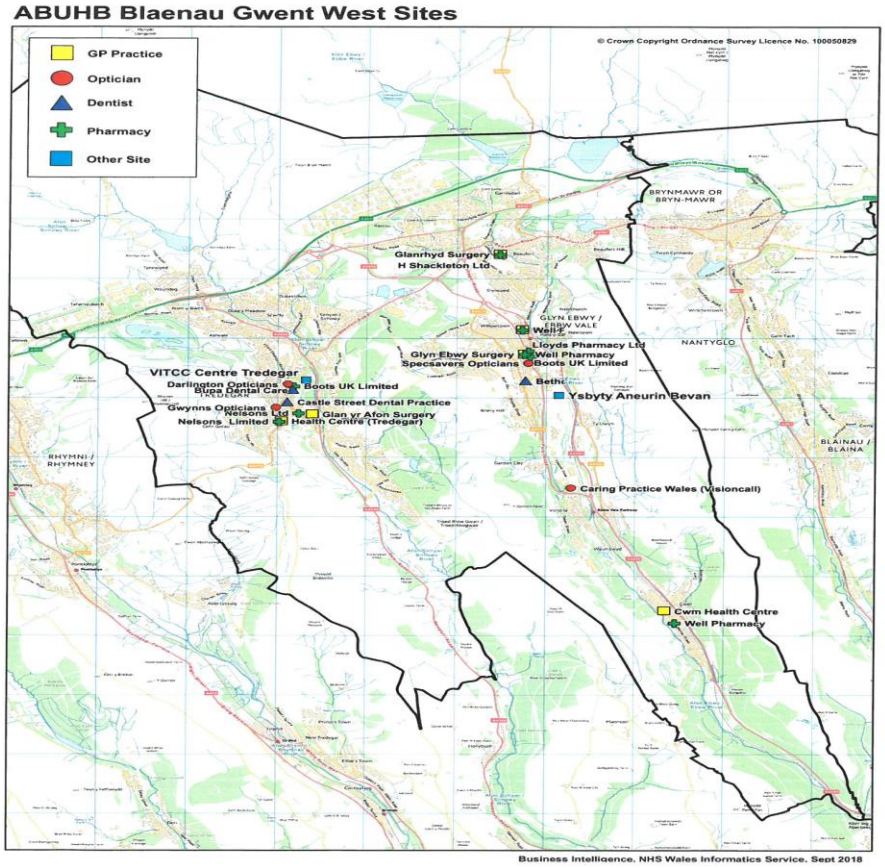
Primary Care

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

The Blaenau Gwent NCN has a practice based population of 38,378 and services are orientated around the following places:

1. Ebbw Vale
2. Tredegar

The map below outlines the NCN Footprint.



Primary Care

There are 6 GP practices within Blaenau Gwent West NCN as outlined within the table below:

Practice	Practice Population	Population >65 years	%age
Cwm Health Centre	3,522	706	20.05
Glan Rhyd	8,554	1,747	20.42
Glan Yr Afon	6,746	1,330	19.72
Glyn Ebwy	7,100	1,291	18.18
Pen Y Cae	6,874	1,305	18.98
Tredegar Health Centre (Managed)	5,582	1,260	22.57
Totals	**38,378**	**7,639**	**19.90**

Tredegar Health Centre became a Health Board managed practice in April 2017.

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

Dental Practices			
Main Surgery Name	Branch Name	Branch Address	Branch Postcode
BUPA Dental Care	Ebbw Vale	Dental Surgery,51 Bethcar Street,EBBW VALE,Gwent,	NP23 6HW
Bethcar Dental Practice	Ebbw Vale	Dental Surgery,97 Bethcar Street,EBBW VALE,Gwent,	NP23 6BB
Ebbw Vale Community Clinic	Ebbw Vale	Ebbw Vale Community Clinic, Bridge Street, Ebbw Vale,	NP23 6EY
BUPA Dental Care	Tredegar	Tredegar Dental Clinic,20 - 21 Gwent Shopping Centre,TREDEGAR,Gwent,	NP22 3EJ
Ali Jahanfar & Regina Appah	Tredegar	Castle Street Dental Practice,24 25 Castle Street,TREDEGAR,Gwent,	NP22 3DG
Tredegar Community Clinic	Tredegar	Tredegar Community Clinic, Health Centre, Park Row, Tredegar,	NP22 3NG

Within the West Blaenau Gwent NCN, there are **five Optometry Practices**:

Optometry Practices			
Name	Place	Address	Postcode
Caring Practice Wales Ltd (trading as Visioncall)	Ebbw Vale	Caring Practice Wales Ltd (trading as Visioncall), Unit 104, The Innovation Centre, Festival Drive, Ebbw Vale, Victoria Business Park, NP23 8XA	NP23 8XA
Ebbw Vale Optical Centre	Ebbw Vale	Ebbw Vale Optical Centre, 23 Market Street, Ebbw Vale, Ebbw Vale, NP23 6HL	NP23 6HL
Specsavers Opticians	Ebbw Vale	Specsavers Opticians, 24 Bethcar Street, Ebbw Vale, NP23 6HQ	NP23 6HQ
Darlington Opticians	Tredegar	Darlington Opticians, 37 Commercial Street, Tredegar, NP22 3DJ	NP22 3DJ
Gwynns Opticians	Tredegar	Gwynns Opticians, 90 Queen Victoria Street, Tredegar, NP22 3PY	NP22 3PY

Blaenau Gwent West NCN also has **nine Community Pharmacies** for its residents to access:

Community Pharmacies			
Name	Place	Address	Postcode
H. Shackleton Ltd.	Ebbw Vale	Cwm Hir Road, Riverside, Beaufort	NP23 5PB
Boots Uk Ltd	Ebbw Vale	11 Market St	NP23 6HL
Lloyds Retail Chemists Ltd.	Ebbw Vale	3/4 Market St	NP23 6HP
Well Pharmacy	Ebbw Vale	6 Marine St, Cwm	NP23 7ST
Well Pharmacy	Ebbw Vale	New Health Centre, James Street	NP23 6JG
Well Pharmacy	Ebbw Vale	Health Centre,Bridge Street	NP23 6EY
Nelson's (tredegar) Limited	Tredegar	4 Morgan St	NP22 3NA
Nelson's (tredegar) Ltd.	Tredegar	Health Centre, Park Row	NP22 3NG
Boots Uk Ltd	Tredegar	5/6 Gwent Shopping Centre	NP22 3EJ

There are two **Hospital Sites** within the Blaenau Gwent West NCN footprint:

Hospitals			
Name	Place	Address	Postcode
Ysbyty Aneurin Bevan	Ebbw Vale	Lime Road, Ebbw Vale, Gwent	NP23 6GL
Ysbyty Tri Cwm	Ebbw Vale	College Road, Ebbw Vale	NP23 6GT

There is **one shared Team Base** within the Blaenau Gwent West NCN:

Other Sites (e.g. Health Centres, Team Bases)			
Name / Description	Place	Address	Postcode
ViTeC	Tredegar	Tredegar Business Park, Tredegar, Gwent	NP22 3EL

Community services

Hospital Services

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

Community Resource Team

Our community resource team provides services including Reablement, Community OT, Community Physio, Falls, Assistive Technology, VI support, CARIAD, Rapid Medical and Rapid other to citizens in Blaenau Gwent in order to minimise unnecessary secondary care admissions and promote independent living within the local community.

District Nursing

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

Blaenau Gwent Adult Social Services

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

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

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

supported housing schemes, Direct Payments Team and Domiciliary Care Brokerage Unit.

Our Commissioning Team are responsible for the commissioning and quality monitoring of our external providers including local Care Homes both residential and nursing, Domiciliary Care agencies, Supported Living Projects and our Third Sector agencies. We also have a specific team that support unpaid family carers. We have recently developed bespoke telecare facilities within our intermediate care (CARIAD) facilities and work closely with colleagues in our integrated Community Resource Team to provide seamless reablement support and have hospital discharge staff based at both YAB and Nevill Hall Hospitals.

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

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

Third Sector Partners

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

- Aneurin Leisure Trust
- Job Centre
- Learning Action Centre
- Credit Union
- Supporting People
- Tai Calon
- Gwent Police
- Community Connectors
- Coal Fields Regeneration
- 50+ Forum
- Age Cymru
- GAVO
- Groundworks
- NET Team
- Digital Communities
- Living Well Living Longer

- Mental Health Services
- Expert Patient Programme
- Carers Project
- Citizens Advice Bureau
- National Exercise Referral Service
- Bryn Bach Park
- Blaenau Gwent Partnerships Team
- DEWIS

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

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

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

2.2 Vision Statements

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

If we achieve our vision, this will mean:

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

2.2.1 Achieving our vision

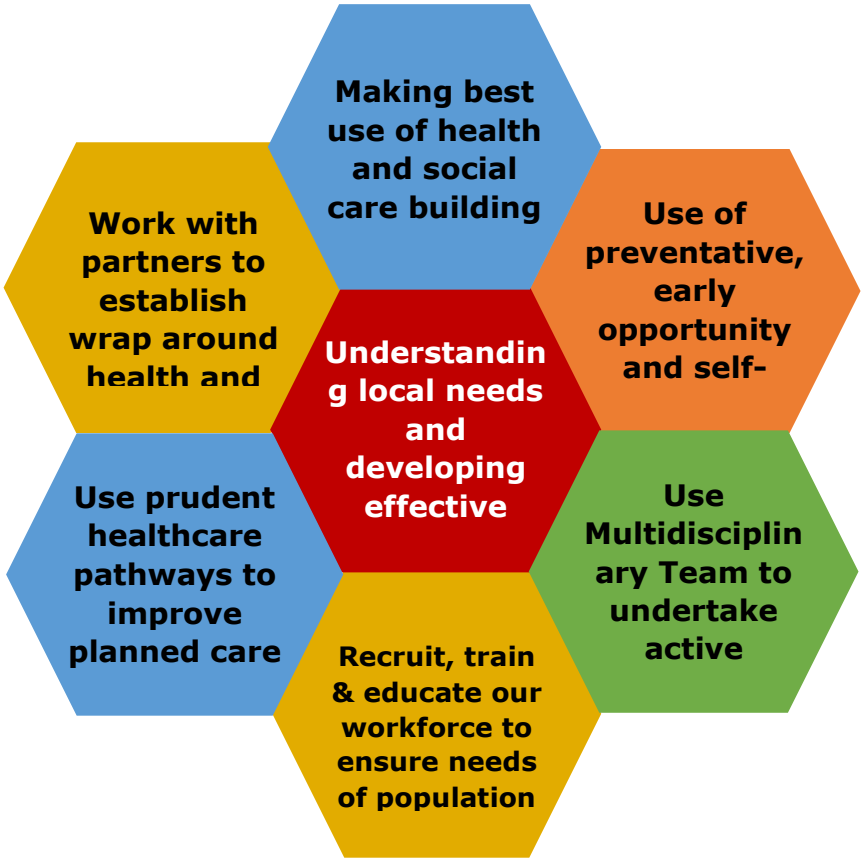
To achieve this vision in Blaenau Gwent West NCN we aim to achieve the following outcomes:

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

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

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

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



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

2.3 Neighbourhood Care Network Governance

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

2.3.1 Membership

Name	Role	Organisation
Dr David Minton	NCN Lead	ABUHB
Aimee Goulding	Community Support Officer	GAVO
Alison Minett	Social Worker Manager	Social Services
Anne Sprackling	Pharmacist	ABUHB
Ashleigh O'Callaghan	Assistant Head of Services	Aneurin Bevan UHB - Community Services
Avinash Mohindru	GP	Cwm Health Centre
Ceri Owen	Housing Officer	Tai Calon
Claire Dance	Practice Manager	Cwm Health Centre
Claire Wilkshire	Social Worker	Social Services
Clifford Jones	GP	Glanrhyd Surgery
Dupinder Chopra	GP	Cwm Health Centre
Georgy Mathews	GP	Glan Yr Afon Surgery
Grant Usmar	CEO	Hospice of the Valleys
Gurninder Kaur	Practice Manager	Glyn Ebwy Surgery
Hannah Baulch	District Nurse Manager	ABUHB
Helen Thomas	Practice Manager	Glanrhyd Surgery
Ian Fido	Network and Community Services Manager	ABUHB
Ian Haywood	Network and Community Services Support Officer	ABUHB
Ian Jones	GP	Glyn Ebwy Surgery
Ian Stuart	Primary Care GMS Contract Manager	ABUHB
Jason Davies	IAA Manager	Blaenau Gwent LA
Joanne Burchell	CRT Manager	Blaenau Gwent LA
Julie Price	Practice Manager	Tredegar Health Centre
Karen Gully	Clinical Director	ABUHB
Kath Thomas	Primary Care GMS Contract Support Officer	ABUHB
Kathryn Cross	Integrated Well-Being Networks Manager	Public Health Wales

Name	Role	Organisation
Kelly Love (IAA)	IAA Manager	Blaenau Gwent LA
Krishan Syal	GP	Glan Yr Afon Surgery
Leanne Light	Practice Manager	Glan Yr Afon Surgery
Lissa Friel	Community Connector	Blaenau Gwent LA
Louise Simpson	Social Worker	Blaenau Gwent LA
Louise Tovey	Health Social Care & Wellbeing Coordinator	GAVO
Lynwen Law	District Nursing – Senior Nurse	ABUHB
Michelle Church	Supporting People Officer	Blaenau Gwent LA
Michelle Wyatt	Supporting People Officer	Blaenau Gwent LA
Nichola Maggs	Public Health Operational Manager Health Visitor	ABUHB
Rachel Price	Social Worker	Blaenau Gwent LA
Rachel Rees	Housing Officer	Tai Calon
Richard Pryce	Head of Services, Blaenau Gwent	ABUHB
Robert Attridge	Practice Manager	Pen-Y-Cae Surgery
Sharon Whittaker	Primary Care Mental Health Support Services Manager	ABUHB
Simon Donovan	GP	Pen-Y-Cae Surgery
Sue Scully	Health Visitor	ABUHB
Tom Kivell	Fitness Development Manager	Aneurin Leisure
Yousuf Kunju	GP	Glyn Ebwy Surgery

2.3.2 NCN Leadership and Support Teams

Within each borough, NCNs have a support structure consisting of fellow NCN Leads and members of the Primary Care & Community Services Division. These individuals will ensure that NCN governance is maintained, collaboration is supported and will provide a link between the NCN and the mechanics of the Health Board in order to assist in the delivery of identified objectives.

