Monmouthshire County Council

# Integrated Services Partnership Board
# (Pan Cluster Planning Group)

# Monmouthshire

## Integrated Medium Term Plan
## 2023 -2026


Hereford
Brecon Beacons National Park
Birmingham/ Midlands
Brecon
Abergavenny
Monmouth
South Wales Valleys
Blaenavon World Heritage Site
Wye Valley Area of Outstanding Natural Beauty
Usk
Pontypool
Gloucestershire
Chepstow
Newport
West Wales / Cardiff
Caldicot
Magor
London/ Bristol
Severn Tunnel Junction

## Setting The Scene

*For the purpose of this plan, information and data relating to specific towns and surrounding areas will be aligned with the North and South Monmouthshire Neighbourhood Care (Cluster) Network (NCN) footprints – please see appendix 3 for NCN boundaries.*

Gwent Public Services Board (PSB) describes Monmouthshire as occupying a strategic position between the major centres in South Wales and the South West of England and the Midlands. The main settlements are Abergavenny, Chepstow, Monmouth, Caldicot, Usk and Magor/Undy, with approximately half of the total population living in wards defined as being in urban areas. Monmouthshire's distinctive settlement pattern arises from its historic market towns and villages and their relationship with the surrounding rural areas. A good road network connects Monmouthshire to major population centres such as Cardiff, Newport and Bristol and many of the population take advantage of these links to commute out of the area for employment opportunities.

The county is predominantly rural and has a rich and diverse landscape stretching from the coastline of the Gwent Levels in the south, and the uplands of the Brecon Beacons National Park in the north, to the picturesque river corridor of the Wye Valley Area of Outstanding Beauty in the east. The county contains some good quality agricultural land and has a high proportion of farming land. Monmouthshire is generally a prosperous area offering a high quality of life for its residents. However, there are pockets of deprivation, made starker when compared with areas of relative wealth.

Monmouthshire borders England to the East, Newport and Torfaen to the West and Powys to the North. It is 1 of 5 boroughs in Gwent and populated by approximately 93,000 people. However, in terms of NCN responsible populations due to GP registration, the North NCN population is approximately 55,000* and of those, around 5,000* reside across the England and Powys borders. The North NCN is supported by 7 GP practices, a Local General Hospital (Nevill Hall), Mardy Park Integrated Health, Social Care and Wellbeing Hub (Abergavenny), Monnow Vale Health, Social Care and Wellbeing Hub in Monmouth Town, and an Integrated Hub at Usk.

The South NCN area is supported by 5 GP practices, a community Hospital at Chepstow, which houses the Integrated Services Team, two GP practices and a range of diagnostic, inpatient and outpatient services. There is also an Integrated Health, Social Care and Wellbeing Hub at Caldicot. The South NCN has a population of approximately 48,600* residing in a semi-rural area with around 6,500* of those living across the border in England.

According to the 2019 Welsh Index of Multiple Deprivation (WIMD), the official measure of relative deprivation for small areas in Wales, no areas of Monmouthshire were in the most deprived 10%, and only 19.6% (or 11 areas) in the most deprived 50% in Wales. The 2021 census identified the neighbourhoods with the lowest level of deprivation as Chepstow North and Trellech at 40.1% of households. There are three main areas of where deprivation is higher than other areas and these are North Abergavenny with 57.2% households (down from 65.5% in 2011), South Caldicot with 56.7% (down from 64.2% in 2011) and South Chepstow with 53.3% (down from 59.4% in 2011).

Monmouthshire has a well-established partnership working landscape enabling community-based support across health, social care and the Third Sector. As an Integrated Services Partnership Board (ISPB), we will continue to drive a Place-Based care agenda enabling more people to make personal choices regarding the support they need to live their lives. This plan looks at significant challenges facing us, and our workforce, derived from a number of causal factors, not least, increasing workload pressures, a growing and ageing population, increased life expectancy and with that, heightened complexity of need. A further challenge for us is understanding our role as members, therefore we recognise that to produce successful outcomes, we all need to be accountable for delivery of the priorities set out within this plan.

Aneurin Bevan University Health Board and Monmouthshire County Council are duty bound by The Social Services and Well-being (Wales) Act 2014 to plan, to develop and improve services jointly, working with stakeholders including the general public to engage, plan and promote services in relation to well-being. This strategic and operational plan takes into account the Well-being of Future Generations (Wales) Act 2015, to ensure that what we do supports its ambitions for a prosperous, resilient, sustainable, healthier, more equal Wales with cohesive communities, a vibrant culture and thriving Welsh language.

**In summary:**
This IMPT builds on the firm foundations of 'integration in practice' with a culture of learning together and respectful collaboration that focuses on the strengths of individuals, families and communities. Over the next 3 years we envisage that we will have learnt even more about the residents and communities of Monmouthshire; what is important to people in terms of the services that are available to them and how and where those services are provided. Responding to this will involve change - letting go of some aspects of service and growing others with robust monitoring and measurement, as our population needs change over time. Communication and engagement with our service users and integrated teams will be key to understanding our journey together. The next 3 years will see us prioritising the development of a confident, flexible and multi-skilled workforce who are passionate about what they do. As a partnership we will learn from the experiences of our users, and although we face considerable challenges; with clear shared priorities laid out, a strong sense of collaboration and a determination to grow community based, preventative support we are confident that this IMTP provides a positive foundation for a successful 3 years.

## The Integrated Services Partnership Board

The image below details the strategic planning structure for Gwent and shows the flow of responsibility & accountability in respect of how we plan develop and deliver our plans for Monmouthshire:


**The Integrated Services Partnership Board (ISPB)** – *Also known as the Pan Cluster Planning Group (PCPG).*

The ISPB is chaired by senior members of ABUHB and MCC & has representatives from Neighbourhood Care Networks, Integrated Services, Mental Health and Third Sector etc. As members, we are signed-up to supporting delivery of Place-Based care and other key workstreams as detailed below. We have relied on needs assessment data & other key information to ensure our plan accurately reflects population need. As a board we meet approximately 6 times a year to address operational delivery issues, monitor performance of our services and progress against our plans.

**Key objectives from national PCPG guidance:**

- To provide the local footprint for the tactical delivery of the Regional Partnership Board's (RPB) Area Plan
- To coordinate the use of all available resources to meet local needs
- To provide strategic direction to inform the development of respective cluster plans
- To commission services and develop agreements to support partnership working
- To utilise intelligence from Clusters (NCNs) to ensure plans reflect population health, care and wellbeing needs, and supports actions to address issues raised

# ISPB Priority Workstreams

**Workforce**

| Theme | Action | Outcome Measures |
|---|---|---|
| Integrated Service/ Primary Care Team workforce modelling & sustainability | To develop a clear, strategic approach to our workforce to meet increasing demand placed on front-line staff and ensure we have the right workforce for the future. To consider resourcing the 3rd sector, generic roles, blended roles, layering the health and local authority workforce. | • ISPB meetings/ Outcome of workforce modelling sessions<br>• Workforce strategies<br>• Sustainability workshops & escalation framework |
| Integrated Services short term support | Evaluate the level of dedicated therapeutic input. Consider option to embed Occupational Therapists & Physiotherapists in reablement teams to drive proactive risk, pace and levels of independence. | • ISPB evaluation and report |
| Hospital Discharge Teams | Review current structure & workforce across all hospital discharge teams | • Integrated Service Managers/ ISPB review |
| Direct Care in-house modelling | To map current demand and provision alongside independent providers. Correlation with unmet need list and the response in line with in-house as an 'umbrella' provider. Ensure all Teams are sized according to local need and population. Consider 'umbrella' role for in-house services. | • Outcome of mapping process etc reported at ISPB |
| Recruitment and Retention | Focus on retention and associated strategies. Critical to bring in resources to recruit the right workforce for the next 3 years. | • As above |
| Training and Development | Whole sector approach to training and development. Equality of access to outcome-based training, collaborative communication etc. | • Training needs analysis reported at ISPB |

**Early intervention and prevention**

| Theme | Action | Outcome Measures |
|---|---|---|
| Community Hub development | Continue to develop our health, social care and wellbeing hubs ensuring they meet community need and that the community is well informed about them. To assess internet connectivity to focus resources. | • Community engagement feedback/ social media campaigns<br>• Connectivity map |
| Review our 'Front Doors' | A blended and fully integrated approach that sees partners and statutory services working together to drive personal and community asset-based responses. Collaboration with partners in our communities building relationships and working together better to make the best use of what we have | • Data collection:<br>• Acute admission avoidance via Rapid Medical Service<br>• Use of the Direct admission pathway<br>• MDT meetings in Primary Care |
| Link workers | Co-produce support for people, building on their strengths to find their own solutions. Connecting primary care teams to well-being resources (all age support/integrated employment model/multiple locations community hubs, GP practices and wards) | • Develop activity baseline & measures with GAVO for Wellbeing Links Coordinator service<br>• Assess impact & increased GP capacity/ reduced GP contact |
| Family support | Strengthen community-based support for families building on the link worker model – connecting parents, carers and children to wellbeing resources. Use community hubs to strengthen connections between and across generations and whole family approaches. | • Numbers of and outcomes for families accessing very early help services (via InFACT)<br>• Numbers of referrals and outcomes into SPACE-wellbeing panels |
| Assistive technologies | To maximise the use of available technologies to prevent social isolation and loneliness and support independence. | • To monitor investment in digital platforms via service provider evaluation |

**Hospital Admission and Discharge**

| Theme | Action | Outcome Measures |
|---|---|---|
| Nevill Hall Hospital Monmouthshire Ward - Abergavenny | To pilot a community led ward whereby all Monmouthshire residents (where feasible) within NHH will be on one ward. This will allow a pilot team of Therapists, Social Workers, and Discharge Liaison Nurses working alongside hospital staff and reablement technicians to concentrate effort on the quickest possible discharge for people who are medically fit to return home. A change in practice involving reablement from the earliest opportunity and positive risk taking should lead to lower care needs and potentially the ability to return home sooner. Information concerning the person's current situation should support the positive risk taking and allow people to know where a care package in place is at risk of being lost. | • Pathways of Care process - Reduced Length of Stay (LOS)<br>• Reduced reliance on Domiciliary Care<br>• Service user satisfaction<br>• Monitor financial efficiencies from reduced LOS<br>• NHH monthly project board meetings<br>• Lightfoot data<br>• Progress reports to ABUHB/MCC SLT as required |
| Grange University Hospital | Understanding a person's social care circumstances at the point of attending an acute hospital site are not always known or included in the assessment process. When a person receiving a POC is admitted to hospital the POC is suspended for a period of time. If this time lapses the original POC is removed and a new referral is required. In essence the POC cannot be restarted and will have been allocated to another service user. Many people admitted to hospital overcome their acute episode and have a prolonged period of time in hospital solely because the POC they require is no longer available and this prolonged stay in hospital places them at risk. The primary purpose of this work to is heighten awareness of the importance of understanding when a POC runs out in order to optimise a person's well-being before this happens. To raise awareness within professional groups of the importance of knowing the POC status and to improve the current information system. | • Package of care [POC] continues<br>• Reduction in LOS<br>• POC included on ward Patient Status at a Glance Boards<br>• Information systems regarding POC are more comprehensive, robust and valid |
| Falls Response | To explore option for a response team able to attend people who have fallen as quickly as possible. This will avoid complications associated with a "long lie" and will also ensure only those people who need to attend hospital are admitted. | • Data collection via ABUHB corporate & community falls services, WAST to understand demand<br>• Falls strategy & pathway overview |