Name	Title	Role and Responsibility
Dr David Minton	NCN Lead (West)	
Dr Isolde Shore-Nye	NCN Lead (East)	
Richard Pryce	Head of Service	
Ashleigh O'Callaghan	Assistant Head of Service	

Ian Fido	Network and Community Services Manager	
Claire Evans (secondment)	Network and Community Services Support Officer	
Ian Stuart	Primary Care Contracting Manager	

2.3.3 Frequency of Meetings

The Blaenau Gwent West meetings take place every two months.

2.3.4 Secretariat Support

The Network and Community Services Support Officer provides this function.

2.3.5 Quorum

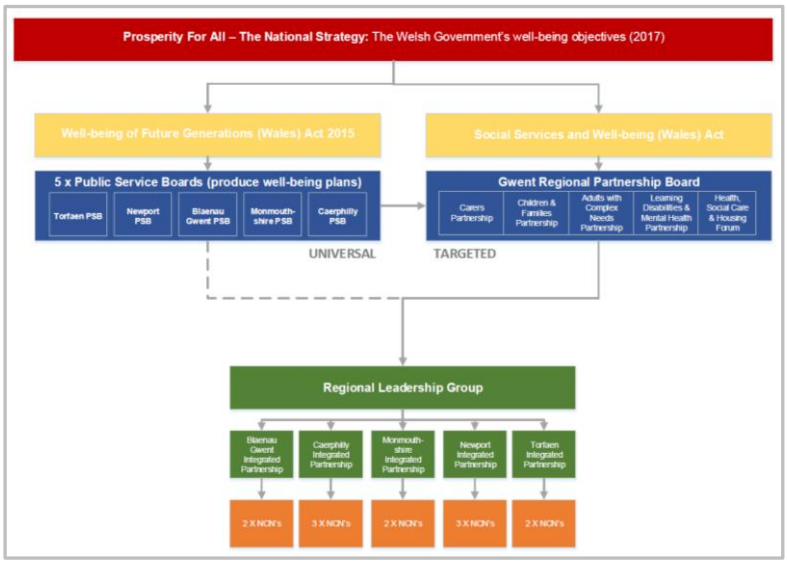
To be quorate, the NCN would need to have two thirds of the membership by profession, either primary membership or nominated deputies, as per the list of members at 2.3.1 above. Where voting is necessary it will be along the lines of a vote per professional entity. Where no majority is achieved, the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

2.3.6 Communication

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

2.3.7 Reporting Framework

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

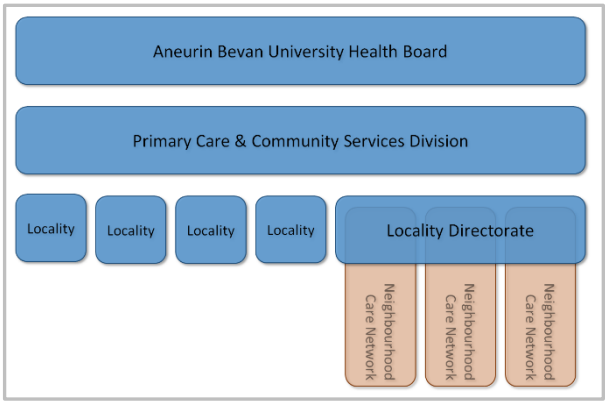


The NCNs are a key component of the Integrated Services Partnership Boards (ISPBs) in each of Gwent's five boroughs, which report to the Regional Leadership Group and onwards to the Public Service Boards and Gwent Regional Partnership Board.

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

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

2.3.8 Organisational Alignment within Aneurin Bevan University Health Board



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

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

3 Planning Context

3.1 A Healthier Wales

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

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

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

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

3.2 Clinical Futures Strategy

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

- Improve citizen well-being and patient outcomes (including patient experience) for people of all ages, by designing and delivering new models of care for the population of Aneurin Bevan University Health Board across the whole health and wellbeing system. The models are designed with a focus of prevention, delivering care close to home where ever possible, routine care and specialist and emergency care in the most appropriate care setting.
- Improve the efficiency and sustainability of service provision from 2018 – 2022 by ensuring that service development, model of care

design and implementation is patient-centred, transformative, evidence based and economically viable.
- Ensure that care quality and safety is of the highest importance during a period of transition to different delivery models, that any changes are well planned.
- Improve staff satisfaction, recruitment and retention through the enhancement of patient and citizen focussed services.

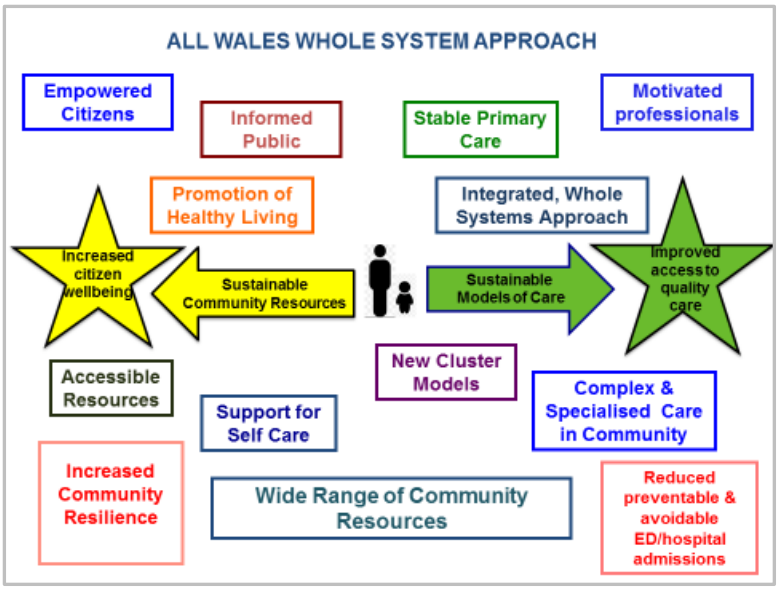
The design principles of Clinical Futures are:-

- ***Patient centred***, concentrating on safety, quality and experience.
- ***Home to home***: integrated services in the community to prevent illness and improve wellbeing, and providing care closer to home where appropriate
- ***Data*** and ***evidence*** driven, patient ***outcome*** focussed.
- ***Innovative*** and transformative, considering new ways of organising and delivering care around the patient and their 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, cluster, integrated care fund). The model seeks to address the well-established challenges facing primary care, which includes increasing workload from a growing, aging and increasing complex population and a shortage of GP numbers to deliver the traditional model of primary care.



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

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

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

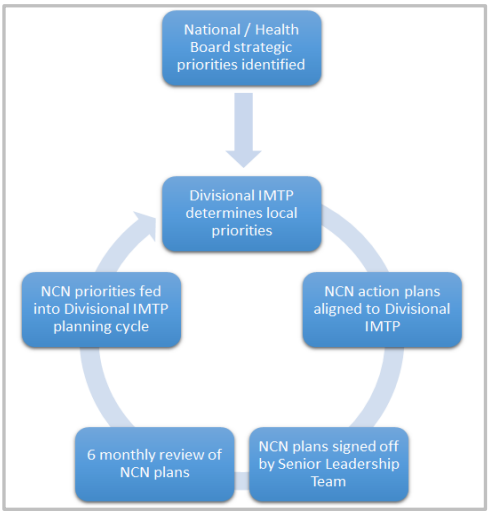
3.4 Primary Care & Community Services Integrated Medium Term Plan

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

Strategic Workstream	Delivery Committees	Workstream Description	Example of Priority Areas
1) Prevention, Wellbeing & Self-care	NCN Leads Meeting	Improving long term population health through a focus on early intervention, prevention and well-being services which may prevent or delay future ill-health. Empowering the population to take greater responsibility for their own health and well-being.	Enhanced services, risk stratification, screening, immunisation, smoking cessation, tackling obesity, integrated wellbeing network
2) Care Closer to Home		Delivering care closer to home by shifting demand out of secondary care services and into primary and community settings. Implemented through re-designing services and pathways, using primary care practitioners' full scope of practice.	INR & DVT management, extended skin surgery, community audiology services, ophthalmic diagnostic & treatment centres
3) Access & Sustainability	Access Group / Sustainability Board	Maintaining timely access to services and ensuring the long term sustainability of primary and community care provision, in the face of growing demands and an aging workforce.	Access standards in primary care, urgent care hub(s), GDS Reform Programme, 111 Programme, sustainability risk matrix, workflow optimisation
4) Implementing the Primary Care Model for Wales		The new Primary Care Model for Wales has been developed over recent years. Through a combination of care navigation, first contact practitioners and direct-access services, demand for primary care services is now being managed through a multidisciplinary approach.	First contact practitioners / multidisciplinary skill mix, care navigation, direct-access services, working at scale, multidisciplinary team meetings
5) Re-designing Community Services	Transformation Delivery Group	Gwent is committed to developing integrated place-based teams which reduce hand-offs and increase continuity of care. New models to deploy community services more effectively, closely synchronised with primary care and social services, is a key priority for the region.	Integrated place-based teams, compassionate communities, graduated care, neighbourhood nursing, district nursing principles

6) Digital, Data & Technology	Digital Technology Group	Utilising new developments in technology to improve communication between professionals, reduce workload for staff and enhance care and the experience of patients.	WCCIS, GP System Migration, electronic referrals, virtual consultations, electronic triage, My Health Online, escalation reporting, assistive technology, point-of-care testing
7) Skilled Local Workforce	Primary Care Workforce Group	Recognising the changing workforce requirements outside of the hospital setting, this workstream focuses on the training and development of both newly qualified and existing staff in line with the new ways of working.	Primary Care Academy, Diploma Level 4 (Health & Social Care), rotational posts in community nursing, palliative care education, workforce planning, demand & capacity analysis
8) Estates Development	Primary Care Estates Group	Recent estate developments outside of hospital have accounted for the new model of service delivery, providing integrated health & wellbeing hubs. However, many estates are not fit for purpose and a programme to improve facilities is underway.	Primary Care Estates Strategy, 6 facet survey of primary care estates, major / minor improvement grants, health & wellbeing hub developments, discretionary capital programme
9) Communication & Involvement	Senior Leadership Team	Involving both local practitioners, patients and the general public in the planning of services is key to their success. Particularly with the changing face of primary care, an awareness of the new options for care is essential to change behaviours.	Health talks, public engagement, social media campaigns
10) Quality, Value & Patient Safety	Quality & Patient Safety Committee	All services should be continually seeking opportunities to improve the way that care is delivered, making it more effective, of higher quality and safe. A quality / continuous improvement programme	Medicines management, Strategy for Falls & Bone Health, management of wounds & pressure damage, infection prevention and control, healthcare needs assessments, peer reviews, Primary Care QI Programme, advance care planning

3.5 NCN IMTP Process



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

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

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

4 Key Achievements from the 2017-2020 Plan

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

Strategic Work stream	Key Achievements	Benefits/outcomes
Prevention, Well-being and Self-Care	• **Funding for Bowel Screening pilot.** • **Established Smoking Cessation Champions in each Practice.** • **Support for Living Well Living Longer Programme.** • **Established annual flu planning process.** • **Early stage implementation of the Compassionate Communities programme.** • **Established Care Navigation principles in Practices and community settings to enable access to services without seeing a GP.** • **Recruitment to the Information, Assistance and Advice (IAA) Team.** • **Community Connectors have been appointed to each Practice in the West NCN.** • **Development of the Period Equity**	• Increased uptake in responses from residents was recorded. • Identified member of staff on site to direct residents to services. • Pilot for programme was launched in Blaenau Gwent West NCN. • Effective process operating over past three years to ensure readiness for flu season. • Programme aims to build on local community networks to develop resilience and self-care management. • Six pathways (Physiotherapy, Minor Injuries, Mental Health, Eye Services, Emergency Dental, Pharmacy) in operation across all West NCN Practices. • Strengthened the preventative services provided through the CRT via the IAA Team. • Connectors attend Practices on a rota basis to offer advice and support on services availability to residents.

Strategic Work stream	Key Achievements	Benefits/outcomes
	Programme in Blaenau Gwent.	• Sanitary products are freely available at Health and Local Authority venues, Sports Centres, Schools and Food Banks via this sustainable scheme.
Rebalancing Care Closer to Home	• **Dedicated session at NCN meeting to discuss Care Closer to Home.** • **Piloted Audiology Services in Primary Care across the West NCN.**	• ABUHB Programme was outlined and discussed with NCN members. CC2H is now a regular agenda item. • Residents with hearing loss issues are able to be seen locally in Practice rather than in hospital, improving user experience.
Access & Sustainability	• **Direct Access Physiotherapy funding** • **Sustainability workshop held for Practices.** • **Dedicated sessions held to specifically discuss the Access LES.** • **Delivery of a Demand Analysis exercise across all Practices in the NCN.** • **Provision of QR Information Boards across the West NCN Stakeholder membership.** • **Securing Transformation Funding to support Primary Care Services.**	• Funded 15 slots per day, per week at YAB which reduce demand on GP time. • Open forum for Practices enabled shared issues and potential inter practice working to be discussed. • Practices were helped to understand the LES and the funding available to support its implementation. • Insight in to demand on Practice resources and identification of appropriate relevant staff grade to treat patients. • Immediate Patient access, by mobile phone, to information and resources about locally available services provision. • Practices are able to trial extended staff roles, funded short term by ABUHB, with a view to employing staff

Strategic Work stream	Key Achievements	Benefits/outcomes
	• **Successfully maintained Locality based services during inclement weather.**	once HB funding has ceased. • Services have been available to residents throughout the Borough during inclement weather.
Redesigning Community Services	• **Employment of HCSW to undertake venepuncture.** • **Establishment of Graduated Care Services at Ysbyty Aneurin Bevan.** • **Development of an emergency care team (DASH).** • **Establishment of CARIAD Beds in Blaenau Gwent.** • **Successful submission of ICF bids.**	• District Nurses enabled to deliver services to more complex cases. • Ward based, CRT Assessment and Treatment Units, Nurse Led Wards, Virtual Home Beds and DN led Weekend Wound Clinics established at YAB. • Development of an emergency care at home service providing a 'bridging' service for citizens to cover the gap between hospital discharge and a care package commencing. • Step Up / Step Down Beds established as a viable discharge destination for medically fit patients awaiting a package of care as opposed to remaining in a hospital bed. CRT / IAA bids successful for: • Regional Advocacy • Resilient Provider Services • BG Health and Social Care social media project • BG Community Meals and Catering enterprise • BG Integrated senior practitioner post CRT/ IAA • BG Young Persons project • BG Artificial intelligence project

Strategic Work stream	**Key Achievements**	**Benefits/outcomes**
Effective Medicines Management	• **Reviewed prescribing budgets and made appropriate switches and substitutions.**	• Enabled CEPP savings and awards to be made to the NCN and Practices, respectively.
Improving Quality, Value and Patient Safety	• **Completed National Audits for EOLC, USC and Polypharmacy.** • **Provision of Defibrillators for use at Practices.**	• Open discussion between peers to review practice, issues and outcomes – shared learning. • Lifesaving equipment readily available at Practices for immediate use.
Developing a skilled workforce	• **Appointment of Community Dietician.** • **Provided top sliced funding to support Independent Contractor attendance at NCN Leads meetings.**	• Strategic development, support and guidance being driven at a Divisional level.
Digital Technology	• **Introduction of text message reminders at West NCN Practices.** • **Purchase of Dopplers for Practices and District Nursing Teams.** • **Laptops provided for Practices to support mobile working for staff.** • **Installation of patient calling systems in Practices.**	• Patient attendances have been shown to be more consistent with fewer DNAs. • Resources readily available for Teams to review patients. • Portable equipment enabling on the spot testing to be delivered to residents. • Improved patient experience when attending appointments at Practices.

5 Population Health Needs Assessment

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

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

5.1 Population and Future Projections

We know that:

- The population of Blaenau Gwent is declining over time
- Blaenau Gwent has an aging population which is predicted to increase
- Blaenau Gwent West NCN has the 2nd highest rate of deprivation of all the Health Board Clusters
- The gap in health inequalities does not appear to be reducing in Blaenau Gwent
- The annual premature mortality rate in Blaenau Gwent from all causes, standardised for age, whilst declining slightly, is higher than Wales as a whole
- By 2035, the number of people aged 65 and over predicted to be living alone will increase
- Data from the 2011 survey shows that more than one third of unpaid carers in Blaenau Gwent aged over 65 provide 50 or more hours of care per week to people who are disabled or infirm
- Blaenau Gwent has the 2nd highest % of people who state they have a long-term health problem or illness in Wales; this leads to a high proportion of people claiming disability—related benefits
- Local Development Plans for the Blaenau Gwent West NCN footprint includes 2,415 dwellings up to 2021 – this is 2.4 x 2,415 people.

Our NCN plans need to consider:

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

5.2 Health and Wellbeing

We know that:

- Hypertension, obesity and asthma combined accounts for 51.40% of the disease prevalence within Blaenau Gwent West NCN
- Cardiovascular disease and Cancer are the biggest causes of premature mortality in Blaenau Gwent.
- The % of people who are overweight, obese, who do eat 5 portions of fruit and vegetables a day and who are active for less than 30 minutes a week in Blaenau Gwent is significantly higher than Wales.
- Blaenau Gwent have poorer mental wellbeing than the rest of Wales as a whole, often associated with multiple comorbidities
- Blaenau Gwent has the highest rates of childhood tooth decay in Wales, and the highest rate of Total Dental Clearance (TDC) in children in the UK.

Our NCN plan needs to consider:

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

5.3 Incidents & Concerns

We know that:

Primary Care- Independent Contractors

Since September 2018, there have been 3 complaints received by the Primary Care directorate in relation to practices within the Blaenau Gwent West NCN.

These complaints are associated with 2 of the practices.

- 2 complaints were in relation to GP attitude and care
- 1 complaint was regarding communication of a change in appointment

Community

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

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

In terms of the speciality:

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

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

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

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

Incidents

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

Our NCN plan needs to consider:

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

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

5.4 Patient Safety Indicators

We know that:

- Blaenau Gwent West has particularly high use of Tramadol, and an overall Opioid burden- driven by high tramadol and co-codamol use.
- Blaenau Gwent West is one of the highest users of 4Cs antibiotics, and antibiotics in general.
- Uptake of flu immunisations have improved markedly over the last few year
- The NCN quality dashboards highlights that childhood immunisations need to be improved in Blaenau Gwent West.
- Ysbyty Aneurin Bevan (YAB) is an outlier in comparison with other community hospitals in ABUHB in terms of falls per 1,000 patients; this is a consequence of the patient cohort in YAB which is a combination of ongoing orthopaedic rehabilitation, General medical rehabilitation and enhanced Dementia Patients. Statistically, patients at most risk of an inpatient fall are generally within one of the three cohorts above. Recent scrutiny of the use of the Multiple Falls Risk Assessment (MFRA) in YAB by the ABUHB Falls Scrutiny Panel has given assurance that all mitigating actions are implemented on site where possible, and ward staff are fully embrace a proactive culture towards falls prevention.
- The recent Patient Related Experience Measures (PREMS) audit in YAB, completed in September 2019 identified that there is a high level of patient satisfaction, patient safety and delivery of care across the three wards on site.

Our NCN plan needs to consider:

- Working with pharmacist colleagues to review how we can improve our prescribing rates and consider wider partnership working that may help to address the underlying causes that can lead to high dependence on medication.
- Pilot areas for trialling the use of CRP point of care testing equipment in general practice, starting in late 2019. The ability to rapidly ascertain a CRP result from a patient will provide a primary care clinician with previously unavailable information, which will aid decision making when considering whether antibiotics should be prescribed or not.
- Targeted action to improve our immunisation rates

5.5 Clinical Audits

In summary:

- All practices within the NCN participated in the national diabetes audit
- All practices within the NCN participated in the National COPD Audit Programme; Compared to ABUHB, Blaenau Gwent East NCN and All Wales Comparators, Blaenau Gwent West NCN shows: a lower percentage of patients with Asthma; a lower percentage of patients with Bronchiectasis than ABUHB and All Wales comparators; a higher percentage of reported Lung Cancer.
- Stop a stroke project; The percentage of patients with Atrial Fibrillation, treated with Warfarin, is lower than Blaenau Gwent east NCN and ABUHB comparators, but not as low as the all Wales figure; the percentage of patients with Atrial Fibrillation, treated with NOAC, is higher.

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

5.6 Enhanced Services

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

5.7 Activity Benchmarking

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

- Percentage of Person Centred Medical Home (PCMH) assessments undertaken within 28 days of referral
- High GP referrals to Trauma & Orthopaedics (All Wales) per 10,000 population
- High GP referrals to surgical specialties (All Wales excluding T&O) per 10,000 population
- Occupied bed days > 65 years of age following EMA per 10,000 population

5.8 Engagement Events

A Public Engagement event at Bedwellty House was held in May 2019 to inform local residents of the developing Health, Social Care and Well-Being Centre in Tredegar. Over 120 people attended the event over the course of the day and the feedback was very positive. There was generally good support for the

development, which was seen as positive investment in the Tredegar area and as the next legacy for Tredegar.

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

5.9 Access

Primary Care- GPs

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

The standards are:

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

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

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

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

- Demand and capacity analysis
- Telephone systems
- Use of IT technology

- Patient information
- Patient survey/feedback

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

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

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

100% of Blaenau Gwent West practices deliver on the 5As.

General Dental Services (GDS)

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

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

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

Current Access

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

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

Child Access

The Primary Care Team and Designed to Smile Team have been working collaboratively to develop a 'child referral pathway' in order for more children to access dental services with local general dental practitioners.

8 practices within the Health Board area now receive direct referrals from the D2S team which may be instigated by Health Visiting, Flying Start and/or D2S teams. Caste Street Dental Practice within Blaenau Gwent West is participating in this scheme.

Children are given a unique patient code on referral in order to be tracked through the system in case they DNA appointments.

The aim of this pathway is to allow as many children as possible to access mainstream Dental services.

Since April 2018, the D2S team has sent 126 child referrals to the 8 practices taking part in the pathway of which there were 46 children referred into the service in Blaenau Gwent West.

Contract Reform

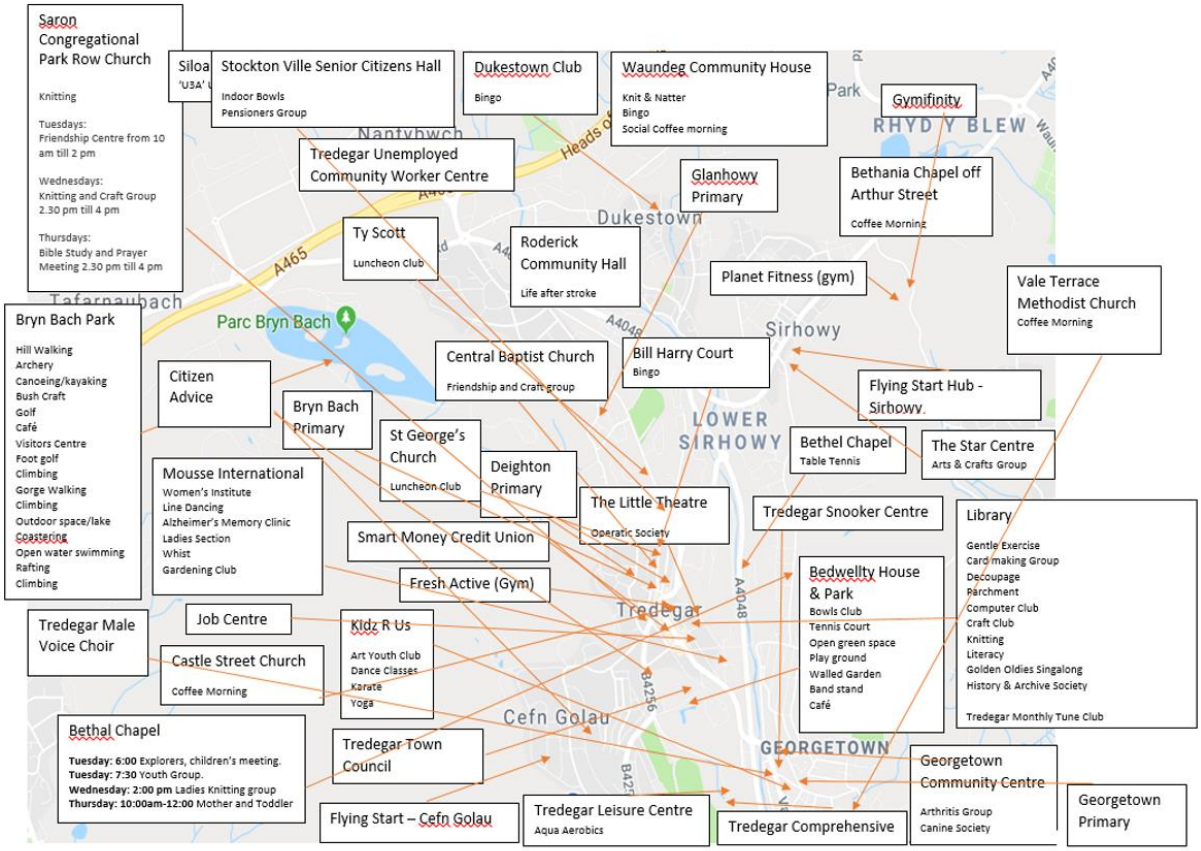
The new Contract Reform programme was first introduced in September 2017. Since this date, 1 Practice from Blaenau Gwent West have successfully applied to join the programme.

Bethcar Dental Practice (Ebbw Vale) joined the programme from April 2019. One of the stipulations of the programme more latterly has been the issue that no practice should have a Unit of Dental Activity (UDA) value of less than £25. Both the latest Practices to join the programme have benefitted from this criteria with an investment of almost £99,000. All the above Practices have also benefitted from a 10% reduction in their annual UDA target as part of the programme. The Health Board is currently in the process of collating expressions of interest from practices to join the programme from October 2019.

6 Assets Profile

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

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



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

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

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

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

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

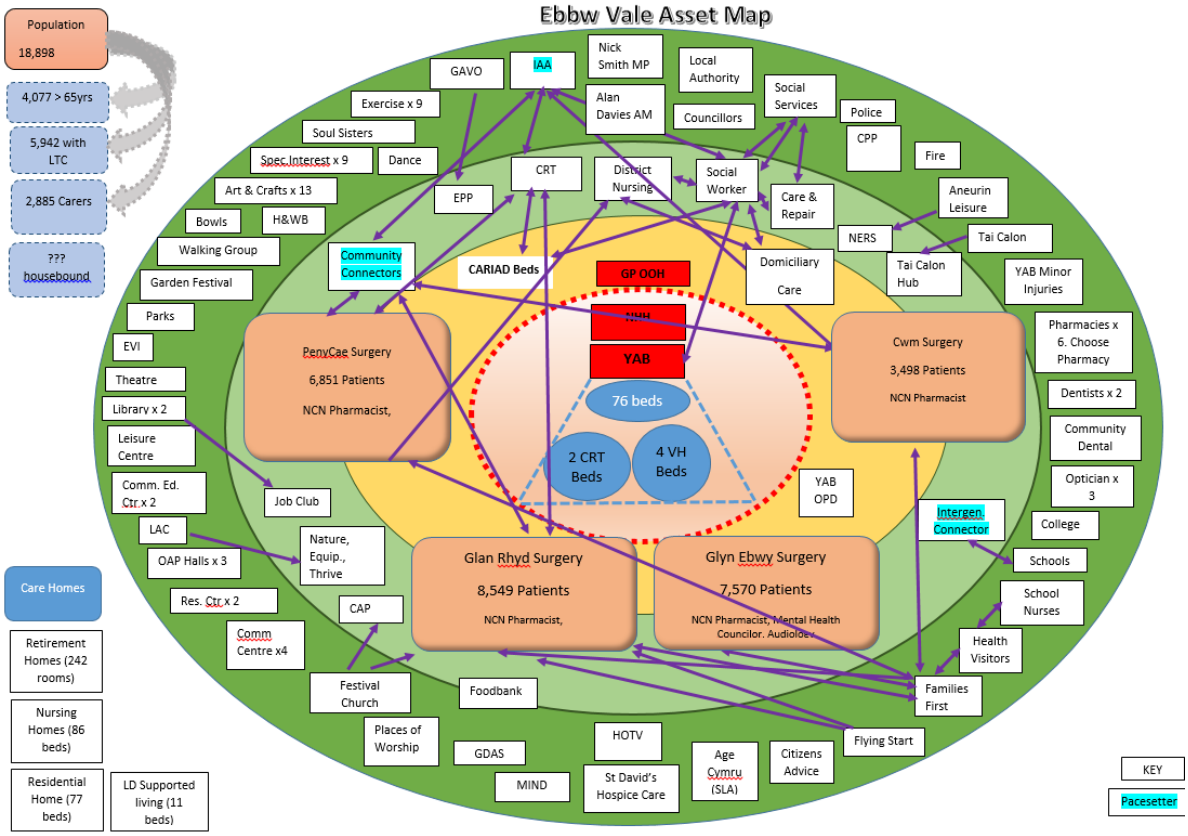
However, some early gaps that have been identified anecdotally whilst scoping are;