| | | |
|---|---|---|
| Review of Home First Strategy | A need to understand the current process, the extent of avoidable admissions and the development of an integrated plan to address. We need the right resources in the right place (7 days? /Which skills? /Which staff?) | • Data collection exercise to understand the number of avoidable admissions via Home First team - >20% of MCC residents having 0-1 day LOS in GUH |
| Redesigning Older Adults Frailty Service | To evaluate the Rapid Medical service to support business case to expand in North Monmouthshire | • Outcome of evaluation reported at ISPB, NCN & Assurance meetings<br>• Increase numbers of people referred to rapid response (medical)<br>• Reduce GP referral to Flow Centre<br>• Improve compliance with 4-hour target to see person on handover between primary care and CRT (currently 30%) and move to 2 hours<br>• Increase number of people admitted directly to a community bed by 100% (from 100 to 200). |
| Managing unmet need | Develop an active management strategy of unmet need within the teams via Flo focussing on at risk cases at home and those blocking reablement. This will possibly impact the speed with which people can be discharged from hospital and may prevent hospital admission due to people without care in place hitting crisis in the community. | • Strategy development needed<br>• Reduced waiting times |
| Review Step-Up-Step-Down Beds | Understanding of all available Step-Up Step-Down resources including Step Closer 2 Home to ensure we are making best use of these. | • Direct Admission Pathway (DAP) & Step Closer 2 Home activity data<br>• Progress reports to ABUHB/MCC SLT & RPB as required |
| Reablement | An intake model should be evident and the resources to deliver against this must be in place. Reablement to coalesce with place with two reablement teams in each area: Abergavenny North & South, Central East & West and Chepstow & Caldicot. A preventative approach needs to be commonly adopted. Those people who are discharged from reablement with no long-term condition but are deemed to be at risk should be supported long-term via ad-hoc visits to monitor and support. | • Increased reablement teams<br>• Decrease in unmet need<br>• Decrease in long term care cases within reablement<br>• Increase in those showing a decrease in need following reablement |

| | | |
|---|---|---|
| Assistive technologies | To maximise use of available technologies to support hospital discharge. | • ISPB reporting<br>• ISM monitoring<br>• Available data |
| Welsh Ambulance Service Trust | The ability to provide WAST with appropriate information for an informed risk assessment to take place needs considering. | • Establish ISPB / WAST forum & report progress at ISPB |
| Micro carers | Increase the number of micro carers supporting people, this will increase capacity in care thus reducing unmet need and preventing delayed discharges due to the care crisis. | • Increased number of micro carers<br>• Increased number of hours of care provided by micro carers<br>• Decrease in unmet need |
| Review discharge model in various hospitals | Communication between patient, ward and Integrated Services. Co-ordinated & safe discharge based on the fullest understanding of what fit for discharge is. Vanguard approach. Review all failed discharges within a given period. | • Reduced LOS<br>• Reduced Delayed Pathways of Care<br>• Number of DAP beds ringfenced and utilised<br>• Progress reports to ABUHB/MCC SLT & RPB as required |

**Children's Services**

| Theme | Action | Outcome Measures |
|---|---|---|
| Children with complex needs | To increase the number of foster placements for children who are looked after<br>To increase the sufficiency of in-region residential placements for children<br>To ensure that children who need on-going support as adults have good transitions<br>To ensure that children with complex needs are supported via multi-agency / MDT approaches | • Numbers of children placed with in-house carers<br>• Baseline data from the population needs assessment |
| Family support and prevention | Build further on the range of support services that are in place to help children stay safe within their families including extending the Families Together Team and The Family Time Team. | • Numbers of and outcomes for children and families accessing family support services |
| Good mental health and emotional well-being for children | Effective partnership working between health, education and social care to ensure that children's emotional and psychological wellbeing is promoted | • Numbers of children accessing SBC<br>• Numbers of schools adopting whole school approaches to wellbeing<br>• YOS substance misuse service |

| | | |
|---|---|---|
| Children get a good start in life | Work in partnership with Flying Start services to ensure that parents receive the right help and support from the outset | • TBC |
| Adopting the Marmot principles (appendix 2) | To adopt the 8 key principles and develop a range of measures to evidence progress. | • As part of the work to develop a framework strategy |

**Information and Communication**

| Theme | Action | Outcome Measures |
|---|---|---|
| Update Primary Care One, Health Board and Monmouthshire Council websites | Ensure all information relating to social care and health is readily accessible to people and that people know where to go when in need of support. | • Data capture to show level of activity to websites over a set time-period.<br>• Comparison re number of calls to IAA via duty desk |
| Easy Access to Wellbeing Information | A range of ways for people to access reliable well-being information. A network of hubs that connect people with health and well-being resources, activities, and other people. Raise the profile of hubs in communities to develop their well-being role and access to the right services and support. | • Increased 'traffic' to adult services website following refresh/ relaunch.<br>• Linked to internet connectivity work. |
| Create joint communications | Shared script and understanding between integrated services and GPs about what we are able to provide. Gather and review all existing information leaflets we provide to develop clear information for use on admission and on discharge from hospital. | • Monitoring Tool/ progress reports at ISPB |

**Social Care and Health Estate**

| Theme | Action | Outcome Measures |
|---|---|---|
| Completion of Severn View Parc | To support ambition for people taking up residency in September 2023. | • Inspection reports/ISPB/NCN reports<br>• Progress updates to RPB as required |
| Estate review | Review of all Health and Social Care estate to identify efficiencies and opportunities for co-location etc. | • Outcome of audit reported at ISPB & ABUHB/MCC estate meetings |

**Finance**

| Theme | Action | Outcome Measures |
|---|---|---|
| Section 33 (North) | To monitor all associated finance and escalate risk via appropriate framework. | • Outcome of ISPB & specific finance meetings<br>• Progress reports to ABUHB/MCC SLT |
| Section 33 (Borough) | Explore option for a whole borough Agreement and develop business case | • Progress reported via ISPB & ABUHB/MCC SLT |
| Commissioning Model | To review existing commissioning model and assess skills deficit. | • Outcome of review/training needs mapping carried out |
| Non-statutory funding | Explore alternative funding streams e.g., Regional Integrated Fund | • Number of successful applications |

**Enabling Delivery**

The table below shows key enablers driving delivery of our priorities, highlighting action for early implementation – additional information can be found at appendix 4.

| Priority | Enablers | Short term action |
|---|---|---|
| Workforce | A well-integrated workforce & commissioning process<br>Fit for purpose estate<br>Effective leadership and governance<br>Engagement with communities and agencies<br>Access to & sharing of data/ information<br>RPB Needs Assessment<br>Access to a network of mental health & Wellbeing professionals<br>Accelerated Cluster Development<br>NCN collaboratives<br>Integrated Wellbeing Networks | Partner workshops identify pressures, Business continuity planning, Workforce modelling |
| Early Intervention & Prevention | | Wellbeing hubs promoted, Increased engagement, service mapping |
| Hospital Admission & Discharge planning | | Person-centred care, Falls response (FIRST), Unmet need mapping, MDT approach in primary care |
| Children's Services | | Building services to support mental health & wellbeing |
| Information & Communication | | Access to information & advice, Communication strategy developed |
| Social Care & Health Estate | | Capacity audit, CCH PFI, new builds, Sustainability modelling |
| Quality & Safety | | Integrated reporting tool, Risk analysis |
| Finance | | Commissioning process/ efficiencies, Section 33 expansion |

The following information offers more detail relating to some of the key partners and services in Monmouthshire enabling the delivery of our key priorities as detailed above:

**Integrated Services Teams - Finding Individual Solutions Here (F.I.S.H)**
In 2008, Monmouthshire County Council worked together with Aneurin Bevan University Health Board (ABUHB) to deliver an integrated approach to supporting older people and adults with a physical disability. The Short-Term Assessment and Reablement Team (START) was established, which included nurses, social workers, therapists and care workers. Although funded by each organisation, Monmouthshire County Council manages the team providing clear direction and shared objectives. In 2011, Monmouthshire County Council conducted a 'systems' review transforming the way it delivers social care support. As a result, there is now a One Front Door approach via geographical 'hubs' encompassing the F.I.S.H model, which puts the individual at the heart of service delivery.

The Frailty Service is a multi-disciplinary service within the Primary Care and Community Services Division in the Health Board and centred on providing people with care and/or treatment close to home and promoting independence via reablement teams. The aims of the service are to reduce unnecessary hospital admission by providing safe alternate pathways, and minimising hospital stay by facilitating early and safe discharge.

**Children's Services**
Children's Services provides services for children from 0 – 17 and their parents, carers and families. The service is based in County Hall in Usk with various additional family friendly sites within the borough to support easy access to services. The service is fully funded through Monmouthshire County Council and additionally supported through a range of short-term grants including Families First and the Regional Integration Fund (RIF) to support early help and preventative services. The service provides a coherent range of support services for families from very early help right through to intensive child protection services and support to children who are looked after and children who have left care, including services for Unaccompanied Asylum-Seeking Children. There is a dedicated team for children with disabilities. The service has built on its strong partnership ethos to develop integration with embedded health practitioners (psychologists; therapists and counsellors) as well as multi-agency teams such as our safeguarding hub and the Youth Offending Service. The whole service is child centred and rooted in an understanding of child development and the impact of adversity in childhood using trauma informed approaches and collaborative, strengths-based practice.

**SPACE Wellbeing Panel**
The SPACE wellbeing panel (formerly known as the Early Help Panel) provides a single point of access to a range of early help and support services for children and families. It provides a coordinated referral pathway and supports families accessing the right help, first time with coherent sequencing or joint working with services is this is appropriate. The services represented on the SPACE wellbeing panel comprises both statutory services and a large range of voluntary and third sector agencies.

**Neighbourhood Care Networks (NCNs/ Clusters – linked to Accelerated Cluster Development)**
The mechanisms by which representatives of individual Professional Collaboratives come together to assess the wider health and wellbeing needs of their population (typically of between 25,000 and 100,000 people) and respond to RPNAs to produce a prioritised 3-year cluster plan. This plan also sets out how any funding allocated for decision at cluster level (such as the £20m from Welsh Government) should be invested. There are two NCNs in Monmouthshire (North & South) with a collaborative professional network featuring GPs, dentists, optometrists, pharmacists, mental health practitioners, integrated services staff including: district nurses, social workers, therapists and direct care staff, plus midwives, dieticians, specialist nurses, psychological health & wellbeing links coordinators, housing representatives and Third Sector colleagues.

Delivering health and social care in a very large rural area has obvious geographical challenges and our NCNs continue to work with partners to identify new ways of working, embracing joint working and co-location where possible. NCNs recognise the need to build on progress made with collaborative working in 2022-23 through the ACD programme and look forward to strengthening our place-based approach in partnership.