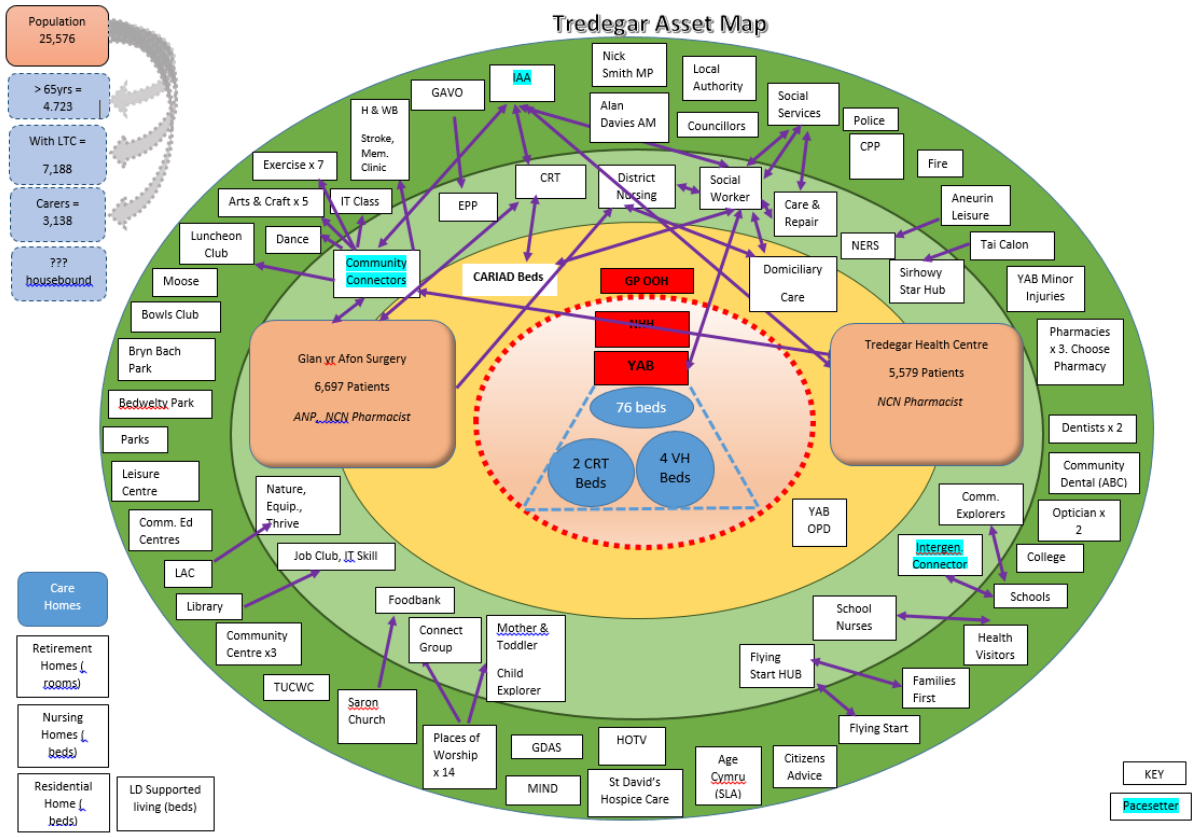
- Lack of support for those suffering with effects of the menopause
- Lack of befrienders
- No suitable venue Brynmawr (within budget)
    - Baby Yoga
    - Baby Massage
- Support for fibromyalgia

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

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

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




Tredegar Asset Map
Population 25,576
> 65yrs = 4,723
With LTC = 7,188
Carers = 3,138
??? housebound
Nick Smith MP
Local Authority
Alan Davies AM
Councillors
Social Services
Police
CPP
Fire
IAA
GAVO
H & WB
Stroke, Mem. Clinic
Exercise x 7
Arts & Craft x 5
IT Class
CRT
District Nursing
Social Worker
Care & Repair
EPP
Aneurin Leisure
Luncheon Club
Dance
NERS
Tai Calon
Community Connectors
CARIAD Beds
GP OOH
Domiciliary Care
Sirhowy Star Hub
YAB Minor Injuries
Moose
Bowls Club
Bryn Bach Park
Bedwelty Park
Parks
Leisure Centre
Comm. Ed Centres
LAC
Library
Community Centre x3
TUCWC
Glan yr Afon Surgery
6,697 Patients
ANP, NCN Pharmacist
YAB
76 beds
2 CRT Beds
4 VH Beds
Tredegar Health Centre
5,579 Patients
NCN Pharmacist
Pharmacies x 3. Choose Pharmacy
Dentists x 2
Community Dental (ABC)
Optician x 2
College
Schools
Comm. Explorers
Intergen. Connector
YAB OPD
Nature, Equip., Thrive
Job Club, IT Skill
Foodbank
Connect Group
Mother & Toddler
Child Explorer
Saron Church
Places of Worship x 14
GDAS
MIND
HOTV
St David's Hospice Care
Age Cymru (SLA)
Citizens Advice
Flying Start HUB
Flying Start
Families First
School Nurses
Health Visitors
Care Homes
Retirement Homes (rooms)
Nursing Homes (beds)
Residential Home (beds)
LD Supported living (beds)
KEY
Pacesetter

7 Estates Profile

7.1 Estate Profile

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

- Six GP Practices (five Independent Practices and one Health Board Managed Practice);
- Six Dental Practices;
- Five Optometry Practices;
- Nine Community Pharmacies;
- One community Hospital;
- One Mental Health Hospital
- One shared Team Base in the ViTCC Centre

Blaenau Gwent West NCN - Estates Mapping

GP Practices			
Name	Place	Address	Postcode
Glyn Ebbw Surgery	Ebbw Vale	Glyn Ebwy Surgery,James Street,Ebbw Vale,Gwent,	NP23 6JG
Cwm Health Centre	Ebbw Vale	Cwm Health Centre Canning Street Cwm Ebbw Vale	NP23 7RW
Pen Y Cae Surgery	Ebbw Vale	Pen-y-Cae Surgery The Health Centre Bridge Street Ebbw Vale	NP23 6EY
Glanrhyd Surgery	Ebbw Vale	Glan Rhyd Surgery,Riverside,Ebbw Vale,Gwent,	NP23 5PA
Tredegar Health Centre	Tredegar	Health Centre Park Row Tredegar	NP22 3NG
Glan yr Afon	Tredegar	Glan yr Afon Surgery,Shop Row,Tredegar,Gwent,	NP22 4LB

Dental Practices			
Main Surgery Name	Branch Name	Branch Address	Branch Postcode
BUPA Dental Care	Ebbw Vale	Dental Surgery,51 Bethcar Street,EBBW VALE,Gwent,	NP23 6HW
Bethcar Dental Practice	Ebbw Vale	Dental Surgery,97 Bethcar Street,EBBW VALE,Gwent,	NP23 6BB
Ebbw Vale Community Clinic	Ebbw Vale	Ebbw Vale Community Clinic, Bridge Street, Ebbw Vale,	NP23 6EY
BUPA Dental Care	Tredegar	Tredegar Dental Clinic,20 - 21 Gwent Shopping Centre,TREDEGAR,Gwent,	NP22 3EJ
Ali Jahanfar & Regina Appah	Tredegar	Castle Street Dental Practice,24 25 Castle Street,TREDEGAR,Gwent,	NP22 3DG
Tredegar Community Clinic	Tredegar	Tredegar Community Clinic, Health Centre, Park Row, Tredegar,	NP22 3NG

Optometry Practices			
Name	Place	Address	Postcode
Caring Practice Wales Ltd (trading as Visioncall)	Ebbw Vale	Caring Practice Wales Ltd (trading as Visioncall), Unit 104, The Innovation Centre, Festival Drive, Ebbw Vale, Victoria Business Park, NP23 8XA	NP23 8XA
Ebbw Vale Optical Centre	Ebbw Vale	Ebbw Vale Optical Centre, 23 Market Street, Ebbw Vale, Ebbw Vale, NP23 6HL	NP23 6HL
Specsavers Opticians	Ebbw Vale	Specsavers Opticians, 24 Bethcar Street, Ebbw Vale, NP23 6HQ	NP23 6HQ
Darlington Opticians	Tredegar	Darlington Opticians, 37 Commercial Street, Tredegar, NP22 3DJ	NP22 3DJ
Gwynns Opticians	Tredegar	Gwynns Opticians, 90 Queen Victoria Street, Tredegar, NP22 3PY	NP22 3PY

Community Pharmacies			
Name	Place	Address	Postcode
H. Shackleton Ltd.	Ebbw Vale	Cwm Hir Road, Riverside, Beaufort	NP23 5PB
Boots Uk Ltd	Ebbw Vale	11 Market St	NP23 6HL
Lloyds Retail Chemists Ltd.	Ebbw Vale	3/4 Market St	NP23 6HP
Well Pharmacy	Ebbw Vale	6 Marine St, Cwm	NP23 7ST
Well Pharmacy	Ebbw Vale	New Health Centre, James Street	NP23 6JG
Well Pharmacy	Ebbw Vale	Health Centre,Bridge Street	NP23 6EY
Nelson's (tredegar) Limited	Tredegar	4 Morgan St	NP22 3NA
Nelson's (tredegar) Ltd.	Tredegar	Health Centre, Park Row	NP22 3NG
Boots Uk Ltd	Tredegar	5/6 Gwent Shopping Centre	NP22 3EJ

Hospitals			
Name	Place	Address	Postcode
Ysbyty Aneurin Bevan	Ebbw Vale	Lime Road, Ebbw Vale, Gwent	NP23 6GL
Ysbyty Tri Cwm	Ebbw Vale	College Road, Ebbw Vale	NP23 6GT

Other Sites (e.g. Health Centres, Team Bases)			
Name / Description	Place	Address	Postcode
ViTeC	Tredegar	Tredegar Business Park, Tredegar, Gwent	NP22 3EL
Civic Centre	Ebbw Vale	Civic Centre, Ebbw Vale	NP23 6XB

7.2 Vision for Estates within the NCN

7.2.1 Place Based Care and the Hub model

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

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

New hubs within the Blaenau Gwent west NCN are either under construction (Tredegar) or in the process of having plans developed (Ebbw Vale) for discussion, agreement and implementation.

7.2.2 Delivering the vision

Re provision of services located in Tredegar Health Centre once development work on the new build begins

The service will be provided from temporary buildings on the existing site, therefore users of the Health Centre may experience a level of service disruption during the project. Ongoing community engagement is in place to maximise public awareness and mitigate a number of expected challenges.

Agreeing the service model

In line with the vision of clinical futures, the new build in Tredegar would enable the delivery of place based care through a single wellbeing hub for the area. There are ongoing discussions with the practices in the local area to agree the service model, transition plan, and workforce recruitment.

Developing the plan for Ebbw Vale Health and Wellbeing Resource Hub

There are proposals, supported by Pipeline Funding, to develop a Health and Well-being Resource Centre in the Ebbw Vale locality. Options are being explored that include a new build and the potential to use existing estate within the borough, again this would enable the delivery of place based care through a single wellbeing hub for the area.

Maximising our estate in the short term

Minor improvement works at Cwm Health Centre and Glyn Ebwy Surgery will make the estates infrastructure more sustainable in the medium term whilst the long term development of health and wellbeing hubs is realised.

Transition and Relocation of services

On completion of the wellbeing hubs, case, there will be vacant Practice sites within the NCN footprint.

There will be costs associated with vacating current premises to move in to a purpose built Hub for the Practices involved, the Health Board intends to work collaboratively with practices to ensure that any negative impacts on practices are mitigated as much as possible.

The Health Board will need to be cogniscent of potential financial packages that may be available for these Practices under The National Health Service (Wales) Act 2006, The National Health Service (General Medical Services – Premises Costs) (Wales) Directions 2015.

This Part of the Directions addresses the following scenarios where Health Board Financial assistance will need to be considered for Practices relocating to a new Hub premises, whether new build or refurbished:

- Repayment mortgage redemption/deficit grants
- Costs that may not be funded with repayment mortgage redemption/deficit grants
- Matters that must be determined before determining repayment mortgage redemption/deficit grant applications
- Conditions attached to repayment mortgage redemption/deficit grants
- Borrowing costs relating to repayment mortgage redemption/deficit costs
- Costs that may not be funded with repayment mortgage redemption/deficit loan repayment payments
- Matters that must be considered before determining applications of the type mentioned in Direction
- Conditions attached to repayment mortgage redemption/deficit loan repayment payments
- Guaranteed minimum sale price payments
- Agreement of a guaranteed minimum sale price
- Grants relating to the cost of reconverting former residential property
- Circumstances where residential property reconversion grants are not payable
- Grants towards the cost of surrendering or assigning leases or to meet vacated leasehold premises costs and conditions to be attached
- Circumstances where an application of the type mentioned in direction 28 must be refused
- Stamp Duty Land Tax payable on agreeing a new lease

7.3 Priority Developments

7.3.1 Major Improvement Grants

There are no priorities for major improvement grants for 2019/20 for the Blaenau Gent West NCN.

7.3.2 Minor Improvement Grants

The following practices received funding in 2018/2019 to undertake improvements to their premises:

- Glan Rhyd Surgery (Beaufort)
  Improvements to update the Treatment Room in line with Infection Control

- Glyn Ebwy Surgery (Ebbw Vale)
  Install automatic doors to front of building and refurbish the sluice room in order to make it operational and comply with infection control.

There were no applications for 2019/20 within the area.

7.3.3 Capital Pipeline Funding

There are two proposed capital pipeline projects within Blaenau Gwent West NCN area.