The NCNs are constantly looking for new and innovative ways to meet the needs of their local populations, and also best support the cluster in terms of long-term sustainability. Recruitment issues relating to GP Practice Bases Pharmacists have provided both NCNs with an opportunity to explore the option to reinvest finite budget in alternative support roles, for example, Physician's Associates and direct access Physiotherapy. The NCNs are required to publish annual plans and these can be found at appendix 1.

**Accelerated Cluster Development - Professional Collaboratives**
The mechanism by which, GMS practices, Dental practices, Community Pharmacies, Optometry practices, Community Nurses, Allied Health Professions, Social Services and others come together within their profession specific groups across a, cluster footprint to consider how they respond to Regional Population Needs Assessments [RPNAs], consider the quality of their service offer and look at how they respond to national strategy for their respective profession, designing local solutions based upon their detailed knowledge and expertise.

**Third Sector**
The Gwent Association of Voluntary Organisations (GAVO) is affiliated to the Wales Council for Voluntary Action and an active member of Third Sector Support Wales. GAVO's 2022-25 strategic plan details how it will be an active member of the new Gwent Public Service Board Framework and all its supporting structures in line with the Wellbeing of Future Generations (Wales) 2015 legislation. GAVO will continue its support of Well-being Plans and will through the next iteration of plans, support and guide the creation and implementation of the new Gwent Well-being Plan, whilst ensuring support is strong and the voice is heard on the Locality Focused plans. Our NCNs work closely with GAVO and is currently funding the Wellbeing links Coordinator roles aimed at reducing demand on GP Practices (please see page 23).

**Local Authority Planning**
ISPB planning is informed by the Replacement Local Development Plan (RLDP) - 2018-2033 - Monmouthshire which highlights specific primary and secondary settlement areas considered for development or re-development

In December 2022 Monmouthshire County Council set the scene for the RLDP underpinned by the following high-level summary of Monmouthshire County. Monmouthshire occupies a strategic location at the gateway to Wales, easily accessible by rail and road from the major centres in South Wales, the South West of England, London and the Midlands. It has a land area of approximately 88,000 hectares (880 square kilometres), of which 3% is defined as 'built on' and an estimated population of 92,900** of which 52% live within the four primary settlements of Abergavenny, Caldicot, Chepstow and Monmouth. The median age is 49 years compared to 34 years in Cardiff, and there is a significantly higher proportion of older age groups (65+) and a lower proportion of young adults (16-44) compared to the Welsh average. The proportion of our population aged 65+ and 85+ is increasing well in excess of the Welsh average. The 2021 Census shows that the population aged 65+ has increased by 26% this compares to a Welsh average of 18%. For the County as a whole, the 2021 Census identifies that nearly 26% of the population is over 65 (compared to 21% in Wales), with 16% under 16 (18% in Wales) and just over 58% in the working age population group (16-64) (61% in Wales).

*** Correct at time of RLDP information being released – Monmouthshire resident population only.*

## Understanding Need

**Regional Partnership Board Needs Assessment**
As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards were required to establish Regional Partnership Boards (RPBs) to manage and develop services to secure strategic planning and partnership working. RPB objectives to ensure partnership bodies work effectively together to:

- Respond to the population assessment
- Develop, publish and implement Area Plans for each region
- Ensure partnership bodies provide sufficient resources for partnership arrangements
- Promote the establishment of pooled funds where appropriate.

In 2022, the Gwent RPB published its second regional Population Needs Assessment (PNA), which is the foundation of planning for future service provision across Health and Social Care, ensuring it meets the needs of the people in Gwent. The PNA was developed during the Covid 19 pandemic. Going forward, we need to ensure an equal focus on those affected through the Covid-19 pandemic as well as recovery planning to respond to the changing needs of our communities. We have worked with the regional Public Service Board to align the PNA with the wider population Wellbeing Assessment required under the Wellbeing of Future Generations Act; in an effort to avoid duplication and lay a foundation for future collaboration and joint working in developing a response to the identified needs.

The RPB have been engaging with the population throughout this challenging time and will continue to do so, as a subsequent Area Plan is developed with a co-productive approach to understand the views and needs of our communities to identify 'What matters' to those who have care and support needs or caring responsibilities. The Area Plan is expected to be issued around March/ April 2023.

**Emerging priorities within the Population Needs Assessment (PNA) relating to services for older people:**

| | |
|---|---|
| To improve emotional wellbeing for older people by reducing loneliness and social isolation with earlier intervention and community resilience | To improve outcomes for people living with dementia and their carers |
| To support older people to live or return following a period of hospitalisation, to their own homes and communities through early intervention, integrated care models and a whole system approach | To mitigate the long term impact of Covid-19 pandemic through, especially, reducing waiting lists and times to access support, appointments and medical procedures |

**Emerging priorities for children, young people and families within the PNA:**

| | | |
|---|---|---|
| Support children and Family Partnership Board's review of local arrangements for children with complex needs and delivery of work programme with a focus on Looked After Children. | Consistent models of practice and alignment of Welsh Government's early intervention and preventative programmes. | Develop and deliver a regional ACE action plan with a focus on earlier intervention and mental health support for children and young people through community-based assets. |

**A Place Based Approach**

An objective of delivering Place Based care, is to build a strong network of community support across the 5 key towns and surrounding areas in Monmouthshire, helping people to make their own choices regarding the support they require, and remain connected to the things that matter most to them. However, we as partners, continue to face difficult challenges in the delivery of integrated health and social care to a geographically distanced population. In partnership, we will respond to these challenges as we move forward with our commitment to delivering a place-based approach, building sustainable and resilient services and communities.

A public health lens published in November 2022 highlighted that the cost-of-living crisis has the potential to affect everyone and likens it to the longevity and impact of the pandemic. Anxiety and depression, homelessness, obesity, domestic crime and social isolation are just a few areas highlighted within the publication. We recognise that Health & Social Care services, Safeguarding, Mental Health and Wellbeing are key areas for support needed to mitigate the negative impact of the crisis, and therefore, will underpin how we allocate resources to try and meet the changing needs of local people.

We have an ageing workforce with 55.5% over the age of 50 therefore succession planning is taking place across the locality and we are building recruitment initiatives into our workforce strategy. The ISPB supports this and is committed to reshaping our workforce, creating collaborative and meaningful conversations with stakeholders to ensure opportunities and challenges specific to Monmouthshire, drive workforce and service developments, ensuring sustainability in the delivery of integrated services. Our geography and integrated structure make a 'one size fits all' approach difficult to replicate.

In the management of unmet need and in the promotion of voice, choice and control, we know we must focus not only on supply, but also the sources and reasons for demand. Having the flexibility and autonomy to adapt to our locality's rurality, population mass and integrated structure will ensure that our services meet the needs of the cluster. Delivering services where 44% of the population live in rural and semi-rural communities is challenging and therefore the ISPB is continually looking to new ways of working, including digital technologies to try and meet the needs of people living in Monmouthshire.

There are 13 Place-Based 'patches' in Monmouthshire based on small geographical units varying in size between 40 (100 people) and 140 (900 people) households. Therefore, a total of 295 units in Monmouthshire were used to build the 13 places and rivers, roads, villages and bridges were used to define their boundaries. As mentioned previously, NCN footprints have been used for the purpose of this plan and a overview of each place can be seen below.

# North Monmouthshire NCN 'Places'

## Abergavenny

- ***3 GP practices with combined population of 24,138* (Old Station Surgery, Tudor Gate Practice, Hereford Road Surgery)***
- ***Mardy Park Health, Social Care and Wellbeing Hub***
- ***Nevill Hall Hospital***

The Regional Partnership Board's - Wellbeing Assessment (WBA) describes Abergavenny as an important market town, providing a range of services to its rural hinterland, and includes Monmouthshire's only main hospital, a railway station and bus terminus. The Abergavenny area has an extremely vibrant and varied voluntary sector working in the environmental and sustainability field, with an active Transition Town group, Friends of the Earth group, Incredible Edible group, Fairtrade Forum, many 'Friends of' groups working in 6 local parks and green spaces. The strength of the third sector in and around Abergavenny is a great asset.

**The WBA tells us:**

- 12% of the working-age population receive employment-related benefits
- 15% are considered to be income deprived
- 215 people (at time of writing), were claiming Job Seeker's Allowance or Universal Credit for unemployment, with 60 aged 16-24
- 16.6% of children were in low-income families
- Llanover 1, Cantref 2, Lansdown and Croesonen are in the 30% most deprived Lower Super Output Areas in Wales
- Cantref 2 has the highest percentage of people in income deprivation in the county and the second-highest percentage of working-age people in employment deprivation
- Parts of Cantref (Cantref 2) are the most deprived in Monmouthshire, with 28% of people being in income deprivation
- Abergavenny has the highest proportion of areas in the most deprived 20% in Monmouthshire, with 6 out of 11 areas
- Parts of Cantref (Cantref 2) are the most deprived in Monmouthshire
- Croesonen and Lansdown are adjoining areas in Abergavenny where income, employment and health are the most evident types of deprivation
- Grofield is most deprived in terms of community safety, while more rural Llanover suffers from poor access to services and housing
- Some areas in Abergavenny and surrounding communities are ranked amongst the most deprived in Wales for access to services, as classified by the Wales Index for Multiple Deprivation, particularly for public transport travel times. For example, Crucorney is amongst the top 50 most deprived areas in Wales for access to services as classified by the Wales Index for Multiple Deprivation
- Return trips on public transport take over 2.5 hours to reach services such as a library or sports facility.
- The Flying Start service (the Welsh Government's targeted Early Years programme for families with children under 4 years of age who live in some of the most disadvantaged areas of Wales) is available to families in parts of Lansdown, Croesonen and Cantref in North Abergavenny on a postcode basis and childcare is provided by three playgroups. A higher percentage of low weight babies are born in parts of Priory and Mardy. In the Abergavenny area, local indicators for school-age children fare marginally better than Monmouthshire as a whole, although there are proportionately more adults without qualifications. Cantref 2 has poorer educational outcomes; for example,

15% of key stage 4 leavers enter higher education, compared to 33.1% in Monmouthshire overall, while 30.7% of adults have no qualifications, compared to 13.2% across Monmouthshire.

- Abergavenny has the fewest residents of the five areas who report that their health is very good or good, with 77%. In each of the other 5 areas, over 80% of people are positive about their health. Cantref 2, Lansdown and Croesonen are the areas with high rates of people living with long-term limiting illnesses or mental health conditions. Cancer incidences are highest in parts of Grofield.
- Lansdown in Abergavenny has recorded the most domestic-related crime over the last three years. From January 2021 to November 2021, Lansdown made up 21% of all recorded crime in the Abergavenny area.

## Monmouth

- ***2 GP practices with combined population of 19,146* (Castle Gate Medical Practice, Dixton Surgery)***
- ***Monnow Vale Health, Social Care and Wellbeing Hub***
- ***Bridges Community Centre***

This area focuses around the historic town of Monmouth, located where the Rivers Monnow, Trothy and Wye meet, and includes the southwestern quarter of the Wye Valley Area of Outstanding Natural Beauty. House prices in this area are high, with 4 wards among the 10 most expensive in the county but 2 wards are among the 10 least expensive – the least expensive being in Overmonnow, which is in the 30% most deprived LSOAs in Wales. The house prices in this area therefore demonstrate the disparities that are possible within Monmouthshire, with the more affluent wards having the potential to mask those that are more deprived.