The first is the new build of the Tredegar Health and Well-being Resource Centre which is already underway and on course for opening in 2021.

The second capital pipeline project is for developing a new Health and Well-being Centre based in Ebbw Vale. Options are currently being appraised for a new build or renovation and refurbishment of an existing venue within Ebbw Vale. The Locality Team will establish a working group between all respective stakeholders to take this work forward by the end of the Financial Year 2019/20.

7.3.4 Other Developments

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

- There are building works that individual Practices within the NCN require:
  - Window frames and skylights replaced;
  - Cracks in building walls to be repaired;
  - External paved areas are cracked and uneven;
  - Carpets / vinyl flooring needs replacing;
  - Fixed furniture and sanitary ware aged and beyond design life;

- Environmental works in respect of internal and external fixtures and fittings, including mechanical and electrical systems and rain water goods, are required within the NCN;
- Two premises within the NCN do not have separate Male and Female W/Cs;
- Two Practices do not have adequate facilities for disabled patients;
- One practice has inadequate car parking facilities;
- Two Practices are difficult to access by public transport;
- Premises' building condition ratings will be lower if the above remedial works are not undertaken.

8 Workforce Profile

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

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

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

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

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

8.1 Current Workforce Profile

There are 141.13 WTE in BG West, broken down as follows:

	Post	WTE
Primary Care Staff in Post	General Practitioners	17.01
	Extended Roles *(employed by practice)*	1.75
	General Dental Practices	6
	Optometry Practices	5
	Community Pharmacy Practices	9

	Total	**38.76**

	Post	**WTE**
Community Nursing Staff in Post	Rapid Response Nursing *	4.81
	Out of Hours Nursing ^	1.71
	Primary Care Specialist Nursing ^	1.45
	Chronic Conditions Nursing *	0.00
	District Nursing	21.31
	Healthcare Support Workers	1.78
	Total	**31.06**

	Post	**WTE**
CRT Staff in Post	Medical *	1.07
	Social, Therapy & Other Profs *	5.05
	Support Workers / Carers *	14.05
	Total	**20.17**
Community Hospital	**Post**	**WTE**
	Medical *	1.82
	Nursing *	26.35
	Therapy *	-
	Pharmacy *	0.53
	Healthcare Support Worker *	22.44
	Total	**51.14**

Primary Care Capacity and Demand Analysis

The Blaenau Gwent West cluster has undertaken a demand and capacity assessment by utilising the electronic Takt Calculator designed by Operasee Ltd as described below.

Operasee Ltd's software 'Electronic Takt Calculator' (eTC) is designed specifically to both establish demand and calculate the required capacity to meet that demand for use in most sectors and industries.

When employed in a Primary care setting, the software measures patient demand (both volume and mix, according to the readcodes entered by the GPs when seeing patients) across Clusters and the individual GP practices within the cluster.

The benefits of understanding demand in this way are:

- To improve access and enable better target achievement by recruiting the appropriate skills to meet demand
- Improved sustainability as practices would be enabled to better plan recruitment, particularly if there are GP recruitment difficulties and prohibitive locum costs.
- Improved workforce planning at practice and cluster and level.

The results of this analysis suggests that for a future workforce plan in the scenario that GP replacement/recruitment is difficult to achieve then the maximum number of alternative health care professionals to complete a multidisciplinary team approach would be as outlined below

	WTE/Wk inc UL
NER	7.93
PHYSIO	2.46
PHARM	2.42
MH	1.14
AUD	0.64

	Ebbw Vale	Tredegar	Cwm	WTE/Wk inc UL
NER	5.44	1.91	0.58	7.93
PHYSIO	1.70	0.58	0.19	2.46
PHARM	1.14	1.19	0.09	2.42
MH	0.83	0.24	0.07	1.14
AUD	0.42	0.19	0.04	0.64

In a worst case scenario whereby GPs within the cluster leave or retire and cannot be replaced, the figures show the maximum number of alternative HCPs that would be required to meet demand for patients that do not need to be seen by a GP

There are clear opportunities within the NCN to maximise the use of the multi-disciplinary workforce and new emerging roles within primary care, creating a greater resilience of primary care services and enhances career development of the MDT workforce.

8.2 Workforce Risks & Drivers for Change

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

We believe that there are opportunities for:

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

The key drivers for change are:

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

GP Sustainability

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

Practice	Practice List Size 01.10.2018	Pts per session	GP sessions provided	Required GP	NER Hrs	NERE sessions	combined sessions	Shortfall	% shortfall
CWM HEALTH CENTRE	3525.0	175.0	16.0	20.1	0.0	0.0	16.0	4.1	20.6
GLAN RHYD SURGERY	8534.0	200.0	49.5	42.7	0.0	0.0	49.5	-6.8	-16.0
GLAN YR AFON SURGERY	6721.0	175.0	18.0	38.4	35.0	4.4	22.4	16.0	41.7
GLYN EBWY SURGERY	7075.0	175.0	27.0	40.4	0.0	0.0	27.0	13.4	33.2
PEN-Y-CAE SURGERY	6907.0	175.0	26.0	39.5	28.0	3.5	29.5	10.0	25.3
TREDEGAR HEALTH CENTRE	5619.0	175.0	4.0	32.1	37.5	4.7	8.7	23.4	72.9

8.3.1 General Practice Skill Mix

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

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

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

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

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

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

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

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

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

8.3.2 Funding of the Primary Care Model in Independent Contractors

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

This scheme is aimed at supporting practices with the implementation of the Primary Care Model, as detailed above, via the Transformational Bid

monies. This will allow practices to test the extended roles and wider skill mix, with financial support.

8.2.3 Primary Care Academy

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

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

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

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

8.2.4 Sustainability Framework

The Welsh Government and BMA Cymru Wales published the *GP Sustainability Assessment Framework in 2015.* This programme is designed to identify practices at risk of collapse within 12 months and/or sudden service reduction. Practices can submit an application form which is then considered by a Panel to determine if support is required. Recognising the limited availability of direct staff support the Health Board is able to provide, a sustainability financial calculator has been developed, in conjunction with Gwent Local Medical Committee.

8.2.5 Placed Based Care

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

8.2.6 Care Navigation

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

8.2.7 Workflow optimisation

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

8.2.8 Social prescribing

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

8.2.9 Funding for other directly accessible services

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

8.2.10 Workforce vision

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

- Ebbw Vale
- Tredegar

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

GP practices

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

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

Community Resource Team

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

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

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

District Nursing

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

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

- Development of the neighbourhood nursing model in line with the work currently carried out in Newport

Ysbyty Aneurin Bevan

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

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

To achieve this vision we need to:

Develop prudent approach to maximising roles across all staff groups

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

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

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

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

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

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

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

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

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

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

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

8.3 Training Requirements

Training opportunities include:

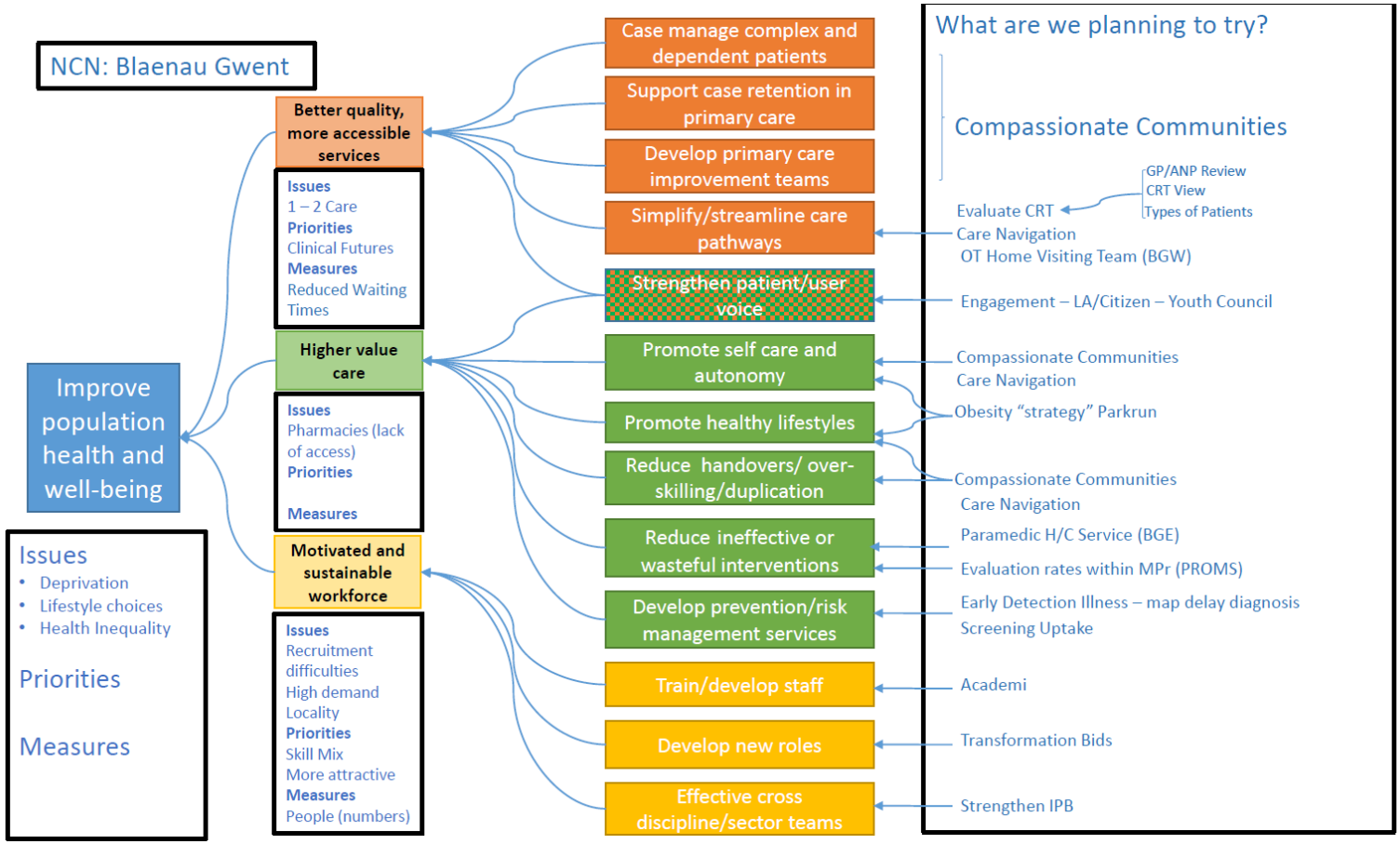
- Making Every Contact Count (MECC) Training for GP practice and partnership organisations staff
- Care Aims training
- Care navigation
- Compassionate Communities mentoring
- Quality improvement training
- Mentorship for Practice Based Pharmacists
- Various training opportunities that arise for upskilling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

9 Opportunities and Challenges for 2020-2023

9.1 SWOT Analysis

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

9.2 Driver Diagrams



10 Prioritised Actions 2020-2023

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

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

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		- Involvement in developing phase 2 of Living Well Living Longer Programme - Pilot home visiting service for pre-emptive and proactive management of frailty and chronic conditions -	- Avoid emergency admissions - Improved community resilience - Improved signposting to services **Wider benefits** - Improved wellbeing of population - Improved health activation - Improved sustainability of services		
4.	To build **capacity of individuals,** to be independent, **maintain good health and well-being** by building on **community development principles** and harness assets readily available in	- Use the IWN methodology to consult with the community regarding support for Fibromyalgia and Menopause to understand what support they need from the community and to develop a support	**Direct benefits** - Reduced demand on health service - Improved community resilience - Improved signposting to services	- Unhealthy behaviours - Health inequalities	Re-designing Community Services

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
	local communities and beyond	system around the needs - Roll out of MDT working via Compassionate Communities programme - Implement proven evidence based interventions and self-management techniques - Work closely with our partners/the IWN to develop practice based schemes and communities specific to local needs, such as free weight loss clubs run community volunteers for areas whereby payment for privately run schemes are a barrier	**Wider benefits** - Improved wellbeing of population - Improved health activation - Improved sustainability of services		

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

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

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

#	Objective	Action(s)	Anticipated Impact	Alignment to PNA *(Section 5)*	Alignment to Strategic Work stream *(Section 3.4)*
		- Co-produce a targeted action plan			
8.	To improve prescribing practices and reduce prescribing rates in line with best practice	- Implement point of care testing	**Direct impact** - Improved compliance with national targets	-Blaenau Gwent West has particularly high use of Tramadol, and an overall Opioid burden-driven by high tramadol and co-codamol use. -Blaenau Gwent West is one of the highest users of 4Cs antibiotics, and antibiotics in general.	

11 Communication & Engagement Mechanisms

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

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

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

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

1.2 Engagement Plan

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

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

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

12 Financial Profile

Cluster Funding

Blaenau Gwent West NCN Cluster Funding – Annual Budget **£122,340**

Currently Supports:

Role / Initiative	Recurrent Cost
Independent Contractors (Top Sliced across all ABUHB NCNs)	£2,347.00
Nursing HCA/HCSW Band 3	£9,667.00
Practice Based Pharmacist Band 8a 0.6 WTE	£38,694.00
Practice Based Pharmacist Band 8a 0.8 WTE	£47,969.00
Physiotherapist Band 6 (Direct Access Service at Yybyty Aneurin Bevan)	£6,604.00
Admin Band 5 Intergenerational Worker Extension of role	£2,197.00
DEWIS Co-ordinator (Top Sliced across all ABUHB NCNs)	£1,448.00
Dementia Road Map (Top Sliced across all ABUHB NCNs)	£653.00
NEWT annual subscription (Top Sliced across all ABUHB NCNs)	£23.00
Room Hire Cont	£660.00
Pharmacist Training	£6,150.00
Total Costs	**£117,119.00**

Since 2016-17 the Blaenau Gwent West NCN has invested around £113,913 in GP Practice Based Pharmacist support. This sum comprises salary and training costs.

The NCN has been funding a Direct Access Physiotherapy Service based at Ysbyty Aneurin Bevan for all Practices to be able to refer to. Investment in the service since 2016 amounts to £49,493. At the end of Quarter 1 2019/20, the uptake of the available service was 64% of available slots.