**The WBA tells us:**

- 7% of the working-age population receive employment-related benefits
- 12% are considered to be income deprived
- 105 people (0.94%) are claiming Job Seeker's Allowance or Universal Credit for unemployment, of which 25 are aged 16-24
- 14.8% of children are in low-income families
- Overmonnow 2, which is in the 30% most deprived LSOAs in Wales and has the third-highest percentage of people in income deprivation in the county, and the highest percentage of working-age people in employment deprivation
- Dixton with Osbaston has the joint lowest level of deprivation for income and employment in the county (along with Mitchel Troy for the latter) – illustrating, the disparity within Monmouthshire
- Monmouth and its surroundings have only one area in the most deprived 20% of areas in Monmouthshire
- Part of Overmonnow (Overmonnow 2) is ranked the second most deprived area in Monmouthshire, where employment and education are the main concerns
- 16% of working-age people in Overmonnow 2 are in employment deprivation, the highest in Monmouthshire, and 23.2% of working-age adults have no qualifications
- Residents in some parts of Overmonnow are eligible for Flying Start for pre-school children.
- Access to services in the area around Monmouth is a key issue, with some areas being ranked amongst the most deprived in Wales. For example, Llantilio Crossenny is ranked the sixth most deprived area in Wales for access to services. In this area, two-thirds of

households suffer from the unavailability of broadband at 30Mb/s and 3 hours average round trips on public transport to key services such as food shop, pharmacy, post office, library and secondary school.
- 80% of people in Monmouth and the surrounding communities report that their health is good or very good. Within the Monmouth area, this varies from 65% in Overmonnow 2 (the second most deprived area in Monmouthshire) to 86% in Trellech United.
- Drybridge in Monmouth has recorded the most domestic-related crime over the last three years. From January 2021 to November 2021, Drybridge made up 21% of all recorded crime in the Monmouth Area.

## Usk / Raglan and Upper Wye)

- ***1 GP practice with registered population of 11,726* (Usk Surgery & Wye Valley Practice)***
- ***Usk Health, Social Care and Wellbeing Hub***

The area is largely rural, with the small market town of Usk being the largest settlement, followed by the large village of Raglan. House prices in this area are very high: its wards have the highest average price in Monmouthshire with 2 among the 10 most expensive in the county. 4% of the working-age population receive employment-related benefits, with 6% considered to be income deprived. 20 people are claiming Job Seeker's Allowance or Universal Credit for unemployment, of which 5 are aged 16-24. 8.4% of children are in low-income families. Given these figures, Usk and Raglan have the lowest proportion of deprivation, compared to the other four areas of Monmouthshire.

**The WBA tells us:**
- 15% of households are below 50% of the median income for the UK, and 20% are below 60%, as compared with 17% and 22% respectively for Monmouthshire, and 25% and 33% for Wales as a whole
- 81% of people's health is reported as good or very good - the Usk community reports the lowest (73.4% in Usk 1) and the highest (85.7% in Usk 2) within this area
- Goetre 2 has a higher than Monmouthshire average (589.6) rate of cancer incidence (683.3).

# South Monmouthshire NCN 'Places'

## Chepstow (and Lower Wye)

- ***4 GP practices with combined population of 28,616* (Mount Pleasant Practice, Town Gate Practice, Vauxhall Surgery & Wye Dean)***
- ***Chepstow Health & Social Care Hub/ Community Hospital***

Severn Bridge tolls were removed in December 2018, which has led to increased congestion in Chepstow as more people are commuting across the border or have moved from Bristol to Chepstow to take advantage of lower house prices.

**The WBA tells us:**

- Data from Highways England shows that in the year after the tolls were removed, the average number of cars crossing the Severn Bridge per day increased by 16%
- Chepstow is the second most expensive area for house prices in Monmouthshire, of which 3 wards are in the county's most expensive. However, it also has 2 wards in the 10 least expensive, demonstrating the potential differences that can be found within a single area. 8% of the working-age population receive employment-related benefits, with 12% considered to be income deprived
- 145 people are claiming Job Seeker's Allowance or Universal Credit for unemployment, of which 35 are aged 16-24
- 13.4% of children are in low-income families
- 15% of households are below 50% of the median income for the UK, and 20% are below 60%, as compared with 17% and 22% respectively for Monmouthshire, and 25% and 33% for Wales as a whole
- Thornwell has the second-highest percentage of people in income deprivation in the county, while St Kingsmark 1 and Trellech United 2 have the joint first and joint second-lowest percentage of people in income deprivation in the county, respectively
- Chepstow and the Lower Wye Valley has one area in the most deprived 20% of areas in Monmouthshire
- Part of Thornwell (Thornwell 1) is ranked the third most deprived area in Monmouthshire, largely due to deprivation in health, income and education
- One-quarter of people in the area are in income deprivation, and repeat absenteeism in school is one of the 7 highest in Monmouthshire
- Pre-school children residing in particular postcodes in Thornwell are eligible for Flying Start.
- Thornwell in Chepstow has recorded the most domestic-related crime over the last three years. From January 2021 to November 2021, Thornwell made up 33% of all recorded crime in the Chepstow area.

## Caldicot (Severnside)

- ***1 GP practice with registered population of 20,080* (Caldicot Medical Practice)***

The Severnside area includes several areas of population in the south of the county – including Portskewett, Caldicot, Rogiet, Magor and Undy – and also has the mainline railway to South Wales and the M4 motorway. As with Chepstow and Monmouth, Severnside includes house prices that are among the most and least expensive in Monmouthshire. Overall, it is the second least expensive area of the county.

**The WBA tells us:**

- 7% of the working-age population receive employment-related benefits, with 10% considered to be income deprived
- 200 people (1.1%) are claiming Job Seeker's Allowance or Universal Credit for unemployment, of which 40 are aged 16-24
- 11.7% of children are in low-income families
- 18% of households are below 50% of the median income for the UK, and 25% are below 60%, as compared with 17% and 22% respectively for Monmouthshire, and 25% and 33% for Wales as a whole
- The Elms has the joint second-lowest percentage of working-age people in income deprivation in the county, while Shirenewton has the joint lowest percentage of working-age people in employment deprivation
- Improvement work focussed on Severn Tunnel Junction will benefit Caldicot, Magor/Undy and Rogiet, by making it easier for people to travel by train
- 3 of the 11 most deprived areas in Monmouthshire are located within Severnside: West End, part of Dewstow and Green Lane and part of Severn. For each area, the main category of deprivation is the physical environment which covers air quality and emissions, flood risk and green space.
- West End has the lowest percentage of key stage 4 leavers entering higher education, at 10.2%
- Flying Start is available to some residents and their young children in West End
- On average, travel times to several services are shorter when compared to other areas in Monmouthshire and are more in line with the Wales average, as classified by the Wales index for Multiple Deprivation
- 81% of people in Severnside reported good or very good health in the 2011 census, variations within the area are notable, ranging from 75% in Dewstow to 89% in The Elms
- Dewstow & Green Lane 2, followed by West End, have the highest rates of people living with long-term limiting illness in the Severnside area
- West End also sees the highest rates of cancer incidence in the Severnside area
- From November 2020 to November 2021, overall crime in Caldicot remained the same, at 20.7% of the county. There has been a reduction of recorded crimes for Shoplifting, Theft, and Commercial Burglaries. However, there has been a marked increase in Residential Burglary, which is up from 34 recorded incidents to 65. Other notable increases are in Criminal Damage and Arson, Rape, and Other Sexual Offences.
- From April 2020 to March 2021, 230 incidents of ASB were recorded in Caldicot, accounting for 20.3% of all reported ASB across Monmouthshire. The wards with the highest prevalence were Green Lane, Mill and Severn Wards. As of January 2021, there were 52 adults accessing support, 29 for alcohol and 23 for other substances.
- Dewstow in Caldicot has recorded the most domestic-related crime over the last three years. From January 2021 to November 2021, Dewstow made up 17% of all recorded crime in the Caldicot area.

* *Source: http://pcsapps.wales.nhs.uk/Reports/Pages/Report.aspx?ItemPath=%2fPcs.Population.Reports%2fResponsibleAndNonResidentByAge*

## What We Will Do

The information below details specific action in relation to some of the key themes affecting people in Monmouthshire:

### Life expectancy

Monmouthshire has the highest in Gwent with the female average age at 84.5 years and male at 81.5 years. However, we know that increased life expectancy places pressure on our integrated services during additional years of life, since it is during older age that the likelihood of developing chronic conditions increases.

**What we will do:** Ensure workforce planning reflects the needs and changing demands of a growing older population

### Smoking & Low-Birth-Weight Babies

Projections suggest there will continue to be a decline in smoking and improvement in low-birth-weight babies in Monmouthshire, however, other health issues influenced by more sedentary lifestyles leading to increased levels of obesity, heart disease and type 2 diabetes.

**What we will do:** Continue to monitor data especially in known areas of deprivation e.g., Abergavenny, Monmouth and Caldicot

### Mental Health and Wellbeing

Around 1 in 10 adults in Monmouthshire are currently being treated for a mental illness and that 1 in 4 experience mental health problems or illness at some point during their lifetime, often with causal factors impacting on individuals such as housing and/ or benefits concerns. We know there are pockets of deprivation within Monmouthshire and therefore, those communities will often have the poorest mental health and wellbeing with problems often being passed on through generations, perpetuating cycles of inequality. We also know that 1 in 10 children experience mental health issues, exacerbated by loneliness, isolation and challenges faced during the recent pandemic. In response to this, Wellbeing Links Coordinators (WBLCs) are focussed in and around the 12 GP practices in Monmouthshire and can be accessed directly by GP Care Navigators etc.

Please refer to additional information relating to our joint NCN / Integrated Wellbeing Network funded WBLC service below:

## Wellbeing Links Co-ordinators - Monmouthshire

Who we are:

We are a small team of colleagues, employed by GAVO and MCC, who work together to enhance the quality of life of people who live in Monmouthshire. We do this by meeting people in the community, and by having meaningful conversations to find out what is important to them and what they are interested in.

Individuals may come to us via a range of routes; through local groups, community hubs, health and social care services and places where people go to ask for information or assistance. The approach we take is preventative; promoting opportunities for positive wellbeing and enabling people to overcome any problems and or barriers they may be facing.

We believe that by concentrating on what matters to people and focusing on their assets and strengths we will be able to work alongside individuals and their families in a creative way to help them make the changes in their lives that they both want and need. We have learned that working alongside individuals can be a fragile and nuanced process requiring not only the traditional interpersonal skills of reflective and active listening, but also an ability to think outside of the box.

## Wellbeing Links Co-ordinators - Monmouthshire

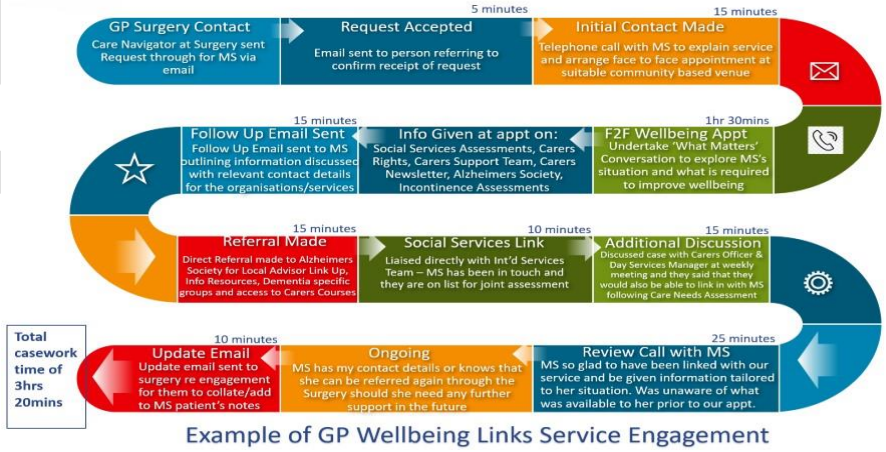
Our Purpose:

To assist people to recognise their strengths and interests, and to develop the support networks required to achieve wellbeing through participation in community life.


## Wellbeing Links Co-ordinators - Monmouthshire

Our Approach:


## Wellbeing Links Co-ordinators - Monmouthshire




Example of GP Wellbeing Links Service Engagement

**What we will do:** We will continue to look to assess the network of mental health and wellbeing support services available in Monmouthshire to identify gaps and build awareness across our health and social care teams, leaning on the invaluable support on offer via the Third Sector including MIND, Melo and our Wellbeing Links Coordinators. Continue to support and promote the Integrated Wellbeing Network (IWN) aimed at improving and strengthening the wellbeing of people in Monmouthshire by connecting and enhancing community assets for people to build relationships and find the things that matter to them. IWNs are integral to providing people with alternative support options and therefore reducing demand on already stretched primary and community services. We will continue to promote whole school approaches to wellbeing and coordinate early help to children and young people through schools-based counselling and through access to support services through the SPACE Wellbeing panel.

**Dementia**

The PNA tells us that life expectancy is higher in Monmouthshire than other Gwent boroughs and therefore, so is the incidence of some diseases, that mostly rise as people get older. This applies most obviously for dementia but also other diseases. We know from available data that incidence rises with age and as Monmouthshire has the largest growing older population, with 25.6% of the population being over 65 years (North & South Monmouthshire combined), we can anticipate high levels of some long-term conditions.
The PNA recognises two key themes in relation to people with dementia:

1. Improve emotional wellbeing for older people to reduce loneliness and isolation with early intervention
2. Improve life outcomes for people living with dementia and their carers.

**Development of Severn View (Dementia Care Parc)**

A new state of the art, Welsh government funded dementia Parc is being built in partnership with Melin Housing Association in South Monmouthshire. This will replace the existing Severn View care home and the aim is for residents to be integral to the new community.

**What we will do:** Continue to work with Older Adult community services in Monmouthshire to ensure mental health services are responsive to the needs of people with dementia. We will support the redesign of the older people's care pathway and also review the effectiveness of the ISPB funded dementia services including Dementia Support Workers, National Exercise Referral Scheme - supported by the Older Adult Mental Health team, Care Home respite bed & Community Transport scheme etc. In 2022-23, more than £150,000 was allocated to support these projects for people with dementia and Carers. We will also monitor progress of the new Severn View Parc.

**Falls response**

Data also tell us that 'Falls' are the most common cause of serious injury in older people and the most frequent reason for hospital attendance. Older people who fall account for 10% of all 999 calls to the Welsh Ambulance Service. A reluctance to leave home due to a fear of falling comes across strongly in Monmouthshire County Council's survey of social care users. What we know:

- In 2021/22, 74% of residents attending the Emergency Dept. following a fall were not admitted compared with 53% pre Covid
- 238 (54%) of those were conveyed by Welsh Ambulance

- 68 residents (21%) of people who fell but not admitted waited more than 12 hours in the ED and 22 waited more than 24 hours.

**What we will do:** Undertake benchmarking exercise with neighbouring Hereford NHS Trust. The outcome of this will underpin the work we are doing to reduce the number of falls related hospital admissions by providing support closer to home. Evaluate the NERS Living with Dementia ISPB funded scheme; evidence to-date shows positive outcomes re falls prevention from strengthening exercises undertaken as part of the programme.

**Domestic Crime -** (Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV)
We know that Domestic Crime in Monmouthshire has shown a steady increase since January 2019. In November 2021, the two-year average stood at 118 crimes per month. It is thought that Covid-19 had reduced the number of reported domestic crimes but data doesn't necessarily back this up, with only a 1% reduction in average monthly domestic crimes recorded in 2021, compared to 2020. Recorded domestic crime in Monmouthshire in the last three years has been more common in Abergavenny.

All areas except Monmouth have seen a decrease in recorded crimes in 2021, looking at average crimes per month for each area over the last three years. Abergavenny makes up 30% of the average crimes per month, Monmouth 24%, Caldicot 23% and Chepstow 22% of average crimes per month. The reduction in crimes could possibly be due to the pandemic and restrictions during that period.

**What we will do:** In 2023-24, we will analyse local data to understand the scale of domestic crime in Monmouthshire and develop a comprehensive map of community-based support options. We will strengthen our connection to the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) and work with others at a regional level to ensure that services are in place to respond to the needs of children and families affected by domestic abuse.

**Substance Misuse**
Key health issues facing the veteran population relate to common mental health problems, but also include Post Traumatic Stress Disorder (PTSD) and substance misuse, including excess alcohol consumption and to a much lesser extent, use of illegal drugs. In addition, time in the Services has been associated with musculoskeletal disorders for some veterans. The 2021 census was the first to ask people about whether they had previously served in the armed forces. Figures from the Office for National Statistics show there were 4,212 veterans living in Monmouthshire in March 2021 – around 1,330 (31.6%) of whom were over the age of 80. The most common problems experienced by veterans (and by the general population) are depression, anxiety and alcohol abuse (13%).

The national *'Prison Health Needs Assessment in Wales'* report, published by Public Health Wales, highlighted substance misuse (including smoking) as a key area to address amongst inmates. The RPB's needs assessment also makes reference to a reliance on drugs and alcohol amongst ex-offenders.

Children and young people in contact with the youth justice system may have more health and wellbeing needs than other children of their age. They have often missed out on early attention to these needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems.

**What we will do:** Work with the North Monmouthshire NCN lead who acts as an advocate for veterans to remain cognisant of issues relating them. To use available NCN and other channels to promote access via the Gwent Drug and Alcohol Service (GDAS). To be informed by the Youth Offending Service's plan for commissioning a dedicated child and young persons' substance misuse service.

**Carers**

We recognise the importance of the care and support provided by unpaid carers and young carers, and that it is pivotal in supporting the health and care system. The support provided by unpaid carers and young carers makes an enormous difference to the people they care for. Difficulties can arise when unpaid carers have competing demands with their own family life, work and school, whilst trying to maintain their own health and well-being needs. It is therefore vital that unpaid carers and young carers are identified and supported by the relevant agencies, to prevent carer and care breakdown.

**What we will do:** We will continue to recognise the valuable work undertaken by carers and work together to support the various projects and schemes across Monmouthshire with continued joint funding of the Monmouthshire County Council carers service level agreement.

**Engagement**

It is key that we keep an informed public and explain services and their benefits in order to gain success as well as educate and empower people to take ownership of their own health. When people understand the importance of self-responsibility, they are more likely to adopt habits that maximise their health and well-being.

**What we will do:** Continue to rely on established engagement mechanisms such NCNs, corporate engagement and communications teams, public engagement programmes, on-line resources.

**Children's Services**

'A Healthier Wales', is the Welsh Government's long-term plan for health and social care, putting prevention of ill health at the heart of health and social care policy and services. Since its publication, progress has been made in designing policy and strategy to support children and young people to stay well. In 2020, the Royal College of Paediatrics and Child Health told us: 'Infants, children, young people and families should have equitable access to cross-sector services, resources, advice and support within the local community to support their health and wellbeing. Services within the community may not be provided by health services but should seek to integrate where possible. Local Authorities should have adequate resource to provide services to meet the local needs of the population they serve.'

**What we will do:** We have adopted the RPB's priorities in relation to children with complex need, and building services to support their mental health & wellbeing. We also adopt the key Marmot principles and will define key measures at ISPB level.

**Childhood Immunisations**

We can see from data detailed below, there are specific areas of concern around immunisation uptake in children aged 2-to-5 years old in South Monmouthshire.

| 2022-23 Indicators | Blaenau Gwent | | Caerphilly | | | Monmouthshire | | Newport | | Torfaen | | Gwent |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | East | West | East | North | South | North | South | East | West | North | South | |
| Childhood Immunisation - PCVf (Age 2yrs) | 94.3% | 94.9% | 96.6% | 98.6% | 100.0% | 96.0% | 81.8% | 88.6% | 92.7% | 89.0% | 92.3% | 94.5% |
| Childhood Immunisation - Hib/MenC (Age 2yrs) | 90.6% | 94.9% | 96.6% | 98.6% | 100.0% | 94.0% | 84.8% | 88.6% | 95.1% | 88.1% | 90.6% | 94.0% |
| Childhood Immunisation - MMR2 (Age 5yrs) | 90.9% | 92.6% | 93.6% | 94.7% | 91.5% | 94.7% | 88.4% | 86.6% | 88.4% | 91.4% | 92.0% | 92.0% |
| Childhood Immunisation – Pre-School Booster (Age 5yrs) | 96.1% | 92.2% | 95.4% | 96.7% | 97.1% | 93.2% | 100.0% | 84.7% | 90.7% | 93.5% | 91.0% | 92.5% |

**What we will do:** We will work with Health Visiting/ Flying Start and other community-based services to identify new ways to promote the benefits of childhood immunisations with a view to improving uptake. This will be monitored via NCNs and Public Health Wales.

## Strategic Context/ Drivers

Examples of key strategic drivers, which underpin the focus and development of this plan and how services have been shaped to best respond to the needs of people in Monmouthshire:


**Primary Care Model for Wales**

*Informed by Pacesetter Programme (2015-18) – 24 projects on 'once for Wales' basis*

1. Multidisciplinary teams working at cluster level are the way forward
2. Safe & effective systems to direct people to the right person / team at the point of contact
3. Integrated teams ensure a holistic approach to care - physical, mental and social well-being
4. Services must work well across in- and out-of-hours to ensure seamless care
5. Success also depends on an informed public who have access to a range of community services


Figure 2: The five ways of working under the sustainability principle within the Wellbeing of Future Generations (Wales) Act 2015 (Our Cwm Taf, 2017).

Diogelu Gwent
Gwent Safeguarding

Gwent Transformation Programme delivery plan Delivering Place Based Care

VAWDASV
Violence Against Women, Domestic Abuse and Sexual Violence
Trais Yn Erbyn Menywod, Cham-drin Domestig a Thrais Rhywiol

A range of strategic drivers are detailed within the Welsh Government's plan for health and social care in Wales: 'A Healthier Wales', and we believe that the list of broad aims below will help improve outcomes for people who live in and around Monmouthshire:

- Service development is based on demand and led through coordinated/ integrated local care teams
- Promotion of healthy living by making wellbeing less of a medicalised term
- A preventative, pro-active, and coordinated whole system approach that integrates health, local authority, and third sector services
- Integrated and effective care on a 24/7 basis, with priority for the sickest people during the out-of-hours period.
- Creating stronger communities empowering people with access to debt and housing advice, social prescriptions for the leisure.
- Technological solutions to improve access to information, advice and care, and to support self-care.