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

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

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

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

Transformation Programme Funding

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

1 x WTE Clinical Pharmacist
1 x WTE Clinical Physiotherapist
2 x WTE Mental Health Practitioners
1 x WTE Advanced Nurse Practitioner
1 x Occupational Therapist led Home Visiting Service

Integrated Care Fund

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

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

13 Actions to Support Cluster Working and Maturity

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

14 Appendices

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**

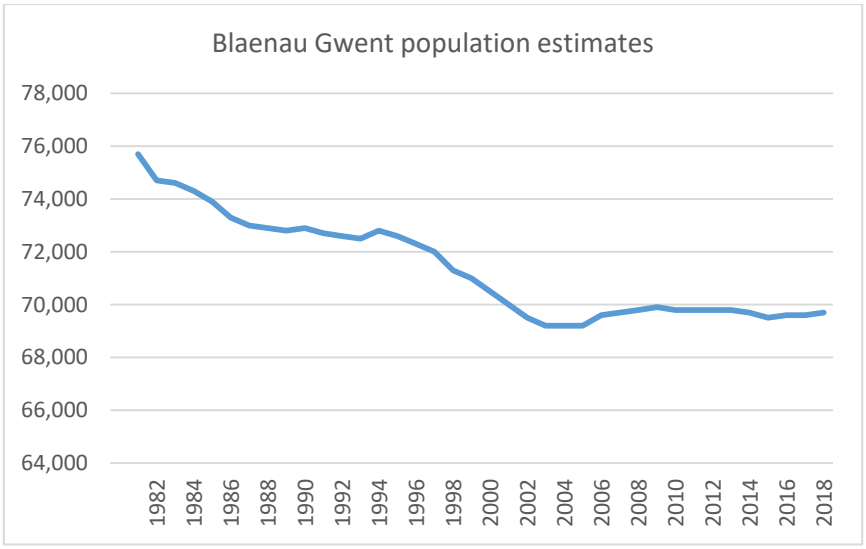
14.3 Population Health Needs Assessment

14.2 Population and Future Projections

Summary of key points from this section:

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

The population of Blaenau Gwent is declining over time;



Source: ONS Crown Copyright Reserved [from Nomis on 29 August 2019]

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

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

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

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

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

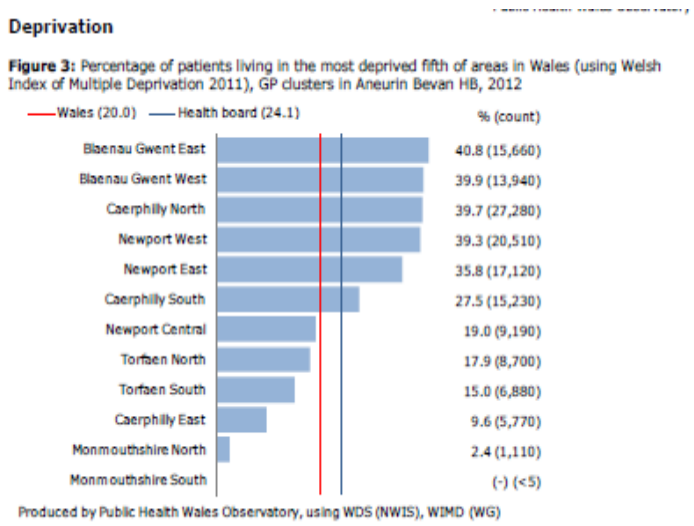
Blaenau Gwent, like the majority of places in the UK, has an overall population which is ageing. Generally, this is because less people are being born than before, and those people that are alive are living longer.

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

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

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

Blaenau Gwent West NCN has the 2nd highest rate of deprivation of all the Health Board Clusters

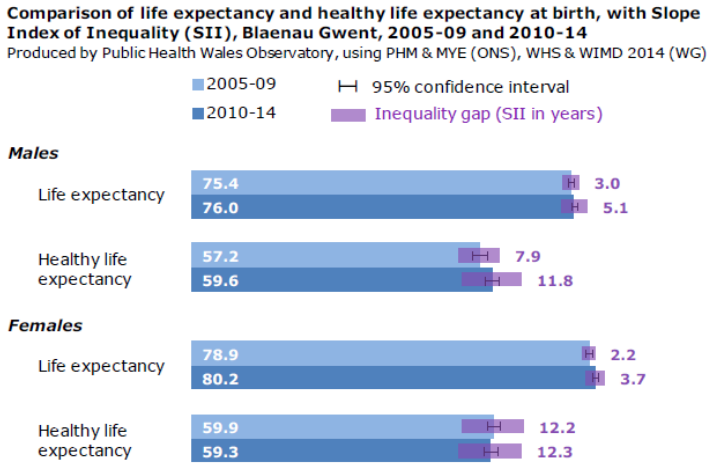


66% of the population in Blaenau Gwent West are living in the 2 most deprived fifths.

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

term conditions, particularly chronic respiratory diseases, cardiovascular diseases and arthritis.

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



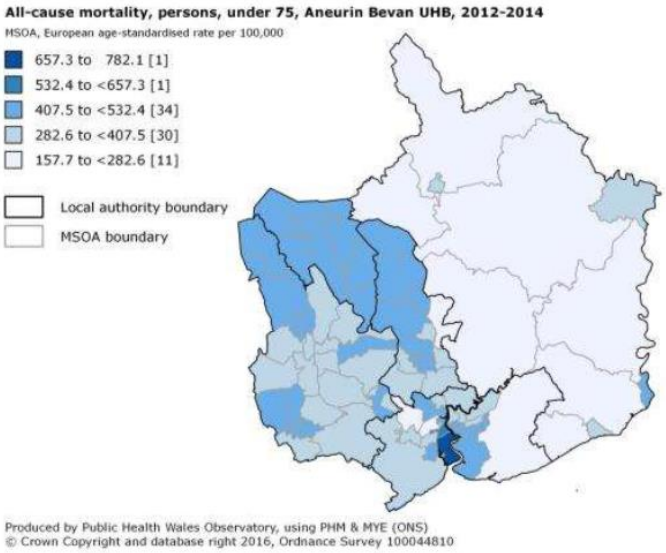
Blaenau Gwent males born today can expect approximately 60 healthy years of life and females about 59 years. For both males and females, Blaenau Gwent has statistically significantly lower healthy life expectancy than Wales as a whole (males, 65.3 years; females, 66.7 years).

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

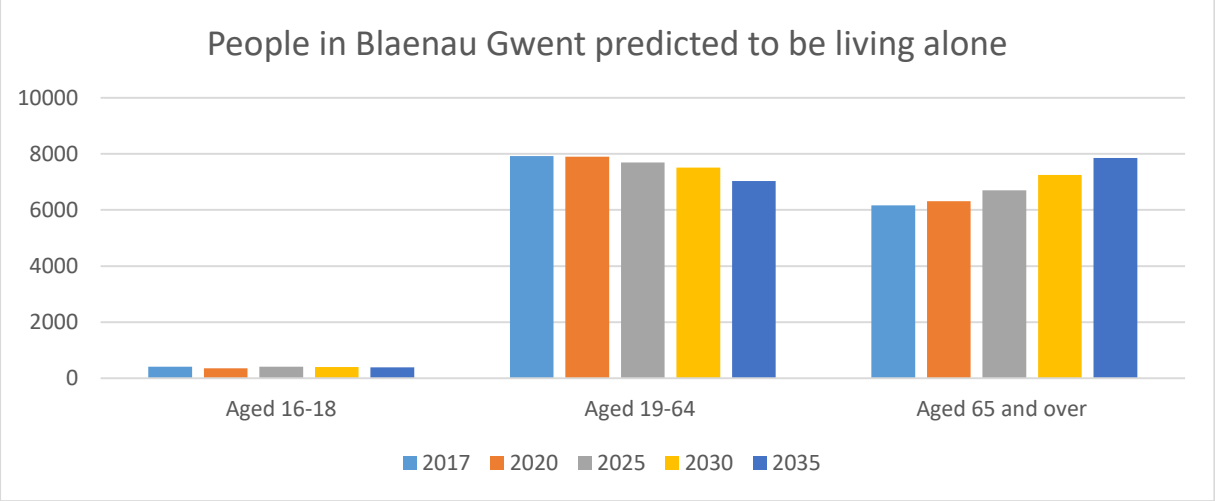
In essence, this means that not only are the most deprived likely to live shorter lives they are likely to enjoy fewer years in good health and for a smaller proportion of their lives. This negatively impacts quality of life, ability to work and the need for health and social services **(PSB Wellbeing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

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

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



By 2035, the number of people aged 65 and over predicted to be living alone will increase



(Source BG needs assess data- performance team)

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

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

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

Unpaid Care

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

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

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

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

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

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

Implications of Local Development Plans (LDPs)

LDP for BGW NCN footprint includes 2,415 dwellings up to 2021 – this is a forecasted population change of 2,415 people.

The Borough Team has regular contact with the local authority planning leads, allowing development plans to be shared and implications to health service provision to be considered in each proposal.

14.3 Health and Wellbeing

Summary of key points from this section:

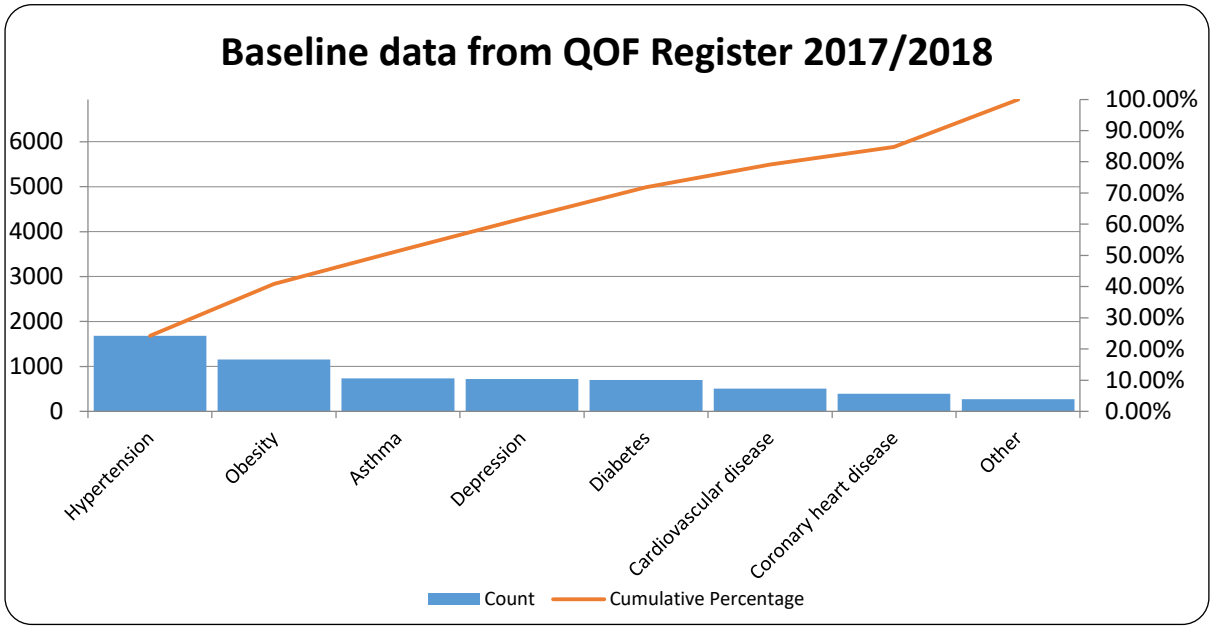
- Hypertension, obesity and asthma combined accounts for 51.40% of the disease prevalence within Blaenau Gwent West NCN
- Cardiovascular disease and Cancer are the biggest causes of premature mortality in Blaenau Gwent.
- The % of people who are overweight, obese, who do eat 5 portions of fruit and vegetables a day and who are active for less than 30 minutes a week in Blaenau Gwent is significantly higher than Wales.
- Blaenau Gwent have poorer mental wellbeing than the rest of Wales as a whole, often associated with multiple comorbidities
- Blaenau Gwent has the highest rates of childhood tooth decay in Wales

Hypertension, obesity and asthma combined accounts for 51.40% of the disease prevalence within Blaenau Gwent West NCN

Baseline Data per 10,000 Population

Borough		Practice List Size			% of pop. living in the 2 most deprive	Disease Registers (2017/18)														
		Total	Over 65 years of age	Percentage over 65 years of age		Asthma	Chronic obstructive pulmonary disease	Atrial fibrillation	Cancer	Cardiovascular disease	Coronary heart disease	Dementia	Depression	Diabetes	Epilepsy	Heart failure	Hypertension	Influenza	Learning disability	Obesity
Blaenau Gwent	East	33,719	6,582	20%	82%	706	354	191	233	775	456	63	1,092	787	93	143	1,389	2,524	47	1,437
	West	38,377	7,566	20%	66%	734	273	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	382	90	712	623	67	157	1,730	2,847	33	1,118
	South	47,455	10,453	22%	9%	636	153	221	310	480	349	73	854	556	62	90	1,529	2,460	29	939
Newport	East	49,885	7,789	16%	59%	650	176	156	225	409	325	38	1,017	621	69	69	1,335	1,969	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	45,364	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**	**10,355**	**7,735**	**928**	**1,205**	**19,440**	**28,167**	**539**	**13,343**

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



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

The above chart demonstrates that hypertension, obesity and asthma combined accounts for 51.40% of the prevalence within the NCN.

Therefore, focusing on preventative measures in these top areas would have the most impact upon demand for health services, and the health and well-being of the population.

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

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

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

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

The QOF register for Blaenau Gwent West indicates a low disease prevalence of cancer (as demonstrated in the section above), however, we know that Blaenau Gwent has the highest cancer mortality rate of all the local authorities in Wales.; 12% higher than the Wales rate **(PSB assessment).**

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

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

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

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

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

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

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

1) Access to primary care services

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

2) Demands on GPs

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

The fact that individual GPs only see a small number of patients with suspected cancer per year, combined with increasing time demands upon GPs which constraints appointment times , creates an inherent risk of targeted conversations to be missed.

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

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

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

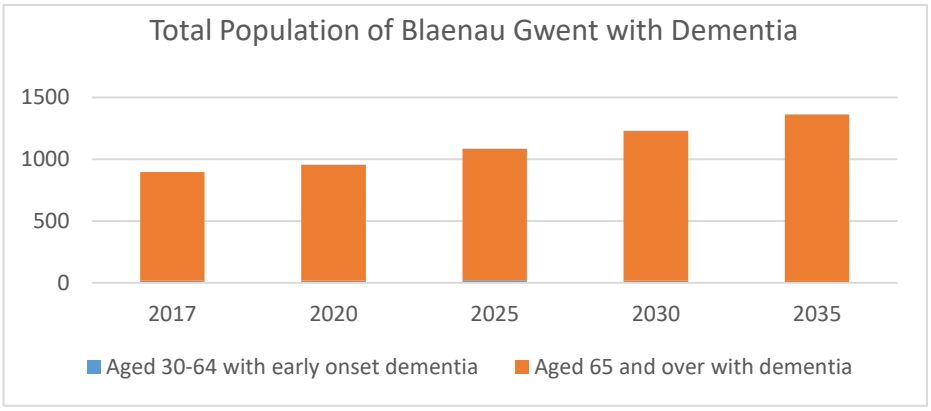
This poses a significant opportunity to Blaenau Gwent West NCN given that a significant proportion of the burden of ill health in Blaenau Gwent could be prevented, if:

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

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

The Blaenau Gwent population has a poorer level of mental wellbeing than the average for Wales as a whole

Dementia



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

Mental Health

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

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

Mental health in children and young people

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

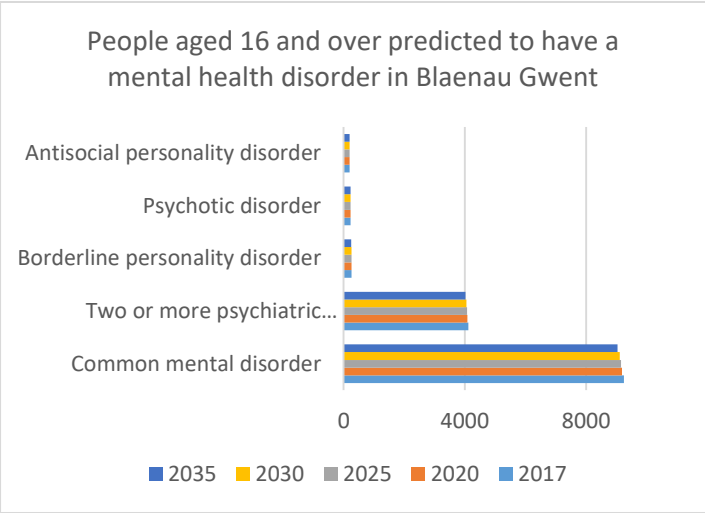
10% of children and young people aged 5-15 had at least one clinically diagnosed mental disorder. The most prevalent disorders included:

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

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

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

Mental health in adults



There is a strong link between deprivation and poor well-being / being treated for a mental illness, with 8% of the people in the least deprived quintile reporting a mental health condition, compared with 20% in the most deprived quintile (Public Health Wales, 2016). This report also found that 24% of those who are long term unemployed or have never worked, report a mental health condition compared to 9% of adults in managerial and professional groups in Wales. **(PSB assessment)**

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

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

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

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

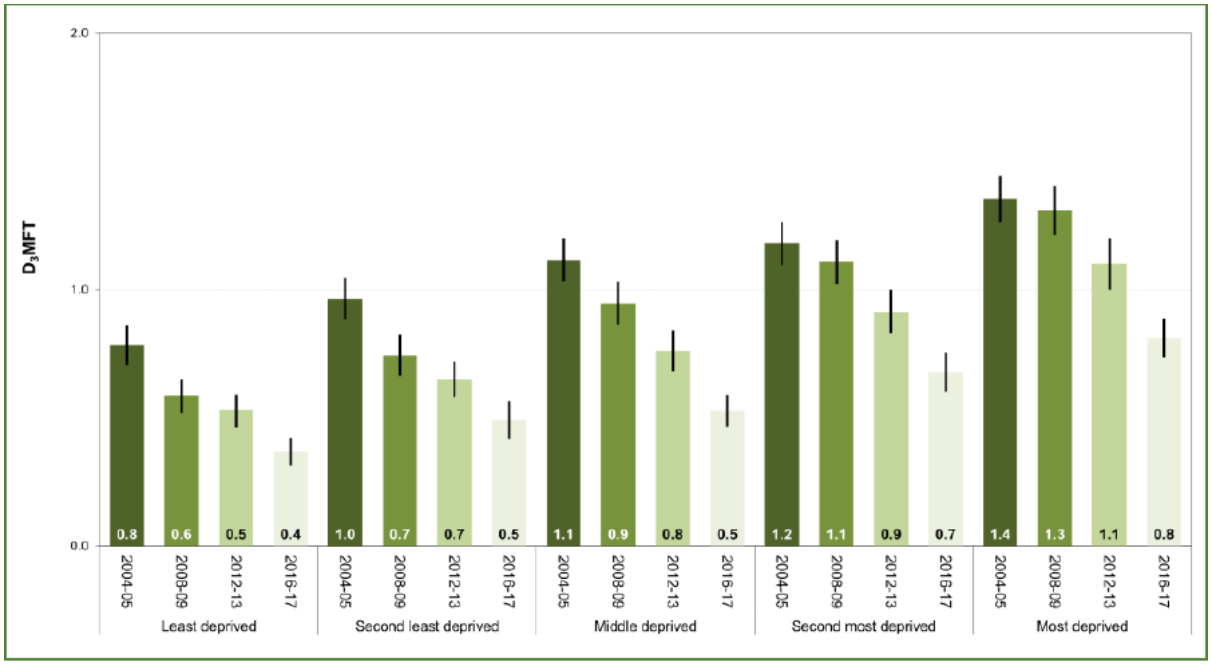
(Taken from PSB report)

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

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

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

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



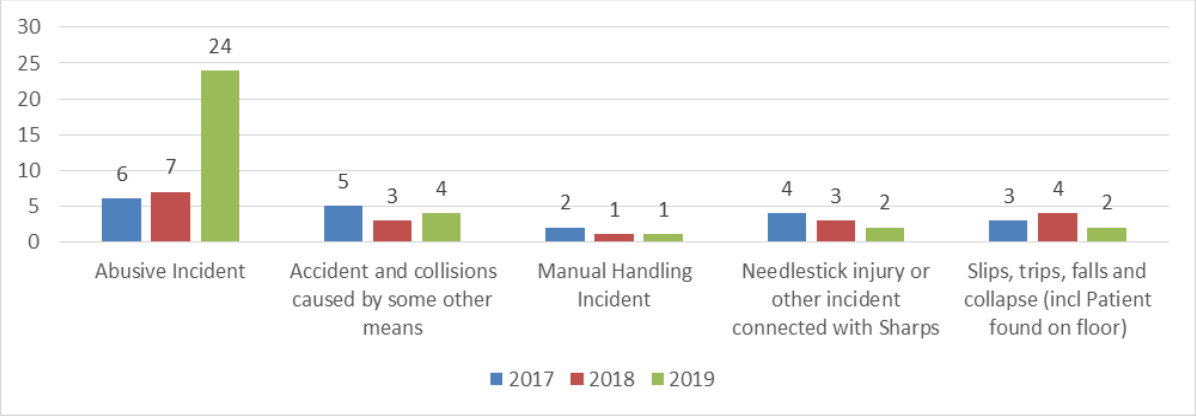
Blaenau Gwent has the highest rates of D3MFT1 in comparison with other boroughs in ABUHB, as demonstrated below, and indeed, of all the boroughs in Wales.

14.4 Incidents & Concerns

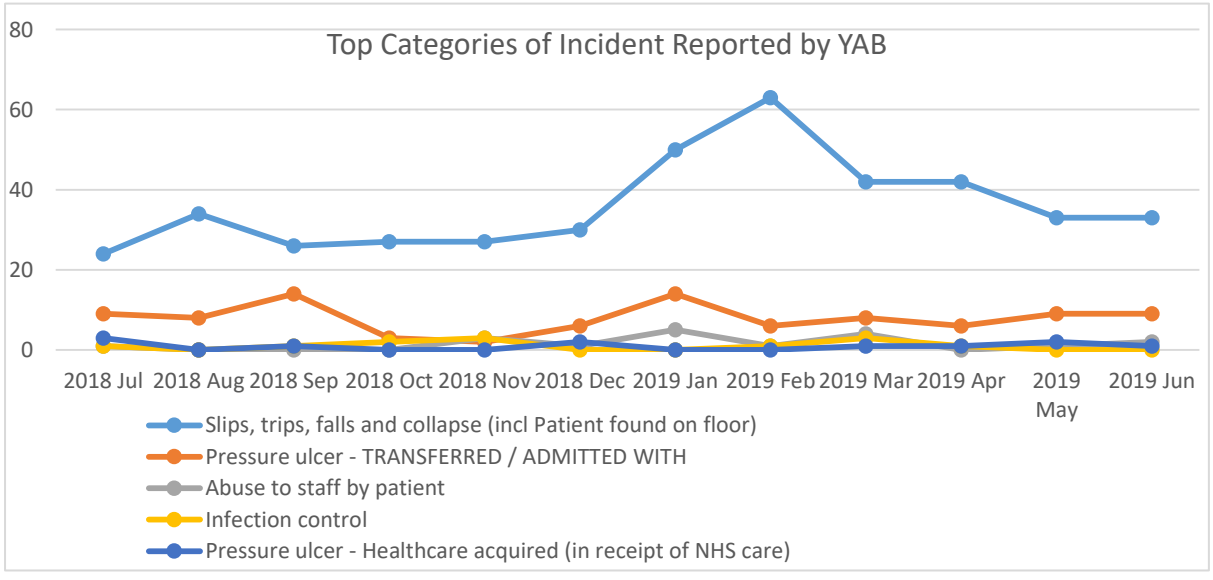
There has been a significant increase in the number of incidents classified as 'abusive incidents' during 2019 in Blaenau Gwent

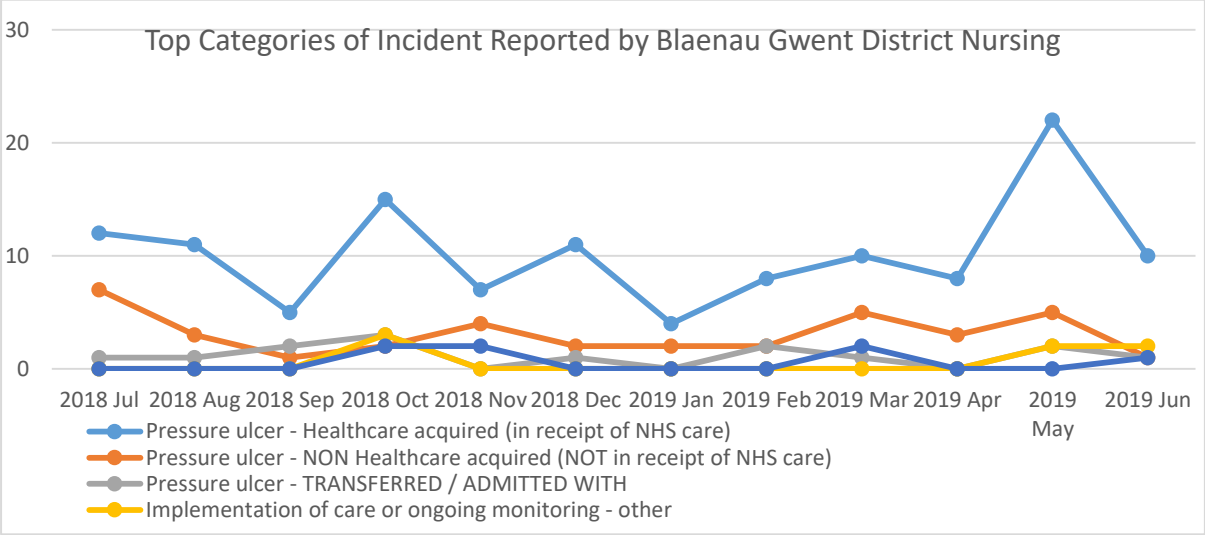
This charts illustrate all incidents affecting staff, visitors or contractors by category during a six month period between January and June for 2017, 2018 and 2019 within Blaenau Gwent Borough.

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



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





Primary Care- Independent Contractors

Since September 2018, there have been 3 complaints received by the Primary Care directorate in relation to practices within the Blaenau Gwent West NCN.

These complaints are associated with 2 of the practices.

- 2 complaints were in relation to GP attitude and care
- 1 complaint was regarding communication of a change in appointment

Community

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

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

In terms of the speciality:

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

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

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

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

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

14.5 Patient Safety Indicators

Prescribing Indicators

Priority areas

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

Blaenau Gwent West has particularly high use of:

- Tramadol
- Opioid burden- driven by high tramadol and co-codamol use
- Total antibiotics
- 4Cs antibiotics

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

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

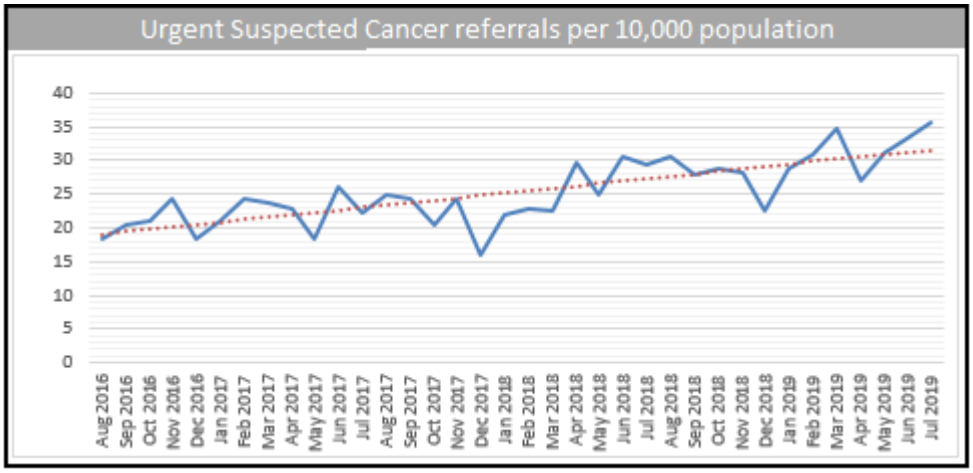
Quality Indicators

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

When benchmarking with others using our NCN dashboard, Blaenau Gwent West perform well in many of the quality and patient safety indicators. That said, there are still areas that we can and should improve on in order to deliver the most effective and efficient services for our patients.