## Challenges and Opportunities

We recognise there are a number of challenges facing us as a partnership board, please note the examples below are not an exhaustive list of challenges we face (data taken from the RPB Wellbeing Needs Assessment).

| Challenge | Opportunity |
|---|---|
| **Outward migration/ workforce issues** | |
| • In the last 5 years wages in some parts of Monmouthshire were below the Wales average with house prices approximately 5 times the Wales average & therefore difficult for young people in particular to live and work locally. | ▪ To find innovative ways to address recruitment and retention concerns, how can we encourage people to stay - to reflect in our workforce strategy |
| **Access to Information, Advice & Assistance / self-care & wellbeing support** | |
| • Ensure easily accessible range of information including web-based options. Cost of living pressures impacting on mental health and wellbeing with increased demand on services. | • To assess IT connectivity shortfalls in rural areas |
| **Estate** | |
| • Health Board & Monmouthshire County Council financial pressures mean increased scrutiny of estate costs. | ▪ We will continue to assess our joint estate and seek opportunities to co-locate. |
| **Service recovery** | |
| • Slow pace of recovery following pandemic impacting on care closer to home with long waiting times affecting people's health, wellbeing, and outcomes. | ▪ Service remodelling leading to new services implemented closer to home |
| **Pathways of Care** | |
| • Ensuring people in Monmouthshire receive the best possible care as they travel through the health & social care system. | ▪ Continue the work started with Grange University Hospital – explore option for whole borough rapid medical service. |
| **Accelerated Cluster Development** | |
| • Slow progress of change beyond transition year, supporting collaboration & integration with wider NCN/ Integrated teams. | ▪ To integrate clinical professionals with wider place-based teams |
| **Medicines Management** | |
| • Medicines shortages and supply challenges remain a key challenge for our community pharmacy and GP practice contractors, increasing workload and delays to accessing medication. | • To implement actions in the Review of Dispensing Volumes in Community Pharmacies through collaboration - to increase prescribing intervals. To ensure national processes for the supply of medication is robust. Digital Medicines Transformation Portfolio (Primary Care Electronic Prescription Service), has potential to reduce workload & improve patient safety. |

## Estate:

We will continue to develop a single estate agenda with focus on pooling assets to support our prevention, early intervention, self-care and keeping people healthy agenda. We continue to look at opportunities for co-locating services to maximise local responses and our workforce strategy will consider resource by 'place' in order to support delivery of a sustainable and integrated service. Detailed below is an overview of Health & Social Care Estate in Monmouthshire:

| Estate | Service | Summary |
|---|---|---|
| Caldicot Health Centre | Integrated Sub-Hub | Sited in a deprived area, the centre hosts Health Visiting & Flying Start services, Integrated Health & Social Care services, Community Dentist, Podiatry and Children's clinics etc. |
| Chepstow Community Hospital (PFI) | Integrated Hub | Opened in 2000 as a Private Finance Initiative & leased until 2025. Negotiations on-going to consider options beyond 2025. CCH hosts a range of services including Integrated Services and two GP practices. |
| Severn View Residential Home, Chepstow | Dementia | Severn View currently serves older people with dementia. A new build is in progress near Caldicot. |
| Monnow Vale Health & Social care facility | Integrated Hub | This facility is a PFI with a long-term lease and hosts Integrated Services, inpatient, outpatient and day activities with coordinated approach to individual care. |
| Monmouth Wellbeing Centre new build (Dixton Surgery) | Wellbeing Hub | Dixton Surgery is a land-locked practice with no room for expansion. A proposal to relocate the surgery is with Welsh Government and will provide an opportunity to shape services for future generations. |
| Maindiff Court Hospital | Mental Health | The site is in relatively poor condition and future utilisation of this site needs to be assessed. |
| Nevill Hall Hospital | Secondary Care | Nevill Hall (Local General) Hospital had a changing role as part of the Clinical Futures programme and has potential to act as an enhanced care hub for North Monmouthshire to incorporate GP Surgeries, an integrated team, OAMH, CAMHS, etc. On-going review taking place. |
| Mardy Park | H&SC Hub | Currently no plans to develop Mardy Park, a local authority owned premises and Integrated Services hub for Abergavenny. Limited space for development opportunities. |
| Usk Hub | H&SC Sub-Hub | Currently hosts Integrated Services with lease funding split between the Health Board & County Council on 50/50 basis. |
| Usk Prison | Secure | Monmouthshire hosts His Majesty's Prison (HMP) Usk with Prescoed prison located 3 miles away. Social care staff support 527 (Ministry of Justice figures 2018) inmates in line with the SSWBA. ABUHB provide primary care to offenders in partnership with the National Offender Management Service. We recognise that ex-offenders may require additional support, particularly those who misuse drugs and/or alcohol can have mental health problems and therefore, are able to access our network of primary mental health practitioners who can advise on both medical and social interventions. |

# Finance

Strategic (IMTP) plans are underpinned by 'A Healthier Wales', 'Wellbeing and Future Generations Act', the 'Socio-economic duty', the 'Foundational Economy', the Decarbonisation agenda and delivering the ambitions set out in our 'Clinical Futures Strategy'. The implications of the Covid-19 pandemic continue to require a dynamic response across health and social care, to resource and financial plan in the short term, while recognising that medium and long term financial, service and workforce sustainability remains the highest priority for the delivery of care. The immediate focus is to ensure resources are available but taking into account uncertainties relating to the on-going impact of the pandemic, but driving transformative change through the delivery of the Clinical Futures and other strategies.

**Section 33 Agreement**
Adult Health and Social Care services are facing unprecedented pressure exacerbated by the global pandemic and a shortage of care workers. In response, we have Integrated Health and Social Care hubs in Monmouth, Abergavenny and Usk in the North underpinned by a Section 33 agreement, which requires us to provide scrutiny, ensure the smooth and effective running of services, set the direction including securing long-term funding, determine corporate and clinical governance arrangements and set the annual pooled and non-pooled budgets. It is worth noting that in respect of South Monmouthshire, Integrated Service Hubs are centred in Chepstow and Caldicot, however, there is currently no Section 33 agreement and therefore this is included as a priority action.

As an ISPB, we monitor, scrutinise and are accountable for the delivery of the Section 33 finances. North Monmouthshire benefits from 3 Integrated Service teams based in Health & Social Care hubs at Monnow Vale in Monmouth, Mardy Park in Abergavenny and a small South-Central unit at Usk. These services are underpinned by the section 33 agreement, which allows for the pooling of both Health Board and Monmouthshire County Council funding (Usk unit is subject to joint funding but not as part of the pooled fund arrangement). We aim to support the development of a fully costed business case to understand the potential for an extension of the current section 33 to cover the South Monmouthshire region. However, this needs to be considered against a backdrop of considerable financial pressure across both the Health Board and County Council.

In 2022-23, there was a combined forecast overspend for Monnow Vale in excess of £400,000. Increased utility costs were also a significant risk with a forecast overspend of approximately £80,000. The pooled fund component of the section 33 agreement is shared on a 72:28 ratio between the Health Board and County Council respectively, and therefore we, as the ISPB, are obliged to provide scrutiny and governance in the management of all financial risk and escalate within each agency accordingly.

**Regional Integrated Funding (RIF)**

We will look at alternative funding streams to support delivery of our key priorities where possible. The RIF is designed to deliver a programme of change from April 2022 to March 2027 and aims to target the following areas:

- Community Based Care - Prevention & Community Coordination
- Community Based Care - Complex Care Closer to Home
- Promoting Good Emotional Health & Wellbeing
- Supporting Families to Stay Together Safely and Therapeutic Support for Care Experienced Children
- Home From Hospital
- Accommodation Based Solutions

**NCN budgets**

The NCNs are well established and in the main able to drive forward their commitment to delivering against the key priorities outlined in the action plans at appendix 1. Going forward the NCNs will report to and be steered by the ISPB in order to achieve the joint ambitions outlined within this plan. An aim of NCN budgets was to test new initiatives and then explore other more sustainable funding options. However, a number of projects have now been funded recurrently due to financial pressures within the Health Board, and lack of other appropriate funding streams. This means NCN budgets have to some degree become 'hamstrung' with limited option to test new schemes unless through diverting funding as vacancies arise. There are also financial restrictions in place for Health Boards that mean NCNs cannot carry budget forward across financial years as is the case with County Councils. This leads to increased difficulty with long term financial planning, and our ability to support services where there are sustainability concerns.

**Sample 2022-23 South Monmouthshire NCN budget:**

| **Monmouthshire South NCN Collaborative budget** | **Funding** (approximate) |
|---|---|
| 1.92 WTE Practice Based Pharmacists | £81,000 |
| 1.6 WTE Psychological Health Practitioners | £37,000 |
| Community Interest Company development | £10,000 |
| Digital solutions for GP practice sustainability | £91,000 |
| Community based HCSW Phlebotomy Service | £12,000 |
| Independent Primary Care Advisors | £1,600 |
| Dementia Roadmap Wales Website | £660 |
| GP Practice Manager led forum | £3,700 |
| Wellbeing Links Coordinator role | £19,000 |
| Protected Learning Time (Continuing Professional Development) | £8,600 |
| **Projected spend** | **£264,560** |
| **Total NCN cluster allocation** | **£272,691** |
| **Anticipated underspend** | **£8,131** |

## Appendix 1:

| Monmouthshire South NCN Action Plan 2023-24 | | | | | |
|---|---|---|---|---|---|
| New or existing activity | Activity/ project description | Results/ outcomes | Budget/ Funding source | Links to other plans/ strategies | Who? |
| **Workforce/ Service Sustainability** | | | | | |
| New | • Workforce modelling includes needs assessment for short & long-term support & resource mapping exercise | • Long term sustainability of health & social care services | £0 | • Transformation & Vision for clusters<br>• Data & Digital Technology<br>• Workforce development<br>• 2022-25 NHS Planning Framework<br>• 24/7 model<br>• Wellbeing of Future Generations (Wales) Act<br>• Marmot principles 2,5,6<br>• ABUHB IMTP priorities 1,2,3,4,5 | ISPB NCNs |
| New | • Business Continuity Plans (BCPs) updated<br>• Escalation reporting in GMS | • BCP annual review identifies workforce issues for escalation | £0 | | NCN<br>ISPB<br>GP contract |
| Existing | • Dedicated NCN sustainability workshops | • Long term sustainability of GMS informs BCPs with escalation to SLT | £5k (NCN) | | NCN |
| New | • Proving the concept - NCNs evaluate existing projects to test effectiveness and support reinvestment | • Reduced reliance on GMS evidenced by regular monitoring at NCN level<br>• Increased capacity in GMS | £0 | | NCN |
| | • Support roles:<br>Physician Associates (PA) 2.0 WTE<br>PA Supervision 0.2 WTE<br>Physiotherapy 1.0 WTE | | £125,000 PA (NCN)<br><br>Supervision PA £8,000 (NCN)<br><br>Physiotherapy £65,000 (NCN) | | |
| Existing | • Healthcare Support Worker Phlebotomy clinic | • Care closer to home avoiding long journeys to secondary care centres including Velindre Cancer Centre | 0.2 WTE<br>£6,000 (NCN) | | NCN |

| | | | | | |
|---|---|---|---|---|---|
| Existing | • Healthcare Support Worker Phlebotomy provision | • Care closer to home for people who are housebound | £12,000 (NCN) | | NCN |
| Existing | • Access to Wellbeing Links Coordinator | • Reduced reliance on GMS<br>• Increased access to non-medicalised mental health & wellbeing support | £19,000 (NCN) | | NCN |
| Existing | • Access to protected learning time<br>• Undertake training gap analysis session<br>• Promote access to outcomes-based training | • Academy & other training options promoted and gaps identified via dedicated NCN session | £8,600 (NCN) | | NCN |
| Existing | • Digital solutions | • Increased capacity & efficiencies in GP practice management/ IT support | £20,000 (NCN) | | NCN |
| New | • To embed the Accelerated Cluster Development programme<br>• To develop the ACD Service Improvement Manager role<br>• ACD toolkit monitors<br>• Take part in local & national ACD meetings | • Progress monitored via ACD toolkit and reported at NCN & ISPB meetings | ACD funded SIM (0.5 WTE) | • Transformation & Vision for clusters<br>• 2022-25 NHS Planning Framework<br>• Marmot principles<br>• ABUHB IMTP priorities 1,2,3,4,5 | ACD<br>NCN<br>ISPB |
| Existing | • On-going development of a Community Interest Company<br>• Explore option for Business Manager support role | • Articles of Association agreed<br>• Board of Directors in place<br>• Social priorities agreed<br>• Business Plan including support functions in development | £5,000 (NCN)<br>£31,000 (0.5 WTE) *Wish list* | • Transformation & Vision for clusters | NCN |
| Existing | • Practice Manager led Forum | • Increased collaboration and shared best practice<br>• Increased efficiencies & capacity in GMS | £3,700 (NCN) | | |

| Early Intervention & Prevention | | | | | |
|---|---|---|---|---|---|
| Existing | • Increase public engagement via range of settings including community hubs, farmer's markets etc.<br>• Use of technology to support people living in social isolation etc.<br>• Continued support via Dementia Roadmap (DR) on-line support platform<br>• Access to Wellbeing Links Coordinator | • Outcome of hub mapping exercise helps focus resources<br>• Feedback from engagement team helps focus resources<br>• Improved access to Mental Health & Emotional Wellbeing support reduces reliance on core services<br>• Increased understanding of need amongst hard-to-reach groups e.g., migrants, refugees, farming community etc.<br>• Increased access to Information Advice & Assistance | £400 DR (NCN) | • A Healthier Wales<br>• ABUHB IMTP priorities 1,2,3,4,5<br>• Marmot principles 1,2,3,4,5,6,7,8<br>• Well-being of Future Generations Act (Wales) 2015<br>• Prevention & Wellbeing<br>• Engagement<br>• Covid response<br>• 2022-25 NHS Planning Framework | ISPB<br>IWNs<br>NCNs |
| New | • Co-administration of influenza & Covid-19 programmes | • Divisional planning forum supports standardised approach | £0 | | ABUHB |
| New | • To build on high vaccination uptake levels in 2022-23<br>• Explore option for Community Pharmacy & GMS collaborative model | • Social-Media campaigns & Newsletters promote immunisation benefits across all ages<br>• Maximise access via community teams and GMS where possible | £0 | | NCN |
| New | • To monitor uptake of childhood immunisations & promote benefits | • Data identifies areas of low uptake for targeted response | £0 | | NCN |
| New | • Care Home collaborative support for resident & staff immunisations | • NCN collaboration with community pharmacy increased uptake and protection for residents<br>• Data reported at NCN meetings and divisional flu group | £0 | | Primary Care |
| Existing | • Strategic Plans informed by Needs Assessments | • Evidence-based planning helps focus resources | £0 | | ISPB<br>NCN |

| | | | | | |
|---|---|---|---|---|---|
| **Hospital Admission & Discharge planning** | | | | | |
| Existing | • To evaluate the Rapid Medical Service & report to ISPB/ NCN | • Delivers person-centred care closer to/ at home<br>• Enhanced diagnostics locally<br>• Data supports reduced hospital admission<br>• Success supports expansion to North of borough | Business Case | • Redesigning services for older people/ Urgent Care<br>• 6 Goals for urgent/ emergency care,<br>• 24/7 model<br>• Clinical Futures<br>• Graduated Care model<br>• A Healthier Wales<br>• ABUHB IMTP priorities 3,4,5 | ISPB<br>NCN |
| Existing | Explore option for Falls response service | • Reduced hospital admission<br>• Improved outcomes for people in Monmouthshire | Business case | | |
| New | • To increase engagement with Welsh Ambulance Services NHS Trust | • 'Green' call protocol in place<br>• Risk assessments underpinned by appropriate information sharing across agencies<br>• Data used to monitor response times across Monmouthshire & inform planning | £0 | | |
| **Information & Communication** | | | | | |
| New | • Ensure local/ national websites are up to-date<br>• Exploit use of social & other media options to inform service users | • People have access to the right information at the right time relating to accessing services & support near them<br>• Service user feedback supports resource allocation | £0 | • Prevention & Wellbeing<br>• Communication & Engagement | NCN<br>MCC<br>ACD<br>PCOne |
| New | • To ensure information is accurate & agreed by partners | • Social Media & Newsletters increase awareness | £0 | | |
| **Estate** | | | | | |
| Existing | • On-going site audit to understand capacity for co-location of services | • Supports ISPB 'Fit for Purpose' estate priority<br>• Increased option for integration<br>• Improved collaboration<br>• Better outcomes for local people | £0 | • Prevention & Wellbeing<br>• Communication & Engagement | ISPB<br>NCN |

| | | | | | |
|---|---|---|---|---|---|
| Existing | • On-going development of Caldicot Health Centre as Integrated Hub | • Funding secured to further develop site<br>• Local hub offers care closer to home & base for integrated care | £0 | • Workforce/ organisational development<br>• 24/7 model<br>• 2022-25 NHS Planning Framework<br>• ABUHB IMTP priorities 1,2,3,4,5 | |
| Existing | • Maintain membership of Chepstow Community Hospital (CCH) PFI Project Team through transition period<br>• Report progress as required | • Transition meetings support business planning options for future of CCH<br>• Public & staff engagement opportunities offer reassurance<br>• Monitoring via ABUHB/MCC leadership meetings etc. | Business case | | ISPB |
| New | • Monitor progress of Severn View Parc Care Home new build | • Progress monitored via ISPB & NCN meetings | MCC | | MCC<br>ISPB |
| Existing | • Monitor capacity across GMS estate<br>• Explore option for relocation of non-GMS services from practices with low capacity<br>• Promote access to Improvement Grant funding | • NCN funds sustainability workshops<br>• Improvement Grant process supported | NCN - as above | | NCN |
| **Quality, Safety & Safeguarding** | | | | | |
| Existing | • Regular meetings of the Integrated health and social care QPS forum | • Data identifies trends by location and theme<br>• Integrated QPS reporting & monitoring tool provides risk data | £0 | • Prevention & Wellbeing<br>• A Healthier Wales<br>• ABUHB IMTP priorities 1,2,3,4,5<br>• Marmot principles | ISPB |
| Existing | • Explore option for a primary & secondary respiratory forum | • Referral data identifies high demand areas<br>• Focussed support bridging primary & secondary care | £0 | | NCN |
| Existing | • Continued support to GP led child, family & adult safeguarding forum via SLA | • Agreed specification & scope<br>• SLA monitoring arrangements in place | £0 | | NCN |
| Existing | • Domestic abuse: Analyse data, identify gaps and develop local map of support | • Gap analysis undertaken to identify need | £0 | • RPB Needs Assessment | NCN |

| | | | | | |
|---|---|---|---|---|---|
| | | • Collaborative cluster approach re access to support options | | | |
| **Finance** | | | | | |
| Existing & New | • Explore option for whole borough Section 33 agreement<br>• Bi-monthly Section 33 budget meetings | • Business case informs decision making<br>• Further development of whole borough integrated service model<br>• People benefit from whole system service provision locally<br>• Financial risk monitoring and escalation as required | £2m + pooled & non-pooled budgets (ABUHB/MCC) | • 2022-25 NHS Planning Framework<br>• A Healthier Wales<br>• Primary Care Model for Wales | ISPB<br>NCN<br>NCN Leads |
| | • Regular budget meetings track spend plans and report risk | • Supports NCN budget breakeven position<br>• Risk mitigation | £0 | | |
| | • Develop Needs Based commissioning & planning skills | • Skills deficit & development opportunities identified | £0 | | |

**Please note the inclusion of specific priorities and action related to the North only have been included in the plan below.**

| Monmouthshire North NCN Action Plan 2023-24 | | | | | |
|---|---|---|---|---|---|
| New or existing activity | Activity/ project description | Results/ outcomes | Budget/ Funding source | Links to other plans/ strategies | Who? |
| **Workforce/ Service Sustainability** | | | | | |
| New | • Proving the concept - NCNs evaluate existing projects to test effectiveness and support reinvestment<br>Support roles:<br>Physician Associate 1.0 WTE<br>PA Supervision<br>0.1 WTE | • Reduced reliance on GMS evidenced by regular monitoring at NCN level<br>• Increased capacity in GMS | £61,000 PA (NCN)<br><br>Supervision PA £8,000 (NCN) | • Transformation & Vision for clusters<br>• Workforce development<br>• 2022-25 NHS Planning Framework<br>• Marmot principles 2,5,6<br>• ABUHB IMTP priorities 1,2,3,4,5 | NCN |
| **Early Intervention & Prevention** | | | | | |
| New | • Care Home collaborative support for resident & staff immunisations | • NCN collaboration with community pharmacy increased uptake and protection for residents<br>• Data reported at NCN meetings and divisional flu group | £0 | • A Healthier Wales<br>• ABUHB IMTP priorities 1,2,3,4,5<br>• Well-being of Future Generations Act (Wales) 2015<br>• Covid response | Primary Care |
| New | • Respond to the needs of veterans relating to accessing support for their mental health & wellbeing. | • Veterans receive appropriate support and advocacy, and are prioritised according to guidance | £0 | • A Healthier Wales<br>• ABUHB IMTP priorities 1,2,3,4,5 | NCN Lead |
| **Hospital Admission & Discharge planning** | | | | | |
| Existing | • To be informed by the outcome of the Rapid Medical Service evaluation & consider option to roll-out in North Monmouthshire | • Delivers person-centred care closer to/ at home<br>• Enhanced diagnostics locally<br>• Data supports reduced hospital admission | Business Case | • Redesigning services for older people/ Urgent Care | ISPB<br>NCN |