Based on this benchmarking, areas of focus should be childhood immunisations and flu immunisation. We will learn from those who are performing well in these areas, such as Caerphilly South and Torfaen South.

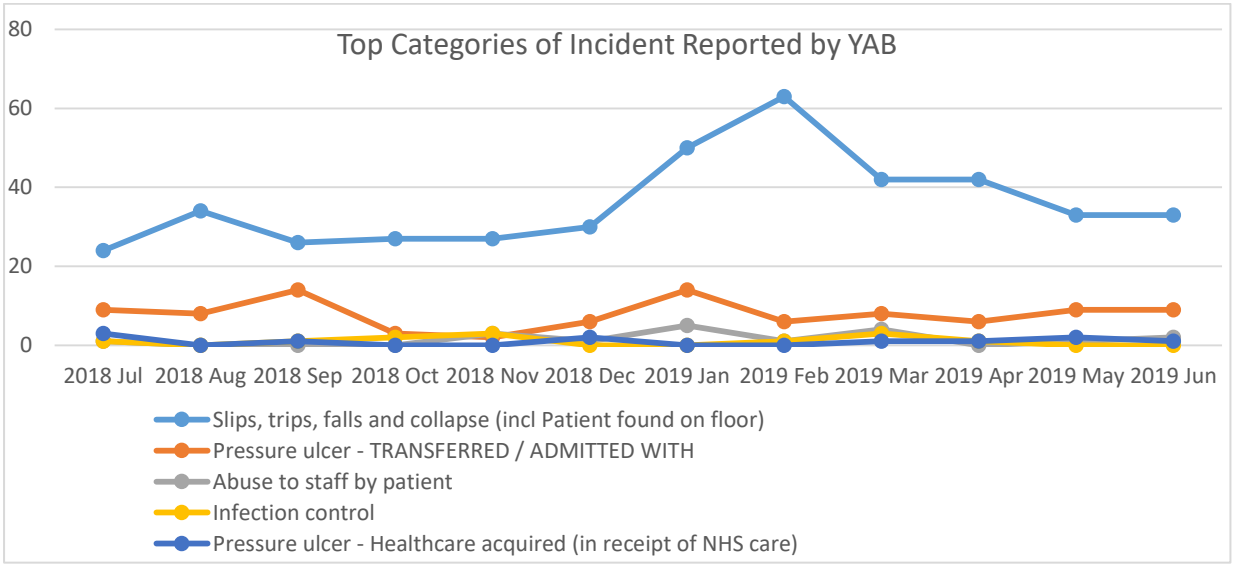
Urgent Suspected Cancer Referrals



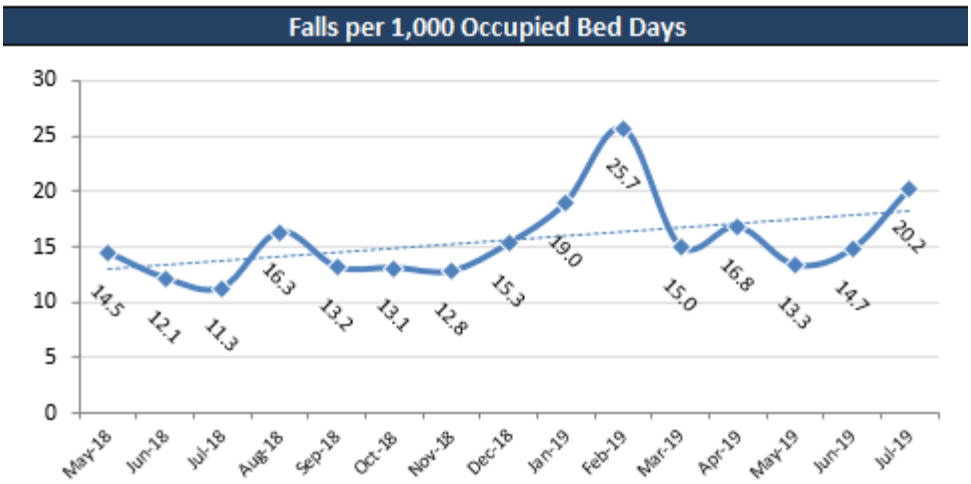
The Welsh Government Cancer Delivery Plan recognises that in order to improve early diagnosis, we need to encourage people to recognise the symptoms and signs of cancer, and seek advice from their doctor as soon as possible. We also need doctors to recognise these symptoms and (if appropriate) refer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

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

Falls Rates



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



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

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

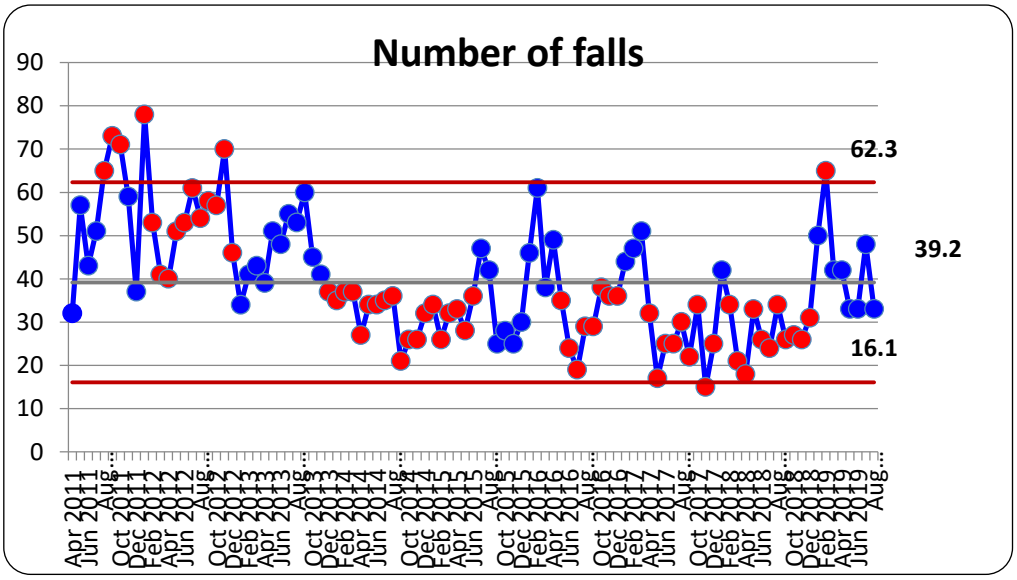
We believe this is due in part to the patient cohort in YAB. The hospital receives patient cohorts consisting of:

- Ongoing orthopaedic rehabilitation.
- General medical rehabilitation
- Dementia Patients

Statistically, patients at most risk of an inpatient fall are generally within one of the three cohorts above. A high number of falls are seen in patients who are actively regaining independence and increasing their mobility as part of their rehabilitation, therefore the probability of an inpatient fall is increased in this group, however all ward staff are fully compliant with statutory training relating to risk assessing patients for falls and managing patients who have fallen.

Tyleri Ward is the nurse led unit in YAB, the purpose of the ward is to promote independence ahead of patients being discharged home, in order to better prepare patients for the environment in which they will return when discharged. The prevalence of falls is slightly higher from this ward, as patients will have a greater degree of independence in this environment in comparison to a medical led ward.

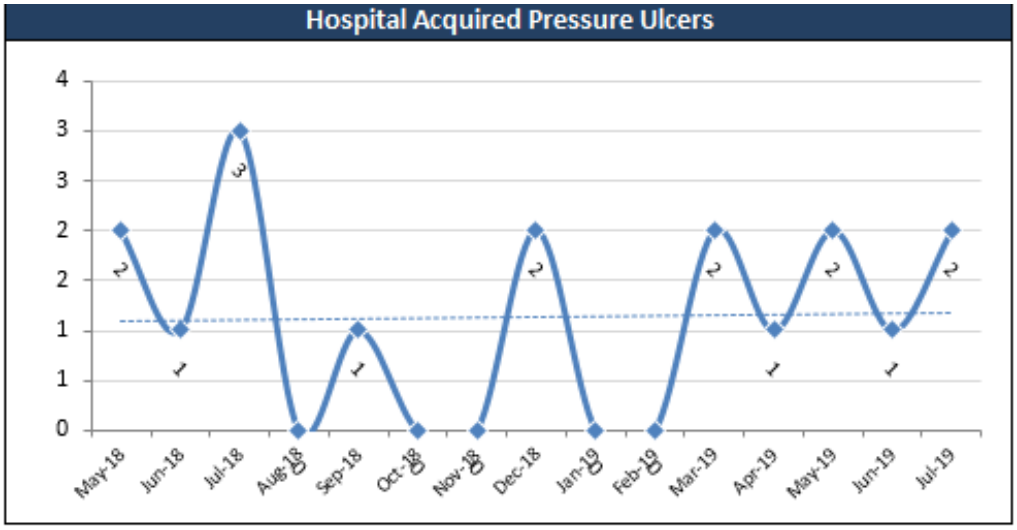
All falls reported that incur an injury to a patient are referred to the ABUHB Falls Scrutiny Panel, where falls are deemed avoidable, robust processes are in place to ensure patient safety is paramount and ward environments are safe.



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

The measure of the number of falls as an ongoing quality indicator is difficult to articulate as the cohort of patients on site varies in terms of need on a regular basis. The number of patients who are specifically at risk of falls can sometimes acutely increase, and in reciprocal can also decrease, therefore it is likely that the range of number of falls will fluctuate.

Hospital Acquired Pressure Ulcers



14.6 Clinical Audits

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

Diabetes.

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

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

NDA reports look at three main areas of diabetes services:

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

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

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

7.	Body mass index – measurement for cardiovascular risk.
8.	Smoking history – question for cardiovascular risk.

2. The treatment targets are:

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

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

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

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

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

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

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

Respiratory / COPD

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

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

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

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

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

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

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

- A lower percentage of patients with Asthma;
- A higher percentage of patients with Bronchiectasis than the East NCN, but lower than ABUHB and All Wales comparators;
- A higher percentage of reported Lung Cancer.

Stop a Stroke Project

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

A key feature of both is the early identification of patients at risk of thromboembolic events and the prompt initiation of an oral anticoagulant as this

has been shown to reduce the risk of stroke by two thirds. These recommendations were supported by the All Wales Medicines Strategy Group and endorsed by Welsh Government.

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

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

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

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

1. The percentage of patients with Atrial Fibrillation, treated with Warfarin, is lower than Blaenau Gwent east NCN and ABUHB comparators, but not as low as the all Wales figure;
2. The percentage of patients with Atrial Fibrillation, treated with NOAC, is higher.

Service Improvement Projects

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

14.7 Enhanced Services

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

The Table below shows the DES arrangements in Blaenau Gwent West NCN.

Blaenau Gwent West NCN - DES	W93032	W93035	W93063	W93065	W93619	W93623
	Glan Rhyd Surgery	Glyn Ebwy Surgery	Health Centre - Tredegar	Glan Yr Afon	Cwm Health Centre	Pen Y Cae Surgery
Pneumococcal	Y	Y	Y	Y	Y	Y
Childhood Imms	Y	Y	Y	Y	Y	Y
Asylum Seeker			Y	Y	Y	Y
Learning Disability		Y	Y	Y	Y	Y
Violent Patients					Y	
Minor surgery - Fee A	Y	Y		Y	Y	Y
Minor surgery - Fee B	Y	Y	Y	Y	Y	Y
Diabetes Gateway DES	Y	Y		Y	Y	Y
Mental Health	Y	Y			Y	Y
CARE HOME		Y			Y	Y
Anti-coagulation Level A	Y	Y		Y	Y	Y
Anti-coagulation Level B			Y			
Homeless						

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

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

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

Blaenau Gwent West NCN - NES	W93032	W93035	W93063	W93065	W93619	W93623
	Glan Rhyd Surgery	Glyn Ebwy Surgery	Health Centre - Tredegar	Glan Yr Afon	Cwm Health Centre	Pen Y Cae Surgery
GLP1 Monitoring		Y		Y		
Flu Immunisation	Y	Y	Y	Y	Y	Y
Unscheduled Immunisations	Y	Y	Y	Y	Y	Y
Non-Routine Imms			Y	Y		
Substance Misuse						
Shingles	Y	Y	Y	Y	Y	Y
Rota virus	Y	Y	Y	Y	Y	Y
Meningitis	Y		Y	Y	Y	Y

For other services different service models could be considered at an NCN level or non-participating practices may wish to review their arrangements. :

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

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

Blaenau Gwent West NCN - LES	W93032	W93035	W93063	W93065	W93619	W93623
	Glan Rhyd Surgery	Glyn Ebwy Surgery	Health Centre - Tredegar	Glan Yr Afon	Cwm Health Centre	Pen Y Cae Surgery
Minor Surgery non-Registered patients						
DOAC	Y	Y		Y	Y	Y
DOAC Monitoring						
Depo-Provera	Y	Y	Y	Y	Y	Y
Depo/Sayana Press						
Contraceptive Implants (Nexplanon)	Y				Y	
Depression/Lithium	Y			Y	Y	
IUCD Registered	Y				Y	
IUCD - Non registered	**Y**				**Y**	
Near Patient Testing	**Y**	**Y**	**Y1A**	**Y**	**Y**	**Y**
Extended Hrs					**Y**	
Denusomab	Y		Y	Y	Y	Y
Pertussis	Y	Y	Y	Y	Y	Y
Gonadorelin/Zoladex	Y	Y	Y	Y	Y	Y
Extended Skin Surgery						

For other services different service models could be considered at an NCN level or non-participating practices may wish to review their arrangements:

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

14.8 Activity Benchmarking

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

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

- Percentage of Person Centred Medical Home (PCMH) assessments undertaken within 28 days of referral
- High GP referrals to Trauma & Orthopaedics (All Wales) per 10,000 population
- High GP referrals to surgical specialties (All Wales excluding T&O) per 10,000 population
- Occupied bed days > 65 years of age following EMA per 10,000 population

The NCN reviews this data to identify where further action is required.

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

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

District Nursing

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

14.9 Engagement Events

A Public Engagement event at Bedwellty House was held in May 2019 to inform local residents of the developing Health, Social Care and Well-Being Centre in Tredegar. Over 120 people attended the event over the course of the day and the feedback was very positive. There was generally good support for the development, which was seen as positive investment in the Tredegar area and as the next legacy for Tredegar.

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

14.10 Access

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

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

100% of Blaenau Gwent West practices deliver on the 5As.