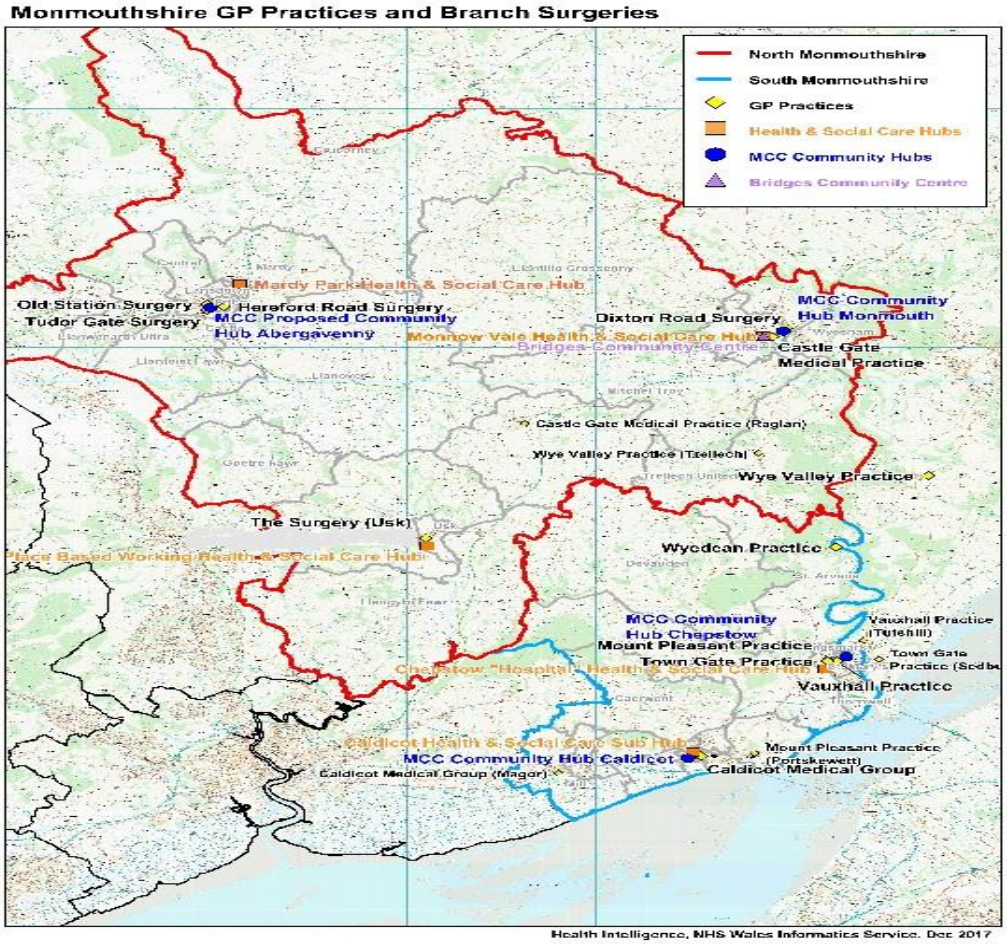
| | | | | | |
|---|---|---|---|---|---|
| | | • Success supports expansion to North of borough | | • 6 Goals for urgent/ emergency care,<br>• Clinical Futures<br>• A Healthier Wales<br>• ABUHB IMTP priorities 3,4,5 | |
| **Information & Communication** | | | | | |
| New | • *Please refer to the South NCN plan* | • *Please refer to the South NCN plan* | £0 | • Prevention & Wellbeing<br>• Communication & Engagement | NCN<br>MCC<br>ACD<br>PCOne |
| **Estate** | | | | | |
| Existing | • Support development of Dixton Surgery relocation<br>• To hold 'future-shaping' engagement sessions | • Fit for purpose estate<br>• Increased access to wellbeing (medical & non-medical) support/ Information, Advice & Assistance | £10m + (WG) | • Prevention & Wellbeing<br>• Communication & Engagement<br>• 2022-25 NHS Planning Framework<br>• ABUHB IMTP priorities 1,2,3,4,5 | ABUHB<br>WG<br>NCN<br>IWBN |
| **Quality, Safety & Safeguarding** | | | | | |
| Existing | • Continued support to GP led child, family & adult safeguarding forum via SLA | • Agreed specification & scope<br>• SLA monitoring arrangements in place | £8,000 (NCN) | • Prevention & Wellbeing<br>• A Healthier Wales<br>• ABUHB IMTP priorities 1,2,3,4,5<br>• Marmot principles 1,2,5,6,7,8 | NCN |
| **Finance** | | | | | |
| Existing | • *Please refer to the South NCN plan* | • *Please refer to the South NCN plan* | £2m + | • 2022-25 NHS Planning Framework<br>• A Healthier Wales Primary Care Model for Wales | ISPB<br>NCN<br>NCN Leads |

## Appendix 2: The 8 Marmot Principles including ABUHB & MCC responses

| Marmot Principle | ABUHB Priority | Monmouthshire CC Priority |
|---|---|---|
| 1. Give every child the best start in life | • Every Child has the best start in life<br>• Getting it right for children and young adult | • The best possible start in life<br>• Future-focused Council |
| 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives | • Every Child has the best start in life<br>• Getting it right for children and young adult<br>• Adults in Gwent live healthy and age well<br>• Older Adults are supported to live well and independently<br>• Dying well as part of life | • The best possible start in life<br>• Lifelong well-being<br>• Future-focused Council |
| 3. Create fair employment and good work for all | • Getting it right for children and young adult<br>• Adults in Gwent live healthy and age well<br>• Older Adults are supported to live well and independently | • Thriving and well-connected county<br>• Lifelong well-being<br>• Future-focused Council |
| 4. Ensure a healthy standard of living for all | • Every Child has the best start in life<br>• Getting it right for children and young adult<br>• Adults in Gwent live healthy and age well<br>• Older Adults are supported to live well and independently | • The best possible start in life<br>• Lifelong well-being<br>• Thriving and well-connected county<br>• Future-focused Council |

| Marmot Principle | ABUHB Priority | Monmouthshire CC Priority |
|---|---|---|
| 5. Create and develop healthy and sustainable places and communities | • Every Child has the best start in life<br>• Getting it right for children and young adult<br>• Adults in Gwent live healthy and age well<br>• Older Adults are supported to live well and independently | • The best possible start in life<br>• Lifelong well-being<br>• Thriving and well-connected county<br>• Future-focused Council |
| 6. Strengthen the role and impact of ill-health prevention | • Every Child has the best start in life<br>• Getting it right for children and young adult<br>• Adults in Gwent live healthy and age well<br>• Older Adults are supported to live well and independently<br>• Dying well as part of life | • The best possible start in life<br>• Lifelong well-being<br>• Thriving and well-connected county<br>• Maximise the potential of the natural and built environment<br>• Future-focused Council |
| 7. Tackle racism, discrimination and their outcomes | • Every Child has the best start in life<br>• Getting it right for children and young adult<br>• Adults in Gwent live healthy and age well<br>• Older Adults are supported to live well and independently<br>• Dying well as part of life | • The best possible start in life<br>• Thriving and well-connected county<br>• Lifelong well-being<br>• Future-focused Council |
| 8. Pursue environmental sustainability and health equity together | • Getting it right for children and young adult<br>• Adults in Gwent live healthy and age well<br>• Older Adults are supported to live well and independently<br>• Dying well as part of life | • The best possible start in life<br>• Thriving and well-connected county<br>• Maximise the potential of the natural and built environment<br>• Lifelong well-being<br>• Future-focused Council |

## Appendix 3




Please note: North Monmouthshire NCN area is defined by a red outline and the South NCN defined by blue outline. There is a red border-line between the two. The map also details locations of GP practices and Health and Social Care Integrated Wellbeing Hubs.

## Appendix 4

| Strategic Drivers: | |
|---|---|
| **Workforce** | **Summary of Care Quality Commission key concerns (2022):**<br>• In many cases, providers are losing the battle to attract and retain enough staff.<br>• Persistent understaffing across health and social care poses serious risk to the safety and wellbeing of people who use services.<br>• More than 9 in 10 NHS leaders have warned of a social care workforce crisis in their area, which they expect to get worse this winter.<br>• Care homes have found it very difficult to attract and retain registered nurses with nurses moving to jobs with better pay and conditions in the NHS.<br>• Of the providers who reported workforce pressures having a negative impact, 87% of care home providers and 88% of homecare providers told us they were experiencing recruitment challenges. Over a quarter of care homes that reported workforce pressures told us they were actively not admitting any new residents.<br>• Children's Services find it difficult to recruit to key social work posts.<br>• Only 43% of NHS staff said they could meet conflicting demands on their time at work. Ambulance staff report high levels of stress.<br>• The workstreams below will ensure we have a sustainable and appropriate workforce for the future. |
| **Early Intervention & Prevention** | **The Social Care Institute for Excellence stated:**<br>• Prevention, as defined in the Care Act Statutory Guidance (2016), is about the care and support system actively promoting independence and wellbeing. This means intervening early to support individuals, helping people retain their skills and confidence, and preventing need or delaying deterioration wherever possible.<br>• The workstreams below will enhance early intervention to prevent people hitting crisis. |
| **Hospital Admission & Discharge planning** | **The Local Government Association…**<br>• describes a preventable admission, as 'one where there was scope for earlier, or different, action to prevent an individual's health or social circumstances deteriorating to the extent where hospital or long-term bed-based residential or nursing care is required. The shorthand collective term 'avoidable admissions' is also often used to refer to admissions which could be considered preventable.' |

| | |
|---|---|
| | • The workstreams below will avoid unnecessary hospital admission and where people have to be admitted ensure they are discharged as quickly as possible. |
| **Children's Services** | **Regional Partnership Board** (Children and Young People - Gwentrpb) **priority outcomes:**<br>• In December 2021, Gwent Public Services Board agreed that the 'Marmot Principles' will provide the framework for reducing health inequalities across Gwent.<br>• The workstreams below were identified through engagement with citizens, partners and use of the prioritisation matrix; and subsequently confirmed through consultation.<br>• The numbers of children looked after has increased over the last 5 years<br>• Children's Services are working to develop increased placements for children who are looked after so that can remain closer to their homes and communities |
| **Information & Communication** | **The Welsh Government in 2018 stated the importance of…**<br>• Empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care; simple clear timely communication and co-ordinated engagement appropriate to age and level of understanding.<br>• The workstreams below will ensure people have the right information at the right time. |
| **Social Care & Health Estate** | **The Welsh Government's 'A Healthier Wales' stated…**<br>• An ambition to deliver modern and fit for purpose facilities to support new models of care, but also having to balance this against maintaining existing infrastructure when prioritising the application of capital funding. This inevitably means continuing to invest in hospital estate alongside improving primary, community and social care facilities. To do this we (WG) will undertake a review of investment in capital and estates programmes to determine a broader understanding of current investment and future need.<br>• The workstreams below will ensure we maintain a sustainable and appropriate estate for the provision of health and social care. |
| **Finance** | **The Welsh Government's 'A Healthier Wales' stated…**<br>• 'To meet the vision of a whole system approach to health and social care, we will need to improve our understanding of how demographic change and other factors impact on future costs for social care, of the interaction between social care and health spending over the long term'.<br>• The workstreams below will ensure we maintain scrutiny of the Section 33 Agreement, all associated finance, and consider an option to expand as a whole borough agreement |